



## memorandum

**To:** Thomas Hamilton  
Director, Survey and Certification  
Centers for Medicare and Medicaid Services

**From:** Robert Jenkins  
Director, The Green House Project  
NCB Capital Impact

**Date:** June 9, 2009

**Re:** Community-based Green House homes certified as a single provider

**CC:** Karen Schoeneman, Cindy Graunke

Thank you for the support you and your team have provided to THE GREEN HOUSE® Project to date. Your early work to clarify compliance issues, educate state and federal staff, and identify The Green House model as a good example of person-centered care has been critical to the spread of the model.

We appreciate your willingness to discuss the next level of the model's de-institutionalization efforts – making Green House homes, licensed as skilled nursing homes, a true part of the home and community-based care options available to elders and persons with disabilities<sup>1</sup> in the communities where they want to live. Realizing this goal requires moving Green House nursing homes off of long-term care campuses and into neighborhoods and small towns across America and doing so in a manner that can be financially viable for providers who primarily serve Medicaid beneficiaries.

We are excited to be entering into these discussions. We feel that the community-based Green House concept fits well with CMS's long standing commitments including your ongoing New Freedom and related Olmstead initiatives. We believe that community-based Green House homes will offer a choice that some consumers will find to be the most integrated setting appropriate for their skilled nursing needs, i.e., skilled care in small, self-directed homes located in real neighborhoods.

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<sup>1</sup> The Green House model serves older persons and people with disabilities who require skilled nursing care. Older and younger persons served in The Green House homes are referred to as “elders” to reflect the wisdom their life experience has provided.

We are also aware that community-based Green House homes raise some important and valid questions for CMS staff that need to be fully explored. This memo and its appendices provide background and details on The Green House model, our community-based Green House homes concept, and some thoughts on items we assume will need to be addressed at our meeting with your staff on June 16, 2009. Specifically, Appendix 1: Evaluation of F Tag requirements for Community-Based Green House Homes, takes a first look at compliance with certain F Tags that community-based Green House homes call into question.

This memo provides a starting point for discussions and is not meant to be comprehensive. We expect our discussion to evolve and that we will need to provide additional background, details, and solutions as your staff and our team identify opportunities and concerns. Our hope is that through a series of these discussions we will be able to create a model and pilot approach to test effective structures and distances that meets our mutual goal of creating additional high quality community-based alternatives for those with the greatest needs and least resources.

The Green House Project is looking forward to our discussion on June 16, 2009 from 9-12. Please contact me at 703-647-2314 or [rjenkens@ncbcapitalimpact.org](mailto:rjenkens@ncbcapitalimpact.org) if you would like any other materials or have any questions that you would like to discuss before our meeting.

## **I. Background**

### **a. The Green House Model**

The Green House model is an effort to transform skilled nursing facilities into caring homes that support meaningful lives. The Green House model combines high quality skilled nursing care delivered 24-hours a day, 7-days a week with a home setting and a culture of mutual respect and relationships. Green House homes are characterized by their small size of 10-12 private bedrooms, high staffing ratios, self-managed and cross-trained work teams, home cooked family meals, and a focus on the preferences and rhythms of the elders as opposed to the rigid demands of institutional scheduling.

The Green House model takes pride in the results of a two year independent research study conducted by Dr. Rosalie Kane which shows that elders in The Green House pilot project enjoy a significantly higher quality of life and care compared to residents in traditional nursing homes (see [www.thegreenhouseproject.org](http://www.thegreenhouseproject.org) > research). Improvements include high levels of elder and family satisfaction, less prevalence of depression, and a higher sense of privacy, autonomy, dignity and overall well being. We are delighted that these same results are evident in the subsequent implementations, totaling 57 homes.

There are two additional research projects underway. One study, by and Siobhan Sharkey of Health Management Strategies and Susan Horn of the Institute for Clinical Outcomes Research (Sharkey, Horn, et al, 2009), is looking at workflow and related outcomes. Another study, by Barbara Bowers of the University of Wisconsin, is evaluating nursing practices in Green House homes and the homes

impact on clinical practices. Preliminary findings from these studies indicate that additional quality of care and quality of life benefits exist in The Green House Project approach:

- “...if anything, the nursing care is better [in a Green House home] than in a conventional nursing facility. “Things don't get overlooked at a Green House, as they might be in a nursing home, where caregivers don't work so closely with each other. If an elder stumbles at a Green House, every caregiver knows it and starts watching that person” (Barbara Bowers as quoted in a Dallas Morning News article on The Green House homes, 2/3/09).
- Preliminary findings from the Sharkey, Horn et al study comparing Green House homes to matched and unrelated traditional nursing homes indicate:
  - No in-house acquired pressure sores in the 14 Green House homes compared to a 4.2% rate in the six unrelated traditional nursing homes
  - 24% more direct care time provided on average in The Green House homes
  - Almost 2/3s less caregivers reporting moderate to high stress related to time available to provide resident care (14% versus 42%)
  - Almost 2/3s less time spent waiting at the table for meals in The Green House homes (18 minutes versus 47 minutes)

Final research findings from these two studies will be available in the late summer of this year.

#### b. The Green House Project

In 2005, the Robert Wood Johnson Foundation funded The Green House Project with a goal to develop 50 Green House projects in five years. At this time, 18 organizations are operating 57 Green House homes, and 22 other organizations have over 130 homes in development. To date, all skilled nursing home implementations of The Green House model have been built on a campus. These campuses often include existing long-term care settings and services (e.g., an existing traditional nursing homes, assisted living).

## **II. Why Community-Based Skilled Nursing Facilities are Needed**

While campus-based Green House homes offer many advantages, they continue to segregate elders from the regular communities that they may seek and prefer. Long-term care campuses segregate elders and others from normal life, including the people, neighborhoods, and routines that have defined their daily lives and often given them meaning. Green House homes in residential areas will allow elders to retain community connections and remain in neighborhoods comprised of people of diverse ages, interests, and abilities.

The Green House Project would like to extend our current implementation options to include multiple Green House homes, certified as a single provider, integrated into communities one or more at a time using a “scattered site” approach - a model we call community-based Green House (CBGH) homes. We would like to add this option to our program to increase the community-based options available and affordable to people requiring the highest levels of skilled care, people that have all too

often been excluded from current community-based settings due to their significant needs or low-incomes. Providing small house nursing homes truly integrated into residential neighborhoods will address this deficit through truly integrated settings offering consumers, advocates, and providers a viable and replicable community option.

A strong secondary benefit of CBGH homes is that their distributed locations and small scale allow them to become part of the residential fabric and life of the neighborhood. This will make them more inviting and convenient to visitors and volunteers, encouraging the preservation of family and community ties and all the attendant benefits. Even if The Green House home is not located precisely in the former neighborhood of an elder, a Green House home located in a residential area, as opposed to an isolated campus of an institution, will allow elders to stay connected to the rhythms of a community. They will be able to smell and perhaps participate in summer time barbeques, watch children going to and from school, and be a part of communal seasonal activities such as trick or treating, holiday singing, and holiday decorating. New relationships will develop between elders and people in the neighborhood while existing friendship will be preserved.

Rural areas have a special need for community-based Green House Homes. Traditional nursing homes can be miles away from an elder's home and community due to the sparse population and limited long-term care resources in these areas. Strategic placements of Green House homes in small towns and rural areas could offer high quality nursing home care with much less disruption to the lives of the elders and their families. The small scale of the individual Green House homes makes such an approach economically feasible as long as they are able to share appropriate leadership, clinical, and programmatic resources.

Aging in place is what seniors increasingly want and demand. The rapid growth and enthusiastic reception of the intentional village concept<sup>2</sup> is testimony to the desire of the elderly to stay in their communities as they age. Leaders of intentional villages understand that there are limits to how much care can be provided to those living alone at home. They are already inquiring about the possibility of having Green House homes within the village area to care for those who wish to age-in-place but whose medical needs require an alternative placement. A Green House home in the community would be in keeping with the intentional village concept and would allow this movement (and other similar efforts to keep seniors at home) to respond to the lack of small, community integrated models of skilled care.

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<sup>2</sup> The first intentional village started in Beacon Hill in Boston in 2004. Residents in the neighborhood who did not want to move to a retirement community formed a membership organization to help members (people over 50 who live on Beacon Hill) age-in-place. Many other communities are creating their own villages. The services offered in an intentional community vary, but typically include transportation, social events, enrichment programs, support from a corps of volunteers and vetted referrals to contractors and healthcare providers. See [www.beaconhillvillage.org](http://www.beaconhillvillage.org), [www.capitolhillvillage.com](http://www.capitolhillvillage.com), [www.lincolnparkvillage.com](http://www.lincolnparkvillage.com), [www.avenidas.org](http://www.avenidas.org).

### **III. The Green House Model**

#### **a. The Home.**

Although there are different architectural models for Green House homes, they all share certain characteristics. Generally, there are 10-12 private bedrooms, each with a private bathroom, a ceiling lift, and locked medicine cabinet. The common rooms consist of an open working kitchen, dining room area with a table that can seat all elders, two guests and staff, a living room with a hearth area, and a den. There is also an office with a computer where medical records are kept. The office is available to the nurses and the clinical support staff members. Each home has direct access to a secured outdoor space.

The Green House homes are built to institutional life safety and building codes. Although they are built on a smaller scale and use materials that have a residential appearance, the homes meet the same standards as traditional nursing homes to protect those who are unable to self-evacuate. Required kitchen safety features include gas shut off valves or induction cook tops, locking cabinets and drawers for sharp utensils and chemicals, and gates which can separate the kitchen area during times of high activity or when a Shahbaz needs to leave the kitchen when hazards are present (e.g., a hot pot of spaghetti sauce is cooking on the stove). There is sufficient refrigerator, freezer and dry storage to meet federal and state requirements as well as other emergency preparedness requirements. Each house has a call system for elders that alerts the staff through a system of pagers, cell phones, or two-way radios.

#### **b. The Direct Care Staff**

The Green House homes are staffed by self-managed direct care teams comprised of cross-trained certified nurses' assistants (CNAs) known as Shahbazim. The Shahbazim are trained CNAs, who manage and perform personal care, meal, housekeeping, and laundry duties (see Appendix 2: The Green House Education Program and Appendix 3: The Shahbaz Role & Responsibilities). In addition to the CNA certification training, all Shahbazim complete approximately 42-hours of training to learn Green House skills needed for effective person-directed care within The Green House philosophy, including enhanced communication, problem solving, conflict resolution, and The Green House values of mutual respect, autonomy, and choice. In addition, Shahbazim are trained in CPR, first aid, safe food handling practices, culinary skills, basic maintenance, and emergency response.

The Green House model requires significant Shahbazim time per elder per day. This requirement is typically met by having two Shahbazim per home on the day and evening shifts, and one Shahbaz per home over the night shift. Other staffing patterns may be used in community-based Green House homes to meet elders' needs and preferences as long as they provide a minimum of four hours of direct care time per elder per day.

Each Shahbaz is assigned to a single house on a permanent basis to provide elders with continuity of care and the opportunity to develop close relationships

with the Shahbazim. To date, anecdotal information and research indicates that Shahbaz job satisfaction is high and turnover quite low.

The Shahbazim are supervised by and report to the nurses for the nursing services they provide under their scope of practice. The Shahbazim report to The Green House “Guide” for all responsibilities outside of their nursing services (e.g., household management, meals, house keeping, laundry, and scheduling). The Guide is a licensed nursing home administrator or someone who reports to a licensed administrator. The supervision of the Shahbazim is divided in this manner to allow good clinical outcomes while, at the same time, allowing day-to-day household management decisions to be driven by a non-medical structure (see Appendix 4: Shahbaz Reporting & Supervisory Structure).

### c. The Clinical Support Team

The clinical support team is comprised of all clinicians required by federal and state rules, including nurses, social workers, physical/occupational/speech therapists, activity director/recreation therapists, dieticians, and a medical director. This team will split its time between the CBGH homes as needed and as scheduled. They will communicate with each other through pagers, cell phones, medical records, and other means as dictated by best practice and federal and state requirements. These communications will be equivalent to the communication systems in traditional nursing home settings (see Appendix 5: The Clinical Support Team).

Nurses: Nurse will be available on-site to each CBGH on a 24-hour basis, 7-days a week. Typically this will be one licensed nurse per two homes during the day and evening shift and one licensed nurse per two to three homes over night. Registered nurse (RN) coverage will be provided through the house nurses or through an RN who visits the homes on a regular basis and in conformance to federal and state requirements. The nurses have responsibility, within their scope of practice, for assessment, planning care in partnership with Shahbazim, care delivery, communicating with the DON and physicians about clinical issues and clinical concerns, evaluating care, and communicating clinical changes with the appropriate clinical professionals.

RNs have clinical responsibility for assessment and all nurses have responsibility for planning care in partnership with Shahbazim, communicating with the DON or his or her designee about clinical issues and concerns, evaluating care, and communicating clinical changes with the elder’s physicians and appropriate clinical professionals.

Other than a requirement for a DON and minimum nursing hours, regulations do not typically set specific requirements for other clinical positions. There is intentional flexibility built into the Green House model’s deployment of the clinical team (outside of the house nurses) to allow team members to spend time where they are most needed. In order to provide flexibility to respond to daily needs, The Green House Project allows each Green House organization to determine how to most effectively meet these standards. The CBGH clinical team

model is designed to allow flexible alternative staffing schedules that meet federally and state mandated requirements and provide good outcomes.

For example, the social worker will be expected to visit each elder shortly after admission, as needed, and at least quarterly. The social worker will also be expected to meet with elders more frequently to address identified needs, concerns and changes, as requested by the elder, the family, or the staff (nurse, Shahbaz, Sage, etc). In contrast, the physical, occupational, and speech therapists will visit the homes on the basis of individual need and physician prescription only. To assure that elders and their families have access to the clinical support team, contact information for all team members and the ombudsman will be given to the elder and the family at admission and at each quarterly assessment. The contact information shall also be placed in a binder in the foyer of each house.

Social Worker: One or more social workers, depending on number of homes, will be available to elders living within The Green House homes. A schedule of regular visits to the homes will be carried out by the social worker. In addition, the Shahbaz and nurse will coordinate needs for medical, dental, podiatry appointments, and family issues with the social worker as needed. Further, the social worker will give his/her cell and office phone number to each elder and family to enable the elder to contact him or her directly if needed. There will also be a binder located in the front foyer of each house with the contact information for all staff so that elders and families will always know how to reach staff members.

Although the social worker will not have a dedicated office in The Green House homes, since each elder will have a private bedroom, the social worker will be able to meet each elder in privacy as desired.

Physical, Speech and Occupational Therapists: Therapists will visit The Green House homes on an as needed basis. Their records will be entered into the medical records of each elder kept at the home or available electronically in the home.

Medical Director: A medical director will be employed as per traditional nursing homes to participate in quality assurance and provide overall medical direction of the care in the homes.

Dietician: A dietician shall be available as required by state and federal rules to participate in care planning and delivery. The dietician will be available to each house to review menus and provide support around dietary issues and will coordinate with the food service manager.

Activities/Recreational Therapy: The activities/recreational therapist shall be available as required by state and federal rules to participate in care planning and to assist Shahbazim plan and conduct individual and group activities.

#### d. The Administrative Team

The administrative team will consist of an administrator, a DON, and department staff as required.

The Administrator/Guide. A licensed nursing home administrator will oversee all Green House homes in conformance with state and federal requirements. The Guide can be a licensed nursing home administrator, or an appropriately qualified team member who reports to the licensed administrator, depending on the size of the SNF (SNF) and regulatory requirements. The Guide will be responsible for direct supervision of Shahbazim (CNAs) in connection with their non-nursing service responsibilities, and will visit The Green House homes to support the self-managed work teams on a continuous but unscheduled basis. Administrative responsibilities for quality of care and quality of life remain with the licensed administrator as in a traditional nursing home. The licensed administrator will be directly involved in reviewing quality assurance data, hiring and performance evaluation of employees, budgeting and resource utilization, and all responsibilities of the nursing home administrator. Depending on the size of the organization, there could also be a CEO or a COO as well as the administrator.

The Guide will be responsible for overseeing the work of the rest of the administrative team. The Green House Project intends to give the Guide great flexibility to carry out the non-medical responsibilities in a manner that takes into consideration the number of Green Houses and the geographic distances between them, the profile of the labor pool, and the ability to draw on staff from other composite parts of the same nursing home.

The Director of Nursing (DON): The DON reports to the Administrator as in a traditional nursing facility. The DON has responsibility for quality of care in The Green House homes and all licensed nurses report to the DON through appropriate structures. Depending on the organizational structure and size of the organization, there could be a staff development nurse, or the responsibilities of that position could be handled by the charge nurses.

#### **IV. The Community-Based Green House Model and Regulatory Compliance**

As The Green House Project has evaluated the unique set of issues posed by placing Green House homes in a community, it has sought informal guidance from state and federal regulators. As part of this process, The Green House Project has identified key questions and concerns, and it has been working to explain compliance strategies and tailor its model to address these issues. This memo lays out the basic structure of the CBGH model and addresses the questions posed by regulators about this iteration of The Green House model. The Green House Project is aware that the decisions of state and federal regulators will apply to all small home skilled nursing homes. Therefore, The Green House Project will set specific standards where appropriate to provide uniform and measurable implementation criteria that will assure compliance with government regulation.

The Green House Project has identified three likely approaches for licensing CBGH homes depending on the circumstances of the organization implementing the project. The first approach, a “partial” CBGH implementation, allows an existing provider to move or expand current skilled nursing capacity into the community while maintaining all or part of an existing operation on campus (the “Affiliated Model”). The second approach, a “full” CBGH implementation, allows an organization to convert

all of its current nursing home operations into CBGH homes or “start-up” a new skilled nursing operation (the “Independent Model”). The third potential model is a “mixed” model where a provider may use existing capacity or obtain additional beds and will build Green House homes on the campus of an existing skilled nursing home and in the community (the Hybrid model).

a. Affiliated Model Implementation

Existing traditional nursing home facility + new CBGH homes: Under 42 CFR §483.5 (c), Green House homes built in the community (one or more homes) could be deemed composite distinct parts of an existing certified nursing home. Under this model, The Green House homes would draw on the resources of the departments that may be appropriately shared and are already in existence on the main campus of the SNF. In this model, many of the leaders on the main campus will assume the same leadership responsibilities for The Green House home. This model would work in a manner very similar to the existing campus-based Green House homes which share certain services and staff, except that the main campus would be further away from The Green House homes and emergency planning and staffing would take this distance into account.

b. Independent Model Implementation:

All CBGH homes (no traditional facility): A newly licensed nursing home or a fully transformed operation comprised of several CBGH homes. This model would certify CBGH homes as composite distinct parts under a new or fully transferred SNF license. Under this model, there is no campus-based SNF and homes would share certain clinical support, leadership, administrative, and maintenance capabilities between themselves. These functions could use a separate building or small additions to the homes to house administrative offices for these staff. If these functions are collected in one building, it could be located adjacent to a pair of homes or in a location that conveniently serves the homes.

c. Hybrid Model Implementation:

Traditional facility + campus-based Green House homes + CBGH homes: This approach would certify CBGH homes as composite distinct parts of an existing certified nursing home. As a combination of the Affiliated and Independent models described above, the Hybrid model would occur when a skilled nursing home operates a traditional SNF and Green House homes on a main campus as well as operating Green House homes in the community. Depending on the organization’s resources and structure, the facility may create one or more satellite administrative hubs in the community to support The Green House homes and meet regulatory requirements.

d. Geographic Boundaries for CBGH homes:

The Green House Project believes that setting performance standards regarding clinical and administrative outcomes as well as emergency response capacity together with detailed care plans and minimum staffing hours is more effective in obtaining high quality outcomes than setting a requirement that the

homes be within a certain maximum distance from one another. Maximum distances between Green House homes can not address diverse needs or recognize local conditions that could render distances a poor proxy for response times because of traffic or unforeseen barriers. Instead, alternate staffing approaches (i.e., part-time staff located close to clusters of homes) will be utilized to meet established federal and state performance standards.

## **V. Issues Raised by Regulators**

This section provides an overview of the significant issues raised in preliminary discussions with CMS staff. For a detailed discussion of related F Tags, please see Appendix 1: Evaluation of F Tag Requirements for Green House Homes.

### **a. Sufficiency of Staffing**

The Green House Project has fielded a number of questions as to the sufficiency of the staffing of Green House homes, particularly when the home is not in immediate proximity to a large nursing home and its resources. The staffing model described in Section III results in an average of 1 to 1.2 hours of direct nursing care per resident per day, and 4.0 hours of Shahbaz (CNA) care per resident per day for a total of 5 to 5.2 hours.

This Green House minimum recommended staffing model meets or exceeds all federal and state requirements and greatly exceeds the average staffing numbers found in traditional nursing homes. As reported on Medicare's Nursing Home Compare website, the average nursing home provides a total of 3.6 hours.

### **b. Emergency Response**

In the event of multiple, simultaneous events or an emergency, The Green House homes have a higher minimum and actual staffing ratio than average nursing homes, providing additional capacity to respond. Should the events or emergency require additional staff assistance, the first request would go to the nurse who would be in the home or the adjacent Green House home. If more than one additional staff is needed and it is during the day or evening shift, the second Shahbaz from the adjacent Green House could also assist, providing 4 trained workers to care for 10 – 12 elders. If the need for additional staff occurred overnight when only one Shahbaz is on duty, the first call would be to the nurse on duty. The second call would be to the supervisor on call or, as appropriate or necessary, to 911. To assure that The Green House Project practices were consistent with CMS expectations and that the clinical outcomes will reflect high quality care, additional analysis and discussion of emergency procedures are set forth in more detail in Appendix 1: Evaluation of F Tag Requirements for Green House Homes.

### **c. Supervision of Elders**

The policies for supervision and maintaining a hazard free environment are set forth through a combination of guidance from The Green House Project and the policies and procedures that will be developed by each project in accordance with state and federal requirements. The Shahbazim will receive comprehensive training

on these policies and procedures and the DON, Guide, and Medical Director will all visit the home at regular and unannounced intervals to insure knowledge of and the consistent application of these policies and procedures (see Appendix 6: The Sage Role & Responsibilities).

#### d. Staff Development

All Shahbazim are CNAs and receive substantial additional training to meet the job requirements of The Green House model. There is emphasis on educating staff on communication and work place skills specific to The Green House model. The Green House training curriculum was developed through the Robert Wood Johnson Foundation Grant. For an complete outline of the full Green House Project Education program for leadership, nurses, Guides, and the core team, please see Appendix 2: The Green House Project Education Program.

Ongoing education will be provided by educators and leaders at each project. National Green House educational programs will be available through in-person, web-based, video-based, and written instruction. The DON and Guide will be on site regularly to ensure that the staff members are performing their duties in accordance with their training.

#### e. Quality Assurance

As mentioned in the introduction, independent research has shown that elders in Green House homes and their families report a greater sense of well being and a high quality of life. The Green House Project is participating in additional independent research which will provide insights regarding staffing and quality. Observations of currently operating Green House homes by Green House staff, researchers, and others suggest that quality of life and care outcomes are replicated in the new homes.

Pressure sores. Avoiding facility acquired pressure sores requires close assessment of each elder's clinical condition, good nutrition and hydration, good hygiene and attention and assistance with positioning and mobility. Both licensed nurses and direct care staff need to be involved and committed to evidence-based skin care. As mentioned previously, the most recent review of data from Green House homes showed a zero % in-house acquired pressure sore rate in the 14 Green House homes surveyed.

Weight Loss. Weight loss is another common problem in skilled nursing facilities. Preparing the meals in the home and filling the home with the sounds and smells of cooking helps stimulate appetites. The Shahbazim know the food preferences of each elder and can prepare specific favorite foods. Many Green House providers comment on the reduced incidence of unexplained weight loss when an elder lives in a Green House home. Research has found that when food is flavorful and is presented in a social atmosphere with a pleasant ambiance, positive changes in body weight and more stable health conditions occur.<sup>3</sup>

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<sup>3</sup> Mathey, MA, Vanneste, VG, Graaf, D, de Groot, L, van Staveren, WA et al, Health Effect of Improved Meal Ambiance in a Dutch Nursing Home: A 1-Year Intervention Study. Preventive Medicine 32, 416-423 (2001);

**Oversight.** The quality assurance system will include the DON, the Medical Director, and the nurses from each house. Providers will analyze data for each house and provide the data to the clinical and Shahbazim teams so they can participate in the process of clinical system improvement.

f. Abuse and Neglect.

Research has shown that the single most important factor in preventing abuse and neglect of elders is high staffing levels to reduce the strain on the staff.<sup>4</sup> The Green House model mandates a high staffing level such that each Shahbaz (CNA) typically cares for no more than 5 elders during the day and evening shift, and the Shahbaz on the night shift cares for no more than 10 to 12 elders. This case load is significantly less than in many nursing homes, thereby helping to alleviate the stress that develops from insufficient staffing. Current research conducted in a sample of Green House home (Sharkey, Horn et al, 2009) has identified that Green House homes provide over 50% more direct care time (Shahbazim and nurses) than the unrelated traditional nursing home comparison sites. This same study shows that only 14% of direct care staff Shahbazim (CNAs) in Green House homes reported moderate to high stress, compared to 42% of the CNAs surveyed in the traditional settings.

The Green House providers also addresses potential for abuse and neglect by conducting rigorous background checks on prospective employees and training staff on how to identify and investigate abuse and neglect per state and federal standards. The administrator and Guide will have established policies and procedures for the investigation of all reported and suspected incidents of abuse and/or neglect. All findings will be reported as required to the authorities having jurisdiction.

Further checks and balances include the role of the nurses in conducting the initial assessment of each elder upon admission followed by regular body checks and routine assessments of overall physical condition and well-being. The social worker, administrator, Guide, and the DON will be in the home on a regular schedule as well as on unannounced visits to observe the care of the elders. Members of the clinical support staff and the Sage will serve as additional eyes and ears at the home.

The Sage is a volunteer position in The Green House model that serves as a resource for the Shahbazim and as an advocate for the health and well-being of the elders. The Sage supports the self-managed work team of Shahbazim to facilitate

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Mathey, M, Siebelink, E, Graaf C, Van Staveren, WA, Flavor Enhancement of Food Improves Dietary Intake and Nutritional Status of Elderly Nursing Home Residents. *J of Gerontology* 56A, NO. 4 M200-M205 (2001).

<sup>4</sup> Lindbloom, EJ, Brandt, J, Hough, LD, Meadows, SE, Elder Mistreatment in the Nursing home: A Systematic Review. *Journal of the American Medical Directors Association* 8: 610-616 (2007); Joerst, GJ, Daly, JM, Hartz, AJ. State Policies and Nursing Home Characteristics Associated with Rates of Resident Mistreatment, *J Am Med Dir Assoc*: 9 648-656 (2008); Pillemer, K, Bachman-Prehn, R. Helping and Hurting: Predictors of Maltreatment of patients in nursing homes. *Res Aging* 1991; 13(1):74-95.

critical thinking and problem solving. He or she also serves as a listener, friend, and advocate for elders and family members. The Sage makes routine scheduled and unscheduled visits his or her Green House home and attends house and team meetings as needed.

Lastly, experience to date indicates that the families of the elders spend more time in The Green House homes than in traditional nursing homes. Although The Green House model does not rely on the presence of family to oversee the staff, The Green House Project believes that greater family participation is important to preventing abuse and neglect in any nursing home setting.

g. Disaster Preparedness.

Green House homes will meet or exceed all federal, state, and local requirements. There has been some concern expressed about the Green House homes' ability to provide equivalent disaster preparedness and protection compared to a larger building. Our view is that large buildings have advantages and disadvantages that, when combined with lower average staffing ratios, do not provide greater emergency response capacity or protection from disasters than The Green House homes.

Smaller homes located throughout a community minimize risks by distributing sites and there by reducing the number of elders at risk at any disaster site. It is much less taxing for staff and emergency personnel to evacuate 10 to 24 elders from a CBGH site in the path of a tornado, flood, or chemical spill than from a larger nursing home. Not only is the evacuation simpler because there are fewer people but because there is a higher staff ratio to assist in the evacuation. The CBGH approach also offers a ready made and fully trained mutual aide network with appropriate facilities and staff capacity immediately available.

Like larger facilities, each CBGH project will develop emergency plans for each shift drawing on local emergency services and resources as needed to assure a comprehensive and successful plan. The Green House Project strongly believes that the most important issue in any emergency response plan is the ratio of staff to residents, not the absolute numbers of staff. The fact that the minimum staffing requirements of a Green House home exceed average nursing home staff and that a distributed network of homes will be able to rely on greater numbers of available emergency resources will, we believe, allow Green House homes to out perform larger facilities in most disaster and internal emergency scenarios.

In addition to the Shahbazim and nurses on site 24-hours a day, 7-days a week, Green House homes will have an extensive on call network to draw from for internal and external emergency response. An administrator and an RN will be on call at all times if they are not on site at the time. All members of the staff will carry pagers or cell phones to facilitate communication during emergencies and the local emergency responders will be briefed about the protocols at The Green House home.

#### h. Physical Environment and Life Code Requirements.

Green House homes currently meet all life-safety code and building code requirements (a detailed evaluation of F Tag compliance is attached in Appendix 1). The Green House Project is aware of concerns that operators with poor motives might be able to develop a small community-based homes in sub-standard residential buildings should CMS agree to license CBGH homes. This will not be possible as the CBGH initiative will require providers to be licensed as skilled nursing homes and existing residential structures will not meet the building and life safety requirements without extensive renovation. Because of the substantial costs associated with such renovations, it is unlikely that anyone would be able to, or seek to, use dilapidated housing as a community-based nursing home.