

# Nursing Facilities for the 21<sup>st</sup> Century



## Report to the Legislature

*Submitted By:*  
**THE DEPARTMENT  
OF  
DISABILITIES, AGING AND INDEPENDENT LIVING**

**January 19, 2007**

## TABLE OF CONTENTS

	Executive Summary	4
I.	Purpose of the study	7
II.	Process used to develop this report	8
III.	Environmental Context	8
	A. Act 160, Choices for Care 1115 Medicaid Waiver	
	B. Nursing Facilities Profile	
IV.	Facility Input	11
V.	Committee Reports	12
	A. How Facilities Can Become More Responsive to Residents and How to Address Accessibility Needs of Residents with Disabilities	
	B. Right-Sizing Committee	
	C. New Revenue Sources	
VI.	Conclusions and Recommendations	24

### APPENDICES

- A. Task Force Membership
- B. Nursing Facility Revenues by Payer Source and Occupancy by Payer Source
- C. Excerpt from H. 881
- D. Facility Input – Interview Guide
- E. Nursing Facility Occupancy Table
- F. Traditional Nursing Facility Compared to the Green House Model
- G. Gold Star Employer Best Practices
- H. Facilities by Type of Ownership
- I. Beds Per 100 Vermonters 18+ population with Disabilities
- J. Details on Nursing Facilities: Date of Construction, 3-4 Bed Rooms, Type of Building Design, Number of Beds, Minimum Age Requirement for Admission
- K. Vermont Veterans' Home - Background Information
- L. Quality Improvement Initiatives

## REFERENCES

- A. *Shaping the Future of Long Term Care and Independent Living* – DAIL, May 2006
- B. *Medicaid Nursing Facilities in Vermont Fact Book*, AHS, Division of Rate Setting, January 2006.
- C. *Licensing and Operating Rules for Nursing Homes*, DAIL/Division of Licensing and Protection, December 15, 2001.
- D. *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities*, Vermont Agency of Human Services, Division of Rate Setting, July 2005.
- E. *HCA Bulletin 112: Certificate of Need Program, March 12, 2004*, Vermont Department of Banking, Insurance, Securities and Health Care Administration, Division of Health Care Administration.
- F. *Report of the Vermont State Auditor, Vermont Veterans' Home*, November 21, 2005.

## Executive Summary

In response to a charge from the Legislature, the Department of Disabilities, Aging and Independent Living convened a task force to examine the future of nursing facilities in Vermont. This report reflects the work of the Nursing Facilities for the 21<sup>st</sup> Century Task Force. The Task Force included representation from nursing facilities, the Agency of Human Services and advocates for older Vermonters and Vermonters with disabilities. Over the last decade, significant changes have taken place in Vermont's long-term care system, reflecting both changes in consumer preferences, and the fact that state and federal funding cannot keep up with the growing need for long-term care if we rely primarily on care in nursing facilities and the growth in home and community based services.

The Task Force focused on three main areas: (1) other revenue sources for nursing facilities; (2) right-sizing the industry; and (3) helping nursing facilities become more consumer-responsive and accessible for the benefit of both residents and visitors.

The Task Force agreed that a home-like environment for Vermonters who receive their long-term care in a nursing facility should be the goal. Nursing facilities should deliver quality care that respects and honors the individual backgrounds, customs, values and preferences.

The following recommendations are offered to the Department of Disabilities, Aging and Independent Living, the nursing facilities and to the Legislature.

### **Recommendations**

#### **The Task Force recommends that DAIL:**

1. Support the infrastructure of the Gold Star Council and encourage nursing home facilities to participate in the Gold Star process.
2. Continue the Nursing Facility Quality Awards as a way to promote quality and best practices.
3. Use Civil Money Penalties<sup>1</sup> to promote culture change and celebrate diversity in ways that enhance the quality of life and/or quality of care for residents.
4. Strengthen the Long-Term Care Ombudsman program as a way to assist with culture change in facilities.
5. Determine whether or not the way allowable costs are allocated for space rented or used for community purposes is a financial barrier to facilities providing those spaces.
6. Continue discussions with facilities about the best method for right-sizing the industry, including the model of contracting for resident days. Any plan agreed upon should also recognize the importance of quality care in the contracting process.
7. Examine incentives to accomplish right-sizing of the industry such as bed-banking and conversion of multi-bed rooms to rooms with double and single occupancy.<sup>2</sup>

---

<sup>1</sup> Civil Money Penalties are funds collected from nursing facilities that have been out of compliance with Federal requirements.

8. Research financial incentives and financing mechanisms that can assist current nursing facilities to develop home-like settings.<sup>3</sup>
9. Analyze whether the threshold of \$750,000 for renovation projects is an appropriate level to trigger the filing of a Letter of Intent re: the determination of whether or not a CON is required.
10. Develop criteria to help decide when major renovation projects should be approved.
11. Encourage additional palliative care services in nursing facilities.
12. Work with facilities to determine what is needed to properly care for geriatric patients at the State Hospital and those being furloughed from the Correctional system who would be better served in a nursing facility.
13. Clarify information about assistive technology, i.e. what is covered, by whom, and the most effective ways of obtaining the needed items. Provide this information to facilities, residents and families
14. Identify barriers in the reimbursement system to the effective use of assistive technology and recommend changes at the state and federal level.

**The Task Force recommends that nursing facilities:**

1. Find and/or develop reasons for community members to come to the facility on a regular basis as way to integrate the life of the residents into the life of the surrounding communities
2. Adopt the Gold Star Employer Best Practices, with the additions recommended by the Task Force.
3. Determine ways to provide staff training and resident education that result in respect for both staff and residents who have various social backgrounds, sexual orientation, religious affiliations and from various races.
4. Participate in town and regional planning initiatives.
5. Seek additional ways to include residents and when appropriate, families, in decision-making about day-to-day life in the facility.
6. Improve the dining experience for residents and visitors, e.g. family-style dining to encourage socialization; cultural sensitivity, and resident-determined dining schedules.
7. Make the facility more accessible for both residents and visitors; pay particular attention to resident rooms when planning renovations.
8. Prepare and serve food as close to the residents' living area as possible.
9. Pay particular attention to learning and responding to residents' requests to sleep, dress, bathe and engage in other activities on their own schedules.
10. Use new information technologies to better utilize staff time and improve resident care and quality of life, e.g. for scheduling, MDS assessments, tracking provision of care.

---

<sup>2</sup> The State of Vermont *Licensing and Operating Rules for Nursing Homes, December 15, 2001*, Section 8.4 (e) (3) and (4) require that "Any downsizing or reduction in licensed capacity initiated by the facility must first reduce the number of beds contained in three- and four-bed rooms such that these rooms are converted to semi-private or private occupancy." The Rules also require that "Proposals for new construction, expansion, renovation or substantial rehabilitation of a facility requiring Certificate of Need approval pursuant to 18 V.S.A. §9434 will not be approved by the licensing agency unless the construction proposal includes a plan for elimination or conversion of all three- and four-bed rooms to rooms which accommodate no more than two persons."

<sup>3</sup> Funds from other parts of the LTC system would not be considered as part of this research.

---

11. Educate residents and family members about the availability of assistive technology and facilitate obtaining any needed items.

**The Task recommends that the Legislature** set aside funding to develop a 10-year plan, which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the residents' preferences, customs and individual histories. It has been our experience that nursing facilities support these desired changes and are in fact striving to achieve many of them; however, there are many regulatory and reimbursement issues that need to be explored and addressed before significant changes can be achieved.

## **I. Purpose of This Study**

For over 30 years, the policy of the State of Vermont has been to help elders and persons with disabilities to live and receive support and care in the appropriate settings of their choice. As funding became available, resources were invested in improving the home and community based portion of the long-term care (LTC) system so consumers would have viable alternatives to receiving their care in a nursing facility. The first milestone in this effort was the passage of Act 160 in 1996 and the second milestone was the creation of the Choices for Care 1115 Medicaid Demonstration Waiver.

As a result of many years of work to create options, changes in LTC consumer patterns have developed and now over 1,350 people enrolled in the Choices for Care 1115 demonstration waiver are receiving their long-term care services in home and community based settings.<sup>4</sup> At the same time, nursing facilities have experienced changes in both their Medicare and Medicaid revenue streams and in the percent of residents using these payment sources. (See Appendix B.)

The Vermont Legislature is aware that the LTC system in Vermont continues to experience many changes and directed that "...The commissioner of disabilities, aging, and independent living shall convene a task force to assist the commissioner in developing statewide recommendations on the future of nursing homes, including the Vermont Veterans' Home, in Vermont. The recommendations shall address the transition issues for nursing homes as more individuals use home- and community-based long-term care services, how nursing homes can convert the services offered to provide long-term care services differently, unmet needs for nursing home services for individuals, accessibility for individuals with disabilities in nursing homes,...." (H.881)

Vermonters who need long-term care and do not receive that care in their own homes, should be able to receive that care and support in settings that are as home-like as possible and that change to respond to consumers' needs and preferences. Nursing facilities are no exception. There are a variety of important quality initiatives taking place in nursing facilities – some spearheaded by state and federal governments and others funded by grants from non-profit organizations.

This report provides background information and recommendations to inform and guide the legislators, policy makers and the nursing facility industry as the long-term care system continues to change in response to consumer demands.

In 2006, the Vermont Legislature amended H. 881 and charged the Department of Disabilities, Aging and Independent Living (DAIL) with completing several studies involving the long-term care system. (See Appendix C for additional language from H. 881.)

DAIL decided on the following approach to meet the legislative directive. An overarching task force, which included the DAIL Advisory Board, was created to study the sustainability of the long-term care system. The work of three other task forces would feed into that study: (1) the

---

<sup>4</sup> This number does not include the "Moderate Group", an eligibility group that does not have to meet the LTC clinical or financial criteria.

Nursing Facilities for the 21<sup>st</sup> Century Task Force; (2) Direct Care Workforce Task Force; and (3) Nursing Facility Reimbursement Task Force.

This report will focus on the work of the Nursing Facilities for the 21<sup>st</sup> Century Task Force. The charge to that task force included developing recommendations in the following areas:

- the future of nursing homes, including the Vermont Veterans' Home, in Vermont;
- the transition issues for nursing homes as more individuals use home- and community-based long-term care services;
- how nursing homes can convert the services offered to provide long-term care services differently;
- unmet needs for nursing home services for individuals; and
- accessibility for individuals with disabilities in nursing homes;

## **II. Process used by the Task Force**

Task Force members included representatives from Nursing Facilities, Area Agencies on Aging, Adult Day Program, the LTC Ombudsman Program, AARP-VT, Home Health Agencies, Vermont Center for Independent Living, the Community of Vermont Elders and Agency of Human Services' staff. The Task Force decided that the best way to tackle the work before them was to break into three subcommittees and then bring the recommendations back to the full group. The committees were named the Right Sizing Committee, the Consumer Responsive Committee and the New Sources of Revenue Committee and each received a specific charge for the work they were asked to complete. (See the descriptions of the committee charges in the section that addresses each committee's work.)

The Task Force also decided that gathering input directly from the facilities was an important step. It would also provide some important background for committee members who were not familiar with the facilities. The Task Force developed a survey which was used by the four people who visited the facilities and interviewed the administrators. The information was collated and the major themes were presented to the Task Force.

The physical structure of the facilities was considered each time the Task Force discussed how to make life the facilities more home-like. They gathered information about other new and emerging models such as the Green House.<sup>5</sup> (See the section on the greater consumer responsiveness for a description.)

## **III. The Vermont Context**

Since the passage of the Act 160, the "Shifting the Balance" legislation, in 1996, the long-term care system has been undergoing gradual changes in response to Vermonters requests for home and community based options in addition to the option of residence in a nursing facility. In October 2005, Vermont started a demonstration waiver called Choices for Care. This waiver removes the long-standing bias toward institutional care which exists in the Medicaid program.

---

<sup>5</sup> The Green House model has been developed by Dr. William Thomas, creator of the Eden Alternative for nursing facilities. <http://www.thegreenhouseproject.org/>

Prior to this waiver, individuals who preferred to receive their long-term care services in the community, rather than in a nursing facility, had to wait until a “slot” opened in the former home and community-based waiver. Enrollees in this new waiver have the ability to choose the setting in which they receive their care and support provided they meet both the financial and clinical criteria for long-term care.

As the home and community based parts of the system continue to grow, more options have become available for Vermonters. Shorter hospital stays meant that patients were in need of more care when they entered a nursing facility. Over time, nursing facilities have continued to increase their capacity to provide post-acute rehabilitation services. Many Level III Residential Care homes participate as Enhanced Residential Care providers and provide care to residents who meet the “Nursing Home Level of Care” criteria. Adult Day Centers provide care for many people who also meet that level of care criteria.

These changes are having an impact on nursing facilities. As of October 1, 2006, there will be 419 fewer licensed beds than existed in 1996. Some nursing facilities are experiencing significant financial pressure; five facilities have received extraordinary financial relief from the State and others have received a qualified opinion on their audited financial statements. This type of qualification is called a “going concern” qualification.<sup>6</sup> One nursing facility receives an enhanced rate as a result of legislative action. Nursing facilities across the country are looking for ways to respond to the changing market and Vermont is no exception.

The nursing facility industry in Vermont is not homogeneous. The following description provides some detail on the facilities operating in Vermont.

#### Nursing Facility bed capacity

Vermont has a total of 43 nursing facilities. Three facilities do not accept Medicaid payments: The Arbors and Merten’s House accept privately paying residents only; Wake Robin’s Linden Health Center is certified to receive Medicare payments and is open only to its continuing care community members. The Arbors and Merten’s are surveyed for compliance with Vermont’s health regulations and Life Safety Code Regulations. Wake Robin is surveyed for compliance with Medicare requirements.

- Facilities range in size from 12 resident beds to 184 resident beds.
- 40 facilities are dually certified to accept Medicare and Medicaid payments.
- As of 10/1/06, Vermont expects to have 3,425 licensed beds<sup>7</sup>.
- Medicare/Medicaid dually licensed beds are expected to number 3,196 as of October 1, 2006.
- Beds certified for non-Medicare use only = 199 (26 are for private pay residents only).
- Nursing facilities fall into 8 different ownership categories (see Appendix H for details.)
  - Owned by “chains”
  - Vermont-based ownership groups

---

<sup>6</sup> This qualification alerts all users of the financial statement that this facility may not be able to continue in its accustomed business in the future.

<sup>7</sup> includes the private pay and Medicare-only facilities, downsizing of Burlington Health and Rehab by 42 beds and a 10-bed increase a Menig Extended Care in Randolph.

- Hospital-based (these non-profit facilities share a common wall with a hospital)
- Hospital-related (non-profit facilities under the hospital “umbrella”, but not physically connected to the hospital)
- Not-for-profit facilities
- For-profit independent facilities
- State-owned facility – Vermont Veterans Home
- Non-Medicaid facilities

Explanation of terms:

- Optimal occupancy – nursing facilities report that optimal occupancy for most is about 96 percent to 97 percent. That number doesn’t work for the smaller facilities who want to stay closer to 100%. (See Appendix E.)
- Certification and licensure –
  - Certification is the federal process run by the Centers for Medicare and Medicaid Services (CMS) which sets the requirements for nursing facilities and then certifies that facilities meet those requirements. Facilities cannot bill for Medicare and Medicaid reimbursement without those certifications.
  - Licensure is the state process that ensures facilities follow the state regulations.
  - Medicare and Medicaid “beds” – nearly all resident beds in Vermont are dually certified as both Medicaid and Medicare beds, i.e. the payment source does not dictate to which part of the facility the resident is assigned. Representatives of nursing facilities that tend to have a lot of Medicare rehabilitation residents, said that they try to group those residents in the same area because the staff that work with residents who are there for rehabilitation following an acute episode like a stroke or hip fracture have more specialized training to meet the needs of those residents. It is also easier for attending physicians to be able to see these residents in a more centralized area.
    - Wake Robin’s Linden Health Care, Merten’s House and The Arbors are not dually certified. Wake Robin takes members as part of the service of the continuing care community and also those CCC residents whose care is paid for by Medicare. The other two facilities accept private pay residents only.

This report will focus on those facilities that are dually-certified for Medicare and Medicaid payments because the State has the ability to influence desired changes through policies, regulations and incentives.

Facilities have seen significant changes in occupancy and in the number of vacant beds. On July 31, 2006, Vermont had 3,401 resident beds in facilities that accept both Medicare and Medicare payments; 273 of those beds were vacant. (See Appendix E.) Since 1996, three facilities have closed and a number have downsized. Five facilities are receiving “Extraordinary Financial Relief” as defined in the Agency of Human Services, Division of Rate Setting’s *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities*<sup>8</sup>). Extraordinary relief may be in the form of a rate adjustment, an advance of Medicaid payments, or other relief appropriate to the circumstances of the applicant. Three facilities receive enhanced rates as a result of legislative action. Two others have requested

---

<sup>8</sup> <http://www.ahs.state.vt.us/DRS/nursinghome.htm>

extraordinary financial relief. Rates for the State Veterans' Home are determined retrospectively, rather than prospectively as is the process for other facilities.<sup>9</sup>

#### IV. FACILITY INPUT

In addition to input from nursing facility representatives at the Task Force and committee meetings, the Task Force agreed that it was important to obtain information directly from the facilities about their perception of the current status, challenges they were facing and their plans for the future. A survey was developed (see Appendix D) and four task force members volunteered to visit a number of the facilities, gather information and report back to the full group. Nine facilities representing the various types of nursing facilities and geographic areas were asked to volunteer for these visits and all readily agreed. In addition, the survey was mailed to all facilities so those who did not participate in a face-to-face interview would have an opportunity to help inform the Task Force and six other facilities completed the survey.

The following facilities were interviewed: Bel-Aire Center (Newport); Berlin Health and Rehabilitation (Berlin); Burlington Health and Rehabilitation (Burlington); Cedar Hill Continuing Care Community (Windsor); Centers for Living and Rehabilitation (Bennington); Eden Park (Rutland); Elmore House at Copley Manor (Morrisville); Greensboro Nursing Home (Greensboro); Vermont Veterans Home (Bennington); and Vernon Green (Vernon). The Task Force would like to thank the administrators of these facilities who spent two to three hours with the interviewers providing information and touring their facilities.

Other facilities returned the completed survey: Derby Green (Derby); Eden Park (Brattleboro); Franklin County Health Care (St. Albans); Mayo Healthcare (Northfield); Springfield Health and Rehabilitation (Springfield).

The Task Force reviewed all the input from the facilities and offers the following highlights.

#### THEMES FROM FACILITY INPUT

The facilities that were interviewed or who filled out the form covered various **types of ownership** (see Appendix H.). The following themes emerged from their input.

**Year constructed** – dates ranged from 1892 (Derby Green Nursing Home) to 2004 (Franklin Co. Rehab Center). The majority of the facilities were built during the early 1970's. (See Appendix J for details on all facilities.)

The **type of construction** (single story or multi-story) varied greatly, but nearly every facility was built using the “medical model”, i.e. long corridors with resident rooms off the corridors, nursing stations centrally located in each wing of the building. One administrator told us that when their architect first walked in the front door he said, “This was built with Hill-Burton

---

<sup>9</sup> State of Vermont, Agency of Human Services, Division of Rate Setting, *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities*, Section 9.4.

money, wasn't it." Most rooms are double occupancy, with some 3- and 4-bed rooms here and there.

**Capital Projects planned** – information gathered included some routine maintenance projects (spruce up projects). Most facilities (with the exception of the newer facilities like Elmore House and Franklin County Rehab) are either planning or are in the midst of capital projects. Several stated that work was needed, but the money wasn't available. The Vermont Veterans' Home had the most extensive list of projects planned.

**Where do you see your facility 10-15 years from now? – Physical Plant:** Except for the newer facilities, administrators expressed frustration with the limitations imposed by the design of their current buildings. They recognize that their future customers will have different expectations, e.g. private rooms, private bathrooms (and larger bathrooms) and a much less hospital-like environment. Several said they would like to replace the entire building. Two facilities expressed interest in developing the Green House model at their sites. Several mentioned operating with fewer beds in the future (closing wings or units). Change three- and four-bed rooms to two-bed rooms and use the additional space to enhance in-room rehabilitation practices. Change double occupancy rooms to private rooms with larger bathrooms to attract the private pay and Medicare rehabilitation market.

**Where do you see your facility 10-15 years from now? – Programmatically:** Ideas mentioned included: drawn in more Medicare/rehab residents; develop or expand special care capacity (e.g. dementia care, special behavioral care, ventilator care, dialysis; TBI care, bariatric care); and offer out-patient rehabilitation. Nearly every facility interviewed said that they want to increase their Medicare admissions and become the "Medicare rehabilitation facility of choice" for their local hospital.

**What do you see as unmet needs in your community that could be met by unused space in the facility?** - Some of the facilities did, in fact, have unused space because of decreased occupancy. Some ideas that were presented included: adult day programs; clinic space for the community; and on-site dialysis.

**Opportunities ahead?** – Expand short-term rehabilitation capacity (Medicare payment); create a "continuum of care" on campus;

**Challenges ahead?** - Adequate funding to stay afloat and make changes needed for the future, staffing (competing with local hospitals was mentioned many times) including RNs, LPNs, LNAs, PTs, OT, and STs, access to consultation for residents with significant behavioral issues, appropriate housing for residents who could be discharged if housing were available and increasing Workers Compensation premiums and general/liability insurance premiums.

**Effect of Choices for Care Waiver?** - Nearly all facilities reported seeing little or no effect; however, two mentioned that they are seeing people stay home longer and then come to the facility with higher care needs than in the past. Another said that they are seeing fewer Medicaid admissions.

## V. Committee Reports

The Task Force wanted their work to address what have been described as the three major problems for residents; loneliness, helplessness and boredom. Before the committees started their work, the Task Force developed the following list of questions for consideration, which provided the basis of much of the committees' work.

1. Does the current building design of a facility actually lead to less rather than more rehabilitation?
2. Is it really a culture change that needed or something more extensive?
3. How can a facility achieve true community integration, not just school children stopping by for holiday programs?
4. What should nursing facilities be/look like in the future and how and where will care be provided?
5. Vermont Veteran's Home – are there opportunities for change there? Is there a new model we should consider where services are more widely dispersed rather than just present in Bennington County?
6. We need to think about who the consumers will be – the “Boomers” may not be like today's nursing facilities residents and might demand very different surroundings and services. They probably will be living longer. What differences will medical advances make, e.g. delay or prevention of Alzheimer's Disease, Parkinson's Disease, and diabetes?
7. What type of building will best meet the needs?
8. Are there other uses for the current structures?
9. What are the current and emerging issues affecting nursing facilities?
10. What's the role of “intentional communities” where services come to you as you need more support?
11. What can nursing facilities do to increase their revenue and have more market appeal?
  - Culture changes that would result in better staff retention (saves \$\$)?
  - Change multi-bed rooms to 2-bed room and 2-bed rooms to single occupancy?
  - Offer specialty services: palliative care, ventilator care, residents with difficult behaviors, dementia units, complementary therapies, greater resident control and choice?
12. What are the unmet needs of residents and families in nursing facilities?
13. What accessibility issues need to be attended to so the resident attains and maintains the highest level of functioning?
14. What financial and regulatory incentives and disincentives exist?

In order to create the vision for nursing facilities for the 21<sup>st</sup> century, we asked ourselves, what we would want if we needed long-term care. Each member of the Task Force was asked what she/he would want, if long-term care were needed. The Task Force created the following list:

1. My own room and bathroom.
2. Control of my environment within my own room.
3. Personalized furnishings.

4. My pets.
5. To be close to my own community.
6. Good food and choice of food, including when I want to eat.
7. Personal control – when I go to bed, when I get up, what I wear, when I bathe, etc.
8. Transportation – medical and cultural/social
9. Small, private spaces where I can comfortably talk with friends and family.
10. Big windows and access to nature.
11. The ability to enter the kitchen and get a snack when I want to.
12. A place where **all** staff go beyond just tolerance for different life styles to real respect.
13. Strong, organized and recognized resident council.
14. Intellectual stimulation.
15. A home where staff feel that they work in a place where they are valued, respected and that their voices are heard.
16. A place where you can stay until death, regardless of whether or not your care needs increase or the source of the payment for your care changes.
17. A place where the community is part of my life. Where there are tangible ways to entice the community in:
  - Café
  - Bakery
  - Music
  - Movies
  - Fitness center (pool, spa, massage, alternative medicines)
  - Internet café
  - Library
  - Hairdresser
  - Community garden
  - Children’s day care
  - Adult Day Center
  - Book clubs and other club meetings
18. A place where you can stay for awhile and then leave again (respite, freedom from abuse, medical needs)

**Committee on “How Can Facilities Become More Responsive to Residents and How Can They Better Address the Accessibility Needs of Consumers with Disabilities”**

This committee was given the following charge:

*“As facilities face more difficult financial pressures and consumers express their desire for a more home-like setting and resident-centered approach to life and care in the facility, what can facilities do to now to attract more customers? Are there financial implications for the state? Please give consideration to the following ideas:*

- *Reduce multi-bed rooms to 2-bed rooms*
- *Reduce 2-bed rooms to single occupancy*
- *Adopt a more resident-focused model – a social rather than medical model*  
*For example, resident choices are honored, rather than making everyone adhere to the facility’s time table*

- *Achieve true community integration.*
- *Institute culture changes that ensure continuity of caregivers (“knowing” the resident improves care and resident and family satisfaction)*
- *The Green House model and similar ideas*

*As nursing facilities change with the changing market and demographics, families and residents identify needs that are unmet, or could open new opportunities. This committee will gather information about those unmet needs and make recommendations about possible solutions.*

*The committee will also examine accessibility issues for individuals with disabilities who reside in nursing facilities. For example, are there ways in which the physical plant actually results in the individual being more, rather than less, dependent? The committee will make suggestions on ways to improve the situation and also determine if there are costs to the State.”*

The committee considered ways in which residents of the facility could truly take part in the life of their surrounding communities. They recommended that facilities find ways to provide reasons for community members to come to the facility on a regular basis. They also felt strongly that space offered would have to make the visits attractive to outside groups. Some of those ideas for attracting the community to the facility are listed in item #17 above. Facilities also need to encourage and support the faith community and other service organizations to include their members who reside in the facilities in the activities of those organizations. Facilities also need to encourage their residents’ continued involvement in community activities and the community should reach out to residents.

The committee also asked the State to ensure that nursing facilities and residential care homes are included in community planning efforts (e.g. the AARP-sponsored Livable Communities project and planning for community events like fairs and cultural events).

One challenge to using facility space is the way costs are allocated by the reimbursement system. According to the Agency of Human Services, Division of Rate Setting, “If a facility rents an area of the facility, we look at the square feet being rented. Normally we would then allocate utility costs, depreciation, property taxes, property insurance and property interest based on the square footage for this area. These allocated property costs would then be joined with allocated housekeeping, allocated administrative costs and general allocated maintenance. We would not allow the total of these allocated costs in the facilities’ Medicaid rate. We would make an adjustment to remove them if the provider had not already done so.” However, our rules do provide for the use of space by community service organizations such that we do not disallow the costs noted in paragraph one for those uses.<sup>10</sup> We do not allocate property or other overhead costs to the Adult Day area, but we do allocate all property and related cost related to a Level III Residential Care

---

<sup>10</sup> State of Vermont, Agency of Human Services, Division of Rate Setting, *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities*, Section 4.17, Community Service Activities Nursing Facilities for the 21<sup>st</sup> Century Task Force Report January 2007

Home area. If this were a material amount of space, or a program growing to a significant size, there might be a problem granting this incentive.”

### Culture Change

The committee (and the full Task Force) agreed that changing the long-standing institutional culture in nursing facilities has great potential to improve the every day lives of residents and to improve staff recruitment and retention. The committee also noted that it is difficult to achieve true culture change unless the facility has a stable administration that is also committed to helping change occur. The past few years have seen significant turnover in both administrators and directors of nursing – two key positions needed to maintain stability so positive changes have a change to take root. The committee reviewed the Gold Star Employer Best Practices (see Appendix G) and made several minor recommendations.

Cultural training should also have a component on sensitivity to sexual orientation for both residents and staff and a component on recognizing and addressing behaviors that occur as a result of perceived class distinctions practiced by both staff and residents.

### New Models

The Green House model was discussed and several members attended a day-long workshop on the subject. This model moves radically away from the current medical model, creating separate buildings for no more than 10 residents with an open “great room” which contains the kitchen, living room and dining room. Single-occupancy resident rooms encircle the great room. Decisions making is made by the resident elders as often as feasible. House councils plan menus, activities and house routines. LNAs, called Shabaz), an ancient Persian word, are universal workers who receive additional training and staff the home. They form self-directed work teams that manage the date to date life in each house, providing personal care and preparing and serving the meals at a family-style table. Nurses visit the house to administer medications and other routine services and are available in emergencies. (See Appendix F.) It would be difficult to fully adopt this model using existing building; however, a few nursing facilities in other states have found ways to use elements of the Green House model such as making each wing of the facility a separate “house”. Doors are added that look like front doors to a standard home, staffing is consistently assigned to the residents in that wing and food service is as home-like as possible.

### Consistent Staffing

The Committee and the full Task Force agreed that assigning staff to work with the same residents on a consistent basis was one of the keys to improving resident life in the facility and recommended that all facilities adopt this practice. They made the following observations:

- All facilities agreed that using the practice of consistent staffing was desirable and many have already instituted the practice. Facilities reported that recruiting and retaining the necessary number of staff is a challenge to being able to provide consistent staffing. One facility reported that using practice of consistent staffing has helped increase retention. Some have moved to self scheduling by unit staff. The Veterans Home reports no problem with recruitment and retention and assumes this is largely because they are a state-owned facility and have to use the state employee pay scales.

- one of the positive outcomes of consistent staffing is that staff come to know the residents well and can often observe situations that cause a resident to become upset or agitated and redirect the situation. They also know what the residents' like and dislikes are and quickly respond to resident requests, making both care and life in the facility more positive.

### Staffing Levels

The Committee discussed staffing levels. The LTC Ombudsman program reported receiving calls from LNAs who felt their resident case loads were unmanageable and from residents and families about high resident to staff ratios. This can also become a recruitment and retention issue as word spreads quickly among potential LNAs when a facility is working short-staff and staff do not want to continually work under conditions where they feel they are unable to adequately care for the residents. At least one home determines the appropriate staffing level by looking at the case mix index and behavioral issues of each resident on a unit and then deciding the staffing needs. Vermont uses a weekly average per resident rather than staff/resident ratios<sup>11</sup>. Some committee members did not feel the approach currently used in Vermont was adequate and advocated using a staff/resident ratio instead.

### Physical Accessibility

The committee examined the issues around physical accessibility. This issue is important for younger adults with disabilities who can perform various activities independently if provided with the proper environment. It is also important to older Vermonters who want to regain their functional abilities as quickly as possible and want to retain them. Family and friends who visit the facilities also need to them to be accessible. Actually visiting the facilities made this subject more understandable for the members. All agreed that the physical layout of the facilities is, in itself, a significant barrier to making the environment more physically accessible. Most facilities were built in the early 1970's or earlier and were built using a hospital model, i.e. units with long corridors, rooms off each corridor, nursing stations in the middle, medication carts that are wheeled from room to room and food served on trays as though everyone were a patients rather than a resident. Most rooms are double occupancy with little space to maneuver. Some facilities still have 3- and 4-bed rooms. Bathrooms were also designed like those in hospitals, where patients are largely dependent on the nursing staff to assist them and few are large enough to accommodate a resident who uses a wheelchair.

The committee also recognized that this is largely a monetary issue for nursing facilities. In order to make sufficient space in a bedroom to easily maneuver a wheelchair, double occupancy rooms would have to be reduced to single occupancy and bathrooms would have to be enlarged. Storage space for motorized wheelchairs and scooters is often a problem. The committee recommended that when facilities were contemplating renovations or improvements, they should determine if there were ways in which they could make their space more accessible.

### Promoting Purchase and Use of Assistive Technology

The committee recommended that facilities promote the use of assistive technology (AT) so residents can use and maintain more of their own functional abilities. It was noted that the

---

<sup>11</sup> *Licensing and Operating Rules for Nursing Homes, December 15, 2000, Section 7.13(d)*

process for obtaining reimbursement for AT purchases is complicated and Medicaid does not readily pay for these items. Members commented that if the resident is returning to the community, he/she often can get the cost of the AT items covered, but it is much more difficult to get those same items covered in a nursing facility, because the federal government does not view a facility as the individual's home. Residents and family members need more education about how assistive technology can improve the resident's ability to function more independently, what products are available and how to obtain payment for them.

#### Giving residents more of a role in the decision-making about life in the facility

The committee agreed that finding ways to involve residents in decisions about life in the facility was important. In order to create a more home-like environment, the residents of that home have to have a say in how their home runs. Making more use of resident and family councils, instituting an open-door policy on the part of the administrator and ensuring that attention is paid to consumer satisfaction surveys were all recommendations of the committee.

#### Meeting Resident Preferences

In order to make the facility as home-like as possible, responding to resident preferences becomes very important. People who move to a nursing facility to have their long-term care needs met, have lived their whole life on their own schedules, i.e. when they get up, when they go to bed, when they have their coffee or tea in the morning, when they get dressed and when they eat their meals. If they must now conform to a institutional schedule, they feel a loss of control and helplessness and boredom quickly set in. They quickly realize that they are no longer living in a home-like environment.

Some facilities have heard this message and are making changes to respond to resident preferences. Adequate staffing, the size and layout of the facility and scheduling of bathing/showering rooms were some of the barriers noted by the facilities. They recognized the importance of this issue, but were finding, for the most part, that they could make only small improvements.

The preparation and serving of meals takes on a whole new meaning when coupled with the term home-like settings. The committee felt that these areas deserved special attention:

- Cultural sensitivity (types of foods)
- Dining style (recommended avoiding the use of trays – try to make everything involved in the preparation of food and the dining experience more home-like)
- Respond to residents' requests to eat when they want to – not on the institution's timetable.

Some facilities have moved to using moveable steam tables, with choices of various foods to create a new dining experience. Based on data from several facilities, it did not appear that using steam tables added to the food service costs and that residents liked the change.

The committee recommended that food preparation and service occur as close to where the residents eat as possible.

### **Committee on Right-Sizing**

This committee was given the following charge:

*“We recognize that the changes in long-term care options and other market forces have left some areas of the state with excess nursing facility bed capacity. Strategies need to be developed that will bring us closer to the stated goal of a balance between nursing facility LTC occupancy and home and community based LTC enrollment of 60 percent – 40 percent (60 percent of the population needing long-term care supports and services residing in nursing facilities and 40 percent receiving services in home and community based settings - HCBS). Eventually this could be a 50%-50% ratio. Some nursing facilities have requested that the State not just ‘bleed us all to death’, but that a clear strategy for right-sizing and stabilizing the industry is created instead. This committee will identify and examine various strategies including:.*

- *Survival of the fittest*
- *Contract for bed days*
- *Criteria for deciding where and when the State should make future investments in a particular facility”*

The committee identified some of the market forces that are affecting the industry such as

- more options now available for home and community based care, including the Choices for Care waiver, adult day, Medicare and Medicaid home health services; and
- people are staying healthier longer and are more educated about their health and have higher incomes, which correlates with better health outcomes.

They discussed the implications of allowing the market forces to determine which facilities stay in business and which fold their tents. They identified concerns about the following outcomes if that approach continues:

- Nursing facilities might close in areas where the bed supply is tight and facilities remain open in areas where we are “over bedded” or have an excess supply of beds.
- We might be faced with needing to find new living arrangements for up to 100 people and the capacity to relocate that many residents in the same area would be doubtful.

The committee concluded that relying on market forces to right-size the industry simply ends up making every one suffer as the system adjusts to the changing market and it does not give the State the ability to manage the bed supply to ensure the needs are adequately met.

The committee discussed one possible method for managing the bed supply, referred to as “Contracting for Resident Days”. Under this concept, the State would determine the number of resident days<sup>12</sup> needed in a particular area of the state, based on historical trends

---

<sup>12</sup> A resident day equals one day of a Medicaid-paid stay in a nursing facility

and population projects, and issue a Request for Proposals (RFP) to select the nursing facilities with which it would contract and the number of resident days it would purchase from that facility. Specific criteria would be used to select the nursing facilities. Provisions would be made for emergency situations where contracted facilities have good reason to exceed their contracted number of resident days.

Some ideas were proposed about criteria that would be helpful to use in deciding with which facilities the State should contract. The committee suggested using the same subject areas that are used for the nursing facility Quality Awards, but not the same descriptions, i.e. surveys, complaints investigations, resident/family satisfaction, efficiency. Another suggestion was to use LTC Ombudsman report. The committee questioned the value of using the measurements currently in use by the CMS-contracted Quality Improvement Organizations (QIOs).

The document called “Special Terms and Conditions” which was issued by the Centers for Medicare and Medicaid Services (CMS) as part of the approval of the Choices for Care 1115 Waiver, would allow the State to pursue this idea, but would not give approval for the concept without further study.

The committee gave this concept a “qualified maybe” for the idea of contracting for resident day, since many questions remain to be answered, e.g. how would nursing facilities be expected to manage to contracted days and what would happen if they used their contracted amount and there was still a need for care in the community.

No other ideas were put forth about how to help the industry “right size”.

#### Future Investments in capital improvements and major renovation projects

In Vermont, any new health care project must seek a Certificate of Need (CON) from the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). “For a health care facility other than a hospital, a new health care project includes: The construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility, for which the capital expenditure exceeds \$1,500,000.00.”<sup>13</sup> In addition, if a health care facility, other than a hospital, would meet the definition of a new health care project, except for this financial threshold and the proposed cost or value is greater than \$750,000 in the case of construction or \$500,000 in the case of equipment, a Letter of Intent must be filed with BISHCA. A CON is then required if the Commissioner “...determines that the proposed project:

- a. has the potential for significantly increasing utilization or rates; or
- b. may substantially change the type, scope or volume of services.”<sup>14</sup>

---

<sup>13</sup> *HCA Bulletin 112: Certificate of Need Program, March 12, 2004, page 5*, Vermont Department of Banking, Insurance, Securities and Health Care Administration, Division of Health Care Administration.

<sup>14</sup> *Ibid.*

The committee considered whether or not the State should adopt additional criteria that would guide where and when funds should be invested when facilities seek permission for significant renovations? Should the state approve renovations at a lower threshold than \$750,000? What about those in areas where we have an excess number of beds? For example:

- if a facility wanted to convert a number of two bed rooms to single occupancy and/or convert 3- or 4-bed rooms to 2-bed rooms, that would be a added value to prospective residents and their families and save money for the state because the total number of beds in the facility would be reduced.

### **Committee on New Sources of Revenue**

This committee was asked to:

*“Examine what other opportunities might exist for facilities to bring in additional revenue. Identify barriers and possible solutions including any necessary changes to regulations. Examine any potential costs to the state. Ideas to be considered include:*

- *Special units – dementia, aging sex offenders, bariatric patients, geriatric patients from the State Hospital, palliative care, and ventilator care, etc.*
- *Culture change – culture change that results in better staff retention has an immediate financial benefit to the facility.*
- *Preparation of Home Delivered Meals.*
- *Community needs that could be met using nursing facilities’ unused space.”*

### **Community Needs**

The committee reviewed information filed by each hospital service area with the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) concerning needs identified by their local communities. The committee did not find any unmet needs that could be fulfilled by nursing facilities.

### **Special Populations**

Nursing facilities are sometimes able to receive a higher rate for providing care to residents with special care needs. A facility must apply for a special rate for a particular resident. The State has provided special rates for a few residents who have difficult behavioral health needs also with the need for functional assistance. Higher rates are also paid for residents who need ventilator care and sometimes for the care of bariatric residents (individuals who are morbidly obese and need special care to lose weight). These residents need special programs, behavior modification and special equipment.

A few nursing facilities offer ventilator care and the committee investigated whether or not there was a need for additional services. When the visits were made to facilities in July 2006, Eden Park of Rutland had six residents who required ventilator care. They have the capacity to take nine. The facility decides whether or not they can admit any additional residents with this special need, based on a number of factors included the physical space and availability of staff with specialized training. Eden Park-Rutland felt that they were meeting the current need. Burlington

Health and Rehabilitation also offers ventilator care, but said they would have to add additional trained staff if they were admit another ventilator patient. The committee asked hospital discharge planners if they felt there was a need for additional ventilator care. Central Vermont Hospital, Fletcher Allen Health Care and Brattleboro Memorial Hospital all said they saw a need for additional beds for this care.

Care for individuals with dementia is an increasing market for nursing facilities. The following table lists the facilities that have state-approved units offering Alzheimers/dementia care. All facilities admit residents with dementia, but not all have state-approved special units. Nursing facilities use the Minimum Data Set (MDS), the assessment used to determine the amount of care needed by a resident. The MDS determines the Resource Utilization Group (RUG) score for each resident, which in turn feeds into determining the case mix score of all the Medicaid residents in the facility. Nursing facilities' rates are determined from their quarterly case mix score. Nursing facilities and advocates for people with dementia have long argued that the MDS does not accurately reflect the amount of care needed by residents with dementia. These residents need lots of cueing, supervision and direction, but are often quite able to perform many of the activities of daily living scored on the MDS. The Centers for Medicare and Medicaid Services (CMS) is currently conducting a study of the MDS, which will include this concern.

<b>Facility</b>	<b>Dementia Care</b>	<b>Alzheimers</b>
Birchwood Terrace		<b>X</b>
Cedar Hill	<b>X</b>	
Crescent Manor	<b>X</b>	
Haven Health - Rutland	<b>X</b>	
Helen Porter	<b>X</b>	<b>X</b>
Maple Lane	<b>X</b>	<b>X</b>
Morrisville Center	<b>X</b>	
VT Veterans Home	<b>X</b>	
Vernon Green	<b>X</b>	

Two other institutional settings house individuals who could live in another setting; the Vermont State Hospital (VSH) and the correctional (Corrections) system. Six elderly VSH patients have geriatric care needs that now outweigh their behavior health needs and they no longer need a hospital environment. Facilities willing to staff appropriately to care for these patients could ask for a higher reimbursement rate.<sup>15</sup>

Corrections has a similar situation involving frail elderly offenders who have been furloughed and need care in another setting. A facility willing to care for these individuals would receive a rate equal to 150 percent of the nursing facilities ordinary Medicaid rate.<sup>16</sup>

---

<sup>15</sup> Agency of Human Services, Division of Rate Setting, *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities*, July 2005, Section 14.2.

<sup>16</sup> *Ibid.* Section 14.3.

The committee also identified an additional need for care for individuals with traumatic brain injuries (TBI). Vermont has had great success in keeping these individuals in the state, close to friends and family, rather than in out-of-state facilities, but the need for additional facilities providing this care still exists until additional capacity is created in the home- and community-based part of the system.

Committee members also said that providing palliative care could be another way for facilities to attract additional market share. Palliative care does not have the six-month life expectancy requirement found in the Hospice program. Three- and four-bed rooms could be used to hospice or palliative care and provide space for families to be near their loved ones.

Because of the high incidence of diabetes in Vermont, the committee also recommended consideration of additional dialysis treatment centers that would treat both a facility's residents and the general public.

Facilities need to consider several issues before deciding to open a special care unit.

- the capacity of the local hospital to provide acute care services for these individuals if it needed;
- staffing including the appropriate number of staff and the necessary specialized training
- whether or not a secure unit is needed

#### Suggestions for unused space and other revenue generating ideas<sup>17</sup>

As of July 2006, there were 273 vacant nursing facility beds. The committee recommended that facilities with unused space consider some of these suggestions for generating additional revenue by leasing space for:

- Doctors' offices
- Clinics, including treatment for substance abuse
- private practitioners of physical therapy, occupational therapy and speech therapy.
- practitioners of complementary treatments (chiropractors and various alternative therapies)
- adult day centers<sup>18</sup>

#### Culture Change as a revenue source

The last area considered by the committee was the effect of significant culture change within the facility on employee retention. A study by the Paraprofessional Healthcare Institute,<sup>19</sup> "...the direct cost of turnover per frontline worker is at least \$2,500, based on a conservative working

---

<sup>17</sup> Preparation of home-delivered meals (often called Meals on Wheels) was also considered, but not included because facilities that have tried this idea in the past have not found that it generated any additional revenue.

<sup>18</sup> Certification of new adult day providers requires demonstration of unmet need.

<sup>19</sup> *The Cost of Frontline Worker Turnover in Long Term Care, page 4, D. Seavey, October 2004*

estimate.” By creating a culture that truly values the direct care workers, staff retention will improve and facilities will not have to spend as much on recruitment and training of new staff.

### **Veterans’ Home**

The Veterans Home is the only state-owned nursing facility in Vermont. The staff are state employees and are paid wages according to the state employee pay scale and have union representation. The Veterans Administration “...may participate in up to 65 percent of the cost of construction or acquisition of State nursing homes or domiciliaries or for renovations to existing State homes.”<sup>20</sup> The Veterans Home will receive these matching funds for the planned renovations. “VA also provides per diem payments to States for the care of eligible veterans in State homes. A State home is owned and operated by a State.”<sup>21</sup> The Task Force looked into whether or not the special stipend (\$63/day) could go to nursing facilities in other parts of the State that have residents who are veterans. Unfortunately, the stipulation that the stipends can only go to State-owned and State-operated facilities currently prevents that possibility. The stipend goes to the Home and cannot be used to reduce the Home’s Medicaid rate.

## **Conclusions**

Several conclusions can be drawn from the work of this Task Force.

1. Nursing facilities are seeing significant changes in the market place that are affecting their financial health.
2. Nursing facilities will continue to see changes as more people choose to receive their long-term care in home and community based settings.
3. The expectations about long-term care services will change radically with the aging of the Baby Boomers.
4. Nursing facilities are all vying for a larger share of the Medicare market.
5. New markets and new revenue sources for nursing facilities are limited.
6. Nursing homes can make cultural changes that improve staff retention and improve the life of residents, but in many ways they are constrained by the physical layout of the facilities that were built as “mini-hospitals”.
7. There are ways that nursing facilities can be consumer responsive by spending little if any additional money.
8. Leaving the right-sizing of the industry to the whim of the market place could leave the State vulnerable to having nursing facilities close where they are needed, while nursing facilities in areas where the bed to population ratio is higher than the state average would continue. The State uses this ratio to define “over-bedded” areas. (See Appendix I.) Stabilizing the industry will also stabilize other important components like administrators and directors of nursing.

---

<sup>20</sup> United States Department of Veterans Affairs Website <http://www1.va.gov/homes/>

<sup>21</sup> Ibid.

## Recommendations

### **The Task Force recommends that DAIL:**

1. Support the infrastructure of the Gold Star Council and encourage nursing home facilities to participate in the Gold Star process.
2. Continue the Nursing Facility Quality Awards as a way to promote quality and best practices.
3. Use Civil Money Penalties<sup>22</sup> to promote culture change and celebrate diversity in ways that enhance the quality of life and/or quality of care for residents.
4. Strengthen the Long-Term Care Ombudsman program as a way to assist with culture change in facilities.
5. Determine whether or not the way allowable costs are allocated for space rented or used for community purposes is a financial barrier to facilities providing those spaces.
6. Continue discussions with facilities about the best method for right-sizing the industry, including the model of contracting for resident days. Any plan agreed upon should also recognize the importance of quality care in the contracting process.
7. Examine incentives to accomplish right-sizing of the industry such as bed-banking and conversion of multi-bed rooms to rooms with double and single occupancy.<sup>23</sup>
8. Research financial incentives and financing mechanisms that can assist nursing facilities to develop home-like settings.<sup>24</sup>
9. Analyze whether the threshold of \$750,000 for renovation projects is an appropriate level to trigger the filing of a Letter of Intent re: the determination of whether or not a CON is required.
10. Develop criteria to help decide when major renovation projects should be approved.
11. Analyze the need for additional palliative care services as a specialty in nursing facilities.
12. Work with facilities to determine what is needed to properly care for geriatric patients at the State Hospital and those being furloughed from the Correctional system who would be better served in a nursing facility.
13. Clarify information about assistive technology, i.e. what is covered, by whom, and the most effective ways of obtaining the needed items. Provide this information to facilities, residents and families.
14. Identify barriers in the reimbursement system to the effective use of assistive technology and recommend changes at the state and federal level.

### **The Task Force recommends that nursing facilities:**

---

<sup>22</sup> Civil Money Penalties are funds collected from nursing facilities that have been out of compliance with Federal requirements.

<sup>23</sup> The State of Vermont *Licensing and Operating Rules for Nursing Homes, December 15, 2001*, Section 8.4 (e) (3) and (4) require that “Any downsizing or reduction in licensed capacity initiated by the facility must first reduce the number of beds contained in three- and four-bed rooms such that these rooms are converted to semi-private or private occupancy.” The Rules also require that “Proposals for new construction, expansion, renovation or substantial rehabilitation of a facility requiring Certificate of Need approval pursuant to 18 V.S.A. §9434 will not be approved by the licensing agency unless the construction proposal includes a plan for elimination or conversion of all three- and four-bed rooms to rooms which accommodate no more than two persons.”

<sup>24</sup> Funds from other parts of the LTC system would not be considered as part of this research.

1. Find and/or develop reasons for community members to come to the facility on a regular basis as way to integrate the life of the residents into the life of the surrounding communities
2. Adopt the Gold Star Employer Best Practices, with the additions recommended by the Task Force.
3. Determine ways to provide staff training and resident education that result in respect for both staff and residents who have various social backgrounds, sexual orientation, religious affiliations and from various races.
4. Participate in town and regional planning initiatives.
5. Seek additional ways to include residents in decision-making about day-to-day life in the facility.
6. Improve the dining experience for residents and visitors, e.g. family-style dining to encourage socialization; cultural sensitivity, and resident-determined dining schedules.
7. Make the facility more accessible for both residents and visitors; pay particular attention to resident rooms when planning renovations.
8. Prepare and serve food as close to the residents' living area as possible.
9. Pay particular attention to learning and responding to residents' requests to sleep, dress, bathe and engage in other activities on their own schedules.
10. Use new information technologies to better utilize staff time and improve resident care and quality of life, e.g. for scheduling, MDS assessments, tracking provision of care.
11. Educate residents and family members about the availability of assistive technology and facilitate obtaining any needed items.

**The Task recommends that the Legislature** set aside funding to develop a 10-year plan which would present ways to achieve the vision of nursing facilities that are able to offer quality care in a home-like environment that honors the residents' preferences, customs and individual histories. We have seen that the nursing facilities support these changes and are striving to implement many of them; however, there are many regulatory and reimbursement issues to be explored in depth before long-range plans that would achieve significant changes can be put in place.

# **APPENDICES**

<b>NURSING FACILITIES FOR THE 21ST CENTURY – TASK FORCE MEMBERSHIP</b>			
<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>AFFILIATION</b>	<b>E-MAIL ADDRESS</b>
Barrett	Laura	Franklin County Rehab (St. Albans)	<a href="mailto:LauraBarrettVT@aol.com">LauraBarrettVT@aol.com</a>
Carter	Michelle	LTC Ombudsman Program	<a href="mailto:Tressa.condon@verizon.net">Tressa.condon@verizon.net</a>
Condon	Tressa	Franklin County Rehab (St. Albans)	<a href="mailto:tressa.condon@verizon.net">tressa.condon@verizon.net</a>
Denette	Kathleen	AHS/Division of Rate Setting	<a href="mailto:denette@wpgate1.ahs.state.vt.us">denette@wpgate1.ahs.state.vt.us</a>
Ellis	Brad	Vernon Green Nursing Home	<a href="mailto:Brad@vernonhome.org">Brad@vernonhome.org</a>
Fleming	Dolly	Community of Vermont Elders (COVE)	<a href="mailto:dolly@vermontelders.org">dolly@vermontelders.org</a>
Kane	Susan	Centers for Living and Rehabilitation (Bennington)	<a href="mailto:kans@phin.org">kans@phin.org</a>
Keeler	Fran	DAIL/Division of Licensing and Protection	<a href="mailto:frances.keeler@dail.state.vt.us">frances.keeler@dail.state.vt.us</a>
Lisi-Baker	Deborah	Vermont Center for Independent Living (VCIL)	<a href="mailto:deborah2@vcil.org">deborah2@vcil.org</a>
Majoros	Jackie	State Long-term Care Ombudsman	<a href="mailto:jmajoros@vtlegalaid.org">jmajoros@vtlegalaid.org</a>
Marganzano	Ursula	Burlington Health and Rehab	<a href="mailto:UrsulaMargazano@cplodges.com">UrsulaMargazano@cplodges.com</a>
Mayhew	Rosemary	Bel Aire Nursing Home (Newport)	<a href="mailto:rosemary.mayhew@genesishcc.com">rosemary.mayhew@genesishcc.com</a>
Peterson	Judy	Central Vermont Home Health & Hospice & VAHHA	<a href="mailto:JPeterson@cvhhh.org">JPeterson@cvhhh.org</a>
Rhynard	Chuck	Central Vermont Council on Aging	<a href="mailto:crhynard@cvcoa.org">crhynard@cvcoa.org</a>
Rosenfeld	Robert	AARP Executive Committee	<a href="mailto:vtrubob@adelphia.net">vtrubob@adelphia.net</a>
Rundell	Colleen	Vermont Veterans Home	<a href="mailto:crundell@vvh.state.vt.us">crundell@vvh.state.vt.us</a>
Senecal	Joan	Dept. of Disabilities, Aging and Independent Living (DAIL)	<a href="mailto:joan.senecal@dail.state.vt.us">joan.senecal@dail.state.vt.us</a>
Shepard	Lynette	VNA Adult Day -Chittenden/Gl Counties	<a href="mailto:shepard@vna-vermont.org">shepard@vna-vermont.org</a>
Shriver	Mary	Vermont Health Care Association (VHCA)	<a href="mailto:mshriver@vhca.net">mshriver@vhca.net</a>
Wargo	Lorraine	DAIL/Division of Disability and Aging Services	<a href="mailto:lorraine.wargo@dail.state.vt.us">lorraine.wargo@dail.state.vt.us</a>
Wendell	Sarah	Alternate for VCIL	<a href="mailto:sdwhap@vcil.org">sdwhap@vcil.org</a>

Sources of Revenues at Vermont Nursing Facilities										
Each Source Shown as a Percentage of the Total Revenues										
Cost Report Year	Medicare, incl prior yr adj	Medicaid, incl prior yr adj	Private	VA	Other	Total Patient Revenue	Level III/IV	Other oper	Total Non-Operating	Total Revenue
1999	14.81%	58.40%	22.41%	0.00%	0.48%	96.10%	1.43%	1.49%	0.98%	100.00%
2000	16.94%	54.99%	22.26%	0.00%	0.81%	95.01%	1.54%	1.79%	1.66%	100.00%
2001	19.91%	49.30%	20.20%	0.00%	0.89%	90.30%	1.92%	3.14%	4.64%	100.00%
2002	20.74%	51.65%	19.14%	0.00%	0.92%	92.44%	1.72%	4.46%	1.37%	100.00%
2003	20.55%	53.24%	18.47%	0.00%	1.30%	93.55%	1.78%	4.10%	0.56%	100.00%
2004	21.27%	52.84%	17.90%	0.00%	1.32%	93.33%	1.66%	2.37%	2.64%	100.00%
2005	21.24%	57.15%	16.89%	0.00%	1.76%	97.05%	1.53%	0.28%	1.14%	100.00%
AHS/Division of Rate Setting										

### Vermont Nursing Facilities Percent of Occupancy by Payer Source

	Licensed Capacity	Vermont Medicaid	Out-of-State Medicaid	Private Pay	Medicare	VHAP Managed Care	Other Managed Care	VA	Commercial Insurance	Hospice	Other	Total
May 1999	3729	62.08%	2.27%	17.58%	8.57%	0.00%	0.19%	0.20%	0.05%	0.01%	0.13%	91.07%
May 2000	3719	61.04%	1.89%	17.99%	8.34%	0.00%	0.12%	0.11%	0.01%	0.07%	0.01%	89.58%
May 2001	3709	58.31%	1.67%	19.21%	9.60%	0.00%	0.10%	0.26%	0.03%	0.11%	0.00%	89.30%
May 2002	3559	59.62%	1.54%	17.88%	9.78%	0.00%	0.15%	0.37%	0.08%	0.06%	0.04%	89.52%
May 2003	3543	61.40%	1.63%	16.43%	11.29%	0.00%	0.30%	0.55%	0.15%	0.11%	0.00%	91.87%
May 2004	3419	62.57%	1.44%	16.35%	12.21%	0.00%	0.16%	0.40%	0.18%	0.05%	0.00%	93.36%
May 2005	3419	60.83%	1.70%	14.74%	11.14%	0.10%	0.20%	0.47%	0.17%	0.14%	0.00%	89.49%

Difference between  
1999 and 2005:

-1.25%   -0.57%   -2.84%   2.57%   0.00%   0.00%   0.40%   -0.01%   0.13%   -0.13%

An excerpt of H. 881 follows:

**Excerpt from H. 881, Sec. 149 - Nursing facilities and the Home and Community Based System**

Sec. 149a. Sec. 1a of No. 56 of the Acts of 2005 is amended to read:

Sec. 1a. TASK FORCE ON THE FUTURE SUSTAINABILITY OF NURSING HOMES as amended by the Senate and passed by both Houses.

(a) It is the intent of the general assembly that the department of disabilities, aging, and independent living collaborate with nursing homes, residential care homes, assisted living residences, home health agencies, area agencies on aging, and adult day providers to develop a long-range plan to address the sustainability of Vermont's long-term care system.

(b) The commissioner of disabilities, aging, and independent living shall convene a task force to assist the commissioner in developing statewide recommendations on the future of nursing homes, including the Vermont Veterans' Home, in Vermont. The recommendations shall address the transition issues for nursing homes as more individuals use home- and community-based long-term care services, how nursing homes can convert the services offered to provide long-term care services differently, unmet needs for nursing home services for individuals, accessibility for individuals with disabilities in nursing homes, an annual projection of the number of nursing home beds to meet the projected need over the next 10 years reported by region, the development of adequate home- and community-based services to support increased numbers of Vermonters receiving that type of care, whether indexing is an appropriate method of sustainable funding for home- and community-based services, and the methods which nursing homes can use to become more resident-centered in the provision of long-term care. The task force shall include representatives from providers of long-term care and organizations representing individuals receiving long-term care. The department of disabilities, aging, and independent living shall chair the task force and shall provide administrative support. One member of the house, to be appointed by the speaker of the house, and one member of the senate, to be appointed by the committee on committees, shall be included in this task force and are authorized to attend up to four meetings outside the legislative session. Legislative members of the task force shall be entitled to compensation and reimbursement for expenses under section 406 of Title 2.

(c) The commissioner of disabilities, aging, and independent living shall convene a second task force to analyze Medicaid reimbursement rates for nursing homes. The task force shall include three representatives of the Vermont health care association, one each representing for-profit, not-for-profit, and independently owned facilities; the director of the office of Vermont health access or designee; and the director of the division of rate setting in the agency of human services. This task force shall coordinate as necessary with the task force developed under subsection (b) of this section. This task force shall make recommendations on changes to the rules, methods, standards, and principles for establishing Medicaid payment rates for long-term care facilities in order to meet the protocols and objectives of the Choices for Care Medicaid Waiver Section 1115. Of the appropriation in Sec. 149 of this act, a total of \$25,000 in funding is provided for this purpose. These funds shall be matched by the Vermont health care association.

**Nursing Facilities for the 21<sup>st</sup> Century**  
**Interview Guide**

---

The Task Force wants to offer nursing facilities a chance to meet with some of the Task Force members and provide input to the study directly. Each facility interviewed will have the opportunity to talk with Task Force members about their view of the future.

**Interview Guide**

Interviewers \_\_\_\_\_

\_\_\_\_\_

Name of Facility \_\_\_\_\_

People Interviewed at the facility \_\_\_\_\_

- What capital projects will you need to complete in the next 1-5 years?
- Where do you see your facility 10 – 15 years from now?
  - Physical plant
  - Programmatically, including populations served (special populations?)
- What do you see as unmet needs in your community that could be met by unused space in your facility?
- Do you see any role for your facility in meeting those needs?
- How do you define your market area?
- What opportunities do you see ahead?
- What challenges do you see ahead?
- Have you seen any effects from the Choices for Care waiver program? If so, what have they been?
- Is there anything else that you would like the Task Force to know about?

**Nursing Facility Occupancy Table**

**Appendix E**

<b>Nursing Home by County</b>	<b>Licensed Capacity</b>	<b>VT Medicaid Days</b>	<b>VT Medicaid Occupancy</b>	<b>Total Days</b>	<b>Total Occupancy</b>
<b>Addison</b>					
Helen Porter	105	2,144	65.87%	3,228	99.17%
<b>Bennington</b>					
Bennington	100	1,777	57.32%	2,813	90.74%
Crescent Manor	90	1,299	46.56%	2,687	96.31%
Prospect	21	403	61.90%	651	100.00%
Veterans Home	184	3,250	56.98%	4,831	84.69%
Centers For Living & Rehab	150	2,209	47.51%	4,399	94.60%
Average (weighted)*			52.90%		91.04%
<b>Caledonia</b>					
Pine Knoll	60	1,298	69.78%	1,851	99.52%
St. Johnsbury	110	2,150	63.05%	3,083	90.41%
Average (weighted)*			65.43%		93.62%
<b>Chittenden</b>					
Birchwood Terrace	160	3,375	68.04%	4,775	96.27%
Burlington	168	3,062	58.79%	4,208	80.80%
Green Mountain	73	1,198	52.94%	2,102	92.89%
Starr Farm	150	2,368	50.92%	4,340	93.33%
Average (weighted)*			58.56%		90.31%
<b>Franklin</b>					
Franklin County Rehab	64	1,179	59.43%	1,911	96.32%
Redstone Villa	30	579	62.26%	838	90.11%
Haven Healthcare-St.Albans	120	2,920	78.49%	3,574	96.08%
Average (weighted)*			70.52%		95.31%
<b>Lamoille</b>					
Elmore House - Copley Manor	40	892	71.94%	1,209	97.50%
Morrisville Center	90	1,870	67.03%	2,131	76.38%
Average (weighted)*			68.54%		82.88%
<b>Orange</b>					
Gifford	20	465	75.00%	610	98.39%
<b>Orleans</b>					
Bel-Aire	44	779	57.11%	1,244	91.20%
Derby Green	23	581	81.49%	713	100.00%
Greensboro	30	528	56.77%	860	92.47%

## Appendix E

Maple Lane	71	1,529	69.47%	2,082	94.59%
Newport	50	946	61.03%	1,151	74.26%
Union House	44	995	72.95%	1,236	90.62%
Average (weighted)*			65.97%		89.71%
<b>Rutland</b>					
Eden Park-Rutland	125	3,144	81.14%	3,740	96.52%
Mountain View	166	3,195	62.09%	4,659	90.54%
Haven Healthcare-Rutland	127	2,873	72.97%	3,671	93.24%
Average (weighted)*			71.09%		93.15%
<b>Washington</b>					
Berlin	152	2,442	51.83%	3,761	79.82%
Mayo	50	687	44.32%	1,492	96.26%
Rowan Court	104	2,104	65.26%	2,655	82.35%
Woodridge	153	2,308	48.66%	4,525	95.40%
Average (weighted)*			53.00%		87.38%
<b>Windham</b>					
Eden Park-Brattleboro	80	1,425	57.46%	2,386	96.21%
McGirr	30	643	69.14%	824	88.60%
Thompson House	43	492	36.91%	1,280	96.02%
Vernon Green	60	1,477	79.41%	1,818	97.74%
Average (weighted)*			61.14%		95.53%
<b>Windsor</b>					
Brookside-WRJ	67	993	47.81%	1,829	88.06%
Cedar Hill	39	795	65.76%	1,210	100.08%
Gill Odd Fellows	56	1,318	75.92%	1,579	90.96%
Mt. Ascutney	50	1,131	72.97%	1,447	93.35%
Springfield	102	1,947	61.57%	2,825	89.34%
Average (weighted)*			63.53%		91.33%
<b>State</b>	3401	64,770	61.43%	96,228	91.27%

## TRADITIONAL NURSING HOME COMPARED TO THE GREEN HOUSE

	<b>Traditional Nursing Home</b>	<b>Green House</b>
<b>SIZE</b>	Usually 120+ beds divided into 20-40 bed units	8-10 elders
<b>PHILOSOPHY</b>	Medical model emphasizes provision of services to frail patients.	Social habilitative model calls for an intentional community that prioritizes elders' quality of life.
<b>ORGANIZATION</b>	Steep bureaucracy, nurses control all unit activity.	Flattened bureaucracy, empowerment of direct care staff. Nurses visit the house to provide skilled services.
<b>DECISION MAKING</b>	Decisions made by the organization.	Decisions made by elders as often as feasible. House councils plan menus, activities, and house routines.
<b>ACCESS</b>	Space belongs to the institution; elders have access to their room and public areas, but many spaces are off-limits.	Space belongs to the elders and they may access all areas of the house.
<b>OUTDOOR SPACE</b>	Often challenging to access, particularly without assistance.	Easy access, fenced, shaded and in full view of the hearth and kitchen to allow observation by staff.
<b>LIVING AREAS</b>	Most commonly double bedrooms and shared baths. Lounges and dining rooms usually at the end of long corridors.	Private rooms with private baths, and a central hearth with an adjacent open kitchen and dining area. Short halls and access to the hearth.
<b>KITCHEN</b>	Off-limits to elders and visitors.	Elders and visitors have access and participate in cooking activities.
<b>NURSES STATION</b>	In the center of most units.	None. Medication and supply cabinets in each room. Nurses visit rooms and administer medications.
<b>DINING</b>	Large dining rooms with many elders.	One long dining table, which acts as a focal point for convivium-an enjoyable community meal.
<b>STAFFING</b>	Departmental with segmented tasks.	Elder Assistant (Shahbaz) is a universal worker providing direct care, laundry, housekeeping, and cooking.
<b>VISITORS</b>	Limited ability to participate	Elders participate in meals and other activities, prepare snacks in the kitchen, or hold family celebrations in the Green House.

Staff  
Recruitment

1. Staff Recruitment

- Community outreach & involvement: Nursing home partners with local high school to place students for community service requirement.
- Collaboration with other agencies: Multiple nursing homes work together to advertise for and train new workers.
- Screen for successful employees: Nursing home has a multi-step

application process that includes initial interview, written test, facility tour, call-back requirements, and meeting with staff; nursing home offers entry level position such as Geri-Aid or Valet which can lead to LNA training for interested employees.

- Honest description of job duties and expectations: Nursing home provides opportunity for prospective employee to ask questions of present employees in similar position.
- Direct care workers are involved in recruitment, interviewing, developing interview questions and conducting tour of facility with prospective employees.

Orientation  
and  
Training

2. Orientation and Training

- Standardized orientation that provides consistent, well-developed orientation program covering information new employees need in order to understand all aspects of the organization (e.g., printed orientation manual that includes all personnel policies, appropriate information on resident care policies and procedures, and organizational structure).
- Regular follow-up with new staff: Weekly meeting with supervisor.

- Hands-on training specific to required tasks & responsibilities, such as expanded LNA training to provide three weeks of classroom instruction and two weeks on the unit for orientation and clinical experience.
- Mentoring and support for new employees: Trained mentors such as LNAII provide orientation and training; new staff are paired with long-term employees.

Staffing  
Levels and  
Work  
Hours

3. Staffing Levels and Work Hours

- Stable, reliable hours sufficient to meet employee's needs.
- Flexible scheduling: Weekend program that pays for 36 hours when staff work 24 hours; work 72 hours on night shift over two weeks and get paid for 80 hours.
- Worker control over hours: Weekly unit meeting to determine

assignments and hours for each staff member.

- Overtime is not coercive, pressured or frequently requested: Track overtime hours, examine patterns to identify problem areas and seek to keep overtime at a minimum.
- Safe work loads: Determine comfortable staffing levels for good patient outcomes, quality of care, and patient acuity levels; carefully screen patients for admission and only accept patients when adequate staffing in place to provide needed care.
- Adequate staffing and time for employees to perform tasks: Ensure appropriate staffing levels to provide coverage when staff members call in sick.

## Professional Development and Advancement

### 4. Professional Development and Advancement

- Career lattices, which provide specific structures to develop skills, increase responsibilities, and increase wages (e.g., LNA II program that provides training in mentoring, coaching, and leadership skills; increases job responsibilities in these areas; and brings increased wages).
- Cross disciplinary training: Skill development across units or departments to enable employees to float across areas of facility.
- Mentoring programs for experienced staff to mentor newer staff (e.g., LNA II program; other mentoring training programs within different nursing home job areas).
- Training in specialized care: ACE Program to provide Alzheimer's care; pain management programs; palliative care programs.
- Ongoing training opportunities on site or through financial support of other programs such as tuition reimbursement programs to enable LNAs to train as LPNs, LPNs to train for RN; partnerships with local colleges to develop leadership training programs.

## Supervision: Training and Practices

### 5. Supervision: Training and Practices

- Training for all supervisory staff on cultural competence, problem solving, communication, and coaching skills (e.g., specific training programs for supervisory staff including funded seminars).
- Provide management staff with tools needed to succeed: Adequate time available for supervisors to mentor and coach direct care staff; coaching and supervision for managers to learn from situations and mistakes; administration support for management decisions.
- Accessible management and supervisory staff: Administration literally keeps office door open.
- Demonstrate/model attitudes and behavior: Demonstrate respect by knowing and using workers' names; administrator and other leadership demonstrate good supervisory practices.
- Treat each employee as important to achieving facility mission.
- Specific, measurable job descriptions that can be used to conduct performance reviews of supervisory staff (e.g., use measures of quality and staff absenteeism and turnover to assess supervision).

### 6. Team Approach

## Team Approaches

- Direct care staff involved in patient care planning: Regular team meetings to discuss care plans that include all service areas and employees who provide direct patient care.
- Shared responsibility for patient care and outcomes: Nurse managers work with staff on the floor to get the job done; explicit job expectation includes collaboration and "one team" approach.
- Permanent assignments to units or teams to promote development of relationships among team members.

- **Team building activities are regularly scheduled and mandatory:** Morning meeting with whole team, with management and supervisory staff required to attend.
- **Regular meetings and communications** to share information (e.g., white board with day's information, direct care staff meet with management).
- **Staff involvement in problem solving and decision making:** Employee Advisory Committee; problem solving teams.

**Staff  
Recognition  
and  
Support**

**7. Staff Recognition and Support**

- **Multiple strategies to express appreciation and respect:** Birthday celebrations, savings bonds for longevity, brag board for good deeds, employee of the month, staff appreciation events.
- **Reward years of service** with pay increases, gifts, and/or opportunities for advancement (e.g., mentoring, care specialization).
- **"Personal touch"** – name tags, mail boxes, voice mail, introductions to others in agency, "welcome new staff" board with photos, personal signatures & presentations of gifts/awards from administrator and/or director of nursing.
- **Fun at work initiatives:** Staff committee to develop events/activities, celebrate holidays; drama club.
- **Counseling resources:** Employee assistance program; arrangement with local therapist for counseling, facility covers co-pay.

**Nursing Facilities by Type of Ownership**

**Appendix H**

<b>Owned by “Chains”</b>	
Central Park Lodges (CPL) – Canadian-based corporation	Berlin Health & Rehab Center
	Burlington Health & Rehab Center
	Bennington Health & Rehab Center
	Redstone Villa
	Rowan Court Health & Rehab
	St. Johnsbury Health & Rehab Center
	Springfield Health & Rehab Center
Haven Health Care – New England chain	Haven Health Center – Rutland
	Haven Health Center – St. Albans
Genesis – Pennsylvania-based chain	Bel-Aire Center
	Morrisville Center
	Mountainview Center
Eden Park chain	Eden Park – Brattleboro
	Eden Park - Rutland
Kindred Healthcare – Kentucky-based chain	Starr Farm (50% ownership by Fletcher Allen Health Care)
	Birchwood Terrace Healthcare
<b>Vermont-Based Ownership Groups</b>	
Kingdom Care (Northeast Kingdom)	The Pines
	Maple Lane
	Union House
Brookside Properties	Green Mountain Nursing Home
	Brookside Nursing Home – White River Jct.
<b>Hospital-Based Nursing Facilities</b> (these non-profit facilities share a common wall with a hospital)	
Mt. Ascutney Hospital and Health Center	
Menig Extended Care (at Gifford Hospital)	

<b>Hospital-Related</b>	
(non-profit facilities under the hospital “umbrella”, but not physically connected to the hospital)	
Woodridge Nursing Home	
Centers for Living and Rehabilitation	
Helen Porter Healthcare and Rehab Center	
Derby Green Nursing Home	
<b>Not-for-profit Facilities</b>	
Greensboro Nursing Home	
Mayo Healthcare	
Elmore House – Copley Manor	
Gill Odd Fellows Home	
Thompson House Nursing Home	
Vernon Green Nursing Home	
<b>For-Profit Independent Facilities</b>	
McGirr Nursing Home	
Franklin County Rehab Center	
Cedar Hill Health Care Center	
Newport Healthcare Center	
Prospect Nursing Home	
Crescent Manor Care Centers	
<b>State-owned Facility</b>	
Vermont Veterans Home	
<b>Non-Medicaid Facilities</b>	
Merten’s House	
Arbors Nursing Home	
Wake Robin-Linden Nursing Home (Medicare-certified)	

**VERMONT DEPARTMENT OF DISABILITIES, AGING  
and INDEPENDENT LIVING  
NURSING FACILITY (NF) BEDS BY COUNTY  
RANKED BY BEDS PER 100 18+ DISABLED POPULATION**

<u>County</u>	<u>Population</u> 18+ Disabled 2005 est.*	<u>Licensed</u> NF Beds 10/1/2006*	Ratio of <u>Licensed NF</u> <u>Beds per 100</u> <u>18+ Disabled*</u>
<b>Counties above the average State ratio of 44.8</b>			
Bennington	794	545	68.7
Washington	815	459	56.3
Orleans	469	262	55.8
Lamoille	278	130	46.7
Rutland	909	418	46.0
<b>Counties below the average State ratio of 44.8</b>			
Franklin	486	214	44.0
Caledonia	393	170	43.3
Windsor	760	314	41.3
Chittenden	1,433	539	37.6
Windham	569	213	37.5
Addison	340	105	30.9
Orange	231	20	8.7
Essex	51	0	0.0
Grand Isle	46	0	0.0
<b>State Total</b>	<b>7,573</b>	<b>3,389</b>	<b>44.8</b>

\* *Data Notes:* Includes Veterans Home and Wake Robin  
 Excludes Non-Medicaid/Non-Medicare Facilities (Arbors-12 beds, Mertens-14 beds)  
 Disabled Population: Lewin Estimates 2005, defined as "needing assistance  
 with 2 or more activities of daily living".  
 NF Beds: DAIL Licensing and Protection, October 2006  
 Does not adjust for beds used by out-of-state residents.

## VERMONT NURSING FACILITY DETAILS

<u>Nursing Home</u>	Year Built	One Story	Multi-Story	Minimum Admit Age	number 3-bed rooms	number 4-bed rooms	Licensed # of Beds	Usable Beds
The Arbors Nursing Home (data not included - all private facility)							12	
Bel Aire Quality Care	1967	Yes		none	0	0	44	
Bennington Health & Rehab	1971		3 Floors	none	0	0	100	
Berlin Health & Rehab	1971	Yes		none	0	2	152	
Birchwood Terrace	1965	Yes		none	0	0	160	
Brookside Nursing Home (WRJ)	1963	Yes		none	1	2	67	
Burlington Health & Rehab	1968		5 Floors	none	4	0	168*	
Cedar Hill Continuing Care	1994	Yes		none	0	0	39	
Centers for Living and Rehabilitation	1985 - addition 1994	Yes		none	0	0	150	
Elmore House at Copley Manor	2000		2 Floors	none	0	0	40	
Crescent Manor Care Center	early 1960s	Yes		18	0	0	90	93**
Derby Green	1892		2 Floors	none	3	0	23	
Eden Park Nursing Home (B)	1973		4 Floors	40	0	2	80	
Eden Park Nursing Home (R)	1971		4 Floors	none	0	6	125	
Franklin County Rehab	2004	Yes		21	0	0	64	
Gill Odd Fellows Home	1974	Yes		18	0	0	56	
Green Mt. Nursing Home	1894		3 Floors	16	7	7	73	
Greensboro Nursing Home	1976	Yes		none	0	0	30	***29
Haven Health Care Rutland	1976		3 Floors	none	2	0	127	123****
Haven Health Care St Albans	1971	Yes		none	0	12	120	
Helen Porter Nursing Home	1991	Yes		18	0	0	105	109*****
Maple Lane Nursing Home	1984		2 Floors	none	1	3	71	
Mayo Healthcare	1974	Yes		none	0	0	50	
McGirr Nursing Home	1898		3 Floors	none	2	0	30	
Menig Extended Care	1999	Yes		none	0	0	20*****	
Mertens House (data not included - all private facility)							14	
Morrisville Center	1970	Yes		none	0	0	90	
Mountain View Center	1971	Yes		18	23	0	166	157*****

				Minimum	number	number	Licensed	Usable
<b>Nursing Home</b>	Year Built	One Story	Multi-Story	Admit Age	3-bed rooms	4-bed rooms	# of Beds	Beds
Mt. Ascutney Nursing Home	1972 - addition in 1992	Yes		18	0	0	50	
Newport Health Care Center	1972	Yes		not under teen yrs	0	0	50	
Pines Rehab & Health Center	1961; NH in 1980		3 Floors	none	6	0	60	
Prospect Nursing Home					2		21	
Redstone Villa					2		30	
Rowan Court Health & Rehab Center	1972		2 Floors	none	1	0	104	99*****
St. Johnsbury Health & Rehab Center	1971	Yes		none	0	0	110	
Springfield Health & Rehab Center	1972		3 Floors	None	0	0	102	
Starr Farm Nursing Center	1987	Yes		None	0	0	150	
Thompson House	1957		3 Floors	55	0	0	43	
Union House	built 1830; NH in 1950		2 Floors	none	2	0	44	
Vermont Veterans Home	1884 additions later	Yes		18	1	1	184	
Vernon Green	1966, adds. in '75 & '88	Yes		none	0	4	60	
Wake Robin (data not included - private CCRC facility)								
Woodridge Nursing Home	1993	Yes		none	0	0	153	
*Burlington H&R will de-license 42 beds October 1, 2006								
**Crescent Manor beds made into privates, could go back to semi if necessary								
***Greensboro septic system precludes using all beds								
****Haven Health Care Rutland restructured rooms to allow more space on rehab unit								
*****Helen Porter has beds available for specialty care based on needs								
*****Menig Extended Care will soon be 30 beds								
*****Mountain View converted six 3-bed rooms into doubles; converted one 3-bed room into country kitchen								
*****Rowan Court converted some 3 rooms to other use, but did not give up any licenses								

## BACKGROUND INFORMATION ON THE STATE VETERANS' HOME<sup>25</sup>

The Veterans' Home is a State-operated facility, governed by a 20-member board of trustees appointed by the Governor. Fifteen members of the Board must be veterans. According to the Vermont State Auditor's Report dated November 21, 2005, ambiguity concerning the role of the Board and the role of the Agency of Human Services still exists.

The Home is licensed for 184 resident beds and there are approximately 220 employees at the Home. In July 2005 there were 163 residents at the Home. The Home provides care to veterans, spouses of veterans, and Gold Star Mothers of veterans. "Today, there are more than 200 chapters of American Gold Star Mothers across the United States composed of mothers who have lost a son or daughter during past wars and armed conflicts, or while serving our country."<sup>26</sup>

All staff are state employees and work under the State contract negotiated with the State employees union.

The Veterans' Home recently entered into a 20-year agreement with the federal Veterans' Administration to share in the costs of the major renovations at the Veterans' Home. During that 20-year time period, the facility space may only be used for services that benefit the veterans.

---

<sup>25</sup> *Vermont Veterans' Home*, November 21, 2005, Report of the Vermont State Auditor

<sup>26</sup> July 2006 Press release from Governor George Pataki's office. Today, there are more than 200 chapters of American Gold Star Mothers across the United States composed of mothers who have lost a son or daughter during past wars and armed conflicts, or while serving our country.

## Nursing Facility Quality Initiatives

**Better Jobs/Better Care** – 3 nursing homes are voluntarily participating in this three-year grant project which ends December 31, 2006.

**LEADS (Leadership, Education.....)** – 2 nursing facilities are voluntarily participating. *Northern New England Leadership, Education and Advocacy for Direct Care and Support (LEADS) Institute* offers training and support to frontline caregivers providing long-term care services in Vermont, New Hampshire, and Maine. The *LEADS Institute* is building a core of strong leaders among direct caregivers, supervisors, and administrators through outreach and education.

**Gold Star Employer Program** – voluntary employee retention program that is Vermont specific. Seventeen nursing facilities are participating in the current cycle and this is the third year of the program.

**Quality First** – this is a voluntary program endorsed by American Health Care Association (represents for-profit as well as not-for-profit nursing facilities - VHCA is the state affiliate), the Association of Homes and Services for the Aging (represents only non-profit nursing facilities), and the Alliance for Quality Nursing Home Care (an organization of large national chains). Thirty two Vermont facilities have taken the “quality first” pledge (this number includes some residential care homes).

**Quality Improvement Organization - QIO (North East Health Care Quality Foundation)** –A CMS initiative that began in 2002 to measure four areas (quality measures) – pain, use of restraints, pressure ulcers, and depression. These measures are publicly reported for all nursing facilities. In addition, the QIO began working with an “intensive” group of nursing homes (initially 15) to help them improve in the four areas mentioned. Employee satisfaction and culture change has been added to the QIO’s charge. Approximately 27 Vermont nursing homes are participating in this area.

**STAR** program (Setting Targets, Achieving Results) - was started about a year ago to allow nursing facilities to set and track their own targets in each of the quality measures. This initiative is part of the QIO quality measures initiative described above.

**NIFT** (the Nursing Home Information Feedback Tool) pronounced “nifty” is another computer-based data collection tool to collect data on the four QIO quality measures.

**The Campaign For Nursing Home Excellence** – this is yet another new quality initiative, announced on September 29, 2006. It is endorsed by the same organizations that backed Quality First. It includes seven areas of focus and participating facilities may choose at least three focus areas; at least two must deal with clinical quality and at least one must deal with employee issues (facilities may choose more than three areas if they want to).

**DAVE** (Data Assessment and Verification) –A CMS program to examine resident records to determine the accuracy of MDS assessments, conduct independent random resident assessments and provide education support to facilities. The initial DAVE started in 2001 and DAVE II began in April, 2006. The first DAVE was basically a paper review. DAVE II is going to be on-site visits.

**State and Federal survey processes** – an opportunity for facilities to improve deficiencies.