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STATE OF VERMONT
AGENCY OF HUMAN SERVICES

MEMORANDUM

TO: Representative Michael Fisher, Chair, House Health Care
Senator Claire Ayer, Chair, Senate Health and Welfare

CC: Doug Racine, Secretary, Agency of Human Services
Susan Bartlett, Special Assistant to the Governor
Steve Kimbell, Banking, Insurance, Securities and Health Care Administration

FROM: Susan Wehry, Commissioner, Disabilities, Aging and Independent Living

DATE: February 15, 2012

SUBJECT: Act 83 Legislative Report

Enclosed please find the Home Health Work Group Report which is required by Act 83 of the 2010 Legislative Session. Please note that the due date had been extended to February 15, 2012.

If you have any questions or require additional information, please contact me.

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Act 83 (2010)

Home Health Work Group Report

Submitted to the
House Committee on Health Care and
the Senate Committee on Health and Welfare

January 6, 2012

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ACT 83 (2010)
HOME HEALTH WORK GROUP REPORT

A. Background

Historically, home health services in Vermont have been delivered through a limited number of affiliated not-for-profit Medicare certified home health agencies, collectively serving the state through designated territories falling roughly along county lines. Under this scenario, Vermonters in any given town generally had only one choice of provider. The Certificate of Need (CON) review program in Vermont was implemented in 1979; and since that time there has been controversy as to whether home health services should continue to be delivered through the same affiliated network of providers or through a more competitive model which would allow for greater choice of providers in any given region. Since the implementation of the CON process other providers have sought CONs to provide home health services with applications being denied until 2005, when Professional Nurses Service was issued a CON to become a Medicare certified home health agency and authorized to provide services statewide. In 2009, Bayada Nurses Inc., purchased Professional Nurses Service and was issued a CON to continue to provide home health and hospice services statewide.

Today Vermont is served by ten (10) not-for-profit Medicare certified home health and hospice agencies providing services to specific geographic areas of the state and one for-profit Medicare certified home health agency, Bayada Nurses, Inc., providing services statewide. Thus, since 2009 Vermonters have had two Medicare certified home health and hospice providers from which to choose when seeking services. Since Bayada's entrance as a home health provider no further entities have applied for a CON to become a Medicare certified home health agency.

In addition, in 2007, the Department of Disabilities, Aging and Independent Living implemented a designation process establishing minimum standards for home health agencies. Organizations that apply for home health agency designation are obligated to provide or arrange for all medically necessary home health and hospice services.

With the aging of the population, and concomitant expected growth in the number of Vermonters needing home health care services in the future, debate continues as to whether the distinct rural nature of the state is best served through the existing network of Medicare certified home health agencies or through a more competitive model. To date, indicators of unmet need have not been established, making it difficult to prove or disprove whether there is need for home health and hospice services that is not currently being met by the existing agencies designated to provide home health services. Typically indicators of unmet need include access, cost and quality measures.

B. Summary of Act 83 (2010)

During the 2010 legislative session Act 83 was passed relating to issuance of certificates of need for home health agencies and addressing patient transportation services in certificate of need applications. Act 83 established a moratorium on the offering of new home health services, including hospice services through June 30, 2013 or until the General Assembly lifts the moratorium after considering and acting on recommendations of a work group. Section 2 of Act 83 requires the Commissioners of the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) and the Department of Disabilities, Aging and Independent Living (DAIL) to convene a work group. Act 83 specified that the work group be comprised of: 1) at least one for-profit home health agency; 2) at least two nonprofit home health agencies, one of which serves a population base of fewer than 35,000 residents and another which services a population base of more than 35,000 residents; and 3) other interested parties. The act specified that the work group meet at least four times a year.

Act 83 directed the work group to develop objective criteria for certificate of need (CON) decisions regarding home health services, including hospice, identifying the following tasks:

- Establish a definition of need;
- Develop a method for measuring the impact of any proposed project on existing service providers and population they serve;
- Identify standards by which to measure unnecessary duplication of services that would increase the costs to the health care system and the state;
- Determine whether any additional standards to govern the approval of new home health services or the offering of home health services should be adopted, including whether changes should be made to the Health Resource Allocation Plan regarding home health services, including hospice.

C. Meetings/Organizations Represented on the Work Group

The Act 83 Home Health Work Group met for an organizational meeting in September 2010 with subsequent meetings in April, June, August, October and November of 2011. Organizations represented included: Vermont Assembly of Home Health Agencies, Bayada Nurses, Inc., Disability Rights Vermont, Community of Vermont Elders, Vermont Association of Area Agencies on Aging, PACE Vermont, Vermont Long Term Care Ombudsman, Vermont Health Care Association, Wake Robin, Vermont Center for Independent Living, Home Instead Senior Care, the Department of Disabilities, Aging and Independent Living and the Department of Banking, Insurance, Securities and Health Care Administration.

D. Criteria identified by the various stakeholders

Vermont Assembly of Home Health Agencies and Bayada Nurses, Inc. each submitted written documents containing criteria to be considered. The Vermont Health Care Association submitted Guiding Principles. DAIL provided a list of data elements currently collected from the Medicare Certified Home Health Agencies by the Division of Licensing and Protection.

E. Process

Following submission of objective criteria by stakeholders, the criteria were discussed and more criteria were identified through the work group discussions. BISHCA staff then compiled a matrix worksheet (titled, Objective Criteria Worksheet) that included each criterion that had been identified by the work group. The matrix included the identification of pros/cons, general or definitional issues relative to each criterion and whether the work group member would recommend the criterion for use in the CON review process. During the meeting process, work group members also identified other factors (titled, Other Considerations Worksheet) that were not objective criteria but factors that might be considered when evaluating a CON. BISHCA staff created a master worksheet representing all factors identified by work group members for meeting discussion purposes. At the end of the meeting process, work group members were asked to complete the two worksheets so that results could be tallied.

F. Results of Worksheets Submitted by Work Group Members

Based on the worksheet submissions, the work group reached limited consensus on criteria they would recommend for use in the CON process. Out of 26 criteria, not one was unanimously recommended by all organizations that submitted completed worksheets. For most criteria identified on the worksheet, work group members were split. Based on submission of the Other Considerations worksheet, there was more unanimous agreement on three factors and the remaining factors were split between finding the factor helpful or not helpful in evaluating CONs. This lack of consensus made it difficult to establish the metrics and standards contemplated by Act 83.

G. Commissioners' Recommendations

The Commissioners of the Department of Disabilities, Aging and Independent Living and the Department of Banking, Insurance, Securities and Health Care Administration recommend the following:

1. **Analyze data from home health agencies currently collected by DAIL:** DAIL currently collects data from home health agencies on a quarterly basis. The following data elements will be analyzed and shared with BISHCA to determine whether the data is useful in determining unmet need for use in evaluating future CONs relative to new home health agencies: independent client satisfaction surveys that indicate less than 90% overall satisfaction rates; provider complaint rates filed with DAIL as compared to Vermont average; significant deficiencies cited related to quality of care resulting in action by the Division of Licensing and Protection; number of persons on wait lists by program; average length of wait by program; and number of persons eligible for but not provided services by program.

2. **Encourage other providers to seek contracts with existing Medicare certified home health agencies and vise-versa:** More formal cooperation between Medicare certified home health agencies and other home care providers may facilitate more timely access to care, continuity in care providers, more flexibility in meeting consumer time preferences for care, and may provide more choice and control for consumers relative to where and how care is provided.

3. **Develop materials in hard copy and on the web with full contact information for available providers by county and contact information for consumer complaints:** Materials should be widely distributed to increase consumer awareness. Require discharge planners, hospitals, nursing homes, home health agencies and physicians to make educational materials about home health services available to patients and their families. Encourage organizations serving elders, younger persons with physical disabilities and children with physical disabilities and their families and employers to disseminate the educational materials.

4. **Maintain the moratorium on the admission of new home health agencies and services until it expires on June 30, 2013:** DAIL will be working with home health agencies over the next year to address outstanding access issues in the system. Therefore, to maintain stability during that process, the moratorium should remain in effect until its natural expiration on June 30, 2013.

APPENDIX 1

SUMMARY OF OBJECTIVE CRITERIA IDENTIFIED BY MEMBERS OF ACT 83 HOME HEALTH WORK GROUP

Summary of Objective Criteria Indentified by Members of Act 83 Home Health Work Group				
OBJECTIVE CRITERIA	**PROS**	**CON**	**ISSUES/DEFINITIONS/etc.**	**RECOMMEND Yes/NO**
Services to Medicare eligible population fall below the national/New England average of individuals served per 1,000 eligible population for 2 consecutive years				Yes-5; No-1
Services to Medicaid eligible population fall below the national/New England average of individuals served per total population for two consecutive years				Yes-4; No-2
Agency provided less than 90% of all service hours identified in Choices for Care Home Based Service Plans (Personal Care, Respite, Companion) for a period longer than two years				Yes-3; No-3

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Statewide population projections indicate a growth in service for eligible populations at rate greater than historic capacity to respond by existing home health agencies				Yes-3; No-3
Independent client satisfaction surveys indicate less than 85% overall satisfaction for 2 consecutive years				Yes-3; No-3
Home Health Compare outcome measures are 10% worse than national average for more than 2 years				Yes-2; No-4

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Provider complaint rates filed with DAIL are 15% greater than the Vermont average per 100 clients served for more than two year period				Yes-1; No-5
Deficiency trends for period greater than 2 years				3-Yes; No-2; Maybe-1
Medicare hospice utilization rate is below national/regional average				Yes-2; No-4

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
At least two home health agencies per designated area				Yes-4; No-2
Number of patients on wait lists by program				Yes-3; No-1; Neutral-1; Maybe-1
Average length of wait by program				Yes-3; No-1; Neutral-1; Maybe-1

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Number of individuals eligible/not provided services by program				Yes-5; No-1
Number of complaints logged by program				Yes-3 No-3
Number of complaints internally resolved by program				Yes-2; No-4

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Number of complaints not resolved in 7 days but resolved in 30 days by program				Yes-2; No-4
Number of complaints agency reported to L & P by program				Yes-2; No-4
Number of complaints referred to outside agency by program				Yes-1; No-5

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Transferred/discharged to hospital by program				Yes-3; No-2; Neutral-1
Transferred/discharged to nursing home by program				Yes-2; No-3; Neutral-1
Goals met discharges by program				Yes-2; No- 3; Neutral-1

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Death discharges by program				Yes-1; No-4; Neutral-1
Other discharges				Yes-1; No-5
Total discharges				Yes-1; No-5

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Hospitalization rate by program				Yes-3; No-3
Cost per unit for administration/overhead and direct vs. indirect cost				Yes-2; No-3; No comment-1

OBJECTIVE CRITERIA	PROS	CON	ISSUES/DEFINITIONS/etc.	RECOMMEND Yes/NO
Your Name:				
Your Organization:				

APPENDIX 2

OTHER CONSIDERATIONS

Other Considerations for Evaluating Need For New Home Health Services for Use in the Certificate of Need Program

Below is a list of other factors to consider when evaluating whether new home health services are needed as well as guiding principles identified, to date, by members of the Act 83 Home Health Work Group relative to the Certificate of Need (CON) program. Please indicate whether you believe each is or is not useful in evaluating need for new home health services by responding "useful" or "not useful".

Other Factors:

1. Is there a significant barrier to obtaining medically necessary home health services in a geographical service area? Useful-7 Not useful-0

2. Are there significant numbers of eligible and identifiable persons presently unable to obtain medically necessary services from the existing home health agencies (HHAs) in a geographical service area? Useful-7 Not useful-0

3. Are there significant and documented delays in the discharge of patients from hospitals, nursing homes and other residential settings due to the inability of HHAs to admit patients in a timely manner? Useful-7 Not useful-0

4. Once patients are admitted for services, are existing HHAs able to promptly and reliably provide the full array of mandatory services? Useful-6 Not useful-1

5. Are existing HHAs in the designated geographical area unable or unwilling to offer the full range of mandatory medically necessary services? Useful-6 Not useful-1

6. Does geographical service area experience significant deficits in the quality of care being provided by existing HHAs measured by the following standards compared to other areas of the state and/or New England region? (A) high levels of surveyed deficiencies involving substantial deficits in quality of care; (B) high levels of verified complaints to DAIL; (C)high levels of poor performance in certain designated performance markers and Home Health Compare standards. Useful-6 Not useful-1

7. Is the population of actual or prospective patients impacted by high levels of unmet need or deficiencies in the quality of care sufficient to financially support an additional full service HHA in the designated geographical area? Useful-4 Not useful-3

8. What would the impact be on the existing HHAs if a new entity is authorized to provide services in the designated geographical area, is the new entity fully staffed, and is there a sufficient number of patients to be served to be financially viable? Useful-3 Not useful-4

9. Is there a sufficient staff in the workforce to cost effectively staff a new HHA without adversely affecting the ability of the existing HHAs in the designated geographical area to recruit and retain staff? Useful-3 Not useful-4

10. Are there sufficient remaining clients to financially support the existing HHAs? Useful-3 Not useful-3 Undecided-1

11. What is the impact on existing HHAs to subsidize all home health programs and services? Useful-3 Not useful-4

12. To what extent are existing HHAs experiencing financial distress that would be further exacerbated by the addition of a new HHA serving the designated geographical area? Useful-3 Not useful-4

13. Does the applicant have the necessary capital to finance the infrastructure and fully staff the proposed HHA for at least three years while it builds its client base? Useful-4 Not useful-3

14. Should OASIS functional status data be used to provide information relative to the capacity of an HHA to provide the level of home health services needed? Useful-2 Not useful-3 Undecided-2

15. Should independent consumer satisfaction surveys be implemented and data used in evaluating patient satisfaction for services provided by HHAs. Useful-5 Not useful-1 Undecided-1 (comment stated, "only if truly independent")

Guiding Principles: Please indicate whether you believe the following principles should or should not be used in the assessing need for new home health services.

16. Criteria should include consumer choice. Yes-6 No-2

17. Criteria should include consumer preference and satisfaction. Yes-6 No-2

18. Criteria should be flexible and allow for innovative care models, recognizing the changing demographics and preferences of consumers. Yes-5 No-3

19. Criteria should allow consideration of care models that enhance continuity of care. Yes-7 No-1

20. Criteria should allow for consideration of care models that improve outcomes. Yes-7 No-1

21. Criteria should consider quality of care and services. Yes-7 No-0 Undecided-1

22. Exempt from CON review, home health services provided by long term care communities offering multiple levels of care and services within their own communities (i.e. skilled nursing, residential care, assisted living, independent living) as long as the home health services are provided to residents residing in the long term care community. Yes-2 No-5 No Position-1

APPENDIX 3

VAHHA PROPOSED STANDARDS

PROPOSED BIFURCATED STANDARD
Proposed by Vermont Assembly of Home Health Agencies
March 18, 2011

No CON application for a new home health agency may be <u>accepted</u> for consideration unless the commissioners of banking, insurance, securities, and health care administration and of disabilities, aging, and independent living have each first certified (1) that a "serious, substantial, and chronic lack of access to home health services" exists in a particular county, (2) that the agencies presently serving that county have been given notice, (3) that they have been given a reasonable opportunity to either challenge that certification or remediate the problem, and (4) that they have failed to successfully challenge that determination or remediate the problem.

Comments on the value of extending this strict standard

It is generally recognized that high levels of service and quality already exist throughout Vermont

There are now two home health agencies certified to provide a full range of services in every town in the state.

There remains a serious question about whether the population base in most areas of the state is sufficient to support the existing home health agencies.

In 2005 the legislature established substantial additional regulatory oversight of Vermont's home health agencies that allows for a wide variety of enforcement mechanisms for deficiencies that serve as effective alternatives to the authorization of new home health agencies.

The current budgetary challenges on Medicaid and Medicare reimbursement rates warrant strict restrictions on the consideration and approval of additional home health agencies.

PROPOSED DEFINITION

Functional definition of "serious and substantial lack of access to home health services."

The Commissioner shall not make a finding that a serious, substantial, and chronic lack of access to home health services has been found to exist in a particular county unless (s)he first determines that:

1. **Services to the Medicare eligible population fall below the national average of individuals served per 1,000 eligible population for a period of two consecutive years;**

2. **Services to the Medicaid eligible population fall below the national average of individuals served per total population for a period of two consecutive years; and/or**

Comments on these statistical and demographic definitions of need.

The initial trigger for even opening consideration of a new home health agency CON Application should be simple, easily determined, objective (and not anecdotal), comparable to a national standard, and focused on the core business of home health agencies – the delivery of medically necessary services under physicians' orders in what is commonly called home care services.

Any trigger and review should be focused on each individual county as a geographical service area. Issues in one area of the state should not drive a decision to grant a statewide CON.

ADDITIONAL CONSIDERATIONS ONCE REVIEW HAS COMMENCED

If and only if the findings required above have first been made regarding a particular geographical service area, then and only then should an applicant be allowed to submit an application for a CON to provide services in that particular service area. In doing so, the Applicant bears the burden of establishing that an additional agency is necessary to address this unmet need and that (a) any unmet need is not attributable to inadequate reimbursement rates that do not cover costs and/or are inadequate to attract the necessary staff and (b) is not the result of workforce shortages unrelated to agency performance. Only then should a more detailed review be conducted that would include a wide range of objective standards for consideration. These include

1. **Is there a significant barrier to obtaining medically necessary home health services in the geographical service area that has been opened for review:**

    A. **Is there a significant number of eligible and identifiable persons presently unable to obtain medically necessary services from the existing agencies already designated to serve this particular geographical service area?**

    B. **Are there significant and documented delays in the discharge of patients from hospitals, nursing homes, and other residential and assisted living facilities because of the inability of the existing home health agencies to admit them in a timely way?**

2. **Once patients are admitted for services, are the existing home health agencies able to promptly and reliably provide the full comprehensive array of mandatory home health services (e.g. PT, OT, SLP, etc.)?**

    A. **Are the existing Home Health Agencies serving this region unable or unwilling to offer a full range of mandated, medically necessary services?**

3. **Does the geographical service area experience significant deficits in the quality of care being provided by the existing home health agencies as measured by the following standards and evaluated in comparison with other areas of the state and the broader New England region?**

A. **High levels of surveyed deficiencies that involve substantial deficits in the quality of care**

B. **High levels of substantial, verified complaints to the DDAIL Hotline**

C. **High levels of poor performance in certain designated performance markers and Home Care Compare standards**

4. **Is the population of actual or prospective patients which is impacted by high levels of unmet need or deficiencies in the quality of care sufficient to financially support an additional full service home health agency in that particular geographical service area of the state?**

5. **What would be the impact on the existing home health agencies and the clients they presently serve, if a new home health agency is authorized to serve that particular area, if the new agency is fully staffed, and if the new agency actually serves a sufficient number of patients to be financially viable?**

    A. **Is there sufficient staff in the workforce to be able to cost effectively staff a new home health agency without adversely impacting the ability of the existing home health agencies to recruit and retain sufficient staff?**

    B. **Would there be sufficient remaining clients to financially support the existing home health agencies?**

    C. **What would be the impact on the existing agencies' ability to subsidize important home health programs and services?**

    D. **Are the existing agencies already experiencing financial distress of one kind or another that would be further exacerbated by the addition of a new home health agency to the area?**

6. **Does the applicant have the necessary capital available to fund the infrastructure and to fully staff the proposed home health agency for at least three years while it builds its client base?**

Comments

These are some of the additional considerations that should be considered once the initial threshold has been established to allow an application to be accepted and considered. This is not an exhaustive list and it is still being developed. However, they are offered as an early example of the bifurcated process that is envisioned in this proposal.

APPENDIX 4

BAYADA PROPOSAL

Bayada Nurses Proposal

Bayada Nurses proposes a 3 element scorecard approach to determine if there is unmet need for Home Health Care in Vermont. The 3 elements consist of Choice, Quantitative data and Qualitative measures. Failure to pass a minimum threshold of standards/needs tests in any of the 3 categories and an overall aggregate score would indicate that an un-met need is present.

Choice.

Choice is the norm for Home Health Care in the United States. At least two states, Montana and Washington, both CON states, have language in their CON regulations that supports a minimum of 2 choices of Home Health providers. H.202 that passed the Vermont legislature this past session clearly supports choice as a governing principle for the state's health care system. ("Every Vermonter should be able to choose his or her health care providers.")

Comparative measures.

Bayada believes that comparative quantitative data is a key element in determining need. Services to the Medicaid and Medicare eligible populations as proposed by VAHHA appear to be appropriate as a measure to ensure that Vermonters are served and receive equitable rates of home care compared to other states. National data might be used as comparative data but is subject to wide ranges of Home Health utilization. For instance, a low rate of 26 persons is served per 1000 enrollees in Hawaii, versus a high rate of 146 persons served per 1000 enrollees in Texas. Comparative regional data from the other New England States allows for regional similarities that may set a higher standard of "content validity" than national data. Hospice data, as a core offering required of Home Health providers in Vermont would be included in these proposed standards. Likewise, Data for the 1115 Waiver, Choices for Care program would also be included.

Quality measures

Qualitative measures serve to address how well Vermont Home Health providers are performing at the "person level," which is a core and critical consideration in any kind of assessment of services to people. Such qualitative measures must be applied equally to all providers. Measures such as client satisfaction should be based on third-party surveys in order to reduce the appearance of survey bias and allow for apples to be compared to apples. Complaint data, Performance Indicator and Home Care Compare data are already externally reported and thus meet the third-party review criteria.

Overview of a proposed 3 tiered scorecard

Less than total 8 criteria met = unmet need

	Choice Less than100% = an unmet need	**Comparative** Less than 4 criteria met =an unmet need	**Quality of services** Less than 3 criteria met = unmet need
Criteria	Do consumers have a choice of Home Health providers?	Is there less than the Medicare National and/or New England average for eligible persons served per 1000 for a period of 2 years?	Do Independent Client Satisfaction surveys indicate less than 85% overall Satisfaction for 2 consecutive years?
		Is there less than the Medicaid National and/or New England average for eligible persons served per 1000 for a period of 2 years?	Are Home Health Compare outcome measures 10% worse than the National average for a period of greater than 2 years?
		Has Home Health provided less than 90% of all service hours identified in the Choices for Care Home Based Service Plans (Personal Care, Respite and Companion) for a period of longer than 2 years?	Complaints filed with DAIL. Does the provider have a complaint rate 15% greater than the Vermont average per 100 clients served for a period greater than 2 years?
		Do statewide population projections indicate a growth in service eligible populations at a rate greater than historic capacity to respond by the existing home health agencies?	Do individual Home Health Agencies have deficiency trends for a period greater than 2 years?

		Is the Vermont Medicare Hospice utilization rate below the national and/or regional average?	

APPENDIX 5

VCHA PROPOSED PRINCIPLES

VHCA Draft Principles and Proposal for Discussion with Act 83 Stakeholder Workgroup

Guiding principles for review of CON process:

- The criteria should include consumer choice with regard to providers;
- The criteria should include consumer preference and satisfaction;
- In recognition of the demographics of Vermont and the continually changing preferences and needs of consumers, the criteria should be flexible and allow for innovative models of care that may be coming in the future;
- The criteria should allow for consideration of care models that enhance the continuity of care in an efficient manner;
- The criteria should allow for consideration of care models that improve outcomes (tbd);
- The criteria should consider quality of care and services.

VHCA recommends that the following services be exempt from state CON requirements:

Home health services provided by long-term care communities that offer multiple levels of care and services (i.e. skilled nursing, residential care, assisted living, independent living) within their communities, as long as the home health services are provided within the long-term care community.

The benefits of allowing for this type of care model without incurring the burden and expense associated with a CON process are many:

- Residents will have greater choice in, and access to, providers of such services;
- Continuity of care, coordination and integration of services across care settings will be improved due to an existing provider-resident relationship, resulting in improved outcomes, lower costs to the healthcare system, and higher resident satisfaction;
- Facilities operate on a 24/7 staffing model, making it easier to meet the individual needs and preferences of residents in an efficient manner, resulting in higher resident satisfaction;
- Recognizes resident's expectations that their care needs will be provided by the community they have chosen to live in.