

APPENDIX 2

NARRATIVE

2. Project Description

Navigator Homes of Martha's Vineyard, Inc. (the "Applicant"), a Massachusetts not for profit corporation with Section 501(c)(3) federal tax-exemption, and with a principal place of business at 257 Main Street, P.O. Box 1356, Vineyard Haven, MA 02568, is filing a Notice of Determination of Need ("DoN") with the Massachusetts Department of Public Health for a transfer of site and substantial capital expenditure relating to Windemere Nursing & Rehabilitation Center ("Windemere"), a 61-bed skilled nursing facility located at One Hospital Road, Oak Bluffs, MA. The proposed project includes the relocation of Windemere and new construction for a 70-bed facility at 490 Vineyard Haven Road, Edgartown, MA 02539 ("Proposed Project"). Pursuant to 105 C.M.R. 153.028(B), the Applicant is exercising its right to add 9 licensed beds to the Facility's license.

The Applicant is a newly formed entity that acquired ownership and the right to operate Windemere from Mass General Brigham on October 1, 2022. Through the Proposed Project, the Applicant seeks to relocate Windemere to a newly constructed facility approximately five miles away at Vineyard Haven Road, Edgartown, MA. As an island community with an aging year-round population and a shortage of affordable housing, Martha's Vineyard has unique barriers to long-term care facility access that the Proposed Project is designed to address.

Windemere currently serves as the only long-term care facility ("LTCF") on Martha's Vineyard. The Facility is physically connected to Martha's Vineyard Hospital ("MVH"). Through the Proposed Project, the Windemere beds will be relocated to a freestanding facility while maintaining convenient access for residents and their families. The facility will be designed and implemented pursuant to the Green House Project, a nationally recognized innovative and consumer-driven care model that provides skilled care in a home-like environment.

To that end, the new facility will consist of five 14-bed homes containing a total of 70 licensed Level II beds. Four homes with a total of 56 beds will be dedicated to long-term care residents. The remaining home will consist of 14 beds dedicated to short-term rehabilitation residents. Through the model's focus on resident privacy, dignity, and autonomy, the Proposed Project will contribute to higher resident satisfaction and better health outcomes. While not part of the long-term care facility itself, the Proposed Project also encompasses a commitment by MVH to develop affordable housing on the campus of the Proposed Project, and a portion of this affordable housing will be reserved for employees of the Proposed Project.

Finally, the Proposed Project will meaningfully contribute to Massachusetts' goals for cost containment through prolonged resident independence, improved health outcomes, and enhanced infection prevention and control. Each of these outcomes results in lower rates of costly hospitalization and reduced lengths of stay when residents are admitted to the hospital. Therefore, the Proposed Project will positively impact the cost growth benchmark set for the Commonwealth in furtherance of its goals of containing the rate of growth of total medical expenses ("TME") and total healthcare expenditures ("THCE").

In conclusion, the Proposed Project is necessary to provide the residents of Martha's Vineyard with improved access to high-quality, short-term rehabilitation and long-term skilled nursing in their community. Furthermore, the Proposed Project provides enhanced resident care and experience through a revolutionary patient-centered care model that is not provided in traditional nursing homes. Accordingly, the Proposed Project meets the factors of review for Determination of Need approval.

F1.a.i Patient Panel:

Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant's existing patient panel and payer mix.

As the Proposed Project is intended to replace the existing Windemere facility, the Applicant expects that its patient panel will include the demographics of Windemere's existing patient panel. Accordingly, the Applicant provides below the demographic and historical utilization data of Windemere.

Presently, Windemere is licensed to operate 61 Level II beds. Historically, Windemere had an occupancy rate of over 90% and maintained a waitlist. Starting in 2019, Windemere experienced significant staffing shortages that were intensified with the COVID pandemic. This required Windemere to reduce its census due to inadequate staffing during the course of the pandemic and through present day. As a result, as of October 2022, Windemere had an average daily census (“ADC”) of 30, with 15 individuals on the waitlist. It is unclear how many patients would have preferred to remain on-island but sought care elsewhere due to capacity constraints at Windemere.

Before consciously reducing the census, Windemere provided care to 87 individual patients in Fiscal Year (“FY”) 2017; 75 individual patients in FY18; and 65 individual patients in FY19. Patient days totaled 23,091 in FY17; 21,218 in FY18; and 19,052 in FY19. Table 1 below provides additional information on Windemere’s historical utilization.

Table 1: Historical Utilization

	FY18	FY19	FY20	FY21	FY22
Resident Days	21,218	19,052	16,949	8,232	9,808
Average Daily Census	58	52	46	37	30
Occupancy	97%	85%	75%	61%	49%

The majority of Windemere’s patient panel is female (87% in FY21). With respect to age, a majority of Windemere’s patients are over the age of 65 (98% in FY21). The majority of Windemere’s patient panel originates in Dukes County (89% in FY21). All individuals in Windemere’s patient panel have activities of daily living (“ADL”) needs. Finally, Windemere’s patient panel is predominately White.¹ As of October 2022, 15 of Windemere’s 30 residents have a diagnosis of dementia.

Based on FY21 data, Windemere’s payor mix consists of approximately 89% Medicaid, 1% Medicare, and 10% private pay.

F1.a.ii Need By Patient Panel:

Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.

The Proposed Project is necessary to ensure access to short-term rehabilitation and skilled nursing services on Martha’s Vineyard. As further discussed below, the island is experiencing both a growing population of older adults and a severe housing and workforce shortage. The confluence of these crises is putting increased pressure on the island’s ability provide an adequate supply of skilled nursing services. In addition, the existing facility is limited in what it can offer residents due to its institutional infrastructure and co-location with Martha’s Vineyard Hospital. Therefore, the Proposed Project seeks to address these systemic and physical limitations by constructing a new facility modeled on the Green House Project which will provide residents with high-quality care in a home-like environment.

A. Need for Long-Term Care on Martha’s Vineyard

Located in Duke’s County, Martha’s Vineyard is a small island community located off the coast of Cape Cod, making it more isolated than cities or towns on mainland Massachusetts. Access to the island is limited

¹ Due to HIPAA privacy rules surrounding low counts, the Applicant is unable to provide relevant percentages with respect to the sex, age, and race/ethnicity information for Windemere’s patient panel.

and transportation is only available by boat or airplane. Approximately 17,000 residents live on the island year-round.

Aging Population

It is well-documented that as decades of the Baby Boomer generation begin reaching the age of 65, the U.S. is undergoing a rapid increase in the overall age of its population. By 2034, the 65+ age cohort is expected to reach 77 million and by 2050, this population will reach 83.7 million, accounting for approximately 20% of the U.S. population.² Massachusetts is projected to have an even greater increase in the age of its population. The UMass Donohue Institute projects that by 2035, the 65 and over age cohort will represent 23% of the state's population.³ Accordingly, Massachusetts must ensure sufficient capacity to meet long-term care needs for the rapidly aging population. While Martha's Vineyard is a popular summer vacation destination, the island's year-round resident population has increased in recent years and is currently approximately 17,000 full-time residents. An estimated 25% of Martha's Vineyard's year-round residents are age 65 and older indicative of the need for continued access to long-term care services on the island. Moreover, residents of Martha's Vineyard with elderly family members requiring care at a long-term care facility may seek to bring the relative to Martha's Vineyard in order to be closer in proximity to the relative. Accordingly, the demand for a long-term care facility on Martha's Vineyard is projected to increase with the aging population. The Proposed Project will meet the demand for existing and future residents of Martha's Vineyard.

Cost of Living and Work Force Housing

The cost of living on the island is higher (12%) than Boston's cost of living and significantly higher (59%) than urban areas nationally. In 2015, the Economic Policy Institute ("EPI") identified Dukes County as one of the most expensive metropolitan areas in the nation for annual expenditures needed for necessities.⁴ The EPI looked at total costs such as housing, food, childcare, health care, transportation and taxes for more than 600 US metropolitan areas, excluding savings or discretionary spending. Based on their findings, the annual amount needed to "attain a secure yet modest living standard" in Duke's Counties was \$85,163.⁵

Similarly, the cost of housing on the island is significantly higher than on the mainland driven in large part by affluent summer homeowners and more year-round residents resulting from increased remote work options. The median home sales price in April 2022 was \$1.325 million, a 33% increase from the previous year. As a result, businesses struggle to find seasonal and year-round employees, including Windemere.⁶ Beginning in 2019, the census was continually reduced at Windemere because it could not retain sufficient staff to maintain operations, despite offering subsidized housing for approximately two dozen employees. To address the need for affordable housing to support the Proposed Project and its staff, MVH acquired land adjacent to the Proposed Project to build dedicated workforce housing. The employee housing will be located within the same development as the Proposed Project, creating a sustainable source of housing for both MVH and the proposed facility's staff. The proposed housing will include 48 units for a total of 76 bedrooms, of which 30 one-bedroom units will be available to the staff of the new facility. The Applicant anticipates this will alleviate capacity constraints caused by lack of sufficient staff to operate the proposed facility.

The Existing Facility

Located inside of Martha's Vineyard Hospital, Windemere was built in 1994 and consists of a traditional, institutional nursing home design, with mostly semi-private rooms that have half baths. Visitors must navigate the hospital's campus and compete for parking with the hospital's patients and visitors. As any

² *Older People Projected to Outnumber Children for First Time in U.S. History*, U.S. CENSUS BUREAU (Mar. 13, 2018), <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>; *Fueled by Aging Baby Boomers, Nation's Older Population to Nearly Double in the Next 20 Years*, *Census Bureau Reports*, U.S. CENSUS BUREAU (May 6, 2014), <https://www.census.gov/newsroom/press-releases/2014/cb14-84.html>.

³ *Long-Term Population Projections for Massachusetts Regions and Municipalities*, UMASS DONAHUE INST. 14 (Mar. 2015), http://www.pep.donahue-institute.org/downloads/2015/new/UMDI_LongTermPopulationProjectionsReport_SECTION_2.pdf.

⁴ Economic Policy Institute. Nantucket County was identified as the other most expensive metropolitan area.

⁵ Economic Policy Institute

⁶ <https://www.washingtonpost.com/dc-md-va/2022/09/16/marthas-vineyard-housing-rentals-crisis/>

potential renovations would be limited to the facility's existing footprint, the Applicant would not be able to develop a Green House model facility, nor would it be able to add 9 beds to meet projected demand.

As the only SNF on Martha's Vineyard, residents in need of skilled nursing services have two options: receive care through Windemere or go off the island. A survey conducted by Healthy Aging Martha's Vineyard determined that many Martha's Vineyard residents are in fact leaving the island for SNF services elsewhere, many of whom are private paying residents with the resources to seek a facility that meets their needs.⁷ One significant factor influencing people's decision to leave the island for care is the institutionalized setting of Windemere. Focus groups and interviews conducted on the availability of SNF services on Martha's Vineyard found that if other options were available, Windemere would not be considered a desired living environment.⁸ As a result, the existing model of care delivery for skilled nursing services is not optimal for the residents of Martha's Vineyard.

B. The Green House Project

For the reasons discussed above, the Applicant seeks to construct, license, and operate a replacement facility to more fully meet the skilled nursing care needs of Martha's Vineyard residents who require long-term care or short-term rehabilitation services. The Proposed Project will offer an innovative, consumer-driven care model to Martha's Vineyard's residents and their families, allowing residents to remain close to their community, family and support systems on Martha's Vineyard for SNF services.

The Green House Model

Following extensive research, the Applicant decided to pursue a model of care delivery developed by Dr. Bill Thomas in 2001. The Green House Project, as explained more fully in Section F1.b.1 below, provides an alternative to the institutional quality of long-term care. In 2005, the Robert Wood Johnson Foundation (RWJF) underwrote a five-year, \$10 million grant to subsidize the development of 50 Green House projects across the United States.⁹ Additional funding was later provided to further the development and sustainability of Green House homes through 2018. Currently, there are more than 300 Green Homes in 32 states.¹⁰ Importantly, studies have shown that Green House facilities across the United States have had dramatically reduced prevalence of COVID than traditional long-term care facilities, as discussed in Section F1.b.i (C) below.

The Green House Project reimagines the traditional nursing home model through facility size, interior design, organizational structure, and care delivery. Central to the Green House model are its core values:

1. Meaningful Life: Homes that are centered on elders, where deep knowing, autonomy and control, and purposeful, meaningful engagement are key;
2. Empowered Staff: As part of an organizational redesign, empowered teams thrive on a collaborative coaching culture and shared decision making; and
3. Real Home: Intentional communities of belonging that leverage the power of normal, deinstitutionalized living, and convivium (the sharing of good food in good company).¹¹

One of the main components of the Green House Project are the physical homes. Called "Green Homes", the structures must be self-contained, and self-sufficient, inclusive of no more than 14 private rooms and bathrooms for each resident, a living room with home-like amenities, a kitchen where meals are prepared, a communal dining area, and outdoor spaces that are easy to access and navigate. The result is a home-like environment that provides high-quality care and a greater sense of well-being, while also meeting all pertinent licensure and certification requirements. By bringing the Green House model to Martha's Vineyard, the Applicant will transform how skilled nursing care is provided on the island.

⁷ HEALTHY AGING MARTHA'S VINEYARD, EXECUTIVE SUMMARY: FEASIBILITY ANALYSIS FOR GREEN HOUSE HOMES, *available at* https://528f089c-7142-4ab5-bda8-77b11ee6385f.filesusr.com/ugd/c951bb_baaab436c32d4c64a789f41972298e6e.pdf.

⁸ *Id.*

⁹ <https://thegreenhouseproject.org/our-story/history/>

¹⁰ *Id.*

¹¹ *Id.*

Resident Privacy, Dignity, and Autonomy

Another contributing factor to the need for a new facility is the resident's living environment. The existing Windemere facility has shared bedrooms, bathrooms, and a communal shower on each hall, none of which are conducive to resident privacy. The Applicant's new facility will prioritize resident privacy, dignity, and autonomy through its design, including single bedrooms with a private bathroom and shower. First, private rooms will contribute to resident autonomy and choice, giving greater opportunities to set their own schedules, including when they wake up and go to bed. Further, private rooms provide a contained environment where the resident is in complete control of the noise level. Private rooms also ensure a quiet, intimate space to visit with family and friends if a communal space is not desired. When visitors are comfortable, they are more likely to visit more often, contributing to the resident's overall psychosocial wellbeing. In addition, unlike the existing facility which has audible bells heard throughout the facility, the new call system will use silent alarms that do not disrupt the entire unit when one resident needs assistance. Residents will also enjoy broadband cable and increased internet access, improving privacy for computer use, phone calls, video calls, and other methods of communication. Finally, the Proposed Project will include plentiful personal storage space in each bedroom, an element that is lacking at Windemere.

In addition, each 14-bed home at the new facility will provide a private, safe environment for residents, while also providing meaningful opportunities for social interactions with other residents and staff. Each home will share a kitchen, living space, communal dining space, outdoor space and other resident spaces not found in a traditional nursing home. This is in contrast to the existing Windemere facility's layout. Windemere's beds are located on the second floor and have limited outdoor recreational space. Residents who wish to go outside must receive assistance from staff to use the elevator and then must be supervised by a staff member outside. The new facility will have dedicated indoor and outdoor recreational space, providing an inviting environment inside and out for residents to enjoy at their leisure. Moreover, Windemere currently shares dining services with MVH, placing limitations on resident meal choices and mealtimes. Each home will have its own kitchen, which residents and family members will have access to, and a home-like communal dining room. This format will provide greater flexibility in resident mealtime, as well as provide enhanced resident choice with respect to what they eat. Accordingly, the Proposed Project will address many of the limitations of the existing facility that will have a positive effect on resident privacy, dignity, and autonomy.

Infection Prevention and Control

The Proposed Project will provide high-quality and dignified care for residents through the physical environment. Currently, many existing long-term care facilities, including Windemere, consist of outdated buildings with two or more resident beds per room, as well as shared bathrooms. As a direct result of the COVID-19 pandemic and its rapid spread in traditional nursing homes, the Massachusetts Department of Public Health and the MassHealth program have taken steps to limit the number of residents per room both in the short term and as a long-term solution to some of the limitations of existing facilities highlighted by the pandemic.¹² As the Green House model provides all single-bed rooms for residents, the physical plant environment will exceed standards for long-term care facilities in Massachusetts, thereby contributing to a safe environment for the facility's residents and supporting effective and appropriate infection prevention and control. As noted previously, each resident will have a private room and an *en suite* bathroom with shower, providing a home-like feel and ensuring heightened privacy not found in a traditional nursing home.

Staffing

Lastly, the Green House model empowers staff and seeks to provide a positive working and living environment. As described in section A, above, staff retention at the current facility is difficult due to the facility's location on Martha's Vineyard and lack of affordable housing. As a result, approximately 70% of the Windemere's staff travel from the mainland each workday. To address the existing need to retain a adequate staffing to meet the needs of the residents, and in furtherance of its commitment to its staff and staff satisfaction, the Applicant will provide staff housing through 30 one-bedroom affordable units in partnership with MVH. This employee housing will aid in staff recruitment efforts and will contribute to staff satisfaction, creating opportunities for individuals seeking work who may not reside on the island. Further,

¹² See, e.g., Massachusetts Department of Public Health, Proposed Amendments to Standards for Long-Term Care Facilities (Oct. 14, 2020); MassHealth Nursing Facility Bulletin 154 (Oct. 2020).

the facility's staffing model, which seeks to empower staff and provide enhanced engagement with residents, will positively affect staff satisfaction and improve staff retention rates.

C. Projected Demand for Level II SNF Services

As described above, current occupancy at Windemere is driven largely by staffing constraints and not the community's need for skilled nursing care on the island. Windemere currently has a waitlist of 15 individuals waiting for an opening at the facility. However, this number does not capture the true number of Martha's Vineyard residents who would remain on the island if capacity were available as many cannot wait for a bed and must relocate off-island. The new facility, together with affordable staff housing, will provide increased capacity for residents seeking care closer to home.

According to the 2015 Nursing Home Data Compendium³⁰, approximately 3.7% of adults over the age of 65 in Massachusetts were residents of nursing facilities, down from prior years.¹³ The Applicant used a conservative estimate of 2.3% to calculate the number of long-term care beds needed on Martha's Vineyard in 2025 based on UMDI population projections.¹⁴ The Applicant determined that 125 beds would be needed in 2025 with at least 108 beds needed in 2030, accounting both for a larger over 65 population and the continued decreased demand for conventional institutional nursing facility care within that population.

To that end, the Applicant proposes to increase capacity by 9 beds through the construction of a 70-bed facility. All current residents of the existing facility will have the option to move to the new facility. Following the initial ramp up in Year 1 of operation, the Applicant anticipates it will operate at full capacity for both long-term and short-term care at the new facility.

Tables 2 and 3 below outline the Applicant's 5-year projected demand for its Level II long-term care and short-term rehab services based on current utilization at Windemere. As Windemere does not currently offer short-term rehab services, no historical demand is provided.

Table 2: Long Term Care Projections

	Year 1	Year 2	Year 3	Year 4	Year 5
Resident Days	22,181	22,904	22,904	22,904	22,904
Average Length of Stay (years)	3	3	3	3	3
Average Daily Census	48.4	49.4	49.4	49.4	49.4

Table 3: Short-Term Rehabilitation Projections

	Year 1	Year 2	Year 3	Year 4	Year 5
Resident Days	4,521	4,873	4,873	4,873	4,873
Average Length of Stay (days)	18	17	17	17	17
Average Daily Census	12.4	13.4	13.4	13.4	13.4

D. Conclusion

Driven by the need for additional capacity and improved care delivery, the Proposed Project involves the relocation and construction of a replacement facility for Windemere. The new facility will implement the Green House model of care, which promotes enhanced patient privacy and autonomy. To that end, the Proposed Project will improve the nursing home experience for residents, family members, and staff, and will contribute to improved health outcomes for residents. Moreover, the Applicant recognizes the need for a highly qualified senior care organization to operate the facility and is currently in active discussions with Hebrew SeniorLife regarding a management agreement for the future facility. Furthermore, historical demand and the island's aging population demonstrates a need for the Proposed Project. Accordingly, the

¹³ Nursing Home Data Compendium, 2015 Edition, published by CMS (the 2015 Edition is the most current version of this annually produced document)

¹⁴ UMDI projects the 65+ population on Martha's Vineyard will be 5,402.

Proposed Project has been thoughtfully designed to provide patient-centered short-term rehabilitation and long-term care services for residents of Martha's Vineyard.

F1.a.iii Competition:

Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.

The Proposed Project will compete on the basis of price, total medical expenses ("TME"), provider costs, and other recognized measures of health care spending by providing the Applicant's Patient Panel and residents of the Island with high-quality, patient-centered skilled nursing services in a home-like environment. While reimbursement rates are not expected to decrease as a result of the Proposed Project, the Applicants anticipates overall health care costs will decrease through improved quality of life and health outcomes. As further discussed in the following section, studies have shown that residents of Green Homes experience fewer hospitalizations, including 30-day readmissions and avoidable hospitalizations, as well as statistically significant fewer bedfast residents, catheterized residents, and pressure ulcers. These studies further suggest that the Green House Model's patient-centered care and staffing model deliver improved health outcomes, thereby directly reducing TME and health care spending.

F1.b.i Public Health Value/Evidence-Based:

Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

Approximately 70% of individuals over the age of 65 will require long term support and services during their lifetime.¹⁵ The Proposed Project will involve the construction of a new facility to replace the existing Windemere Nursing & Rehabilitation Center on Martha's Vineyard. The new facility will be developed in accordance with The Green House Project, which consists of three core values: A Meaningful Life, Empowered Staff, and A Real Home. These values are represented in the physical plans and operation of the facility, which result in improved resident health outcomes, and enhanced resident and family satisfaction. Since The Green House Project's inception in 2003, it has facilitated the development of nearly 300 homes in 32 states. Accordingly, several research studies have been conducted to measure the efficacy of the model.

A. The Green House Model Improves Resident Outcomes

Activities of Daily Living

As noted above, the Green House Model is based on three core values which emphasizes quality of care and quality of life for each resident. Residents of Green House facilities often experience improved outcomes as compared to residents of traditional nursing homes, specifically with respect to continued independence and ADLs. ADL function status is a common measure to assess the overall effects of care that nursing home residents receive and is a significant factor for an individual's quality of life.¹⁶ Residents of Green House facilities maintain self-care abilities longer than in traditional nursing home settings and experience lower rates of decline of ADLs.¹⁷ This can be attributed to several aspects of the Green House

¹⁵ Richard W. Johnson, U.S DEP'T OF HEALTH AND HUMAN SERVICES, *Research Brief: What is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports* (April 2019), available at <https://aspe.hhs.gov/system/files/pdf/261036/LifetimeRisk.pdf>.

¹⁶ Yoon et al., *Effects of Green House Nursing Home Model on ADL Function Trajectory: A Retrospective Study*, 53 INT'L J. NURSING STUDIES 238 (2016), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679482/>.

¹⁷ Lauren W. Cohen et al., *The Green House Model of Nursing Home Care in Design and Implementation*, 51 HEALTH SERVICES RESEARCH: SPECIAL ISSUE – GREEN HOUSE MODEL OF NURSING HOME CARE 352, 354 (2016), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5338211/>. DOI: 10.1111/1475-6773.12418; Kane R, Cutler L., et al. *Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program*, 55(6) J. AMERICAN GERIATRIC SOC'Y 832 (2007).

model, including the use of highly trained and empowered nursing staff to provide individualized care, respecting each resident's choices and encouraging resident independence.¹⁸ Moreover, dedicated staff assigned to residents provides better continuity of care and allows staff to identify changes in the residents' health, allowing for earlier intervention and resulting in better health outcomes.¹⁹ In addition, the physical environment contributes to resident independence through single rooms and private bathrooms, encouraging self-care and physical functioning.²⁰ The small-house environment encourages residents to independently interact with other residents and be involved in social activities, which is positively associated with longer survival.²¹ Moreover, communal meals and resident involvement in small unit activities such as laundry, table set up and supervised cooking, may stimulate residents' physical functioning and mobility within the small house unit.²² Accordingly, many aspects of the Green House model contribute to sustained independence through longer maintenance of ADLs, resulting in improved quality of life.

Overall Health Outcomes and Hospital Readmissions

Residents of Green House facilities tend to experience better health outcomes. A study of Green House facilities that transitioned from traditional nursing homes found that overall hospitalizations declined by 1.3%.²³ The study further found outcome improvements across all Minimum Data Set ("MDS") Quality Metrics in Green House organizations relative to comparable traditional nursing home organizations.²⁴ The MDS is part of the mandated clinical assessment of residents in Medicare and Medicaid certified nursing homes. Specifically, the study found statistically significant declines in bedfast residents, catheterized residents, and pressure ulcers in Green House residents as compared to residents of traditional nursing homes.²⁵ Studies have also found the Green House model reduces 30-day readmissions and avoidable hospitalizations by approximately 30%.²⁶ These findings are consistent with evidence from other studies suggesting better quality of care is a direct result of the Green House model's consistent assignment of direct care staff as well as the built environment, consisting of a central living area that results in familiarity among the residents and staff. Through universal assignments, staff observe and interact with the same residents throughout the day and across activities, such as meals, social activities, and clinical care, providing more opportunities for staff to recognize changes in residents and communicate the need for the clinical team to evaluate and address changes in condition.²⁷ The Green House model increases communication among the care staff, which may allow for early identification of changes in resident condition and early interventions, resulting in greater overall health outcomes.²⁸ Some examples of ways Green House homes can maximize these interactions and improve resident outcomes include: aligning provider (e.g., Primary Care Physician ("PCP") and Physical Therapist) schedules for enhanced face-to-face communication; increasing PCP availability when at the home, including sitting in a central location to review notes and engaging in conversations with staff and families; and minimizing the number of providers (e.g., PCPs) assigned to a resident, which in turn maximizes the familiarity among staff and physicians.²⁹

¹⁸ Yoon et al., *supra* note 16.

¹⁹ Cohen et al., *supra* note 17.

²⁰ Cohen et al., *supra* note 17; Cutler, *supra* note 17.

²¹ Cohen et al., *supra* note 17; Cutler, *supra* note 17; See also D. K. Kiely et al., *The Protective Effect of Social Engagement on Mortality in Long-Term Care*, 48(11) J. AMERICAN GERIATRIC SOC'Y 1367 (2000), <https://doi.org/10.1111/j.1532-5415.2000.tb02624.x>

²² Cohen et al., *supra* note 16; Cutler, *supra* note 17; D. K. Kiely et al., *supra* note 21.

²³ Christopher C. Afendulis et al., *Green House Adoption and Nursing Home Quality*, 51 HEALTH SERVICES RESEARCH: SPECIAL ISSUE – GREEN HOUSE MODEL OF NURSING HOME CARE 455, 467 (Feb. 2016), *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5338208/pdf/HESR-51-454.pdf>. DOI: 10.1111/1475-6773.12436

²⁴ *Id.*

²⁵ *Id.* at 468.

²⁶ *Id.* at 469; Barbara Bowers et al., *Inside the Green House "Black Box": Opportunities for High-Quality Clinical Decision Making*, 51 HEALTH SERVICES RESEARCH: SPECIAL ISSUE – GREEN HOUSE MODEL OF NURSING HOME CARE 378 (Feb. 2016), *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939731/pdf/HESR-51-378.pdf>. DOI: 10.1111/1475-6773.12427; Sheryl Zimmerman et al., *New Evidence on the Green House Model of Nursing Home Care: Synthesis of Findings and Implications for Policy, Practice, and Research*, 51 HEALTH SERVICES RESEARCH: SPECIAL ISSUE – GREEN HOUSE MODEL OF NURSING HOME CARE 475, 483 (Feb. 2016), *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5338207/pdf/HESR-51-475.pdf>. DOI: 10.1111/1475-6773.12430.

²⁷ Bowers et al., *supra* note 26, at 385.

²⁸ Afendulis et al., *supra* note 23, at 469-70.

²⁹ Bowers et al., *supra* note 26, at 388-89.

Accordingly, there is evidence to suggest Green House homes facilitate better overall quality of care for residents as compared to traditional nursing homes.

B. The Green House Model Improves Quality of Life and Resident, Family, and Staff Satisfaction

Residents

In a Green House facility, residents live in a home-like environment with a private room and a private en suite bathroom with shower. This increased privacy results in greater resident satisfaction. In addition to privacy, Green House homes recognize resident autonomy, allowing residents to set their own schedule with respect to awake times, bedtimes, mealtimes, and bath times.³⁰ Residents have the choice to bring some of their own furniture and may rearrange the furniture in their bedroom, providing a sense of comfort.³¹ A two-year study comparing residents of Green House homes with those of traditional nursing homes found a statistically significant improvement in Green House residents' perception of their quality of life, compared with the control groups.³²

Moreover, the Green House care model is based on a collaborative care system that aims to empower staff and residents so that they retain as much decision-making authority as is feasible.³³ This approach leads to greater satisfaction among residents, as well as staff members, as residents' desires are respected and valued. Additionally, the small-scale of the homes and the dedicated staff fosters relationships among the residents themselves, as well as among residents and staff.³⁴ These important social relationships improve satisfaction within Green House homes. Nearly all Green House homes have standing resident council meetings, improving communication among residents and staff and encouraging resident input in decisions affecting the home.³⁵ Accordingly, the Green House model enhances resident satisfaction through greater resident empowerment and autonomy.

Family

Family support is instrumental in all elements of long-term care, including the initial decision of which facility to choose, and throughout the resident's stay as a connection to the resident's social life and relationships outside of the facility.³⁶ Family members also often provide physical care and are sources of emotional support for the residents. Accordingly, family satisfaction is an important factor to consider for long-term care facilities. Family members of residents at Green House homes are more likely to report higher satisfaction than family members of residents at traditional nursing homes with respect to certain categories such as general amenities, meals, housekeeping, physical environment, privacy, autonomy, and health care.³⁷ The home-like environment of Green House homes as compared to the institutional-like feel of traditional nursing homes was an often-cited contribution to high satisfaction among family members.³⁸ For example, family members felt more comfortable visiting their relative in a Green House setting, could join in meals, and were able to get to know the resident's care team more intimately.³⁹ The physical environment of Green House homes additionally provides greater opportunity for mingling with residents, families, and staff, contributing to a home-like feel and increased familiarity and communication between family and staff, increasing satisfaction but also contributing to greater health outcomes of the resident.⁴⁰ Overall, family members of residents at Green House homes are more engaged in the residents' care than families of

³⁰ Cohen et al., *supra* note 17, at 366-67.

³¹ Cohen et al., *supra* note 17, at 367.

³² Sonya Brownie & Susan Nancarrow, *Effects of Person-Centered Care on Residents and Staff in Aged-Care Facilities: A Systematic Review*, 8 CLIN. INTERVENTIONS IN AGING 1, 7 (2013), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3540911/pdf/cia-8-001.pdf>.

³³ *Id.* at 8.

³⁴ Cohen et al., *supra* note 17, at 364.

³⁵ Cohen et al. *supra* note 17, at 367-68.

³⁶ Terry Y. Lum et al., *Effects of Green House Nursing Homes on Residents' Families*, 30 HEALTH CARE FINANCING REVIEW 35, 35 (Winter 2008-09), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4195056/pdf/hcfr-30-02-035.pdf>.

³⁷ *Id.* at 46.

³⁸ *Id.*

³⁹ *Id.* at 46-47.

⁴⁰ Bowers et al., *supra* note 26, at 386.

residents at traditional nursing homes.⁴¹ Accordingly, the Green House model is a contributing factor to increased family satisfaction and participation as compared to traditional nursing homes.

Staff

The Green House model utilizes dedicated staff in an expanded role for each small-scale home. Direct care staff provide personal care and implement care plans for the residents, as well as perform cooking, housekeeping, laundry tasks, and planning resident activities.⁴² Caregivers operate within a non-hierarchical staffing structure, rotating responsibilities for duties such as creating schedules, ordering supplies, and cooking meals.⁴³ The Green House model empowers staff by encouraging self-management and providing more consistent assignments.⁴⁴ Caregivers note the consistent assignments and small teams contribute to the home-like environment for residents as well as staff, increasing satisfaction among staff.⁴⁵ The model avoids medical-like elements such as nurses' stations, medication carts, and public address systems, giving the residents and staff a more natural, home-like environment.⁴⁶ Moreover, the small-scale environment allows for more rapid staff response time when needed by a resident, and increases staff awareness of the residents and the home.⁴⁷ Accordingly, the Green House model's focus on a home-like environment enhances familiarity and comfort among residents and staff, resulting in higher staff satisfaction as compared to traditional nursing homes.

C. COVID-19 Response and Infection Control

Importantly, the novel design and implementation of the Green House Project has proven instrumental in the wake of the COVID-19 pandemic. Nursing homes residents are especially vulnerable to the virus due to their age and presence of chronic co-morbidities, and unfortunately long-term care facilities were some of the locations hardest hit by the pandemic. Specifically, in Massachusetts, as of October 8, 2020, there were approximately 25,155 probable or confirmed COVID-19 cases among long-term care facility residents and health care workers.⁴⁸ Of the 9,350 total deaths from confirmed COVID-19 cases, 6,168 (66.0%) of those were reported among LTCFs. The actual number of COVID-19-positive cases and related deaths are believed to be underestimated.⁴⁹ Infection control is more important now than ever and must be a focal point of future planning in LTCFs. The Green House Project is designed to address infection control and will enhance the safety of residents, especially in the wake of a future pandemic.

As further discussed below, the "small house" design of Green Home facilities are better equipped to withstand a pandemic such as COVID-19. Preliminary data reported as of June 3, 2020, found that only 9 of 245 active Green House Project homes in the United States reported at least one positive case of COVID-19, with six deaths overall.⁵⁰ This data provides a stark contrast to overall reported cases in long term care facilities. For example, on June 3, 2020, Massachusetts had already noted approximately 21,785 probable or confirmed COVID-19 cases and 4,447 deaths in LTCFs.⁵¹ In the United States as of July 26, 2020, there were 146 cases of COVID-19 per thousand residents in all certified skilled nursing homes, as compared to 32.5 confirmed COVID-19 cases per thousand residents in Green House homes.⁵² In fact, 95% of Green

⁴¹ Lum et al., *supra* note 36, at 48.

⁴² Cohen et al., *supra* note 17, at 369-70; Lum et al., *supra* note 36, at 36.

⁴³ Cohen et al., *supra* note 17, at 354.

⁴⁴ Cohen et al., *supra* note 17, at 369.

⁴⁵ Cohen et al., *supra* note 17, at 370.

⁴⁶ Lum et al., *supra* note 36, at 36.

⁴⁷ Cohen et al., *supra* note 17, at 362.

⁴⁸ Massachusetts Department of Public Health COVID-19 Dashboard (October 8, 2020), *available at* <https://www.mass.gov/doc/covid-19-dashboard-october-8-2020/download>.

⁴⁹ Joseph G. Ouslander, MD & David C. Grabowski, PhD, *COVID-19 in Nursing Homes: Calming the Perfect Storm*, J. AM. GERIATRICS SOC'Y 2 (July 31, 2020), <https://doi.org/10.1111/jgs.16784>.

⁵⁰ Tim Regan, 'Smaller is Better': Covid-19 Primes Senior Living for Rise of Small-House Models, SENIOR HOUSING NEWS (June 3, 2020), <https://seniorhousingnews.com/2020/06/03/smaller-is-better-covid-19-primes-senior-living-for-rise-small-house-models/>.

⁵¹ Massachusetts Department of Public Health COVID-19 Dashboard (June 3, 2020), *available at* <https://www.mass.gov/doc/covid-19-dashboard-june-3-2020/download>.

⁵² Deborah Schoch, *How Family-Style Nursing Homes are Better Weathering the Pandemic*, AARP (Sept. 18, 2020), <https://www.aarp.org/caregiving/basics/info-2020/household-model-nursing-homes-coronavirus.html>.

House homes were COVID-19-free.⁵³ The lower rates of reported COVID-19 infections and subsequent deaths in Green House homes demonstrates that specific elements of the model may contribute to more effective control the spread of COVID-19 and other similarly infectious diseases.

Size of the Homes

One major difference between traditional skilled nursing facilities and Green House facilities is the size of the facility and the presence of individual rooms for each resident. Each Green House facility is made up of multiple smaller homes, which then house individual residents. The number of residents per home is significantly smaller than what is typical of a traditional nursing home. Each resident has their own private room and a private *en suite* bathroom, with a limited number of residents per home. Traditional nursing homes often include semi-private bedrooms and shared bathrooms. The traditional nursing facility design requires residents to breathe in the same air, touch the same objects such as door handles and other items in a shared room or bathroom, thus making residents more susceptible to transmitting diseases such as COVID-19.⁵⁴ The novel architectural design of Green House homes provides the ability to maintain social distancing more easily and effectively. Moreover, the small scale homes and limitation on number of residents in each home provides a more effective model for containing the virus if there were to be a positive case and allows for easier quarantine of residents when necessary.⁵⁵ Accordingly, the architectural design and privacy afforded by Green House homes allows for enhanced infection control as evidenced by the lower rates of infection and deaths associated with COVID-19 at Green House Project facilities.

Care Model and Staffing

Another difference between traditional skilled nursing facilities and those associated with the Green House Project that may contribute to lower rates of COVID-19 infection spread is the care model. While each facility's care model and implementation strategies vary, all Green House homes uses a universal worker concept so that each home has dedicated staff.⁵⁶ In terms of infection control, this results in fewer individuals coming and going to the home, limiting the chances of an outbreak. Further, consistency among caregiving staff enhances relationships among staff and residents, and may allow for more rapid detection of symptoms or unusual or different behavior that otherwise may be difficult to recognize.⁵⁷ Finally, the home-like environment and resident-centric care model means that residents of Green House homes experience less disruption when facilities implement infection control measures, including those implemented in the wake of COVID-19.⁵⁸ Accordingly, evidence suggests the Green House model may contribute to reduced incidents of outbreaks through its physical plant environment and staffing model.

F1.b.ii Public Health Value /Outcome-Oriented:

Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

The Applicant anticipates that a replacement facility operated under the Green House model will result in improved health outcomes, quality of life, and satisfaction among residents, family, and staff.

A. Green House Model to Improve Patient Experience and Health Outcomes

As more fully described in Factor F.1.b.i, the Green House model's core values seek to create a home-like environment for residents that ultimately results in higher satisfaction and better overall health outcomes. As the current Windemere facility cannot be renovated to fit the physical plant specifications of a Green House facility, the Applicant will build a replacement facility at a new location that will house five 14-bed

⁵³ *Id.*

⁵⁴ *Id.*; Regan, *supra* note 50.

⁵⁵ Paula Span, *How to Improve and Protect Nursing Homes from Outbreaks*, N.Y. TIMES (updated Sept. 10, 2020), <https://www.nytimes.com/2020/05/22/health/coronavirus-nursing-homes.html>; Ouslander and Grabowski, *supra* note 48.

⁵⁶ Regan, *supra* note 50; Schoch, *supra* note 5252.

⁵⁷ Ouslander and Grabowski, *supra* note 49; Regan, *supra* note 50; Schoch, *supra* note 55; Span, *supra* note 55.

⁵⁸ Regan, *supra* note 50.

homes, resulting in a total of 70 Level II long-term care beds. The Green House facility will provide all private resident rooms, each with an *en suite* bathroom, facilitating privacy. Each home includes a living and dining room, and generally provide kitchen access to residents and families. These elements of the physical plant environment encourage self-care and physical functioning, resulting in reduced decline of activities of daily living. Resident autonomy is encouraged through flexibility in mealtimes, bath times, and awake and bedtimes. Moreover, resident participation in facility meetings and decision-making forums improve resident perceptions of the facility and provide a more home-like environment, further contributing to enhanced resident satisfaction.

The Green House model also stresses the importance of staff and resident empowerment. Staff assignments are universal and are more consistent than traditional nursing homes. This results in the building of relationships among staff and residents, and further enhances communication. As a result of this staffing model, staff are more likely to notice changes in resident condition, resulting in earlier interventions and better outcomes. These early interventions reduce avoidable hospitalizations and readmissions as compared to traditional nursing homes. Accordingly, many elements of the Green House model contribute to higher resident, family and staff satisfaction and better overall health outcomes.

B. Assessing the Impact of the Proposed Project

To assess the impact of the Proposed Project, the Applicant developed the following quality metrics to measure overall satisfaction and quality of care at the new facility:

1. **Quality of Care – Person-Centered Care Goals:** Patient-centered care intends to empower individuals and encourage them to communicate personal preferences. Residents who receive patient-centered care will have better overall health outcomes.

Measure: The Applicant will measure the extent to which the facility meets the state and federal standards with respect to Person-Centered Care Goals as outlined by CMS via AHRQ CAHPS survey scores.

Projections: As the Proposed Project will result in the development of a new facility, the Applicant will provide baseline measures following one full year of operation.

Monitoring: The Applicant will report this data to DPH on an annual basis.

2. **Quality of Care – Infection Prevention and Control:** Due to risks associated with increased age, residents of long-term care facilities are more susceptible to poor outcomes when faced with infections. In a post-COVID-19 environment, infection control is at the forefront of concerns at long-term care facilities. The Green House model's physical plant environment contributes to the containment of infections.

Measure: The Applicant will measure the incidence rate of new nosocomial infections.

$$\frac{\text{\# of new nosocomial infection occurring in one month}}{\text{number of resident days in the month}} * 1000 = \text{incidence rate}$$

Projections: As the Proposed Project will result in the development of a new facility, the Applicant will provide baseline measures following one full year of operation.

Monitoring: The Applicant will report this data to DPH on an annual basis.

3. **Resident/Family Satisfaction –Cleanliness:** Residents that are satisfied with the cleanliness of a long-term care facility will have an improved quality of life. Due to the Green House model's use of universal and consistent staff with responsibilities ranging from direct resident care to cooking and light cleaning, the Applicant anticipates resident satisfaction will improve.

Measure: The Applicant will measure resident experience and satisfaction specific to staffing and facility cleanliness via the Long-Stay Resident Instrument, the Discharged Resident Instrument, and the CAHPS Family Member Survey.

Projections: As the Proposed Project will result in the development of a new facility, the Applicant will provide baseline measures following one full year of operation.

Monitoring: The Applicant will report this data to DPH on an annual basis.

- 4. Resident/Family Satisfaction – Staffing:** Residents that are satisfied with the staff at a long-term care facility often experience an improved quality of life. Due to the Green House model's use of universal and consistent staff, the Applicant anticipates there will be enhanced communication and comfort among residents and staff. In turn, this will improve resident satisfaction.

Measure: The Applicant will measure resident experience and satisfaction specific to staffing at the facility via the AHRQ CAHPS Resident Member Survey scores.

Projections: As the Proposed Project will result in the development of a new facility, the Applicant will provide baseline measures following one full year of operation.

Monitoring: The Applicant will report this data to DPH on an annual basis.

F1.b.iii Public Health Value /Health Equity-Focused:

For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's need-base, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g. culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.

To ensure health equity to all residents, the Applicant plans to implement multiple programs to promote language access. The Applicant will establish an interpreter services program through a contract with the Massachusetts General Interpreter Services Program, which utilizes nationally trained and certified interpreters. This program will ensure equal access for residents and their families who are Limited English Proficiency or Deaf and Hard of Hearing when a language need is identified upon a resident's admission. The Applicant is also seeking to establish a screening process to determine the need for on-site language assistance technology and video services for residents who may require such services.

Furthermore, to ensure equal access to the health benefits offered by the Proposed Project, and in accordance with Medicare and Medicaid conditions of participation, the Applicant does not discriminate on the basis of race, sex, gender, national origin, age, disability, or payor source. All current Windermere residents will be offered a bed in the new facility, regardless of payer source. In planning the Proposed Project, the Applicant has engaged, and will continue to engage, the Martha's Vineyard community regarding the benefits offered by the new facility and the Green House model.

F1.b.iv Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

The Proposed Project seeks to provide access to a long-term care model that is proven to result in high resident and family satisfaction, as well as improved health outcomes. The Proposed Project will offer high-quality long-term care services to the residents of Martha's Vineyard and the mainland to allow facility residents to remain in their community or to be closer to family. The Green House model of care provides for improved health outcomes, including reduced readmissions and reduced preventable hospitalizations. The Applicant will continue to monitor resident and family surveys concerning quality and satisfaction measures to ensure that resident needs are met.

F1.c Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.

The Applicant is committed to ensuring effective care coordination and integration with other care providers for its residents. This coordinated effort will emphasize the importance of team-based care, making resident care more efficient and effective. The new facility will have effective and continued communication between the facility's Medical Director, nurse practitioners, and staff. Medical and home staff will review each resident every 60 days or more frequently as needed if change of condition or concern arises. Additionally, the resident's care team, including the Medical Director will participate in transitions of care meetings and Quality and Process Improvement meetings. External care team members will be contacted by phone or secure messages for continuous communication. Changes in the care plan will be communicated to team members using multiple methodologies. First, the care plan is updated in the resident's electronic medical record ("EMR") which will generate a message to users to provide an update. Additionally, the team verbally communicates care plan changes in the shift-to-shift report, team meetings/communications, and a written communication book. These procedures result in efficient and effective communication of care plans for each resident and foster a team-based approach to resident care.

When residents require medical care off-site, the Applicant will provide a paper copy of the resident's medical file to accompany the resident to their appointment. This will allow the outside providers to have access to all pertinent information contained within the resident's records, contributing to the coordination of care. The availability of electronic medical records also will provide an effective mechanism for transmitting medical records among the resident's care team, including physician visit notes, lab and imaging results, and medication orders and adjustments. Accordingly, the facility will be able to address any necessary changes the resident's care plan as a result of consultation and treatment by an off-site specialist. Additionally, the facility will have a telemedicine program in place, increasing access for its residents to specialists both on and off the island. The telemedicine capabilities at the facility will enhance communication among the resident's care team and foster involvement in the resident's care plan.

The facility also will have policies and procedures to address and plan for a resident's discharge from the facility. The facility's social worker is responsible for leading all discharge planning efforts. For short-term rehab patients who have short lengths of stay of approximately two weeks, the discharge planning process begins shortly after the patient is admitted to the facility. The social worker meets with the entirety of the patient's clinical team including nursing, rehab, dietary, pharmacy. The patient and/or family members are also in attendance to ensure contribution from all interested parties. Upon consultation with the patient's care team, a discharge care plan will be provided in written form to the patient and reviewed with the patient and their family, as appropriate. If the patient is being discharged to home, the discharge planning process will include the coordination of any wrap-around services such as medical equipment, specialist follow-up, and other aspects of the resident's continued need for services in the community. All information will be communicated verbally and in writing to the patient and the individual responsible for the patient's care post-discharge. The social worker will follow up as necessary with the patient and/or family as appropriate to ensure continuity of care subsequent to the patient's discharge from the facility. The Applicant recognizes the importance of care coordination among and between the resident and his/her entire care team both within and outside of the facility. Accordingly, the Applicant will ensure that the facility's policies and procedures will facilitate quality coordination of care for its residents.

F1.d Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project.

The Applicant consulted with individuals at various regulatory agencies regarding the Proposed Project to obtain a broad range of input. The following individuals are some of those consulted regarding this Project:

- Rebecca Rodman, Esq., General Counsel, Department of Public Health
- Dennis Renaud, Director, Determination of Need Program, Department of Public Health
- Massachusetts Executive Office of Health and Human Services
- Health Policy Commission
- Center for Health Information and Analysis
- The Centers for Medicare & Medicaid Services

F1.e.i Process for Determining Need/Evidence of Community Engagement:

For assistance in responding to this portion of the Application, Applicant is encouraged to review *Community Engagement Standards for Community Health Planning Guideline*. With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.

In an effort to ensure appropriate community engagement, the Applicant held numerous open dialogue meetings regarding the Proposed Project with current residents, family members, and the broader island community. In addition to providing the community with information about the Proposed Project and its ongoing developments, these engagements also provided an opportunity for the Applicant to obtain feedback and answer questions.

To that end, the Applicant took the following actions:

- TV interview on MVTv with Bob Tankard on April 16, 2020
- Radio interview on MV Radio on May 7, 2020
- Public meeting at the Edgartown Public Library on May 12, 2020
- Public meeting at the West Tisbury Library on May 14, 2020
- Presented at the West Tisbury Town Meeting on May 14, 2020
- Public meeting at the Vineyard Haven Public Library on July 15, 2020
- Presented at the Edgartown Town Meeting on July 22, 2020
- Presented at the Oak Bluffs Town Meeting on July 29, 2020
- Public meeting at the Oak Bluffs Public Library on July 30, 2020
- Public meeting at the Chilmark Free Public Library on August 20, 2020
- Presented to Town of Chilmark Board of Selectmen on September 24, 2020
- Presented to Town of Aquinnah Select Board on September 30, 2020
- Presented to the Town of Edgartown Planning Board on January 12, October 14, November 9, and December 14, 2021
- Presented to the Unitarian Universalist Society of Martha's Vineyard on February 21, 2021
- Radio interview on WCAI Radio Station "The Point" on October 7, 2021
- Presented to the Town of Edgartown Planning Board on January 18, February 15, March 1, 2022
- Presented to the Martha's Vineyard Neighborhood Convention on May 3, 2022
- Presented to St. Andrew's Church on July 24 and August 28, 2022
- Presented to Grace Church on September 11, 2022
- Radio interview on MVY Radio on September 25, 2022

Feedback at each of these meetings was overwhelmingly supportive of the Proposed Project.

F1.e.ii Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".

Copies of the following community presentations are included as Appendix 3.

- Healthy Aging Martha's Vineyard, May 21, 2020
- Unitarian Universalist Society of Martha's Vineyard, February 21, 2021

Factor 2: Health Priorities

Addresses the impact of the Proposed Project on health more broadly (that is, beyond the Patient Panel) requiring that the Applicant demonstrate that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.

F2.a. Cost Containment:

Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

The Commonwealth's goals for cost containment focus on providing low-cost care without sacrificing high quality. The Proposed Project will meaningfully contribute to Massachusetts' goals for cost containment as a direct result of the Green House model of care which provides enhanced quality of care for the facility's residents. The Green House model emphasizes resident choice and staff autonomy, provides consistent staffing and encourages increased communication among and between staff and residents. As a result, residents maintain independence with ADLs longer than residents of traditional nursing homes. However, when changes in a resident's condition do occur, staff are better equipped to recognize those changes sooner. The ability to react quicker leads to lower rates of costly hospitalization and reduced lengths of stay when residents are admitted to the hospital. Moreover, the physical plant environment provides private bedroom and bathroom space for residents, contributing to enhanced infection prevention and control, which additionally reduces costly hospitalization or other treatment costs. Accordingly, the Proposed Project's positive effect on quality of care and health outcomes has the effect of reduced overall health care spending, positively contributing to the Commonwealth's cost containment goals.

F2.b Public Health Outcomes:

Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

The Proposed Project will improve public health outcomes through improved access to short-term rehabilitation and long-term care as well as through better health outcomes. Better health outcomes will be achieved through lower rates of infection and hospitalization and prolonged independence, resulting in improved resident satisfaction, quality of life, and slower rate of health decline. Residents and the overall health care market will benefit from the new facility.

F2.c Delivery System Transformation:

Because the integration of social services and community-based expertise is central to the goal of delivery system transformation, discuss how the needs of their patient panel have been assessed and linkages to social services organization have been created and how the social determinants of health have been incorporated into care planning.

As outlined in Section F.1.c, the Applicant will ensure residents have access to receive care from an provider outside of the facility. Furthermore, the Applicant will ensure appropriate care linkages to Martha's Vineyard community organizations ranging from social, behavioral health, housing, and medical organizations through regular and continued communication with these organizations. These relationships and linkages will be especially effective for short-term rehab patients upon discharge from the facility. Moreover, to address the linguistic needs of Deaf and Hard of Hearing or non-English speaking residents, the Applicant will implement an interpreter services program through a contract with Massachusetts General Hospital Medical Interpreter Services. This program will ensure residents have access to culturally and linguistically appropriate care.

F5.a.i Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

The Proposed Project: The Proposed Project will provide improved access to short-term rehabilitation and long-term care services through the establishment of a 70-bed skilled nursing facility, comprised of fourteen 5-bed homes for residents in accordance with the Greenhouse Model. Of the five homes, four (56 beds) will be dedicated to long-term care, while one home (14 beds) will be dedicated to short-term rehabilitation care.

Quality: The Proposed Project will allow the Applicant to build a new replacement facility for Windemere in accordance with the Green House model, which will result in high-quality care for residents of the facility. The facility's physical environment, staffing pattern, and model of care contribute to better health outcomes for residents, especially with respect to infection control, an element of utmost importance following the COVID-19 outbreak and the high volume of at-risk individuals at the facility.

Efficiency: The Proposed Project will enhance operational and care efficiencies through construction of an appropriately sized facility to meet current demand for skilled nursing care. The facility's staffing pattern, physical plant environment, and overall care model will enhance communication among residents and staff, creating care efficiencies.

Capital Expense: The Applicant will expend \$53,530,459 to implement the Proposed Project.

Operating Costs: First year incremental operating costs resulting from the Proposed Project are estimated to be approximately \$9,307,000.

Option 1

Alternative Proposal: One alternative for the Proposed Project would be to forego the Proposed Project and continue operation of Windemere in its current state.

Alternative Quality: The existing facility is aging and needs extensive renovations. Furthermore, it cannot accommodate the physical requirements needed to implement the Green House model and therefore would not result in the quality improvements realized through the model.

Alternative Efficiency: No operating efficiencies would be created through continued operation of the existing facility in its current state, as no space, staffing, or care efficiencies could be achieved.

Alternative Capital Expenses: There would be no capital expense associated with this alternative, as there would be no renovation or construction involved.

Alternative Operating Costs: There would be no change to the current operating costs as Windemere would continue to be operated in its existing state.

Option 2

Alternative Proposal: The second alternative would replace Windemere with a traditional Skilled Nursing Facility.

Alternative Quality: The Green House model would not be implemented in this alternative. Accordingly, this alternative would not have the lower hospitalization rates and lower rates of infection found in Green House homes.

Alternative Efficiency: While this alternative may result in some operational efficiencies, it would not reach the full extent of operational efficiencies realized through the Green House model, such as the universal staffing mode.

Alternative Capital Expenses: This alternative would have a capital expense similar to that of the Proposed Project as it would involve the construction of a new facility.

Alternative Operating Costs: Operating costs associated with this alternative would likely be lower than those of the Proposed Project but would not achieve the quality and efficiencies associated with the Proposed Project, which contribute to lower operating costs.