STAFF REPORT TO THE PUBLIC HEALTH COUNCIL FOR A DETERMINATION OF NEED	
Applicant Name	Navigator Homes of Martha's Vineyard, Inc.
Applicant Address	257 Main Street P.O. Box 1356 Vineyard Haven, MA 02568
Filing Date	November 30, 2022
Type of DoN Application	Long Term Care Substantial Capital Expenditure (including Transfer of Site)
Total Value	$53,530,459
Project Number	# NHMV-22090717-LE
Ten Taxpayer Group (TTG)	One
Community Health Initiative (CHI)	$1,605,913.77
Staff Recommendation	Approval
Public Health Council	March 8, 2023

Project Summary and Regulatory Review

The Applicant, Navigator Homes of Martha's Vineyard, Inc. d/b/a Windemere Nursing & Rehabilitation Center seeks to relocate and construct a replacement facility comprising 70 licensed beds at 490 Vineyard Haven Road, Edgartown, MA 02539 (Proposed Project). This total includes adding 9 beds to the facility's license pursuant to G.L. c. 111, § 25B and 105 C.M.R. 153.028(B). The Applicant's new facility will use the Green House Model for long term care. The capital expenditure for the Proposed Project is $53,530,459; and the Community Health Initiatives (CHI) commitment is $1,605,913.77.

This Application for Determination of Need (DoN) falls within the definition of Substantial Capital Expenditure, which is reviewed under the DoN regulation 105 CMR 100.000. The Department must determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each Determination of Need Factor set forth within 105 CMR 100.210. This staff report addresses each of the six factors set forth in the regulation.

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Background and Project Summary

The Applicant

Navigator Homes of Martha's Vineyard, Inc. (Applicant, Navigator, d/b/a Windemere) is a Massachusetts not for profit corporation[1] with a principal place of business at 257 Main Street, P.O. Box 1356, Vineyard Haven, MA 02568. The Applicant is a newly formed entity that acquired ownership and the right to operate Windemere, a 61-bed skilled nursing facility located at One Hospital Road, Oak Bluffs, MA, from Mass General Brigham, Inc. on October 1, 2022.

Currently Windemere is the only long-term care facility (LTCF) on Martha's Vineyard and is physically connected to Martha's Vineyard Hospital (MVH), which is part of Mass General Brigham, Inc. Following staff inquiry about the agreements with MVH and the current structural configuration, the Applicant explained that it currently owns the license and operates the facility within the leased space at MVH.

The proposed project includes new construction of a 70-bed facility at 490 Vineyard Haven Road, Edgartown, MA 02539, and the relocation of Windemere to that location, which is approximately five miles from its current site. Upon relocation of the facility, it will be known as Navigator Homes of Martha's Vineyard. Pursuant to 105 C.M.R. 153.028(B), the Applicant is exercising its right to add 9 licensed beds to the facility's current 61-bed license. The facility will be designed and implemented pursuant to the Green House Model that provides skilled care in a home-like environment which the Applicant asserts offers benefits that will be further discussed in this Staff Report.

The Green House Model

In order to provide an alternative to the institutional nature of traditional long-term care facilities, the Applicant conducted what it describes as "extensive research" before electing to develop a Green House project,[2] (the Model) of care delivery. The Model has been under development nationally and received funding from prominent national organizations for many years. 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,[i] with additional funding through 2018. Currently, there are more than 300 Green Homes in 32 states.[ii] Recent studies have shown that Green House facilities across the United States have had a lower prevalence of COVID-19 than traditional long-term care facilities, as discussed along with other Model attributes of the model in Section F1(b) below.

The Applicant stresses throughout that the Model reimagines the traditional nursing home. One of the main components of the Green House Project is the physical homes. "Green Homes," are self-contained, inclusive of no more than 14 private rooms, have private bathrooms, a living room with home-like amenities, a kitchen where meals are prepared, a

[1] with Section 501(c)(3) federal tax-exemption.
[2] developed by Dr. Bill Thomas in 2001.

communal dining area, and outdoor spaces that are easy to access and navigate. Central to the 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).[iii]

The Proposed Project

The new facility will consist of five 14 Level II-bed homes[3]. Four homes (totaling 56 beds) will be dedicated to long-term care residents; and one home (14 beds), will be dedicated to short-term rehabilitation residents. The Applicant asserts that the Proposed Project will contribute to higher resident satisfaction and better health outcomes, through the Model's focus on resident privacy, dignity, and autonomy.

While not part of this Application,[4] in an effort to ensure adequate staffing, MVH has committed to develop affordable housing on the campus of the Proposed Project, and a portion of this affordable housing, will be reserved for employees of Navigator. (This is discussed further under Factors 1(a) 4, and Factor 6.)

As discussed throughout this Application, the Applicant asserts the Proposed Project will improve public health value and health outcomes while meaningfully contributing to Massachusetts' goals for cost containment.

In summary, the Applicant states that as an island community with growing and aging year-round population, and with a shortage of affordable housing, Martha's Vineyard (the Island) has unique barriers to access to long-term care that the Proposed Project intends to address. As such, the Applicant states, the Proposed Project is necessary to provide Island residents with improved access to high-quality, short-term rehabilitation and long-term skilled nursing in their community while enhancing the residents' care and experience through a Model that is patient centered.

Factor 1 Patient Panel[5]

The Patient Panel information shows that the current facility, operating under the ownership of MVH until October 2022, provided care to 60 individual patients over the most recent 36-

[3] Level II beds
[4] Staff housing does not fall under DoN regulatory purview.
[5] As defined in 105 CMR 100.100, Patient Panel is the total of the individual patients regardless of payer, including those patients seen within an emergency department(s) if applicable, seen over the course of the most recent complete 36-month period by the Applicant or Holder.

month period. As discussed further in this report, the number of patients treated has declined from previous years.

Table 1: Overview of Patients Served- FY17-FY19

	2017	2018	2019
Unique Patients Served	87	75	65

As of October 2022, the census consisted of 30 residents. Patient Panel historical demographic information is presented below.[6]

Gender: The majority of the Patient Panel is female (87% in FY21).

Age: The majority is over the age of 65 (98% in FY21).

Patient Origin: The majority originates in Dukes County (89% in FY21).

Race: The Patient Panel is predominately White (~90%).[7]

Diagnosis/ Activity Levels: All individuals in the Patient Panel have activities of daily living (ADL) needs. As of October 2022, half of the 30 residents have a diagnosis of dementia.

Payer Mix: The last four years shows fluctuation among the various payers. Table 2 shows that while Medicaid fee for service (FFS) has ranged from 81-89% and private pay from 10-18%, Medicare has shifted from 1-3% over the reporting period.

Table 2: Payer Mix FY 2019-2022

Payer	FY19	FY20	FY21	FY22
Medicare FFS	3%	1%	1%	2%
Medicaid FFS	83%	81%	89%	85%
Private Pay	14%	18%	10%	13%
TOTAL	100%	100%	100%	100%

The Applicant explains while historically the facility had high occupancy rates and maintained a waiting list, beginning in 2019, staffing shortages that were worsened by the COVID-19 pandemic required it to reduce the census. As discussed further herein this issue which continues to present. As of October 2022, the facility had an average daily census (ADC) of 30, less than half of that of FY18, and an occupancy rate of 49%.

Table 3: 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

[6] Due to HIPAA privacy rules surrounding low counts, the Applicant is unable to provide race/ethnicity information for Windemere's patient panel.

[7] Varies by the year.

Occupancy	97%	85%	75%	61%	49%
Individual Patients	75	65	49	45	30
ALOS	2.2 yrs.	3.7 yrs.	4.0 yrs.	3.8 yrs.	5.5 yrs.

Factor 1a) Need

In this section, staff assesses if the Applicant has sufficiently demonstrated need for the Proposed Project components by the Applicant's Patient Panel. The Applicant attributes the need for the Proposed Project to the following:

1. The Need for Continued Access to Long-Term Care on Martha's Vineyard
2. The Growth in the Aging Population
3. The Need to Replace the Existing Facility
4. Need to address Lack of Workforce Due to the High Cost of Housing on the Island

1. Need for Continued Access to Long-Term Care on Martha's Vineyard

Martha's Vineyard (the Island) is a small island community located off the coast of Cape Cod with a growing year-round resident population that has increased to ~17,000 full-time residents.[8] The Applicant asserts the Proposed Project is necessary to ensure the residents of the Island have continued access to skilled nursing services there, including access to short-term rehabilitation, which is currently unavailable. Windemere is the only SNF on the Island, therefore residents in need of skilled nursing services have two options: receive care at Windemere or leave the island. Since travel on and off the island is limited to boat or airplane, it is more isolated than cities or towns on the Massachusetts mainland.

Staff asked the Applicant for additional information regarding the number of patients who leave the Island due to capacity constraints at Windemere but would have preferred to remain on-island. The Applicant reported that number is not tracked but noted that through community engagement, the Applicant has "repeatedly heard of residents going off-island for care because services were not available on the island. While Navigator was able to confirm a minimum of 13 residents who have gone off-island for care through informal survey, this number does not accurately reflect the true number of residents who are receiving long-term care off-island. This number is in addition to Windemere's existing 15-person waitlist of Island residents who are not interested in seeking care off-island" additionally, the Applicant noted that some residents forgo care so as to remain on the island.

2. The Growth in the Aging Population

Approximately 70% of individuals over the age of 65 will require long term support and services during their lifetime.[iv] An estimated 25% (~4,250 residents) of Martha's Vineyard's year-round

[8] It is best known as a summer vacation destination.

residents are age 65 and older which, the Applicant states, affirms the continued need for long-term care services on the Island, and it projects the demand for a long-term care facility on Martha's Vineyard is projected to increase with the aging population.

The proportion of the 65 and over age cohort is slightly higher than the projections for the aging population in the Commonwealth. The UMass Donohue Institute projects that by 2035, the 65 and over age cohort will represent 23% of the state's population.[9] 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.[10]

The Applicant also suggests that in addition to the number of year-round 65+ residents of the Island, other residents may wish to bring their relatives who reside elsewhere, to the new facility, Navigator Homes of Martha's Vineyard, in order to be in closer proximity to their family.

3. The Need to Replace the Existing Facility

Windemere was built in 1994 and consists of a traditional, institutional nursing home design, with mostly semi-private rooms and shared bath among four residents. Because of the co-location within MVH, the current facility is limited in design that it can offer residents and renovations would be limited to the facility's existing footprint. Consequently, the Applicant would not be able to develop this care Model or add 9 beds to meet projected demand.

Following staff inquiry, the licensed bed and bath configuration of the existing facility was provided in Table 4. Only 39 beds are in operation currently. While the Proposed Project is not related to the Department's requirements for de-densification, the details highlight some shortcomings of the existing leased space that the Proposed Project will address with private resident rooms and private baths, easy parking and access to the individual houses.

Table 4: Current Licensed Room and Bath Configurations at Windemere

• 24 double rooms (48 beds total) share a bathroom with a second 2-bed room. This means that when operating at capacity, 48 residents are sharing just 12 bathrooms.
• 5 double rooms (10 beds total) do not share a bathroom with a 2nd room.
• 3 single rooms (3 beds) each have a private bathroom.
• 32 rooms (61 beds) Total
• Visitors must navigate the MVH parking and facility to see their family members.

[9] *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.

[10] *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.

Through focus groups and interviews highlighted in Healthy Aging Martha's Vineyard, the Applicant determined that Island residents are leaving the Island for skilled nursing facility (SNF) services.[v] Windemere's institutionalized setting influenced people's decision to leave, however, the focus groups found that if more desirable options were available, many would remain on the Island.[vi] These findings suggest that the existing model of care delivery for SNF services is not optimal at Windemere, and some residents of the Island, including private paying residents seek alternate facilities. The Applicant asserts the Proposed Project will meet the demand for existing and future residents of the Island through the Model, the benefits of which will be discussed further under Public Health Value.

4. Need to address Lack of Workforce Due to the High Cost of Housing on the Island

The cost of living on the Island is 12% higher than Boston's and 59% higher than urban areas nationally. As a result, approximately 70% of the Windemere's staff travel from the mainland each workday. In 2015, the Economic Policy Institute (EPI) identified Dukes County as one of the most expensive areas in the nation for annual expenditures needed for necessities,[11, vii] and based on their findings, the annual amount needed to "attain a secure yet modest living standard" in Duke's County was $85,163.[viii] The median home sales price in April 2022 was $1.325 million, a 33% increase from the previous year.[12]

Because the Windemere has had low Average Daily Census and occupancy rates, ~49%, Staff asked the Applicant to explain further the extent this is due to constraints related to 1) staffing, 2) the issues of infection control and 3) the multi-bedded room blocks, other than infection control. The Applicant replied that currently "*The decrease is entirely due to staffing...In FY21, travel staff were difficult to find. In FY22, travel staff are more available but there is no workforce housing available on the island."* During the 2020 COVID-19 surge, Windemere limited the number of residents, decreasing the number of available beds from 61 to 39 but prior to COVID-19 Windemere average annual occupancy was 96.7%, (i.e., 59 occupied beds of the licensed 61 available beds.)

To address the need for affordable housing to support the Proposed Project and its own staff, MVH acquired land adjacent to the Proposed Project to build dedicated workforce housing for both facilities' employees. A total of 76 beds will be developed within which 30 units will be available to the staff of the new facility.

The Applicant anticipates the availability of employee housing will facilitate staff recruitment efforts and also contribute to staff satisfaction. Further, the Model, which seeks to empower staff and provide enhanced engagement with residents, will positively improve staff retention rates.

Projected Demand for Level II SNF Services

[11] 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.

[12] According to the report, these high costs are driven in large part by affluent summer homeowners and more year-round residents resulting from increased remote work options.

The Applicant states that Windemere currently has a list of 15 individuals waiting for an opening at the facility and believes this number does not capture the true number of Island residents who would remain if capacity were available, stating that many cannot wait for a bed and must relocate off-island.

The Applicant states it 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,[13] because according to the 2015 Nursing Home Data Compendium, approximately 3.7% of adults over the age of 65 in Massachusetts were residents of nursing facilities, down from prior years.[ix]

This calculation showed that 125 beds would be needed in 2025 with at least 108 beds needed in 2030, accounting for a larger over 65 population, and what Applicant asserts is a continued decreased demand for conventional institutional nursing facility care.

As such, the Proposed Project will increase capacity by 9 beds[14] 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. The Applicant anticipates it will operate at full capacity for both long-term and short-term care at the new facility after a year 1 ramp-up period. Tables 5 outlines the Applicant's 5-year projected demand for Level II long-term care services based on current utilization at Windemere.

Since Windemere does not currently offer short-term rehab services, no historical utilization data is available as a basis for the projections shown in Table 6. Therefore, Staff asked how the Applicant derived these numbers. It responded that currently, short-term rehabilitation is only available through a limited number of swing beds at Martha's Vineyard Hospital for inpatients of the hospital. As a result, patients who have needed and seek inpatient care off-island, cannot access on-island short-term rehabilitation. The Applicant cited a study by *Massachusetts Health & Hospital Association* showing that in November 2022, 107 inpatients from Southeastern hospitals could not timely access post-acute care due to a lack of available beds.[15] As a result, it concludes that the shortage of post-acute care beds limits access to short-term rehabilitation for residents of Martha's Vineyard, that it asserts will be ameliorated with the Proposed Project's 14 bed short-term stay beds Green House. Upon viewing the report, staff notes that 1) of those 107 patients, 71 were in need of SNF care,[16] 2) there were 284 patients in Boston area hospitals[17] awaiting SNF care, a few of whom may also be from the Island.

Table 5: Long Term Level ll Care Projections - Navigator Homes of Martha's Vineyard

Total Beds: 56	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Available Days-capacity	20,440	20,440	20,440	20,440	20,440
Resident Days	17,374	18,907	18,907	18,907	18,907

[13] UMDI projects the 65+ population on Martha's Vineyard will be 5,402.
[14] Pursuant to 105 C.M.R. 153.028(B).
[15] *Massachusetts Health & Hospital Association, Throughput Survey Report, November 2022*
[16] Others were- 18 were awaiting LTACH care, and 18 were awaiting Home Health care.
[17] that includes AMCs who serve patients needing tertiary and quaternary care

Occupancy	85.0%	92.5%	92.5%	92.5%	92.5%
Average Length of Stay (*years*)	3	3	3	3	3
Average Daily Census	48.4	49.4	49.4	49.4	49.4

Table 6: Short-Term Level ll Rehabilitation Projections - Navigator Homes of Martha's Vineyard

Total Beds: 14	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Available Days-capacity	5,110	5,110	5,110	5,110	5,110
Resident Days	4,599	4,855	4,855	4,855	4,855
Occupancy	90.0%	95.0%	95.0%	95.0%	95.0%
Average Length of Stay (*days*)	18	17	17	17	17
Average Daily Census	12.4	13.4	13.4	13.4	13.4

Analysis

While the State's new de-densification licensure requirements prohibit placing residents in three and four-bedded rooms, the Applicant states the genesis of this project is not related to that requirement since there are no 3 or 4-bed rooms in the facility, as shown in Table 4. Staff notes that the Applicant highlights elements of the current 29-year-old facility that do not promote privacy and quality of life and quality of care, such as shared bathrooms among four residents, an institutional setting within an existing acute care hospital, limited access to outdoor space and challenges for visitors since it is located on the second floor of an acute care hospital.

The Proposed Project would remedy these elements through the construction of a replacement LTCF facility consisting of five homes. Driven by the need for continued long term care services and improved care delivery on the Island, the Applicant has made a case for building a replacement facility due to the age and constraints of the existing co-located facility, the rising aging population, the lack of short-term rehabilitation, and the effects of the high cost of living on workforce availability. The Proposed Project is designed to include patient-centered short-term rehabilitation, which is currently unavailable on the Island, and improved long-term care services for residents of Martha's Vineyard, while also improving staff satisfaction that it anticipates will improve retention as well.

The Applicant additionally states it recognizes the need for an experienced, qualified senior care organization to operate the facility and that it is currently in discussions with Hebrew SeniorLife regarding a management agreement for the future facility.

Staff finds that the Applicant has shown sufficient need for the replacement Proposed Project that will follow an innovative Model of long-term living and care delivery. As a result of information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project has met Factor 1(a).

Factor 1b) Public Health Value: Improved Health Outcomes and Quality of Life; Assurances of Health Equity

In this section the Applicant must demonstrate that the proposed project adds measurable public health value in terms of improved health outcomes and quality of life for the Applicant's patient panel, while providing reasonable assurances of health equity.

Improved Health Outcomes and Quality of Life

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.

Overall Better Health Outcomes and Reduced Hospital Readmissions

The Applicant cites studies noting that residents of Green House facilities tend to experience better health outcomes. One study of a facility that transitioned from traditional nursing homes to the Model found that overall hospitalizations declined by 1.3%.[x] Outcomes improved across all Minimum Data Set (MDS) Quality Metrics[18] in Green House facilities relative to comparable traditional nursing homes[xi] in a study that found statistically significant declines in 1) bedfast residents, 2) catheterized residents, and 3) pressure ulcers.[xii] Studies have also found the Green House model reduces 30-day readmissions and avoidable hospitalizations by approximately 30%.[xiii]

Evidence from other studies suggests better quality of care is a result of the Model's consistent assignment of dedicated direct care staff as well as the built environment, consisting of a central living area that results in familiarity among the residents and staff. As a result, staff observe and interact with the same residents throughout the day and across activities, such as meals, social activities, and clinical care, which affords staff more opportunities to recognize changes in residents and communicate with the clinical team the need address changes in condition.[xiv] This may facilitate early identification of changes in resident condition and early interventions, and lead to better overall health outcomes.[xv]

Improved Infection Prevention and Control

The novel design and implementation of the Green House Model has proven instrumental in during the COVID-19 pandemic, where nursing home residents have been more vulnerable to the virus due to their age and presence of chronic co-morbidities. 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.[19, xvi] Of the 9,350 total deaths from confirmed COVID-19 cases, 6,168 (66.0%) of those were reported among LTCFs.[xvii]

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[18] The MDS is part of the mandated clinical assessment of residents in Medicare and Medicaid certified nursing homes.

[19] The actual number of COVID-19-positive cases and related deaths are believed to be underestimated.

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,[xviii] and 95% of Green House homes were COVID-19-free.[xix] As of June 3, 2020, preliminary data 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 [xx]

The "small house" design of the Proposed Project with all single-bed rooms and private baths for residents of Green Home facilities makes them better equipped to withstand a pandemic such as COVID-19, thereby contributing to a safe environment for the facility's residents and supporting effective and appropriate infection prevention and control.

Improved Activities of Daily Living (ADL) Due to Consistent Dedicated Staffing

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.[xxi] Residents of Green House facilities maintain self-care abilities longer than in traditional nursing home settings and experience lower rates of decline of ADLs.[xxii] This can be attributed to several aspects of the Green House model, including the use of highly trained and empowered nursing staff to provide individualized care, respecting each resident's choices and encouraging resident independence.[xxiii]

In addition, the physical environment contributes to resident independence through single rooms and private bathrooms, encouraging self-care and physical functioning.[xxiv] 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.[xxv] 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.[xxvi]

Improved Quality of Life and Resident, Family, and Staff Satisfaction

The Applicant asserts that many aspects of the Green House model contribute to sustained independence through longer maintenance of ADLs, resulting in improved quality of life and cites studies in support of this.

In a Green House facility, residents experience increased satisfaction and comfort as a result of living in a home-like environment with a private room and a private *en suite* bathroom having the choice to bring and arrange some of their own furniture in their bedroom.[xxvii] The Homes also recognize resident autonomy, allowing residents to set their own schedule with respect to awake times, bedtimes, mealtimes, and bath times.[xxviii] 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 traditional facilities.[xxix]

Maintaining family satisfaction is a consideration as family involvement throughout the resident's stay as a connection to the resident's external relationships is important.[xxx] 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 such areas as general amenities, meals, housekeeping, physical environment, privacy, autonomy, and health care.[xxxi] Family members reported feeling more comfortable visiting their relative in a Green House setting where they could join in meals and were able to get to know and communicate with the resident's care team, and other residents more intimately.[xxxii] This familiarity fosters important relationships that increases family and resident satisfaction thereby contributing to better health outcomes of the resident.[xxxiii, xxxiv]

In summary, 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[xxxv] Which leads to greater satisfaction among residents, as well as staff members, as residents' desires are respected and valued. 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.[xxxvi]

Analysis

Staff researched the existing publicly available nursing home quality metrics to determine where the current facility ranks.

As of November 15, 2022, the facility is rated five out of five stars on the CMS Star rating and scores 121 on the Massachusetts Nursing Home Scorecard, an assessment based on three major factors: 1) health inspections, 2) staffing, and 3) quality of resident care measures.[20] This is above the statewide average of 116 but falls short of the 75th percentile of 123. However, as the Applicant asserts, the replacement facility is designed to remedy such issues.

The Applicant stresses that the current Windemere facility cannot be renovated to improve due to the constraints of being co-located within MVH, and its shared rooms and baths make monitoring infection control and outcomes measures a challenge. The Applicant stress that it will continue to monitor resident and family surveys concerning quality and satisfaction measures to ensure that resident needs are met. To assess the impact of the Proposed Project, the Applicant proposed quality metrics to measure overall satisfaction and quality of care at the new facility that will be reported annually and that can be found in Appendix 1.

The Proposed Project seeks to provide Island residents access to a long-term care model, The Green House Model, that some studies show result in higher resident and family satisfaction, as well as improved quality and health outcomes compared to traditional LTCFs. This replacement facility will enable residents to remain on the Island, in their community.

Additionally, the Applicant seeks to extend services beyond the current patient panel by enabling Island residents to bring family members who reside off the Island and are in need of LTCF services, to the facility. Staff is concerned that off Island private pay residents could be

[20] Data Source: Centers for Medicare and Medicaid Minimum Dataset and The Massachusetts Nursing Home Score Card is a state-based scoring system for licensed skilled nursing facilities in the Commonwealth of Massachusetts. Scores are based CMS certification and complaint facility surveys from the previous three years. Deficiencies are of any scope and severity.

prioritized over Island residents. As a result, Staff recommends as a condition of approval that the Applicant prioritize the approved beds for Island Residents. To monitor this Staff requests that the Applicant track and report on the percentage of residents by payer whose home prior to admission originated on the Island and those who were brought to the Island whose home prior to admission was off the Island.

Health Equity

The Applicant affirms that 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 and states all current Windermere residents will be offered a bed in the new Navigator facility, regardless of payer source. Consequently, the Applicant maintains the Proposed Project will increase the availability of affordable, senior housing on the Island for long-term LTCF residents as a result of the new bed capacity. However, the Applicant intends to extend services beyond the current patient panel by enabling Island residents to bring family members who reside off the Island and are in need of LTCF services, to the facility.[21]

To ensure health equity to all residents, the Applicant plans to implement 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. When a language need is identified upon a resident's admission, this program will ensure equal access for residents and their families who are Limited English Proficiency or Deaf and Hard of Hearing. 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.

Analysis

As a standard condition of approval of the Proposed Project, as set out in DoN regulation 105 CMR 100.310, all Determination of Need Holders must provide a plan for approval by the Office of Health Equity for the development and improvement of language access and assistive services provided to individuals with disabilities, non-English speaking, Limited English Proficiency (LEP), and American Sign Language (ASL) patients.

Staff finds that with the additional condition and standard conditions, and reporting measures in Appendix 1, the Applicant has sufficiently outlined a case for improved quality of life, health outcomes and health equity and as a result has met Factor 1(b).

Factor 1c) Continuity and Coordination of Care

The Applicant affirms its commitment to ensuring continuity and coordination of care through the Model's emphasis on the importance of team-based care, which it states lead to more efficient and effective patient care. The care team, including the Medical Director will

[21] Navigator DoN Narrative p. 3

participate in transitions of care meetings and Quality and Process Improvement meetings and those care team members located externally will be contacted by phone or secure messages for continuous communication.

Clinical staff will evaluate each resident every 60 days or more frequently if a concern or change in condition arises, as discussed in Factor 1(b). Changes in the care plan will be entered in the resident's electronic medical record (EMR) which will generate a message to users. Additionally, care plan changes are communicated in the change in shift report, team meetings, and a written communication book. As a result, these procedures ensure efficient and effective communication of individual care plans and foster a team-based approach to resident care.

When residents have offsite appointments, a paper copy of the resident's medical file will accompany the resident ensuring outside providers have access to all pertinent information within the resident's records and contributing to coordination of care. Additionally, the facility will have a telemedicine program in place, increasing access to specialists both on and off the Island which 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. The facility's social worker will be responsible for leading all discharge planning efforts. For short-term rehab patients whose length of stay is approximately two weeks, the discharge planning process begins shortly after admission. The social worker meets with the patient's clinical team (including nursing, rehab, dietary, pharmacy) and family to develop a written discharge care plan for the patient. If the patient is being discharged to home, the discharge planning will coordinate with any wrap-around services such as medical equipment, specialist follow-up, and other ongoing needs of the resident. 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 with the patient and/or family as appropriate and to ensure continuity of care subsequent to the patient's discharge.

The Applicant states that in recognition of the importance of care coordination among and between the resident and his/her entire care team within and outside of the facility, it will ensure that the facility's policies and procedures facilitate quality coordination of care for its residents.

Analysis

Staff finds that the Applicant has sufficiently described meaningful programs to demonstrate it has met Factor 1(c).

Factor 1d) Consultation

The Applicant has provided evidence of consultation, both prior to and after the Filing Date, with all government agencies that have licensure, certification or other regulatory oversight, which has been done and will not be addressed further in this report.

Factor 1e) Community Engagement

The Department's Guideline for community engagement defines "community" as the Patient Panel and requires that, at minimum, the Applicant must "consult" with groups representative of the Applicant's Patient Panel. Regulations state that efforts in such consultation should consist of "engaging community coalitions statistically representative of the Patient Panel."

To ensure appropriate community engagement, the Applicant attended over 20 meetings regarding the Proposed Project with Windemere's current residents, family members, and Island community members at churches, Town Meetings, libraries, Planning Boards and radio interviews. These provided an opportunity for the Applicant to present information about the Proposed Project also and obtain feedback and answer questions.[22] Feedback at each of these meetings was supportive of the Proposed Project.[23]

Analysis

Staff finds that the Applicant engaged a broad array of community coalitions and attended and held multiple meetings and has therefore addressed the community engagement standard for Consult in the planning phase of the Proposed Project. As a result of the above analysis, Staff finds that the Applicant has met the provisions of Factor 1(e).

Factor 1f) Competition

The Applicant asserts the Proposed Project will compete on the basis of price, total medical expenses (TME), provider costs, and other recognized measures of health care spending. While

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

[23] Copies of two community presentations are included as Appendix 3.

reimbursement rates are not expected to decrease as a result of the Proposed Project, the Applicants anticipates overall health care costs will decrease through improvements in quality of life and health outcomes leading to savings due to fewer hospitalizations, catheterizations, pressure ulcers, as discussed under Public Health Value. The studies also suggest that the Model's patient-centered care and staffing model deliver improved health outcomes, thereby directly reducing TME and health care spending.

The Applicant asserts that operating the replacement facility will be more cost effective as the current building is old and requires costly emergency repairs. New technology advancements for all appliances and infrastructure, will positively impact utility costs, and better air quality will improve infection control. The layout of the replacement facility will allow direct care staff to function more efficiently.

Analysis

As a result of information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project meet Factor 1(a-f).

Factor 2 - Health Priorities

Cost Containment

The Applicant asserts the Proposed Project will meaningfully contribute to Massachusetts' goals for cost containment in several ways: the new physical plant, the layout, and the Green House model of care. First the new physical plant will be more cost-effective to operate, while the current facility is aging and requires emergency repairs. The proposed project will be a modern, state-of-the-art facility that will result in additional clinical staffing costs due to the added beds. However, the Applicant states these costs will be offset by the operational and energy efficiencies gained. Second, as discussed herein, 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.

Third, as discussed under Public Health Value (Factor 1b), since the Model provides dedicated staffing and encourages increased interaction among and between staff and residents, independence with ADLs is maintained longer than for residents of traditional nursing homes, and when changes in condition do occur, staff are better positioned to recognize those changes earlier leading to lower rates of hospitalization and reduced hospital lengths of stay if patients are hospitalized and reduced costs.

Consequently, the Applicant asserts, 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.

Public Health Outcomes

As discussed under Factor 1(b), the Proposed Project will improve public health outcomes through improved access to short-term rehabilitation and long-term care. As described above under cost containment, better health outcomes will be achieved through lower rates of infection and hospitalization, and slower rates of health decline leading to prolonged independence, resulting in improved, quality of life, and higher resident and staff satisfaction.

Delivery System Transformation

To ensure elements of delivery system transformation are in place for all residents, short and long-term, the Applicant asserts it will ensure residents have access to providers, such as specialists, outside of the facility, as outlined in Factor 1(c), and it will ensure access to Martha's Vineyard community organizations ranging from social, behavioral health, housing, and medical organizations through consistent coordination and communication with these organizations. These relationships will be particularly effective for short-term rehabilitation patients upon discharge. Further, to ensure that Deaf and Hard of Hearing and/or non-English speaking residents receive appropriate care and to address their linguistic needs, the Applicant will implement an interpreter services program through a contract with Massachusetts General Hospital Medical Interpreter Services.

Analysis

As a result of information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project has met Factor 2.

Factor 3 - Compliance

Applicant certifies, by virtue of submitting this Application that it is in compliance and good standing with federal, state, and local laws and regulations, including, but not limited to M.G.L. c. 30, §§ 61 through 62H and the applicable regulations thereunder, and in compliance with all previously issued notices of Determination of Need and the terms and conditions attached therein.

Factor 4 - Financial Feasibility

Under Factor 4, the Applicant must demonstrate that it has sufficient funds available for capital and operating costs necessary to support the Proposed Project without negative effects or consequences to the existing Patient Panel. Documentation sufficient to make such finding must be supported by an analysis conducted by an independent CPA.

The Applicant submitted a report performed by Forvis (CPA Report[24]). The scope of the analysis and conclusions in the CPA Report are based upon a review of relevant information, including

[24] The CPA states it was *prepared in accordance with the attestation standards established by the American Institute of Certified Public Accountants*

the Applicant's current and compiled financial information for each of eight years (2022-29) with 2025 being the first full year of operation and ending December 31, 2029.

The CPA reports the projected revenue consists of net patient service revenue (NPSR). NPSR revenue for residents is based upon the daily fee of the respective bed and the project number of patient days. During the projection period, the annual daily fees are assumed to increase 3.0% for private pay residents, 2.0 % for Medicaid, and 1.0% for Medicare residents. The projected private pay daily fee for Proposed Project falls within the range of six Green House homes that were benchmarks used in project planning.

The CPA analysis showed that facility management had assumed that the Proposed Project will achieve and maintain an occupancy of 89.6% in fiscal years 2026-29. Staff noted that this is below the average occupancy (93.85%) of the six benchmark homes. Further Staff noted that management had plans to reduce the number of Medicaid residents with a more favorable payor mix of Private Pay and Medicare Residents over time. When staff inquired about these findings, the Applicant performed a sensitivity analysis to determine the impact of increasing occupancy to 65.1 beds (93.0%) and increasing the Medicaid occupancy to 28.0 beds. Table 7 [25] shows the effects of such an analysis.

Table 7 – Sensitivity Analysis of incremental increase in Occupancy and Medicaid Beds (1)

Financial Estimates for the Year Ending December 31, 2027		
Occupied Beds:	**Original Projections**	**Sensitivity I Following Staff Inquiry**
Private Pay	24.7	23.8
Medicaid	24.7	28
Medicare	10.4	10.4
Managed Care	2.9	2.9
Total Occupied Beds	62.7	65.1
Occupancy Percentage	89.6%	93.0%
Key Metrics		
Annual Debt Service Coverage Ratio	1.44x	1.39x
Days Cash on Hand	152	139
Source: Management of NHMV		

(1) For purposes of the sensitivity analysis, occupancy was reduced without a corresponding adjustment to certain fixed or staffing expenses.

The CPA analyzed the Applicant's assumptions for operating expenses for reasonableness and supportability and stated that operating expenses were benchmarked against other Green

[25] From the Responses to DoN questions.

House Projects and also the 2020 Healthcare Provider Cost Reporting Information System (HCRIS) Medicare data ("HCRIS Data").[26]

When analyzing operating expenses the CPA states that the total expense per resident day is between the median and upper quartile benchmark; the assumed total expense per resident day for administrative and general, maintenance, dining services, housekeeping are below the lower quartile benchmark; and total expense per resident day for health services and benefits are above the upper quartile benchmark.[27] As such, the Project's total salary expense per resident day is above the upper quartile of the benchmark because health care hours per resident day are higher than the benchmarks. Subsequent years factored in anticipated 2% inflation to the Benchmark data.

The CPA also reviewed capital expenditures to determine whether the Applicant will likely have sufficient funds to service the debt associated with the proposed United States Department of Agriculture Community Facilities Guaranteed Loan Program of approximately $8,500,000 (the "Guaranteed Loan"), and Direct Loan of approximately $36,000,000 (collectively, the "USDA Loans").

The CPA Report summarizes that the financial ratios and benchmarks analyzed throughout the analysis demonstrate that the Project consistently falls within the range of the benchmarks. As a result, the CPA stated *"In our opinion, the underlying assumptions provided by management of Navigator Homes of Martha's Vineyard are suitably supported and provide a reasonable basis for Management's projection. …The projection indicates that sufficient funds could be generated to meet the Corporation's operating expenses, working capital needs and other financial requirements, including the debt service requirements associated with the USDA Loans, during the projection period.*

Analysis

The Applicant states that its current facility operates at a loss that it cannot sustain. For the Proposed Project to be financially viable, it states that the facility's payer mix must be "managed" to make up for Medicaid reimbursement shortfalls.

Following staff's Inquiry concerning the reduced number of Medicaid beds, Navigator revisited its projections, as discussed above and shown in Table 7, to determine the average occupied beds by payer that would maximize its ability to care for Medicaid beneficiaries while preserving the financial viability of the facility. This was achieved by increasing the facility's occupancy to 93%, which is consistent with other Green House facilities. As a result, Navigator

[26] The Centers for Medicare & Medicaid Services (CMS) ensure that facilities provide up to date data in their cost reports that are then summarized in the HCRIS Data which consists of 12,401 total skilled nursing facilities.
[27] Health services expenses include CNAs who are assumed to be utilized as "Shahbazim" according to the Green House staffing model, which can include duties beyond the traditional scope of practice of a CNA such as cooking, cleaning, laundry, and activities.

revised its projections to an average of 28 Medicaid beds beginning in 2025, which it states creates an *increase* of Medicaid beds from the facility's current average of 25.

Staff finds that the CPA and Applicant's subsequent analysis has sufficiently documented the availability of funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's Patient Panel. As a result, Staff finds the CPA analysis to be acceptable and that the Applicant has met the requirements of Factor 4 with the aforementioned additional Condition #4 to report on and maintain the ~28 projected Medicaid beds.

Factor 5 - Relative Merit

The Applicant considered two alternatives to the current project:

1) Continue with the status quo, and
2) Construct a traditional long-term care facility

The first alternative would have no substantial additional operating costs or capital costs however, the Applicant describes an aging facility in need of frequent maintenance. With this option, the growing needs of the Island residents for access to short-term rehabilitation and long-term care services would not be met, and the quality of care and operational efficiency issues that will be achieved through this Proposed Project, and discussed throughout this narrative, would not improve.

The Applicant asserts alternative number 2 would not result in the same outcome and quality benefits described under Factor 1(b) related to reduced hospital admission, and shorter lengths of stay, along with lower infection rates found in Green House homes. The Applicant acknowledges that while the capital costs would likely be similar, the operating costs with the Proposed Project may be higher, however, these may be offset by efficiencies gained as well as the cost savings achieved through improved efficiencies and quality gains.

Analysis

Staff finds that the Applicant has appropriately considered the quality, efficiency, capital and operating costs of the Proposed Project and recognizes that the alternatives considered would not likely achieve the short-term and long-term care efficiencies and quality of the Proposed Project. As a result of information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project has met Factor 5.

Factor 6 - Community-based Health Initiatives

Summary and Relevant Context for This Application:

The Applicant, Navigator Homes Martha's Vineyard, Inc. (NHMV), is completing a substantial capital expenditure project which is a CHI project that amounts to $1,605,913.77. Standard CHI practice for compliance with the DoN regulation requires Long Term Care Facilities, such as NHMV, to contribute CHI funds fully to the Massachusetts Statewide Community Health and Healthy Aging Funds. The Applicant is requesting "the Department to consider acknowledging that a contribution to the workforce housing satisfies part of the CHI" and is seeking to invest part of the required contribution in an affordable, workforce housing program for individuals residing on Martha's Vineyard, in addition to contributing to the statewide fund.

In support of their request, the Applicant stressed key points from the MVH 2022 Community Needs Assessment, emphasizing the need for housing on the Island.

Analysis

Through extensive follow up communications between DPH and the Applicant, the Applicant provided additional documentation to highlight community engagement and transparency among community stakeholders[28] on the Island, regarding the existing subsidized housing policies and how the process would work and satisfy the CHI requirements. DPH staff and the Applicant have agreed that it may meet its Factor 6 obligations by providing a portion of the total CHI obligation to the Massachusetts Statewide Community Health and Healthy Aging Funds and by expending the remainder on its workforce housing program commitment. Navigator shall comply with the Conditions of this Approval, as set out below, regarding the amounts and reporting on its workforce housing program commitment. As a result of this analysis, and with additional conditions, staff finds the Applicant meets the terms of Factor 6.

Ten Taxpayer and Public Comments on the Application

Any person, and any Ten Taxpayer group (TTG), may provide written or oral comment at any time during the first 30 days following the Filing Date of an Application, or during the first ten days after a public hearing. No public hearing was requested or held on this Application.

Any ten taxpayers, organized as a group, may participate in the review of an Application for Determination of Need or request to amend a previously issued Notice of Determination of Need. Said group must register with the Department at any time during the first 30 days following the Filing Date of an Application, or during the first ten days after a public hearing held pursuant to 105 CMR 100.445.

One ten taxpayer group (TTG) registered in support of the Proposed Project.[29]

[28] Including MVH, Dukes County Regional Housing Authority, Martha's Vineyard Commission, http://www.mvcommission.org/

[29] Registration information is available on the DoN website. https://www.mass.gov/doc/navigator-homes-of-marthas-vineyard-pdf/download

Summary of Written Comments

The Department received 30 written comments, all supportive, during the initial comment period, including that of the one TTG. Comments considered in the DoN program's review and analysis are those that address the Applicant's ability to meet the requirements of the relevant factors.[30]

While those commenting included mostly residents of the Island, five elected town and state officials, the Navigator Board of Directors, and the President of Hebrew Senor Life Health Care Services (which acted as a consultant on the project) also submitted written comments. The comments were fairly consistent and stressed the current challenges, the benefits of the Green House Model and the need due to the growth in the over 65 age cohort on the Island.

Current Challenges

- Excellent care provided but the setting is outdated and institutional and located on upper floors of the MVH campus which is not a homelike environment.
- Lack of short-term rehabilitation on the Island.
- Most rooms have two beds and most share a bathroom with another 2-bed room.
- As a result, the facility design makes it less desirable to private-pay residents which are vital to long term financial sustainability of the facility.
- Only 30 beds are in operation- over half its licensed beds are closed due to inability to recruit staff because of the lack of affordable housing on the island.
- As a result, a new town bylaw permits the development of senior residential communities co-located with workforce housing, and in partnership with Martha's Vineyard Hospital, 30 bedrooms of workforce housing will be available to Navigator staff on a sliding rent scale.
- Staff will be members of the community – increased personal satisfaction, economic boost, with reduced call-outs due to weather.

Benefits of Green House Model stressed include

- Residents will live in private bedrooms with their own en-suite full bathroom and have access to shared living space, encouraging socialization and companionship.
- Care will be provided by a consistent, empowered work team of universal caregivers who are responsible for the range of personal, clinical, and home care activities.
- In-home staff provide direct care as well as cooking, cleaning, ordering, scheduling, and other holistic caregiver tasks.

Growth in the 65 and over population on the Island

[30] All comments are available on the DoN website. https://www.mass.gov/info-details/navigator-homes-of-marthas-vineyard-inc-long-term-care-substantial-capital-expenditure

- 35% of Martha's Vineyard's year-round residents are age 65 and older.[31] Assuming just 2.3% of residents over the age of 65 will need skilled nursing, the Island will need more than 100 beds to meet demand.

Analysis

The comments on the challenges and the need to operate more than the current 30 beds are addressed under Factor 1a) and b). The comments related to affordable housing are addressed in Factor 6.

As a result of this analysis, and with additional conditions, staff finds the Applicant meets the requirements of all the Factors and recommends approval of this Application.

Conditions

1. Half of the total required CHI contribution of $802,956.89 will be directed to the Massachusetts Statewide Community Health and Healthy Aging Funds.

2. To comply with the Holder's obligation to contribute to the Massachusetts Statewide Community Health and Aging Funds, the Holder must submit the payment, a check for $802,956.89, to Health Resources in Action (HRiA) (the fiscal agent for the CHI Statewide Initiative).
    a. The Holder must submit the funds to HRiA within 14 days of receipt of financing from the USDA
    b. The Holder must promptly notify DPH (CHI contact staff) when payment has been made.
    c. Payment should be sent to:
    Health Resources in Action, Inc., (HRiA)
    2 Boylston Street, 4th Floor
    Boston, MA 02116
    Attn: Ms. Bora Toro

3. To comply with the remaining Workforce housing program commitment (the remaining $802,956.89), the Applicant must comply with the following:
    a. within 6 months of the Notice of Approval date, the Applicant must provide DPH with an accountability and sustainability plan that includes a process of funding from Navigator's ongoing operations as well as tracking all CHI investments in the program.
    b. the Applicant will report to DPH annually until such time as the total commitment has been satisfied on the anniversary date of project implementation to provide documentation and reporting related to the housing investment.
    c. Any deviation to this payment and tracking schedule will require DPH approval.

[31] Staff notes that while most of the comments stated 35% the actual percentage is 25% as cited on p. 6 of this report.

4. To ensure that the Proposed Project is addressing the needs of the Patient Panel, on Martha's Vineyard, and that off Island private pay residents are not prioritized over Island residents, and Medicaid residents, the Holder must demonstrate that Island Residents are prioritized over off Island residents. To monitor this the Applicant must track on monthly and begin reporting the following information as part of the annual report required by 105 CMR 100.310(A)(12):

    a. the number and number of Navigator admissions: differentiating short-term rehab and long-term care by payer whose home prior to admission originated on the Island
    b. and the number of Navigator admissions: differentiating short-term rehab and long-term care by payer who whose home prior to admission was off the Island.

Appendix 1

A. 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.

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

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.

Endnotes

[i] https://thegreenhouseproject.org/our-story/history/
[ii] *Id.*
[iii] *Id.*
[iv] 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.
[v] 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.
[vi] *Id.*
[vii] Economic Policy Institute. Nantucket County was identified as the other most expensive metropolitan area.
[viii] Economic Policy Institute
[ix] Nursing Home Data Compendium, 2015 Edition, published by CMS (the 2015 Edition is the most current version of this annually produced document)
[x] 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
[xi] *Id.*
[xii] *Id.* at 468.
[xiii] *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.
[xiv] Bowers et al., *supra* note xiii, at 385.
[xv] Afendulis et al., *supra* note x, at 469-70.
[xvi] 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.
[xvii] 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.
[xviii] 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.
[xix] *Id.*
[xx] 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/.
[xxi] 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/.
[xxii] 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).
[xxiii] Yoon et al., *supra* note xxii.
[xxiv] Cohen et al., supra note xxiii, Cutler, *supra* note xxiii.
[xxv] Cohen et al., supra note xxiii; Cutler, *supra* note xxiii; *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

[xxvi] Cohen et al., supra note xxiii; Cutler, *supra* note xxii; D. K. Kiely et al., *supra* note xxvii.
[xxvii] Cohen et al., *supra* note xxiii, at 367.
[xxviii] Cohen et al., *supra* note xxiii, at 366-67.
[xxix] 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.
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[xxxi] *Id.* at 46.
[xxxii] *Id.* at 46-47.
[xxxiii] Bowers et al., *supra* note xiii, at 386.
[xxxiv] Lum et al., *supra* note xxxii, at 48.
[xxxv] *Id.* at 8.
[xxxvi] Cohen et al. *supra* note xxiii, at 367-68.