Board of Selectmen
Broad Street
Nantucket, MA 02554

July 15, 2013

Dear Board Members:

Our Island Home Work Group is pleased to present its final report to the Board of Selectmen. This report is the culmination of the Work Group's, analysis, benchmarking, discussion and deliberations and represents the unanimous conclusions and recommendations of its members.

Since the Work Group's final meeting the Nantucket Cottage Hospital has advanced a proposal to locate a new hospital at Wannacomet Water Company property. In the course of our meetings and deliberations we discussed the option of tying Our Island Home and the hospital closer together but this option never seriously advanced due to land constraints at the hospital's current location.

Non-the-less, our care conclusions and recommended future course for Our Island Home remain. If availability is no longer a constraint the Work Group would strongly recommend that discussions with Nantucket Cottage Hospital be enjoined.

On behalf of the entire Work Group we have appreciated the opportunity to serve the Town in this important undertaking.

Respectively submitted,

Our Island Home Work Group
David Worth, Chairperson

Our Island Home Work Group

Future Options and Recommendations for Our Island Home and Senior Citizen Related Services

June, 2013

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Executive Summary

Mission, Introduction, Methodology & History

In September, 2012, the Board of Selectmen established the Our Island Home (OIH) Work Group (WG) to report back to them with the following:

1. Future options and recommendations regarding OIH and associated town-operated senior citizen-related services, including Senior Day care.
2. A timeline for the development of a report outline and final report for the Board of Selectmen, including what if any resources the work group may propose be acquired for completion of its work i.e., market studies, detailed financial analysis.
3. Review reports, data, documents and other information that are on hand, including 2007 architectural plans and presentation to the Board of Selectmen.
4. Review, discuss and make recommendations pertaining to Riverwood/Servant's (to be delivered) status report to the Board of Selectmen as to the Senior Day Care program.
5. Discuss pros, cons, costs and revenues of current delivery systems of the local organizations that provide senior citizen-related services.
6. Review and discuss the Town's lease with Sherburne Commons, in terms of long-term planning

Since that charge was given there have been several intervening events that have particular bearing on OIH including the potential sale of Sherburne Commons by Cornerstone nee Riverwood/Servant to Northbridge Companies and the plans for the construction of a new, expanded hospital.

In the course of our review the WG has concluded that the need for skilled nursing care on Nantucket is going to remain and that demand for skilled nursing care, given demographic trends, is likely to grow over the next 20+ years.

Major Conclusions of the Work Group

- *The status quo is not a viable long (or even short term) strategy for OIH.*
- *The nature of skilled nursing care, how it is paid for, and the federal and state reimbursement structure for skilled nursing is changing.*
- *No real viable options exist on island to the skilled nursing care currently provided through OIH*. The WG notes a growing national trend toward keeping those potentially requiring this level of care in the community as long as possible. While other forms of care exist on island, none rise to the level of care provided by OIH.

- *A significant burden will be placed on families if skilled nursing care is not available on-island.* Individuals requiring skilled nursing care generally chose care within 35 miles of where they or their families currently live. For most families this provides a reasonable number of options. But, as we all know, Nantucket's geographical location would necessitate local residents who require skilled nursing care and can't get it on-island to procure the care off island. While transportation alternatives have greatly improved it would place an undue burden on island residents and their families.

- *The current operating model at OIH is not sustainable over the long term without continuing or increased taxpayer subsidy.* The current trajectory of increasing operating costs, declining federal and state reimbursements and an intended shift of state and federal reimbursement agencies from institutional care to community based care make projecting future options difficult and complex. This problem is not unique to Nantucket although the potential solutions may be more limited due to the island's geographical location.

- *Reimbursement rates from Mass Health, which makes up 68% of yearly OIH revenue, are declining and currently are below the cost of providing the services.* The Center for Medicare and Medicaid Services (CMS), the federal entity that is responsible for these programs, projects growth in skilled nursing facility (SNF) reimbursements to grow at 50% of the cost of providing the services at OIH.

- *The operating costs at OIH will continue to rise annually as employee costs, which make up 80% of total operating costs, continue to rise at around 5% per year.*

- *OIH is in need of major refurbishment or a new facility within the next few years.* Recent citations from the MA Department of Public Health point to the need for investment in deferred maintenance and other improvements to the existing structure or risk sanctions in the form of fines or the freezing of admission of new residents. Repair costs have not been estimated but are very likely to exceed $5MM.

- *The state's Certified Public Expenditure program (CPE), a reimbursement program currently available to municipally owned skilled nursing facilities in MA, is a program that is likely to disappear in the coming years.* Without CPE, the operating deficits at OIH are significant and widening requiring larger yearly Town subsidies.

- *Alternative care models such as community-based care are arising nationwide to combat the increasing costs of skilled nursing facilities and the fiscal demand it is placing on Medicaid and Medicare.* Nantucket does not have a well formed and coordinated community based care.

- *Fragmentation of services for seniors on Nantucket needs to be eliminated and better coordinated.* While many individual support services exist they are not coordinated in a way that optimizes senior care outcomes for all. As reimbursement methods change and the care model shifts to more community based care, increasing the coordination among and optimizing all senior services will rise in importance.

- *Locally, there is increasing competition to OIH for residents and their revenue. This competition is coming from Nantucket Cottage Hospital and Sherburne Common.*

Recommendations

- *Develop community based care that provides skilled nursing services delivered in a home setting.* Repurpose/reorient OIH to provide community based care in addition to institutional care. This can be accomplished by adding a community based care arm to OIH and reorienting staff to this new mission. Commission and or convene a group to develop a plan to "operationalize" community based care. To the extent that community based care (v. institutionalized care) is the direction skilled nursing is heading, the Town does not (currently) have the infrastructure in place to meet or be proactive in making the switch, a transition that will have to come sooner or later.

- *Establish, or serve as a catalyst, for the formation of an entity that would formally coordinate senior services among the many entities now providing some, but not all of these services on island.* A combination of the Town and/or a non-profit should begin the task of bringing these services together and expanding services to the senior population via privately supported concepts such as "The Village Model" which got its start in Boston and has spread nationwide.

- *Begin planning for a new OIH to be located at Sherburne Commons, re-envisioned, smaller, that utilizes the non-medical infrastructure services such as food preparation, laundry, and facilities maintenance currently provided at Sherburne Commons.* Plan construction so that it can be expanded if demand for institutionalized skilled nursing expands the facility can expand. Open immediate discussions with the operator of Sherburne Commons about the co-location of a new OIH at that location. The economics a potentially compelling. Using the last available financial information from Sherburne Commons, the combined entities – Sherburne Commons and OIH – together spent $1,635,000 on dining and $490,000 on housekeeping/laundry, services that could possibly be delivered in a more financially efficient manner.

- *Sell the land where the OIH currently exists to the Land Bank at fair market value*. Use the land sale proceeds to pay for or offset the costs of a new facility and to fund startup costs for community based care delivery.

While the WG has proposed recommendation, none of these solutions can advance without a community dialogue; this is, after all, a community decision on how to spend our resources and care for our seniors.

Internal Environment

Community understanding of the current internal environment at OIH is an important step in making informed decisions about its future. Who the residents are, where they come from, the Town's prior and on-going financial support, and the physical condition of the facility all bear on future decisions that the Town must make regarding OIH.

Resident Demographics

Prior year demographic patterns, patient origin, and revenue mix point to a facility that exists primarily for the benefit of island residents or individuals with next of kin who are island residents. Historically, OIH has served the needs of the island's senior population with very few, if any, residents coming to OIH without some family tie or close friendship with an island resident.

Average census is 42 for OIH's 45 bed facility. For the past two years OIH has maintained a 94% occupancy rate. There were 59 separate residents for all or part of the year which amounts to a 40% turnover in residents on average.

Financial

OIH has been operating with a subsidy from the Town's general fund for at least the past 17 years. Except for the intermittent reimbursement from the State and its Certified Public Expenditure (CPE) program that manages to cover a considerable amount of the operating deficit, OIH operates at a deficit that has ranged from a low of $560K in 1996 to a high of $3.9MM in 2009; deficits that the Work Group has concluded will continue into the future. This operating deficit has two major drivers: increasing personnel costs and declining Medicaid and Medicare reimbursement rates directed toward institutional care.

The two year average of payee mix Figure 1: Revenue by Payee Source

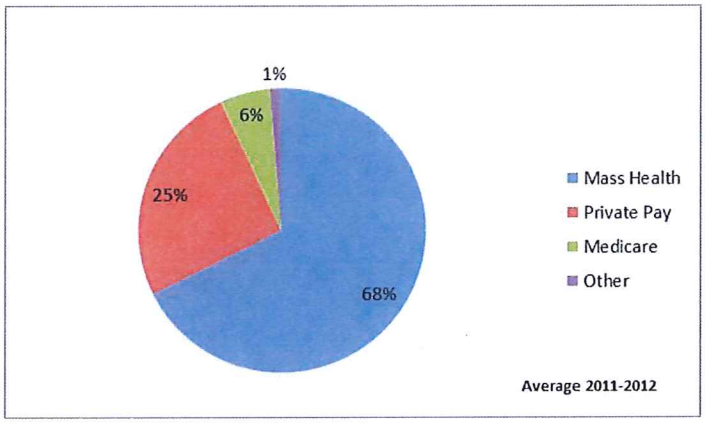
shows Mass Health- Medicaid (68%) as the predominant source of payer revenue. Private Pay (25.5%) and Medicare (5.74%) are the other two primary sources of revenue.

As reported in the Larson Allen 27th Annual Licensed Nursing Facility Cost Comparison[1] study the average payee mix in the Northeast consists of 61.5% Medicaid, 22.3% Private Pay and 13.2% Medicare. The payee mix at OIH is increasingly toward Medicaid at the expense of private pays. This places OIH at a somewhat greater dependency on Medicaid reimbursement than the Northeast as a whole, and significantly below Northeast averages for Medicare reimbursement.

Increasing personnel costs are driven by pay rates and benefit costs negotiated as part of the collective bargaining agreements for the staff at OIH. The 3 year growth trend in personnel costs (wages and fringe benefits, but excluding pension costs) shows year over year (Y/Y) growth around 5%. The Study Group projects that this trend will continue in perpetuity.

OIH Organizational Structure and Implications

One of the most often heard positive comments about the Island Home is about how caring the staff is toward the residents and the family and friends of the residents. This level of caring brings comfort to the families, friends and to the community that care is being provided in a humane fashion and with the knowledge that the residents are living in a safe place.



Against this backdrop is the inexorable rise in staffing costs. Personnel costs at nursing facilities are a very significant part of the cost structure. In the Larson Allen Benchmarking Study[2] approximately 75% of a nursing facility's operating costs relate to labor costs. At Our Island Home labor costs make up approximately 80% of operating costs (2012 actual – 80.5%; 2013 budget – 79.9%; 2014 budget – 80.6%). By this measure OIH labor costs, as a percent of operating costs, are higher but not appreciably higher than other facilities.

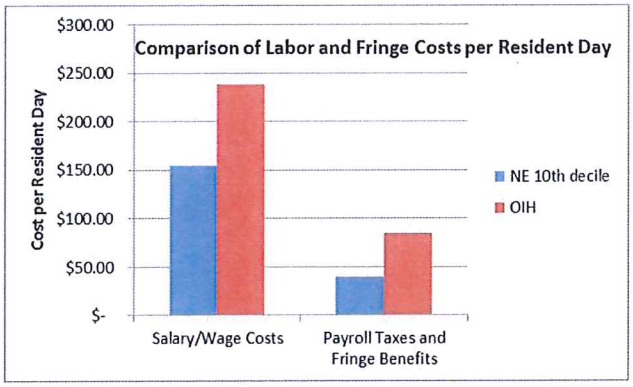


Figure 2: Comparison of Labor and Fringe Costs

The larger discrepancy between national and regional trends comes from overall absolute labor costs. On a per bed basis OIH labor costs track considerably higher than benchmark facilities in the Northeast. The top decile (highest costs) for salary/wage costs on a per resident day basis

[1] 27th Annual Licensed Nursing Facility Cost Comparison Larson Allen, LLP. 2010
[2] ibid

(number of beds X 365 days) according to the Larson Allen study[3] is $154.12/resident day versus $238.57/resident day and for payroll taxes and fringe benefits (other non-wage costs) is $39.21/resident day versus $84.22/resident day at OIH.

When benchmarked against the Taunton, MA municipally owned 101 bed skilled nursing facility, which operates at a breakeven when its CPE reimbursement is included, that facility runs a payroll per resident day $128.86[4].

Fringe benefits for OIH staff run, on average, 28% of labor costs. This compares with 21% of labor costs reported in the Larson Allen study. This represents a 33% differential between OIH and Larson Allen's clients who reported data.

Figure 3: Comparative Analysis of Labor Costs

Comparative Analysis of Labor Costs

	RN	LPN	Aides	Maint	Housekeeping	Laundry	Dietary
OIH	$ 42.62	$ 31.06	$ 24.08	$ 26.98	$ 22.59	$ 23.72	$ 20.39
Taunton	$ 32.86	$ 23.69	$ 13.85	$ 20.52		$ 13.09	$ 18.79
Northeast	$ 35.40	$ 29.24	$ 15.11	$ 20.47	$ 11.86	$ 11.93	$ 13.52
v Taunton	30%	31%	74%	31%		81%	9%
v Northeast	20%	6%	59%	32%	90%	99%	51%
2009 Base	$ 33.36	$ 27.55	$ 14.24	$ 19.29	$ 11.18	$ 11.24	$ 12.74

The Work Group concluded that this discrepancy with labor costs is driven by the collective bargaining agreement that the Town has with the Service Employees International Union (SEIU) coupled with the "Nantucket Factor". The agreement with the SEIU is less favorable than the SEIU's agreement with Nantucket Cottage Hospital covering many of the same class of employee. Sherburne Commons, which also employs many of the same classification of employee, operates without any union.

The labor agreement with the SEIU contains a "so-called" successor clause which, short of the Town totally closing the OIH for at least two years, binds any successor to the same collective bargaining terms currently in place under the existing contract. This means that, for example, if the Town chose to hire a health care management company to run OIH the health care management company would be bound by the same terms as the current contract unless the Town was totally out of the skilled nursing business for two years. If, for example, the Town were to transfer operating responsibility to Sherburne Commons and its management team, Sherburne Commons would be bound by the same contract terms.

This has led the OIH Work group to conclude that there will be a great deal of difficulty in bending the labor cost curve downward or leveling it off. In fact we project annual 4-5% labor

[3] Ibid
[4] Does not include benefit costs

cost increases for the foreseeable future. When 80% of your operating costs are increasing at 5% per annum and your revenue base is flat to slightly declining this business model becomes increasingly unsustainable without increasingly generous taxpayer support.

OIH Operating Efficiency

The Work Group was not specifically charged with looking at the operating efficiency of OIH but in the course of our benchmarking with the municipality owned Taunton, MA skilled nursing facility and through the review of benchmarking reports such as the Larson Allen, LLP report[5] the Work Group has concluded that OIH is being run in a professional and efficient manner. We believe, as does the current OIH management, there are additional improvements that can be made to operations that will further manage costs but with 80% of operating costs directly related to labor costs, the improvements, while meaningful, will have relatively little impact on the financial sustainability of OIH.

Facility

OIH was constructed in 1980 rendering it over 33 years old. It's a 20,850 square foot, 45 bed facility with a nearly 35 year old design and layout; indicative of the prevailing nursing care philosophy at the time of a "mini" hospital. This philosophy resulted in its institutional-like appearances and attitudes, and regimented daily routine where residents are bored and depressed, increasingly dependent on their caregivers and where no one wants to go.

LarsonAllen reports[6] the average age of nursing facilities in 2009 (including those that have undergone significant renovations) in the Northeast is 16.1 years old. Nationwide, the average age of facilities is 12.6 years old.

The OIH has an outdated kitchen, long gloomy corridors, shared rooms and shared baths, not enough area for activities, limited working areas for therapies, poor energy efficiency, out of date nurses stations and call system, no lobby or reception area and an overall 'institutional' appearance.

In a recent (January, 2013) audit by the Department of Public Health, OIH was cited for physical conditions and deficiencies to the facility. While the quality of care remains high the physical facility has become problematic. Remedying these deficiencies will necessitate that the Town embark on a course of action related to the facility to either improve the existing facility or construct a new facility.

Today, the prevailing nursing home philosophy has changed from *Quality of Care* to *Quality of Life* without sacrificing quality of care. This means modern nursing facilities offer a broader

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[5] Ibid

[6] 27th Annual Licensed Nursing Facility Cost Comparison Larson Allen, LLP. 2010

range of services that range from inpatient and outpatient rehabilitation, specialized dementia programs, adult day health, assisted living and hospice and end-of-life care. In short, expanded choices of when, where and what to eat, wider control over daily activities and a wider choice of meaningful activities.

External Factors Affecting the Sustainability of OIH

The group assessed external factors which would impact the ability of the Town to maintain and continue to operate OIH. The initial list included:

- Community demographics; demand projections
- Medicaid reimbursement rates
- Affordability of long term care services in meeting the needs of Nantucket seniors
- Competition

Community Demographics

The OIH Work Group has been mindful that population demographics are changing and to suggest that our only option to the aging OIH is to replicate the facility in size and in either the same or a different location is to look "in the rear view mirror" to determine where we should be going in the future. In other words, that would be the opposite view of what should be considered for the future of OIH.

In conjunction with the desire to be forward looking with our planning options, the Work Group invited Peter Morrison, retired island resident and professional demographer to address the committee about future demographic trends and their likely bearing on our now and future aging population. Mr. Morrison's slide deck[7] is attached as an appendix but his analysis is summarized here.

Mr. Morrison spoke of the Demographic Context in which to frame the discussion around the:

- Knowable future, which consists of
  - Baby boomers, most of whom will age in place
  - Older residents with longer life expectancy
  - Traditional family caregivers a thing of the past
- Less certain
  - Elderly increasingly will live alone
  - Prospect of more alternative living arrangements (e.g., elderly cohabitation)

More Nantucket household members are 65+[8]. In 2000, 19% of the population as reported in the census was 65+. By 2010, 21% of the population was 65+, a 10.5% increase. The same trend is true for those over 75. Nationally, the trend is similar.

[7] Demographic Forces Shaping Demand for Elderly services on Nantucket December 7, 2012
[8] Sources: 2000 SF1 P23, P24, P25; 2010 SF1 P26

Elderly service demand is shaped by several things: the relative mix of younger (65-74) and older (75+); household disposal income and net worth; and cost pressures that shift demand away from hospitals and nursing homes to less costly forms of assisted living all creating a competition for (scarcer) resources.

Mr. Morrison's concluding comments regarding the island's strategic choices in the face of this coming demographic wave suggest that with the extensive 'intergenerational' connectivity on Nantucket there is a need to strike a balance between numbers served and services offered. This is balanced against ability to pay, which will vary widely, suggesting a course of action that creates an 'a la carte' choice of services to prolong independent living for others.

Medicaid and Medicare Reimbursement Trends

There are three major revenue sources for OIH: Medicaid (MassHealth), Medicare and Private Pay. Medicaid (MassHealth) and Medicare make up 75% of OIH revenues on average in any given year therefore any downward trends in reimbursement rates from these two programs will have a significant impact on the long term sustainability of OIH.

The current expected future trend in Medicaid reimbursement is toward redirecting these payments away from institutional settings like OIH and toward Home and Community Based Services (HCBS) which can be provided at a lower cost. As the following data from the Centers for Medicare and Medicaid Services (CMS) shows the national trend toward the redirection of expenditures is stark and will have a significant disruptive effect on OIH in future years.

Figure 4: Long Term Medicaid Care Expenditures by Type

	2000		2011		2012			
	$	%	$	%	$	%	% Change 2000-2012	Annual Rate of Growth
Nursing Facilities	$ 39.6	57%	$ 51.9	43%	$ 50.5	43%	28%	2.3%
ICFs/MR	$ 10.4	15%	$ 13.3	11%	$ 12.6	11%	21%	1.8%
Home & Community Based Services	$ 12.5	18%	$ 36.2	30%	$ 38.8	33%	210%	17.5%
Personal Care & Home Health	$ 7.0	10%	$ 19.3	16%	$ 16.3	14%	133%	11.1%
Total	$ 69.5		$ 120.6		$ 118.2		70%	5.8%

Source: CMS Medicaid Statement of Expenditures (CMS-64) 2000, CMS Medicaid Program Budget report (CMS-37) August 2010 & 2011, Annual Estimate 2012. Figures in $ Billion

The WG believes that these trends[9] in Medicaid expenditure constraints will seriously disrupt the OIH operating model. Overall, there are four trends to watch:

1. Reduction in the number of Medicaid beneficiaries using nursing home facilities
2. Slower/contraction in state payments
3. An increasing gap between the cost of providing care and the reimbursement rates from the state.
4. Capitated, Long Term Care Programs which will work to constrain the overall reimbursement for a patient between Medicaid and Medicare. This is an issue for OIH as the Medicare margins help subsidize Medicaid reimbursement shortfalls making the competition with the Nantucket Cottage Hospital for the higher margin Medicare patient a rising issue.

"Historically, there has always been a major disconnect between what Medicaid pays for nursing home services and the cost of providing those services. That gap is rapidly expanding leaving nursing homes with significant Medicaid volume little choice but to further constrain costs to survive. The challenge is not whether costs can be cut, but whether doing so will allow skilled nursing care providers to deliver the quality care and quality of life consumers expect and regulators demand.[10]"

At the same time, reimbursement rates from MassHealth and Medicare are on a downward sloping curve. Nationwide, the average shortfall in Medicaid nursing home reimbursement for 2011 is projected to be $19.55 per Medicaid patient day[11]. The actual shortfall in 2011 will likely be somewhat higher, since actual cost increases historically have outpaced projected inflationary increases for nursing homes.

> *For every dollar of allowable cost incurred in providing long term care for a Medicaid patient in 2011, the Medicaid program reimbursed approximately 90 cents on average. Unprecedented state budget deficits and the expiration of federal stimulus funds on July 1, 2011 contributed to the second lowest percentage of cost coverage in the ten years that this annual report has been compiled*[12]

Medicare cross-subsidization of Medicaid continues to serve an important function in sustaining nursing home care. Reimbursements from these two government programs combined have resulted in a break-even margin for 2009 nationwide; however, we project a very different scenario for nursing care in 2012. With planned Medicare rate reductions in 2012 and a projected negative Medicaid margin topping 14%, the margin percentage for these two

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[9] 2011 Report on the Shortfalls of Medicaid Funding in Nursing Home Care prepared for the American Health Care Association by Eljay, LLC

[10] ibid

[11] A Report on Shortfalls in Medicaid Funding for Nursing Home Care ELJAY, LLC FOR THE AMERICAN HEALTH CARE ASSOCIATION December 2011

[12] 2011 Report on the Shortfalls of Medicaid Funding in Nursing Home Care prepared for the American Health Care Association by Eljay, LLC

government programs combined will only reach a negative 2.7%. The combined shortfall of both Medicare and Medicaid is projected to exceed $2 billion, marking an end to the current reliance on Medicare cross-subsidization of Medicaid shortfalls and the beginning of greater uncertainty.

Competition for OIH Residents

There is emerging competition for OIH residents, specifically from the Nantucket Cottage Hospital and its plan to continue to offer "Medicare" or "swing" beds. NCH provided "Medicare" beds before OIH had received its Medicare certification and it intends to continue its practice. This competition cuts into the Medicare revenue generated by our OIH further eroding the cross-subsidization that Medicaid receives from Medicare and leaving the OIH caring for residents who have the lowest reimbursement rates.

The other source of competition may come from Sherburne Commons and the plans of its proposed buyer, Northbridge Communities. Northbridge intends to open and market its dementia unit which has the potential to attract private pay residents who now are residents or who may be residents in the future of OIH. While the WG has no official position on these two possibilities, both have the potential to impact the sustainability of OIH.

The Town, in the course of negotiating with Northbridge has secured their agreement to offer "shared services" – food, laundry, and facilities – non-medical services – on a contract basis, subject to arriving at mutually agreeable commercial terms if OIH were to relocate its facility to Sherburne Commons. Further, Northbridge has pledged to provide space and host a "social model" Adult Community Day Care at its facilities, whether or not OIH were to relocate.

Summary and Conclusions, Next Steps

The WG believes the need for long term care services on Nantucket will increase and change over time following the demographics of our time. Demographic trends and the increasing desirability of Nantucket as a retirement destination make this a high probability outcome. At the same time there is an increasing mismatch between present and projected future needs of elderly Nantucketers and the Town's finite financial capacity to meet those needs. Basically, mature Nantucketers will advance in age, expanding the population of concern, and family members with the will to care for them may find they have no practical means of doing so.

The options for resolving this mismatch, though, are inherently controversial. At the heart of the issue is a public choice: At what stage of the aging process might the Town serve a compelling "public purpose" by dedicating resources to the wellbeing of its elderly residents?

That choice represents a statement of collective community values, within a context of present-day fiscal limits.

	Facility	Employees	Skilled Nursing Facility Alternatives	Financial Realities	Demand
Current Situation	Substantial investment (>$5MM) over next few years to meet audit findings and deferred maintenance	Union and labor contract locks in ever increasing (5%+/- per year) employee costs.	No other on-island facilities. Geographic isolation foreshortens skilled nursing facility options.	CPE reimbursement going away. Medicaid reimbursement rates declining. Operating costs increasing. Taxpayer subsidies increasing. Competition for higher reimbursement care.	Competition for residents. Demographics suggest increased demand as population ages. New operating models (community based) may siphon off residents.
Reposition OIH			Scale back services Curtail Costs Shift care responsibility to other providers	May not achieve desired financial impact Perceived as a service reduction?	
Sell OIH	Retain land Cost share in new/refurbished facility?	Potential loss of jobs	Facility still operates under private ownership	May not end the financial subsidy required Political fallout	
Hybrid – private or non-profit operator	Retain ownership of facility Operated by private or non-profit	Union and labor contracts renegotiated with new ownership Market based compensation		Operations reformed under direction of new operator Will likely require a fixed subsidy from the Town	
Maintain current operating model	New facility ($15MM+/-) constructed to meet resident and community needs.	Town options for contracting with or selling operations to private operators limited by terms of contract.	Utilize facilities on Cape.	Execute radical operating shift in conjunction with a new facility. Reduce resident capacity. Increase investment in community based care.	Demand difficult to predict but push for community based care may (will) impact residents/revenue

The Facility

It's clear that OIH will need a substantial investment (>$5M) in its physical plant over the next few years to meet the audit findings identified by the Department of Public Health in its January, 2013 audit of the facility. This could take the form of general refurbishment of the facility or the construction of a new facility ($15MM +/-). This capital investment decision faces the voters in the next few years.

Employees

The current union and labor contracts binds the Town to ever increasing personnel costs in the face of declining reimbursement rates. This severely limits the Town's options either in contracting with other entities to operate OIH or (re)organizing the work force to meet the fiscal realities of today's reimbursement landscape.

The revenue and cost trends for OIH (and skilled nursing facilities in general) point to an ever widening divergence between the two necessitating ever increasing subsidies from the Town in order to remain in operation.

Lack of Skilled Nursing Facility Alternatives

OIH has served several generations of islanders. Our geographic isolation foreshortens our nursing home care options. As we all know, if OIH didn't exist the only options would be off-island.

Financial Realities

The State's CPE reimbursement program to municipally owned nursing facilities (for which Nantucket received $1,873,000 in FY 2012) and for which reimbursement is variable and sporadic, is likely to go away in the next 3-5 years. While this reimbursement doesn't totally eradicate the operating loss it goes a long way toward reducing the Town's general fund subsidy.

There is a growing need for subsidized/affordable home and community based services to provide support to enable the frail elderly to remain in the community.

Case management and referral services will become increasingly important to address prioritizing long term care service delivery due to Office for Aging budget cutbacks and growing need for services.

Demand

Long term demographic trends suggest that demand for skilled nursing facilities will increase as the population increases. But as a counterbalance to this potential demand government reimbursement may drive demand into alternative forms of care with elders "aging in place"

and remaining in the community longer, either of necessity or practicality, and alter the demand for skilled nursing facilities.

Alternatives

The "Village" concept originated as a grassroots effort in Boston's Beacon Hill in 2001 when a group of neighbors came together to develop services that would enable older adults to remain in their home and community. The resulting "village" notion has since been replicated around the country, with over 100 active or developing communities.

AARP reports that 90% of older adults want to remain in their home as they grow older. With the geographic dispersal of families and with older adults wishing to keep from burdening their families, growing older at home has become more of a challenge. "People end up moving because they can't change the light bulbs or (they) get isolated when they get home from the hospital and can't coordinate everything," Judy Willett, director of Beacon Hill Village commented. "Villages" present a solution by connecting members with the services and resources they need to live a comfortable, safe and healthy life at home.

Many "villages" are a neighbor-helping-neighbor system in that they rely on volunteers to provide services at no additional cost to the members. When volunteers are not able to provide services, "villages" refer members to vetted and often discounted vendors.

The "village" allow people to live how they want to live – in the comfort of their own home surrounded by their neighbors, friends and community.

Acknowledgements

The OIH Work Study Group would like to acknowledge the support and efforts of Ms. Pam Meriam and Ms. Rachel Chretien for providing insight and data for this work group. A special thank you goes to Mr. Peter Morrison for sharing his demographic knowledge and insights and to Mr. John Brennan, Administrator of the Taunton, MA municipal skilled nursing facility for an early February morning journey to Nantucket to share his knowledge and benchmarking data.

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