

Shaping the Future of Long Term Care & Independent Living

2003 - 2013

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Table of Contents

Executive Summary i

Methodology.....1

Demographics and Need.....4

Shifting the Balance 2004 10

Nursing Homes.....14

Independent and Special Needs Housing 17

Adult Day Services 21

Caregivers 23

Transportation 25

Prevention 27

Future Steps.....29

Appendix 30

Executive Summary

The Vermont Department of Aging and Disabilities is pleased to publish the 2nd edition of *Shaping the Future of Long Term Care*. The original report covered the period 2000-2010; this report spans 2003-2013. *Shaping the Future of Long Term Care & Independent Living* is intended to be a living document, adjusted annually to reflect changing demographics and trends. This rolling forecast will give the Department the opportunity to plan for each forthcoming ten-year period. In addition, information from past reports can be evaluated and updated.

For over 30 years, the State of Vermont has had a policy of helping elders and adults with disabilities live with dignity and independence in the setting of their choice. Vermont's aging population and growing number of adults with physical disabilities will generate increased demands on the long term care system. Using a model developed by The Lewin Group that incorporates both demographic and program use data, the Department is able to project the need for long term care services and make recommendations for addressing that need.

Vermont's 1996 landmark legislation known as Act 160 has allowed the State to alter the balance between institutional and home-based services. The Act required the State to take saved dollars from reduced Medicaid nursing home utilization and shift those funds to home-based care. Prior to Act 160, Vermont spent 88% of its public long term care dollars on nursing home care leaving 12% for home and community-based services. Today, the ratio is 70% and 30% respectively, giving Vermonters greater choice in their long term care options.

Vermont's fastest growing age group is its eldest—those 85 years old and older. Although the state's total population is projected to grow by 4.5% during the period 2003-2013, the number of Vermont's eldest will increase by a dramatic 27%. While a comparatively small group, these elders have the greatest need for long term care services. However, demand for services will not peak until after 2030, when the oldest baby boomers turn 85.

The prevalence of disability for the younger population is projected to climb during the period 2003-2013. Conversely, the disability rate among people 65 years old and older is dropping. Utilization of nursing homes continues to decline. Since Act 160, nearly 300 nursing beds have closed while another 300 remain empty.

Savings from the decline in nursing home utilization have been used to expand home and community-based services. Since these services tend to be less expensive than institutional care, Vermont has been able to increase the number of people served. However, demand continues to outstrip capacity. Services such as adult day, home health, case management, and public transportation are stretched thin. Funds for the development of accessible and affordable housing are insufficient as are funds

to improve caregiver wages and benefits. The Department's model predicts that by 2013, the number of low-income people living in the community who require assistance with at least two activities of daily living will climb by 43%. Use will rise accordingly.

Recommendations:

Progress has been made since the issuance of recommendations in *Shaping the Future of Long Term Care 2000-2010*. Many of these recommendations remain "works in progress" as evidenced by the updates below (in red). The most significant item is a new recommendation to obtain and implement an 1115 Waiver to create equal access to either nursing home or home and community-based care.

These recommendations, if implemented, will result in a balanced and sustainable system of care for elders and adults with physical disabilities. Actual implementation in any given year will depend on the State's fiscal situation and assumes that Federal/State Medicaid programs remain relatively unchanged. Vermont needs to strike a better balance between the number of nursing home beds and the number of people served in community settings. If the goal to achieve a 40/60 balance were realized in each county (40 Home and Community-Based Waiver slots for every 60 Medicaid funded nursing home beds), there would be sufficient savings to fund the needed Medicaid Waiver slots and many of these recommendations. However, additional sources of money are needed in order to raise caregiver wages, fund new infrastructure for adult day programs, and develop new housing options.

Recommendations From *Shaping the Future of Long Term Care 2000-2010*:

1. In accordance with consumer preference, continue to decrease reliance on nursing home care. Develop alternatives so that at least 40% of the people needing Medicaid funded nursing home level of care receive that care at home or in other community settings. Update this target annually based on utilization and projected need. *Five of 12 counties have met or exceeded this target. (Grand Isle and Essex are excluded because they lack nursing homes.)*
2. Increase Home and Community-Based Medicaid Waiver slots by 100 each year and continue to allocate them to people in greatest need. *Due to budget constraints, only 54 slots were allocated in FY 2003 but 100 will be allocated in FY 2004.*
3. Increase the Attendant Services Program to serve an additional 100 people by 2010. *Growth was slower than expected, having risen from 250 clients in FY 2000 to 261 in FY 2003. To maintain the 2003 rate of use, while keeping pace with demographics, the program would have to serve 58 more clients per year by 2013 (i.e., 319 clients in 2013). (See Appendix, Table 4, p.38.)*

4. As funds permit, continue to improve wages and benefits for personal caregivers in all settings until caregivers receive a *starting* wage of at least \$10/hour, along with basic benefits such as health insurance, sick time and vacation leave. Wages in all settings should be increased annually by an inflation factor. *The only program with a starting wage of \$10/hour is the Consumer or Surrogate Directed Option in the Home and Community-Based Medicaid Waiver program. Progress has been made in both nursing home wages and home health wages but more needs to be done.*
5. Develop additional supportive housing such as Enhanced Residential Care, Assisted Living, group-directed congregate housing, and adult family care. Increase funding for home modification. Continue to promote universal design in all new housing construction. *Enhanced Residential Care and Assisted Living have expanded. Funding for home modification is increasingly inadequate. Promotion of universal design is in progress.*
6. Increase the capacity of adult day centers to serve 1,500 people in 2010, up from 800 in the year 2000. This reflects an increase in daily capacity from 441 to 720. *Daily capacity has grown to 565 in FY 2003. To maintain the 2003 rate of use, while keeping pace with demographic changes and the expected decline in nursing facility use, the program would have to serve 353 more clients per year by 2013 (i.e., 918 clients in 2013). (See Appendix, Table 4, p.38.)*
7. Expand the capacity of the Area Agencies on Aging to provide case management to more elders not participating in the Medicaid Waiver program. Develop a program to provide case management assistance to adults with physical disabilities between the ages of 18 and 60 who do not qualify for such assistance from any other program. *No progress to date.*
8. Expand community-based health promotion and disease prevention programs for elders and adults with physical disabilities. *Expansions include strength training classes led by elders, the Senior Farmers' Market Nutrition Program, and a quarterly food and nutrition newsletter for providers.*
9. Expand the Homemaker Program to serve 1,300 people by the year 2010. In 2000, this program served 700 people. *Due to budget constraints and increased costs per client, the Homemaker Program served 614 people in FY 2003, 86 fewer than in FY 2000. To maintain the 2003 rate of use, while keeping pace with demographics, the program would have to serve 404 more clients per year by 2013 (i.e., 1,018 clients in 2013). (See Appendix, Table 4, p.38.)*
10. Expand and improve the dissemination of public information so that all elders and adults with physical disabilities know how to access the services they need

through web sites, publications, the media, and information and assistance lines. *The Senior Help Guide has been widely distributed, the Guide to Services has been updated on the Department's web page, and radio and TV Public Service Announcements have been created. Funding has been found for a public information initiative in 2004.*

New Recommendations:

Shaping the Future of Long Term Care & Independent Living 2003-2013

1. Obtain permission from the Centers for Medicare and Medicaid Services to implement an 1115 Waiver to create equal access to either nursing home or home and community-based care, according to the consumer's preference.

Methodology

The Department of Aging and Disabilities (DAD) contracted with The Lewin Group to project both the need for long term care services and the capacity of Vermont's system to meet that need. The target populations are elders and adults with physical disabilities. Vermont-specific data on population growth, demographics, and program utilization were incorporated into Lewin's model to derive both "need" and "use" projections for 2008 and 2013.

Vermont population data from the U.S. Census 2000 served as the baseline. The University of Massachusetts Institute for Social and Economic Research (MISER) developed population projections for the period 2000 to 2020. These projections are more reliable than the projections used for the *2000-2010* report because of the subsequent incorporation of U.S. Census Bureau migration data, an important element in projecting population. Compared to the projections used in *the 2000-2010* report, the current projections show less overall growth in the Vermont population (639,240 people versus 659,456 for 2010) and different rates of growth for the various age groups.

The Lewin Group integrated the population projections with a variety of data sources, including disability data, population characteristics, income and program participation, nursing home utilization, and the Department's Fiscal Year (FY) 2003 actual program use, to produce a set of tables that describe Vermont's need and use of long term care services by county.¹ (See Appendix, p.30.) The Department's FY 2003 program data is more reliable than its FY 2000 program data because methods of data collection have improved. Detailed methodology reports from both MISER and The Lewin Group are available from the Department.

Two essential assumptions drive the results of this model: the disability rate trend and the nursing facility use rate trend. The first is a major determinate of long term care need, and the second influences the level of services required in the community. These assumptions can be adjusted over time as demographics and trends change. (See Appendix, Assumptions Sheet, p.31.)

The disability rate trend for individuals younger than 65 years old utilizes growth assumptions from the Social Security Administration to determine the increase in the

¹ Lewin relied principally on the following sources of data, all from the U.S. Bureau of the Census: (1) for detailed data on Activities of Daily Living (ADLs), the 1996 Survey of Income and Program Participation; (2) for county-level general disability data, the 1990 Public Use Microdata Sample (PUMS); and (3) for the most recent state-level general disability data, Current Population Survey (CPS) data from 1999 to 2001. The Department will have access to the 2000 PUMS in 2004 and will incorporate it into the next edition of this model. The U.S. Census released general disability data by county from the 2000 Census after this model was developed. However, the disability questions on the 2000 Census questionnaire are not directly comparable to those on the 1990 Census, making it difficult to build these data into the model. Lewin therefore relied on the 1999-2001 CPS data, rather than the 2000 Census, to update the estimates to 2000.

percentage of workers receiving Disability Insurance benefits. This trend was applied to children as well because Lewin lacked superior data on which to base childhood trends. For people age 65 and older, the disability trend was derived from Manton's analysis of the 1999 National Long Term Care Survey.² This analysis showed a 1% decline per year (between 1989 and 1999) in the age-adjusted rate of disability. Lewin assumed a slightly smaller and flattening decline for the projections because there is debate as to whether these declines will continue into the future.

The nursing facility use rate trend assumptions are based on an analysis of Vermont's actual nursing home use during the period 1992-2003. These data include all payers, both public and private, and incorporate observed trends in nursing home use through the second quarter of 2003. The trends show the annual percent change in the per capita nursing facility use rate by age group. In comparing the trends from the 2000-2010 report with those contained in this report, one can see lower percent changes. This is because FY 2003 saw a slower decline in nursing home use than was previously observed. Overall, the trend assumptions used for the projections assume a gradual slowing of the decline in use through 2013. Changes in the nursing facility use rate largely drive the model's projections of long term care need in the community.

"Long term care need" is defined as requiring "hands-on" assistance with two or more activities of daily living (such as dressing, bathing, transferring, toileting, eating). This measure approximates the Department's definition of "nursing home level of care", which is in keeping with eligibility criteria for many of the community-based programs. The "low-income" delineation refers to people whose income is below 175% of the Federal Poverty Level, capturing the majority of the publicly funded long term care clients served by the Department. The model excludes individuals with mental retardation and developmental disabilities. *The numbers in this model are "point in time" as opposed to a yearly total.* All "user" data encompass the State's fiscal year. As a general rule, county designations for "user" data represent the user's current residence.

The tables in the Appendix (p. 30) display the results of the model. Tables 0 and 1 (p.32, 33) compare the number of people having "long term care need" with the number of unduplicated people who use services. The projections of use for 2008 and 2013 assume that use of home and community-based services increases only enough to accommodate any demographic changes as well as the shift from nursing facilities, assuming that historical trends in nursing facility use continue. Statewide projected use for 2008 and 2013 is based on the State's actual use in 2003, projected forward.

² Manton, Kenneth F, and Gu, XiLiang, Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population above Age 65 from 1982 to 1999. *Proceedings of the National Academy of Sciences*, Vol. 98, No. 11, 2001. This paper defines disability as having difficulty with one or more activities of daily living (ADLs). Lewin applied these age-adjusted trends to the estimates of disability, which are defined as requiring assistance with two or more ADLs. Separate analysis of National Long Term Care Survey data performed by The Lewin Group indicates that these two measures of disability, while different, experienced similar trends from 1982 to 1999.

However, the county-level use projections for 2008 and 2013 are based on each county's share of the State's 18+ disabled population.

Tables 2 and 3 (p.34-37) show the number of Vermonters with long term care needs, employing more detailed population characteristics.

Tables 4 and 5 (p.38, 39) indicate the number of "users" for each program or service. Statewide projected use for 2008 and 2013 is based on the State's actual use in 2003, projected forward. Estimates of use in Tables 4 and 5 differ from those in Tables 0 and 1 in two important ways. First, Tables 4 and 5 show the number of users of specific types of service. "Users" in these tables may be served by more than one program, and therefore would not sum to the unduplicated total number of "people" shown in Tables 0 and 1. Second, unlike Tables 0 and 1, county-specific projected use for 2008 and 2013 is based on each county's actual rate of use in 2003, projected forward. The projections of use for 2008 and 2013 assume that use of home and community-based services increases *only enough* to accommodate any demographic changes as well as the shift from nursing facilities, assuming that historical trends in nursing facility use continue.

Demographics and Need

The Vermont population as a whole is projected to grow 4.5% during the period 2003-2013. In general, the number of younger Vermonters will decline while those in the older age groups will increase. The fastest growing group is the eldest cohort, those 85 years old and older, which will expand 27% between the years 2003 and 2013. As illustrated in the table below, this group of elders is relatively small in number; nevertheless, they have the greatest need for long term care services.

Vermont Projected Population Growth*

Age	2000 Actual	2003 Projected	2008 Projected	2013 Projected
Under 18	147,523	143,555	135,139	129,265
18-39	180,529	176,918	175,366	177,750
40-64	203,265	218,176	234,271	234,206
65-74	40,683	41,679	47,889	61,788
75-84	26,831	28,002	29,061	30,380
85+	9,996	10,762	12,193	13,627
Total	608,827	619,092	633,919	647,016

The table below depicts the percent change in the population by age group. For example, the number of elders aged 85 and older will grow 13% in the first period and an additional 12% in the second. The number of children will decrease 6% initially and then another 4%, ending the period with a 10% decrease.

Projected Percent Change in Population over Five Year Period*

Age	2003 to 2008 Projected	2008 to 2013 Projected
Under 18	-6%	-4%
18-39	-1%	1%
40-64	7%	0%
65-74	15%	29%
75-84	4%	5%
85+	13%	12%
Total	2%	2%

* U.S. Census 2000 Vermont for "Actual"
MISER for "Projections"

Migration

Domestic migration data from the U.S. Census 2000 describes “movers” for the period 1995-2000. The Census shows that Vermont’s domestic in-migration totaled 69,748. During the same period, 67,494 Vermonters left the state, producing a net *in*-migration of 2,254 people. People moving into Vermont were dispersed throughout the various age groups. For those leaving the state, the 25-29 year old age group showed the most significant shift with a net out-migration of 2,900 people. Other groups with a net loss were the 45-54 year olds (-506) and the 65-79 year olds (-293).

A commonly held perception is that out-of-state elders have moved to Vermont to be near their adult children and grandchildren, swelling the number of elders. The data proved otherwise, with one exception. The Census data show 4,736 people 65 years old and older moved to Vermont during 1995-2000. The majority of these people came from New York (836), Florida (592), Connecticut (537), Massachusetts (536), New Jersey (479), and New Hampshire (405). However, there were 4,717 elders who left Vermont during this same period resulting in a net gain of only 19. Of those elders who left, over 1,500 moved to Florida and more than 600 moved to New Hampshire. Lastly, a surprising 12,000 Vermont elders moved *within* the state during this five-year period.

The most mobile group of elders was the oldest old, those 85 years old and over, who had the highest net migration rate of all elderly cohorts. This group had a net *in*-migration of 219 people during 1995-2000. At a 22.6 net in-migration rate³, this cohort showed evidence of a “return” migration pattern. Presumably, many of these individuals were reversing their retirement move and returning to Vermont. This notable finding has implications for Vermont’s long term care system since the oldest old are the most likely to use services.

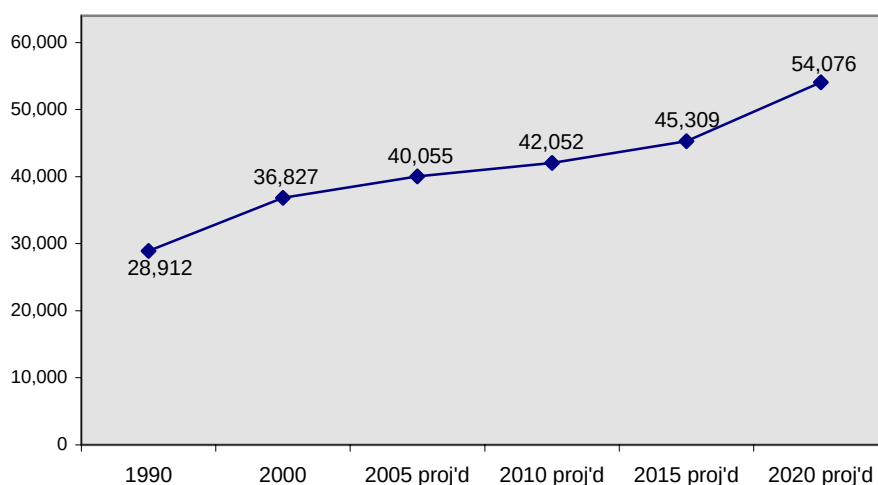
Trends

The “baby boom” generation will have a dramatic effect on the long term care system; however, society will not witness the beginning of this widely heralded phenomenon until 2020. “Baby boomers” are generally considered to be those people born between 1946 and 1964. Assuming that many people need support and services by their mid-seventies, the oldest “baby boomers” (born in 1946) will begin to require services in 2020, while the youngest will turn 76 in 2040. Demand will not peak until after 2030, when the oldest “baby boomers” turn 85.⁴

³ He, Wan, and Schachter, Jason P., Internal Migration of the Older Population: 1995-2000. *Census 2000 Special Reports*, August 2003.

⁴ Redfoot, Donald L, and Pandya, Sheel M, Before the Boom: Trends in Long-Term Supportive Services for Older Americans With Disabilities. *AARP Public Policy Institute Issue Paper*, #2002-15 (October 2002)

VT Elderly Population Growth - Age 75+



As the population has aged, it has become healthier. National findings show a decline in the disability rate for people 65 years old and older.² This decline is attributable to a number of factors: improvements in health, nutrition, and medical treatments; a shift away from manual labor; new medical technologies; lifestyle changes; and improved socioeconomic status, especially with regard to education. Studies have shown that more educated individuals have a disability rate half that of less educated people.

The Department's model predicts a decline in the disability rate of almost 1% annually for Vermonters aged 65 and older during 2003-2008. This decline persists through the second period, slowing only slightly to -0.8%. (See table below.) (See Appendix, Assumptions Sheet, p.31.)

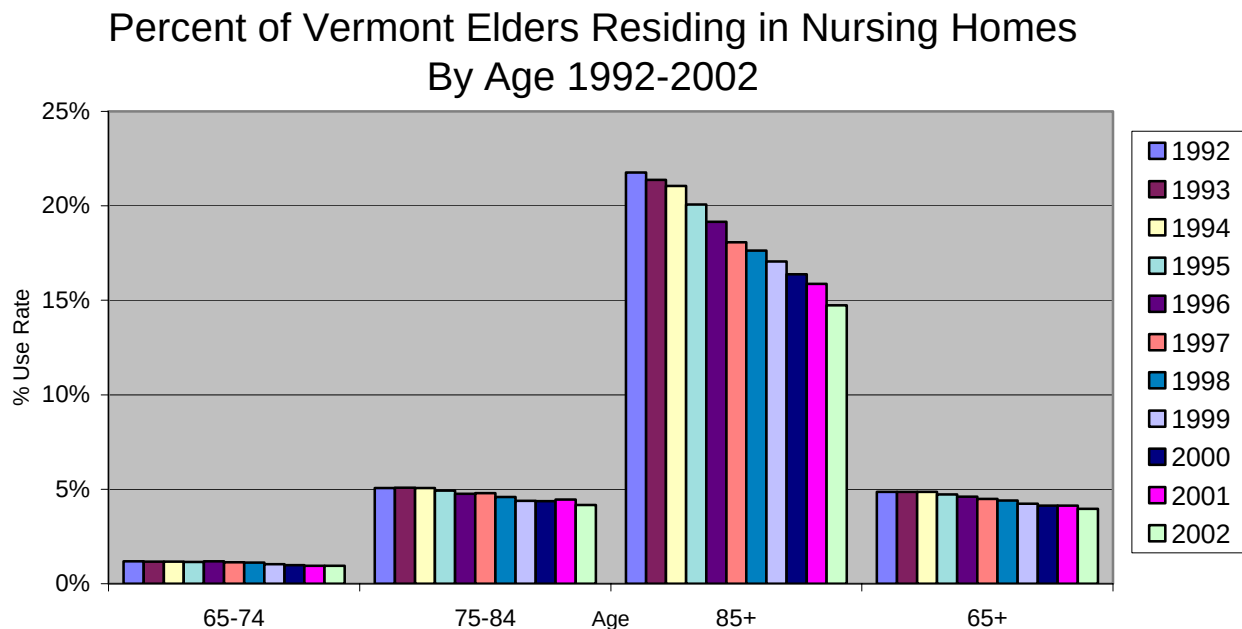
Trends in Vermont Disability Rates: Projected *Annual* % Change in Per Capita Disability Rates

Age	2000-2003	2003-2008	2008-2013
Birth-64	3.8%	3.1%	2.6%
65+	-0.9%	-0.9%	-0.8%

For younger adults, the disability trend is on the rise. The prevalence of disability will climb by 3.1% annually for the next 5 years and another 2.6% annually for the period 2008-2013. (See table above.) Disability rates for younger adults are expected to grow in part because of improved medical care that has allowed children with disabilities to survive birth and early childhood, and allowed adults with disabilities to live longer.

² Ibid.

Vermont has witnessed a significant drop in nursing home use since Act 160 became law. The Department's aggressive efforts to improve and expand home and community-based services have contributed to this decrease. In 1996, there were 3,600 people in nursing homes; as of December 2003, there were 3,256. For Vermonters aged 85 and older, nursing home utilization has shown an unusually dramatic decline. (See chart below.) In 1992, approximately 22% percent of Vermont's 85+ year olds lived in nursing homes. In 2002, that number has dropped to less than 15%.



This striking drop in nursing home use is expected to continue into the future. For example, the percent of elders aged 85+ using nursing homes is projected to decline 3.5% annually during the first period, down from 4.3% in the 2000-2010 report. (The decrease reflects the slower decline in nursing home use in FY 2003.) Nonetheless, the 3.5% reduction is particularly noteworthy given that the 85+ age group makes up nearly half of Vermont's nursing home population. The Department's model continues to predict declines in the other age groups as well, albeit flatter than those reported in the 2000-2010 report. (See table below for current trends.) These trends are based on an analysis of Vermont's actual nursing home use during the period 1992-2003, and assume a gradual slowing of the declining trend through 2013. (See Appendix, Assumptions Sheet, p.31.)

Trends in Vermont Nursing Home Use Rates:
Projected *Annual* % Change in Per Capita
Nursing Home Use Rates

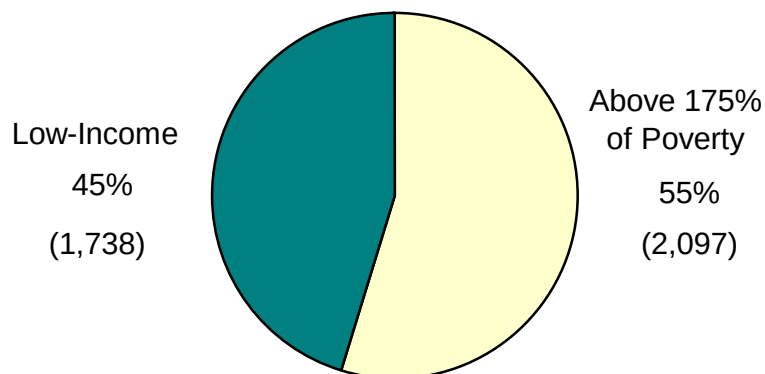
Age	2003-2008	2008-2013
Birth-64	-2.1%	-1.3%
65-74	-2.0%	-2.3%
75-84	-2.4%	-2.1%
85+	-3.5%	-3.5%

The decline in both nursing home use and elder disability coupled with the delay in “baby boom” demand suggest that the need for institutional services will decrease over the next two to three decades. In contrast, the demand for home and community-based care is projected to grow dramatically. (See Appendix, Table 4, p.38 for growth rates.)

Need

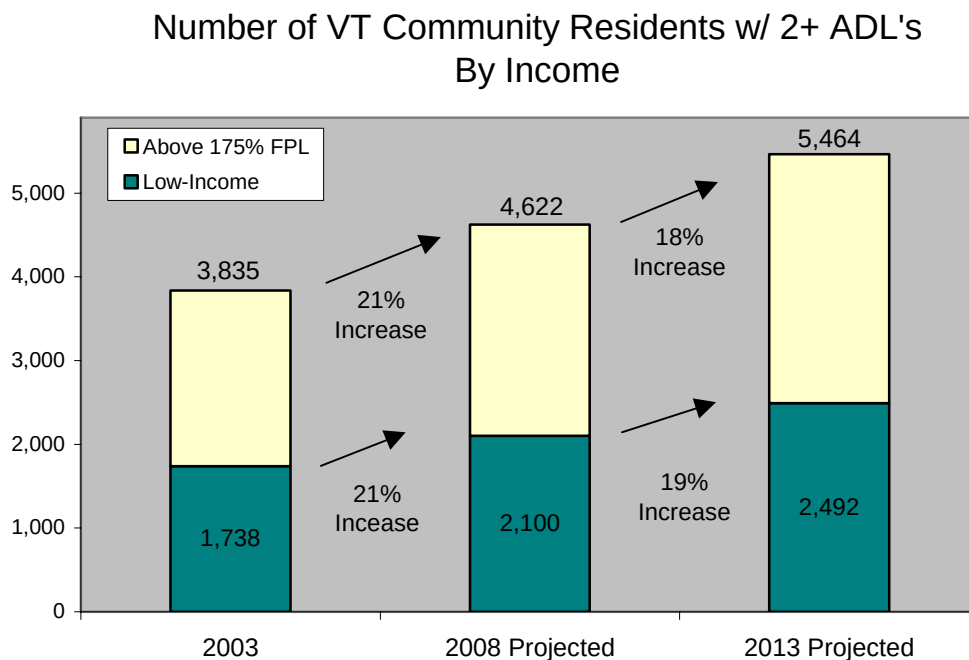
In 2003, there were 3,835 Vermonters living in the community who required assistance with at least two activities of daily living (ADLs). (See Appendix, Table 1, p.33.) Almost half (45%) of those individuals were low-income [below 175% of the Federal Poverty Level (FPL).] These numbers reveal the close connection between disability and poverty, and underscore the importance of a long term care system strongly supported by public funds. (See chart below.) (Excludes people under 18 years old and those with mental retardation and developmental disabilities.)

VT Community Residents with 2+ ADL's
Total 3,835 in 2003



The following chart shows the growth in the number of people living in the community who are projected to need long term care. By 2013, the total will expand to 5,464, a 42% increase from 2003. Contrary to findings in the 2000-2010 report, the current projected increase in the overall number of people needing long term care for the 10 year period is less (42% versus 52%.) This difference is largely explained by MISER's lower but more reliable population projections for the 2000-2020 period. (See Methodology.)

This chart underscores the importance of shifting resources from institutional care to home and community-based options. The number of low-income people living in the community who require assistance with at least two ADLs is predicted to rise 43% during the period 2003 to 2013 (from 1,738 to 2,492). (See Table 1, p. 33.)



Note: The Department defines a “person with long term care need” as someone who needs “hands-on” assistance with two or more activities of daily living (ADLs). This measure approximates the Department’s definition of “nursing home level of care” (in keeping with eligibility criteria for many of its programs), and captures those people most in need of long term care services. The Department chose 175% of the Federal Poverty Level as the definition for “low-income” because it embraces the majority of Vermont’s publicly funded long term care clients. However, some of the publicly funded programs do serve people who are above 175% of the Federal Poverty Level.

Shifting The Balance 2004

Since the release of *Shaping the Future of Long Term Care 2000-2010*, Vermont has experienced both advances and setbacks in trying to build a comprehensive home and community-based system of care.

Accomplishments include:

- During the period 2000 to 2003, the number of people on the Home and Community-Based Medicaid Waiver increased 24% (920 to 1,138) while the number of Medicaid nursing home residents fell 6% (2,221 to 2,089).
- In a fiscally difficult year, the 2003 Legislature increased the residential care home ACCS* rate \$3 per day and promised an additional \$3 per day in the coming legislative session;
- Six Adult Day Service providers are currently planning expansions to serve more people;
- The first licensed Assisted Living Residence opened in Burlington. A Rutland residential care home has converted to Assisted Living and nine entities are actively planning Assisted Living projects;
- The federal Centers for Medicare and Medicaid Services (CMS) reviewed and approved program quality in the Enhanced Residential Care Home Waiver which has grown to serve 149 people in FY 2003;
- The first-ever caregivers association, the Vermont Association of Professional Care Providers, was formed to give caregivers a voice in their education, training, work conditions, and in shaping the public image of caregiving as a career choice;
- The Department successfully helped preserve a Windham County nursing home on the verge of closing due to chronic low occupancy; and
- Vermont submitted a proposal to CMS for an 1115 Waiver that would allow the Department to re-structure the long term care system, giving consumers equal access to either nursing home or home and community-based care.

There were some setbacks:

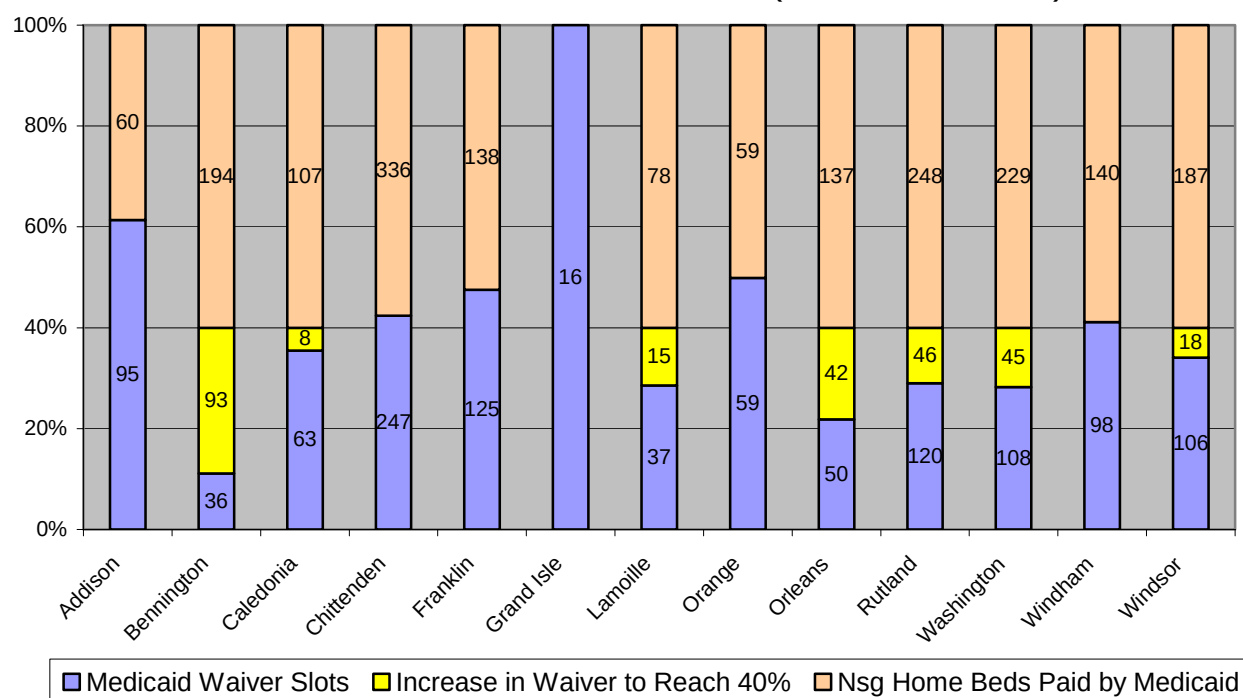
- Due to budgetary constraints, the Department could only issue 54 Home and Community-Based Medicaid Waiver slots in FY 2003. As a result, nursing home Medicaid days rose above FY 2002 levels and cost the State \$1.1 million more than planned.
- Except for the residential care home ACCS* rate which rose to \$47 per day (\$3 per day increase), no other home and community-based service received an increase. Funds to support the Long Term Care Community Coalitions fell victim to budget reductions.

* Assistive Community Care Services in the Medicaid State Plan

These setbacks demonstrate the importance of continuing to invest in “shifting the balance”. Without additional Home and Community-Based Medicaid Waiver slots and other program expansions, consumers will have no choice but to utilize nursing home care.

The chart below illustrates the “balance” that is developing around the state between Medicaid funded nursing home beds and the Home and Community-Based Medicaid Waiver program. The Department’s stated goal is to establish a county minimum of 40 Home and Community-Based Waiver slots for every 60 Medicaid funded nursing home beds. In five counties, the “40/60” balance has been achieved or exceeded. Several other counties are poised to reach that balance soon. In three counties (Addison, Franklin, Orange), the balance is approaching or beyond a “50/50” balance. The Department believes a “40/60” balance is achievable in all parts of the state.

Medicaid Waiver Slot Increases Needed to Achieve 40/60 Balance (November 2003)



(Numbers in yellow are currently Nursing Home Beds Paid by Medicaid.)

As Vermont moves towards this balance, a small number of nursing homes may experience lower occupancy. The Department is collaborating with the Vermont Health Care Association to develop a strategic plan which will determine the most efficient supply of nursing home beds in any given area and work to preserve that number. This process may call for an approach similar to that taken with Windham County’s Eden Park Nursing Home. In that case, the Department came to an agreement with the facility. Eden Park would downsize from 124 beds to 80 (including

over 30 beds that were chronically empty) and the State would reimburse the facility at a higher rate to cover fixed costs. This unique approach saved essential infrastructure for that community.

1115 Research and Demonstration Long Term Care Waiver

The Department of Aging and Disabilities is proposing a new program that will respond to consumers' requests for choice and equal access to long term care services. DAD engaged in a yearlong planning process with providers, advocates, consumers and other interested parties to gather information and discuss optimal characteristics of an "1115 Waiver." Subsequently, the Department filed a proposal for an 1115 Research and Demonstration Waiver with the Centers for Medicare and Medicaid Services. Under an 1115 Waiver, the Department would be allowed to test innovative approaches to the organization and delivery of Vermont's long term care system. The intent of the 1115 Waiver is to give all eligible people *equal* access to the full array of long term care services.

The primary goals of Vermont's demonstration proposal are to:

1. provide consumers with choice and equal access to long term care;
2. serve more people;
3. better manage the costs of long term care;
4. develop a more balanced long term care system;
5. improve quality assurance; and
6. highlight the value of preventive services.

Today approximately 2,100 individuals are benefiting from the entitlement to nursing home care yet no such guarantee exists for those receiving home and community-based services. Under the current system, there is a limit to the number of people who can be served in the Home and Community-Based Medicaid Waiver program. The State allocates a predetermined number of slots each year; once these slots are filled, eligible clients lose the opportunity to receive home-based services. By default, these individuals may end up entering a nursing home whose services are guaranteed under the Medicaid program. When the budget needs to be reduced, home-based programs suffer since the State is obliged to fund nursing home care. The tight budget in FY 2003 necessitated minimal growth of the home-based system but predictably larger growth in the nursing home budget. This new proposal will permit the State to manage the budget according to consumer preference rather than by entitlement.

The 1115 Waiver long term care program would constitute a wholesale replacement of most of Vermont's existing Long Term Care Medicaid services. Financed by a global budget, the program would combine Home and Community-Based Waiver funds⁵ with the State's nursing home appropriation. At the start of the

⁵ Includes both the Home-Based and the Enhanced Residential Care Medicaid Waivers.

program, all individuals who are currently eligible for Medicaid and receiving long term care services in a nursing facility or through the Home and Community-Based Waiver program will be automatically enrolled. Current clients will not lose services.

The Department recognizes that funding constraints are a reality. Accordingly, DAD is proposing a strategy to ensure that people with the “highest needs” are served first, to the fullest extent of their assessed need. The program will categorize eligible individuals into three distinct groups: *Highest Need, High Need, and Moderate Need*.

The “Highest Need” group will be entitled to receive care in *either* a nursing facility or a home or community-based setting⁶. This entitlement to either setting represents a dramatic change in the way long term care services are currently provided in Vermont. The Department projects that an additional 800 people will have an entitlement to home-based long term care where none existed previously. Vermont anticipates that given equal access to either nursing facility or home-based care, more individuals will choose the less costly home and community-based option. As a result, the State will be able to serve more people for the same amount of money.

The “High Need” Group will not be legally entitled to long term care services, however, they will receive services to the degree funds are available. DAD fully expects that all individuals in this group will be served. Given historical utilization, the Department expects this group to consist of approximately 200-300 people each year. These individuals must also meet existing long term care Medicaid financial eligibility criteria, but their clinical needs will not be as high as those in the Highest Need group.

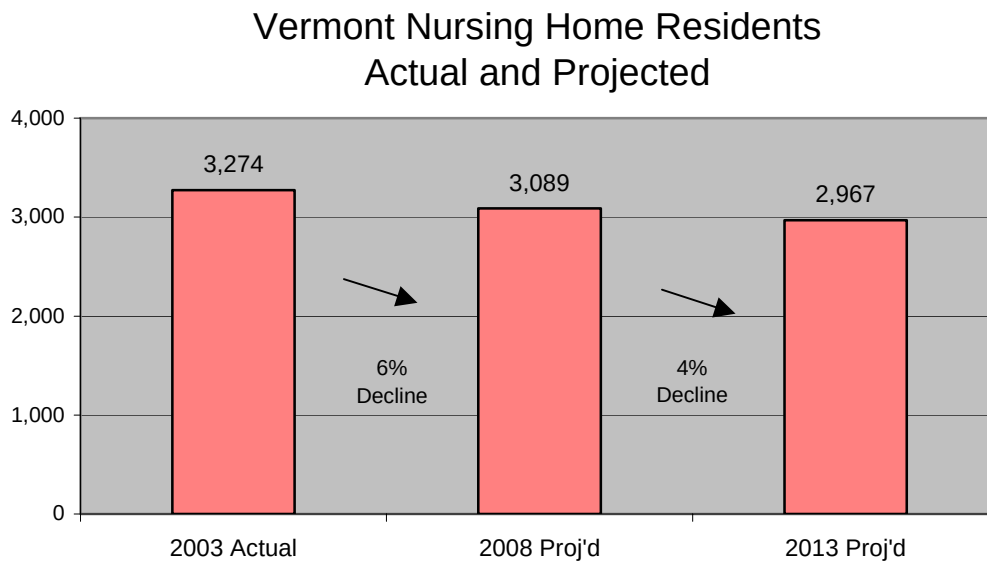
The “Moderate Need” group will include individuals who do not meet current nursing facility nor Home and Community-Based Waiver eligibility criteria but are believed to be at risk of institutional placement based on their assessed care needs. Vermont believes that if services can be provided to these individuals earlier than current practices allow, their conditions can be stabilized or improved thus avoiding or delaying more costly institutional care. As funds become available, these individuals will be provided with preventive and supportive services necessary to help maintain their well-being and independence. At a minimum, all participants in this group will receive case management services. The Department hopes to determine whether targeting preventive services to frail elders and adults with physical disabilities prevents or delays nursing home placement.

The Department will also augment quality assurance efforts by having face-to-face interviews with consumers in addition to requiring case management visits at least once a month. To strengthen accountability, DAD will also add an ombudsman component to this program similar to that provided in nursing facilities and residential care homes.

⁶ Participants must meet both the clinical and financial eligibility criteria for Vermont LongTerm Care Medicaid. The one exception is with respect to resources. The Department is considering the option of letting home-based participants retain more than the currently allowed \$2,000 in resources.

Nursing Homes

As Vermont moves to a more balanced long term care system, the State needs to ensure that nursing home care is available to those who choose or need such care. There was an average of 3,274 residents (at any given point in time) in Vermont's nursing homes in FY 2003. Based on demographic and historical use patterns, the Department's model predicts that the number of nursing home residents will drop to 2,967 by 2013. This projected decline of approximately 300 residents over the next ten years represents an incremental and manageable change.

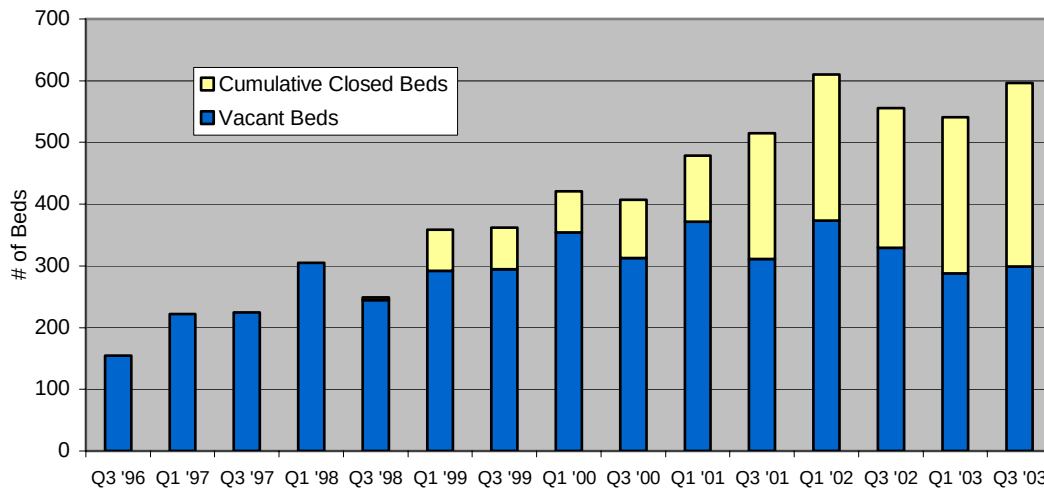


To manage this incremental change, the Department is working with the Vermont Health Care Association to develop a strategic plan to identify needed capacity throughout the state and methods for sustaining that capacity.

Current Status

Since Act 160, there have been dramatic changes in Vermont's nursing home bed supply. Nursing facilities such as Gifford, Copley, Helen Porter, Mt. Ascutney and Eden Park-Brattleboro have downsized while Clarks, Linden Lodge, Sager and Stratton House have ceased operations. In addition, Brookside Bradford is in the process of closing. *Nearly 300 beds have closed while approximately 300 remain empty.* The following chart shows the cumulative bed closures along with the number of vacant beds.

Cumulative Closed Nursing Home Beds & Vacant Nursing Home Beds Since Act 160



The total number of licensed nursing home beds has fallen to 3,499 with overall occupancy at 92% in December 2003. There are a handful of facilities with occupancy below 85%. Prior to Act 160's passage in 1996, there were approximately 3,800 licensed beds with occupancy at 96%.

The State is committed to payment rates that support quality care. Vermont's average daily Medicaid reimbursement rate for nursing home care was \$146.46 in 2003, ranking third in New England. When rates are calculated as a percent of median household income, Vermont's rate looks even more impressive. (See table below.) On the national level, Vermont ranked 13th highest in the country, with Massachusetts 9th and Connecticut placing 7th in the U.S.

Nursing Home Medicaid Daily Rates for New England

State	2003 Nursing Home Medicaid Daily Rate	Median Household Income for 2002*	Annual Nursing Home Cost as % of Median Income
Connecticut	\$168.00	\$53,325	115%
Massachusetts	\$151.00	\$50,587	109%
Vermont	\$146.46	\$41,929	127%
Maine	\$142.72	\$37,654	138%
Rhode Island	\$140.40	\$44,311	116%
New Hampshire	\$126.06	\$53,549	86%

* U.S. Census Bureau, Current Population Survey, 2002; most current data available.

Vermont's nursing homes are due for "re-basing", a process whereby the State adjusts facilities' payment rates to reflect current costs. The effect of re-basing combined with the mandated annual inflation increase will result in a significant rise in daily nursing home rates for FY 2005. Due to factors such as these, the State expects its budget for nursing home care to continually grow at a modest rate despite predicted reductions in Medicaid utilization.

In spite of rising Medicaid payment rates, nursing homes in Vermont are experiencing financial difficulty. Every facility has encountered significantly higher costs for staffing and insurance. Case mix scores of resident acuity, a factor in determining payment rates, have remained relatively constant over the last 5 years. Reimbursement rates from Medicare have decreased. Taken together, these factors weigh heavily on facilities with chronically low occupancy, a primary contributor to financial loss. Unfortunately, the State cannot afford to make up for Medicare decreases nor cover the cost of empty beds.

New Initiatives

The Department and the Vermont Health Care Association have embarked on a unique initiative to improve staff retention in nursing homes. Designed by nursing home professionals in partnership with State staff, the "Gold Star Employer" program intends to highlight and promote those nursing facilities that agree to use "best practices" with their employees. Homes will be given flexibility in how they implement the practices in their particular facility. In order to qualify for the Department's annual Quality of Care Award, a nursing home must be a participating "Gold Star" facility. This program is one of a kind in the nation and represents a strong commitment on the part of nursing homes to address the chronic problem of staff turnover. The Department hopes the first "Gold Star" facilities will be designated in April of 2004.

Independent and Special Needs Housing

Recommendations:

- **Collaborate with the Vermont Department of Housing & Community Affairs and the public to plan for the needs of elders and adults with disabilities in the development of the next 5 year Vermont Consolidated Plan for Housing;**
- **Continue to assist communities to develop affordable Assisted Living;**
- **As funds permit, raise the total ACCS* rate for Assisted Living and Residential Care Homes to at least \$50 per day;**
- **Develop an Adult Family Care program as a Medicaid Waiver option;**
- **Develop a second consumer-directed congregate housing site similar to South Burlington Community Housing;**
- **Continue to promote shared housing and homesharing; and**
- **Continue to work to implement recommendations from the 2000 Home Modification Study.**

Efforts to improve independent and special needs housing remain critical to DAD's mission of helping Vermonters live with dignity and independence in their setting of choice. Affordable, accessible housing with supportive services is a means to this end. While Vermont has made significant progress in developing new housing models, getting those models up and running has been difficult. A shortage of affordable options remains. Vermont's housing community is committed to working with the Department to support existing sites as well as create new ones.

Independent Housing: In some parts of Vermont, seniors have a 2-5 year wait for affordable housing, a seemingly impossible length of time when one is in the later years of life or must move because of immediate care needs. Availability and affordability are issues that will be addressed in the next Department of Housing & Community Affairs's 5 year Consolidated Housing Plan for the U.S. Department of Housing and Urban Development. DAD looks forward to collaborating with the Department of Housing and Community Affairs and the public to address Vermont's critical housing needs.

* Assistive Community Care Services in the Medicaid State Plan

Affordable Assisted Living: Vermont's first licensed affordable assisted living residence, Cathedral Square Senior Living, opened its 28 private, fully accessible apartments in July 2003. All units were leased or under signature within three months of opening. This experience highlights the potential demand for affordable assisted living in other parts of the state. Rutland's Meadows at East Mountain has recently converted its residential care home to an assisted living residence with a dementia care unit. Nine other entities are in various stages of developing assisted living residences. The Department hopes to produce a more specific plan for affordable assisted living in 2004 through the Robert Wood Johnson Foundation *Vermonters Coming Home* project.

As part of that project, the Department is also studying the feasibility of local affordable assisted living in four different sizes or scales. This study will help determine the market size needed to support affordable assisted living residences and will identify partnerships and resources critical to the success of future projects.

The Role of Medicaid in Affordable Assisted Living and Residential Care Homes: The Department estimates that half of the people seeking assisted living are at risk of needing Medicaid assistance. The Assistive Community Care Services (ACCS) program pays for Medicaid covered services delivered to people in assisted living and residential care homes. Adequate payment rates would improve provider participation in the ACCS program. DAD continues to recommend a daily ACCS reimbursement of at least \$50.

The Housing and Supportive Services program (HASS) provides service coordination and gap-filling supportive services to people living in congregate housing sites. The goal of HASS is to allow residents to age in place thus avoiding or delaying entry into institutional settings. As of June 2003, the program delivered services to 797 participants in 29 congregate housing sites throughout the state. HASS participants also benefit from wellness initiatives, regularly scheduled exercise programs, and community meals. In addition, the Department now administers the Community Supported Agriculture program, a component of the Senior Farmers' Market Nutrition Program, bringing locally grown fresh produce to low-income seniors in HASS and other congregate housing sites.

"Adult Family Care" refers to an arrangement whereby an elder or a younger adult with a disability lives with an unrelated family to receive housing, personal care, and supportive services. The Department continues to pursue the creation of a statewide program by 2005. Progress to date includes surveying consumers and providers in Addison County and supporting start up efforts by the Franklin/Grand Isle Advocates for Long Term Care to create an adult family care program in northwestern Vermont.

Consumer-directed congregate living arrangements provide individual apartments and shared caregivers for a small number of younger adults with severe

mobility impairments. The newly constructed 9-unit site, South Burlington Community Housing (Anderson Parkway neighborhood), is now operating at full capacity. The residents are pursuing vocational and social goals that would have been difficult or impossible to achieve in other settings. An upcoming evaluation of this housing model will set the stage for future planning and possible replication by 2010.

Shared housing consists of group shared residences such as Park House of Rochester and Evergreen Place of Waitsfield. The Department has been working with Vermont's housing community to preserve and strengthen these sites. One emerging problem for people residing in shared housing is the management of medications, a service not available in this setting. Residents often need oversight of their medication usage and the lack of such oversight can lead to premature departure. The Department needs to devise mechanisms that will assist shared housing residents with their medication management.

Homesharing brings together a homeowner needing support and assistance with a caregiver seeking a home. Homeshare Vermont has a long history of providing match-up services for Chittenden County residents and has become a model for development of other match-up programs in the state. Its innovative work has allowed many nursing home level of care individuals to remain at home. More recently, Homeshare Vermont has expanded its services to Grand Isle and northern Addison County. The year of 2003 brought the opening of a match-up program in Central Vermont through the collaboration of multiple partners. Two other areas of Vermont have expressed interest in establishing programs. Further replication of this model is needed.

Home Modification funds pay for renovations that permit people to live independently. A physically accessible entrance and accessible bathroom can make the difference in allowing a person to remain at home. The Vermont Center for Independent Living manages the Home Accessibility Program but funding remains inadequate to meet the demand. Based on the 2000 Home Modification Study prepared for the Legislature, the Department estimates the total annual funding for this program should be at least \$660,000 more than funds available in 2000. DAD must also continue to work with stakeholders to implement the balance of the Study recommendations so that excessive waits for funding are reduced.

Adults with physical disabilities have experienced growing success in living independently, leading to the need for home modification funding of newly purchased homes. Often, funding from programs promoting home ownership covers the cost of the home but not the cost of home modification. People may lose the opportunity to purchase a home because of their inability to access home modification resources in time to close the purchase.

At the same time, the Department needs to continue working with the housing community to educate builders and architects about the value of universal design and

adaptability. As the population ages and life spans increase, home accessibility will become more integrated into the norm. The State needs to increase public awareness of the practical and aesthetic potential of universal design. Broader use of such design may help decrease unit costs over time and create less of a need for funds to solve home accessibility problems.

Expanded Awareness and Appropriate Use of Reverse Mortgages:

Reverse mortgages are federally guaranteed loans made to older homeowners, secured by the equity of their homes and paid off at the time of sale. Regular payments from the loan can be used to cover necessary care and related expenses allowing an elder to continue living at home. Collaboration between long term care case managers and financial lenders would be valuable in reducing elders' confusion about reverse mortgages.

Training: DAD-certified case managers received training on housing issues in 2003. The training revealed a great interest in these issues, however, consistent dissemination of information for case managers is lacking. The Department will continue its efforts to equip case managers with information to help clients with housing-related concerns.

Adult Day Services

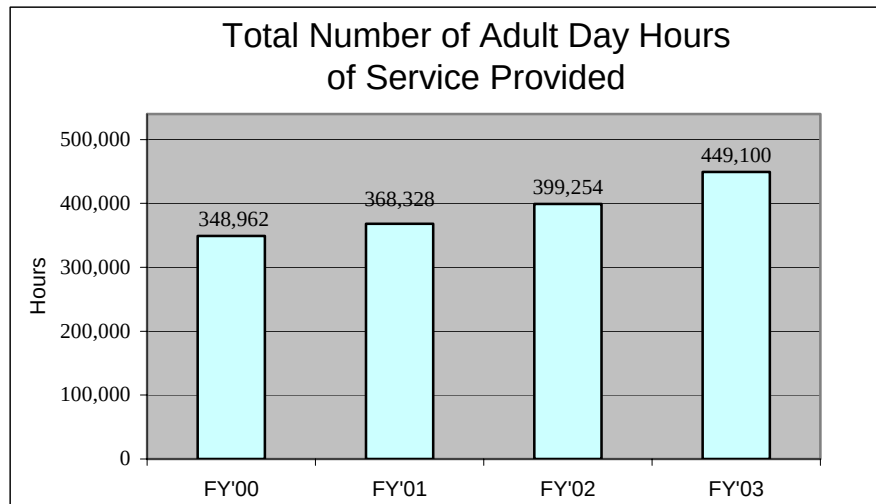
Recommendation:

- **Increase the daily capacity of adult day centers to serve 918 people in 2013, up from 565 in the year 2003.**

As demand has grown to help nursing home eligible people remain at home, adult day centers have come to play a crucial role in Vermont's long term care system. Centers offer a full day's care and supervision to participants while furnishing much needed respite to family caregivers. Adult day centers currently provide intensive personal care and increased nursing services in addition to activities, socialization and meals. When used in combination with other home-based services, adult day centers now offer a true alternative to nursing home care.

Vermont's adult day centers served 28% more participants (daily capacity) in FY 2003 than in FY 2000 (565 versus 441). There are currently seventeen Department of Aging and Disabilities certified adult day centers. Sixteen of these centers have a registered nurse on site daily and new standards will make this mandatory for all centers. The charge for basic adult day services averages \$12.00 per hour. Adult day centers are open a minimum of five days a week, nine hours a day. Some centers have expanded their hours of service to include evenings and weekends, yet waiting lists still remain.

Adult day centers have increased their hours of service as well. Total service hours reached an historic high of 449,100 in FY 2003. Between FY 2000 and FY 2003, the annual number of hours grew 29%, from 348,962 to 449,100. (See table below.) This increase reflects the higher number of participants who, on the whole, seem satisfied with the services. According to the 2002 Consumer Satisfaction Survey completed by ORC Macro, nearly 94% of people who participated in adult day services reported that adult day staff "always" or "almost always" treated them with respect and courtesy; nearly 87% indicated they were "always" or "almost always" satisfied with the quality of services received; and 86.4% indicated that services "always" or "almost always" met their needs.



In the year 2000, the capacity of the existing adult day centers was limited. Many were full and unable to accept new participants. Adult day centers recognized the problem and implemented a variety of expansion plans, many of which have been realized.

In early 2002, both the Brattleboro and Springfield adult day centers moved to larger, more accessible facilities. In the fall of 2002, Chittenden County opened its third adult day site. Morrisville and Lyndonville centers are in the process of expanding their existing facilities. The St. Albans area adult day center is planning to open a satellite site in the near future. Bennington is in the process of purchasing property to build a new site. Middlebury's adult day center is concluding a capital campaign with plans to break ground on a new facility in the spring of 2004, doubling its daily capacity from 50 to 100 participants.

By 2013, Vermont's adult day centers will need to serve 353 more clients per year in order to maintain their 2003 rate of use, while keeping pace with demographic changes and the expected decline in nursing facility use. The Department will continue to work with centers in identifying new funding sources to meet the growing demand for services.

Caregivers

Recommendation:

- **As funds permit, continue to improve wages and benefits for personal caregivers in all settings until caregivers receive a *starting* wage of at least \$10/hour, along with basic benefits such as health insurance, sick time and vacation leave; and**
- **Increase wages in all settings by an annual inflation factor.**

The Department remains committed to improving wages and working conditions for caregivers. As the economy slowly improves, caregiving organizations are beginning to experience renewed difficulty in staff recruitment. Although there were no additional funds to increase caregiver wages in 2003, efforts to improve staff recruitment and retention persist.

The formation of Vermont's first statewide caregiver association occurred under the sponsorship of the Community of Vermont Elders (COVE). The Vermont Association of Professional Care Providers is dedicated to advancing professional growth, employment opportunities, and quality of life for personal caregivers. This new organization will address staffing shortages in long term care, regardless of the setting. The Association also provides information, education, and advocacy to further advance the profession.

COVE also succeeded in obtaining a "Better Jobs, Better Care" grant from the Robert Wood Johnson Foundation. The goals of the grant are to:

- increase wages and benefits for Licensed Nurse Assistants and Personal Care Attendants;
- develop best practice standards across the full spectrum of long term care; and,
- improve training and professional development for direct care workers and long term care organizations.

In an effort to improve retention for nursing home staff, the Vermont Health Care Association has worked with the Department to develop a special recognition program for facilities that use best practices in managing and supervising caregivers. Dubbed the "Gold Star Employer" program, this initiative requires facilities to meet criteria in seven domains:

- Staff recruitment
- Orientation and training
- Staffing levels and work hours

- Professional development and advancement
- Supervisory training and practices
- Team approach
- Staff recognition and support

Any facility that agrees to use best practices in these domains will be designated a Gold Star facility. The Department of Aging and Disabilities will promote these facilities as having an excellent work environment. In partnership with the Vermont Health Care Association, the Department will also develop a process for evaluating each facility to ensure continued Gold Star designation.

Transportation

Recommendation:

- **Identify unmet transportation needs of elders and adults with disabilities to improve access to long term care services; and**
- **Enhance coordination of transportation services to improve efficiency and maximize the use of limited resources.**

Access to flexible and responsive transportation services is essential to the success of a long term care system. Affordable and appropriate transportation becomes imperative as utilization of services increases. At public meetings across the state, consumers have underscored the need for transportation in accessing services and maintaining involvement in their communities.

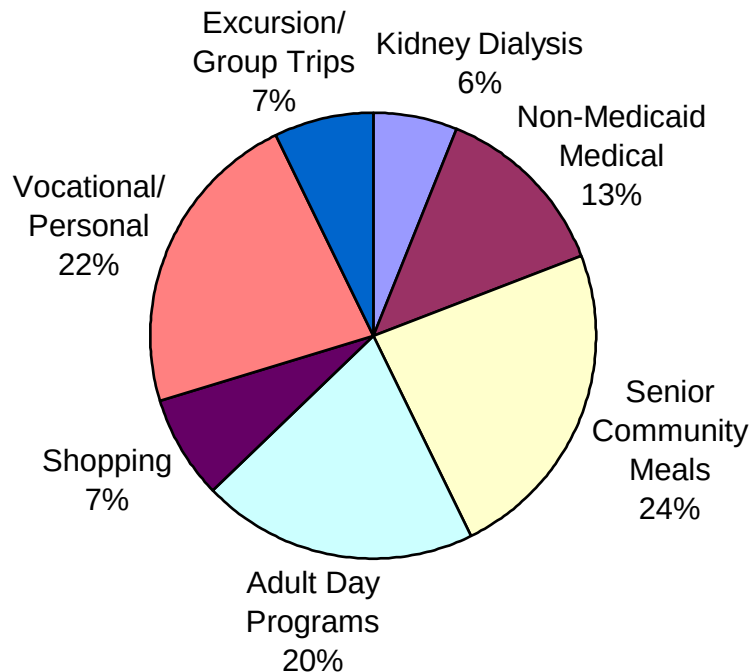
In January 2003, the Department assumed responsibility for administering the Section 5310 Transportation Program. The Department's objectives were to coordinate human services with public transportation, ensure efficiency, and promote access to quality services. Through a grant agreement with the Vermont Agency of Transportation (VTrans), this federally funded program is designed to meet the special transportation needs of elders and adults with disabilities. The Department receives \$2.1 million that must be matched with local support of at least an additional twenty percent. In Fiscal Year 2003, total funding for the program exceeded \$3.6 million. The Department coordinates its efforts closely with VTrans, which maintains responsibility for the portion of the program that provides vehicles and equipment.

In administering the program, the Department contracts with fourteen transportation and human services organizations throughout the state to purchase or provide transportation. At the local level, these organizations work closely with their Regional Planning Commissions and other interested stakeholders to develop transportation projects, prioritize services, and coordinate their efforts. Services can be provided using accessible buses and minivans, taxis, volunteer drivers and other means.

The Department's initial priorities were to identify the number of people served, their travel destinations, and the associated costs of the service. Using data provided by VTrans and the grantees, the Department estimates that 4,436 elders and adults with disabilities received 309,395 trips at an overall cost of \$3,622,291 during FY 2003. Trips to senior community meals programs, trips for vocational/personal purposes, and transport to and from adult day centers comprised the majority of the transportation provided. (See chart below.) Costs were greatest in providing transportation for adult day centers and senior community meals programs. The higher proportion of costs for adult day transportation is likely explained by the need

for accessible buses and/or minivans, which tend to be more costly than other modes of transportation.

5310 Transportation Program Trips



As the Department reaches its one-year anniversary of managing this program, it is convening an Advisory Council to provide input on how to improve the program. Key areas for discussion and future work will focus on tracking and identifying unmet transportation needs, targeting scarce program resources, prioritizing services, and improving coordination. Since program funding has remained level since 2000 while other community-based services have expanded, it is important to ensure that this program operates as efficiently as possible to meet the increased demand.

The Department also works closely with the Medicaid Transportation Program and other departments within the Agency of Human Services to identify and resolve any coordination issues and explore opportunities to expand and enhance transportation for human services. This includes collaborative work with the Vermont Public Transportation Association (VPTA), VTrans and the Regional Planning Commissions.

Future plans include the development and implementation of a pilot project to improve regional planning, coordination, and collaboration among human service and transportation programs. The Department also hopes to obtain better information from consumers regarding special transportation needs, improved access and accessibility, and consumer satisfaction.

Prevention

Recommendation:

- **Expand community-based health promotion and disease prevention programs for elders and adults with physical disabilities.**

The number of health promotion and disease prevention activities for Vermont's elders and adults with disabilities is growing. Participation in these programs in conjunction with healthy lifestyles can have a dramatic effect on overall health and well-being. In addition to increasing independence and improving quality of life, such efforts have contributed to a decline in disability among elders and have the potential to reduce health care expenditures as well. The Department's Successful Aging and Independent Living (SAIL) initiative is driven by four outcomes. Elders and adults with disabilities will:

- have a low risk of disease and disease-related disability;
- be physically and mentally fit;
- be engaged in life to the extent they prefer; and
- live with dignity in the setting of their choice.

Access to health promotion and disease prevention activities for elders and adults with physical disabilities presents challenges given Vermont's rural character. The Area Agencies on Aging remain leaders in supporting successful aging and independent living for elders by offering locally based programs in nutrition, physical activity, and social engagement. More than one million meals are served each year to Vermont's elders in their homes and community settings through the Older Americans Act Nutrition Program. There is a growing network of strength training classes where elders are certified as instructors to teach their peers strength and balance exercises. Waiting lists exist for many of these programs held in meal sites, senior centers and community centers. Other community-based activities that promote the health and well-being of elders include tai chi and dance classes, ongoing social programs, and volunteer opportunities.

Home Health Agencies are leaders in promoting successful aging and independent living as well. Home care agencies provide health screening clinics, foot care clinics, nutrition counseling, and flu vaccinations to elders and other high risk Vermonters. Options for adults with physical disabilities are more limited. A grant funded by the Centers for Disease Control and Prevention is supporting the Department's work of identifying barriers and improving access to health promotion and disease prevention programs for adults with disabilities.

Vermont participates in two other federally funded food and nutrition programs. The Commodity Supplemental Food Program provides a box of nourishing, shelf-stable foods each month to nearly 5,000 elders. The monthly delivery also includes nutrition and health promotion information. In spite of efforts to increase enrollment in this program, the number served has remained level during 2003. The Senior Farmers' Market Nutrition Program provides fresh locally grown produce to nearly 1,500 Vermont elders through farmers' market coupons and Community Supported Agriculture farm shares. Nutrition education includes hands-on cooking demonstrations that feature produce from the farm share.

The Department routinely utilizes data gathered on the health and well-being of Vermont elders and adults with physical disabilities. The primary source of data, the Behavioral Risk Factor Surveillance System survey administered by the Vermont Department of Health, now identifies self-reported disability thus enabling evaluation of health risk behaviors for both elders and adults with disabilities. Compiled and reported every other year in the *Vermont SAIL Report*, the findings allow DAD to target health promotion and disease prevention activities to these Vermonters.

Future Steps

From Shaping the Future of Long Term Care 2000-2010

1. Obtain Vermont population projections through 2020 and incorporate them into the 2004 report. *Accomplished*
2. Analyze and incorporate the U.S. Census 2000 disability data from the Public Use Microdata Sample, which should be available in mid-2003. *Progress is underway.*
3. Continue to gather data on the incidence of specific disability conditions among Vermonters. *Unchanged; data is difficult to obtain.*
4. Gather and incorporate data on Home Health Agency services. This information is not easily incorporated because data sets do not match. However, the Department expects to have preliminary data in 2004. *DAD is the repository for the OASIS data set. The Department plans to obtain a data use agreement with CMS so that data on home health services can be queried directly.*
5. Obtain and incorporate statewide data on in-migration and out-migration of elders and adults with physical disabilities. *Accomplished for elders; data on adults with disabilities not available.*
6. Obtain data on children with significant disabilities in order to plan for their transition to adult services. *Efforts are underway. DAD is working with the Departments of Health, Developmental & Mental Health Services, and Prevention, Assistance, Transition and Health Access (PATH).*
7. Work with the Long Term Care Coalitions, Area Agencies on Aging and other stakeholders to develop county-based plans. *Plan to do in 2004.*
8. In collaboration with the Department of Housing and Community Affairs, establish a joint data set on housing needs for elders and adults with physical disabilities. *Not yet accomplished.*

APPENDIX

ASSUMPTIONS SHEET

Annual % change in per capita disability rate by age group.

Disability Rate Trends (non-MR/DD)

Default values:

	2000-2003	2003-2008	2008-2013
0-64*	3.8%	3.1%	2.6%
65+**	-0.9%	-0.9%	-0.8%

	'00-'03	'03-'08	'08-'13
0-64	3.8%	3.1%	2.6%
65+	-0.9%	-0.9%	-0.8%

*Default disability trends for 0-64 population assumes same rate of increase as assumed by the Social Security administration for Disabled Workers (i.e., individuals receiving Social Security Disability Insurance benefits) from the 2002 Annual Trustees Report. We apply these trends to all individuals younger than age 65, as little good projection data exist for individuals younger than 18.

**Default disability trends for the 65+ population are informed by disability trends reported by Manton from the National Long Term Care Survey. From Manton's age-adjusted trend analysis, we derived that the percentage of individuals having difficulty with 1+ ADL (2+ ADLs were not reported separately) decreased by 1% annually from 1989 to 1999. We assume a slight flattening of this trend in the future.

Nursing Facility Use Rate Trends***

Annual % change in per capita nursing facility use rate by age group.

Note: VT historical trends:

Default values:

	2003-2008	2008-2013
0-64	-2.1%	-1.3%
65-74	-2.0%	-2.3%
75-84	-2.4%	-2.1%
85+	-3.5%	-3.5%

	'92-'03	'99-'01	'00-'03
0-64	-1.3%	-5.0%	-2.9%
65-74	-2.3%	-6.0%	-2.0%
75-84	-2.1%	-2.2%	-2.8%
85+	-3.5%	-4.7%	-3.6%

	'03-'08	'08-'13
0-64	-2.1%	-1.3%
65-74	-2.0%	-2.3%
75-84	-2.4%	-2.1%
85+	-3.5%	-3.5%

***Includes all payers, i.e., both public and private pay nursing facility residents. Default trend assumptions are based on the observed trends in nursing facility use rates through the second quarter of 2003. We assume that the declines in nursing facility use rates will not be as sharp between 2003 and 2008 as observed historically, and that rates will continue to decline but even more slowly between 2008 and 2013.

Ratio of any disability during year to point-in-time disability

1.00

<--- set at 1 for point-in-time estimates

Table 0

Comparison of LTC Need¹ (2+ ADLs) and Use² (Nursing Facility or HCBS) by County
Projected Use Reflects Demographic Changes, but Redistributes Resources to Counties Based on Disability
Persons Age 18 and Above, All Income Levels
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2003															
People with LTC Needs (2+ ADLs) ¹	7,109	321	721	357	1,306	44	441	40	256	236	432	873	776	604	701
People with LTC Use - Actual ²	4,953	272	546	242	852	13	357	19	198	169	333	582	570	322	481
2008															
People with LTC Needs (2+ ADLs) ¹	7,711	349	774	387	1,456	48	488	48	284	264	470	927	816	643	757
People with LTC Use - Projected Based on County's share of 18+ Disabled Pop. ^{2,3}	5,271	239	529	264	995	33	334	33	194	181	321	634	558	439	517
2013															
People with LTC Needs (2+ ADLs) ¹	8,431	385	831	419	1,640	53	542	58	321	298	509	987	878	694	816
People with LTC Use - Projected Based on County's share of 18+ Disabled Pop. ^{2,3}	5,708	261	563	284	1,111	36	367	39	218	202	344	668	595	470	552

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities. Includes individuals in nursing facilities and individuals in the community.

²People with LTC use represent an unduplicated "point-in-time" count of individuals using either a nursing facility or home and community-based services (HCBS). Nursing facility residents represent an average daily census, and include privately and publicly funded nursing facilities. People with HCBS use represent the average monthly number of people with the following *publicly*-funded HCBS use: Medicaid Waiver Personal Care, Adult Day, Attendant Services Program, Homemaker Services, Enhanced Residential Care, and ACCS. People with HCBS use must require assistance with 2+ ADLs.

³Projected number of people with use in 2008 and 2013 reflects two key assumptions: 1) each county's projected use is proportional to its share of the 18+ disabled population in the State, and 2) state-wide use trends reflect changes in age-distribution but assume no changes in service patterns beyond Fiscal Year 2003.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Projected number of community residents with LTC use in 2008 and 2013 are based on FY 2003 use statistics from VT DAD and trend assumptions from the following sources: VT population projections by age group supplied by VT DAD; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

County estimates may not sum to Vermont total due to rounding.

Number of nursing facility residents includes Wake Robin but excludes Arbors and Mertens.

Table 1

Comparison of HCBS Need (2+ ADLs)¹ and Publicly-Funded HCBS Use³ in the Community by County, 2003, 2008, and 2013
Projected Use Reflects Demographic Changes, but Redistributes Resources to Counties Based on Disability
Low Income Persons Age 18 and Above
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2003															
Need: Community Residents with LTC Needs¹															
All Incomes	3,835	220	244	199	762	44	237	40	132	150	179	487	366	378	397
Low-Income ²	1,738	98	112	92	341	21	108	18	60	68	86	224	162	171	178
Use: People Using Publicly-Funded HCBS															
Low-Income ² - Actual ³	1,540	153	62	80	273	11	144	15	65	81	76	184	142	90	164
2008															
Need: Community Residents with LTC Needs¹															
All Incomes	4,622	253	329	237	924	48	292	48	165	180	230	568	444	433	471
Low-Income ²	2,100	113	150	109	416	24	133	21	76	82	109	261	198	196	212
Use: People Using Publicly-Funded HCBS															
Low-Income ² - Projected Based on County's Share of 18+ Disabled Pop. ⁴	2,002	108	143	104	396	22	127	20	72	78	104	249	188	187	202
2013															
Need: Community Residents with LTC Needs¹															
All Incomes	5,464	291	408	275	1,112	53	352	58	204	214	280	649	528	493	547
Low-Income ²	2,492	131	187	128	502	26	160	26	94	98	133	300	236	224	248
Use: People Using Publicly-Funded HCBS															
Low-Income ² - Projected Based on County's Share of 18+ Disabled Pop. ⁴	2,516	132	189	129	507	26	162	26	94	99	134	302	238	226	250

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Low-Income defined as income below 175% of Federal Poverty Guideline.

³Community residents with publicly-funded LTC use represents an unduplicated count of individuals with 2+ ADLs with any use during the month of the following programs: Medicaid Waiver Personal Care, Adult Day, Attendant Services Program, Homemaker Services, Enhanced Residential Care, and ACCS. 2003 user counts represent estimated number of unduplicated users during the month.

⁴Projected number of people with use in 2008 and 2013 reflects two key assumptions: 1) each county's projected use is proportional to its share of the 18+ disabled population in the State, and 2) state-wide use trends reflect changes in age-distribution but assume no changes in service patterns beyond Fiscal Year 2003.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Projected number of community residents with LTC use in 2008 and 2013 are based on FY 2003 use statistics from VT DAD and trend assumptions from the following sources: VT population projections by age group supplied by VT DAD; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 2

Estimated Number of People with LTC Needs¹ by County, 2003, 2008, and 2013
By Disability Level and Income, Persons of All Ages
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2003															
Nursing Facility ^{2,3}	3,274	101	477	158	545	-	204	-	125	87	253	386	411	226	304
Community ⁴	614,148	36,505	36,683	29,753	149,495	6,545	46,285	7,214	23,834	28,560	26,103	63,176	58,087	44,516	57,391
All <175% FPL	143,299	8,048	8,911	7,686	33,232	1,806	10,611	1,591	5,557	6,664	7,163	15,742	12,861	10,463	12,967
2+ ADLs	1,802	102	115	96	356	22	114	19	63	71	89	230	168	175	184
1+ ADLs	2,931	163	194	157	589	36	189	31	103	123	146	363	271	262	302
Any ADL or IADL	7,402	404	502	402	1,524	94	482	77	265	325	376	893	680	608	769
All 175%+ FPL	470,849	28,457	27,772	22,067	116,263	4,740	35,674	5,623	18,277	21,896	18,941	47,434	45,227	34,053	44,424
2+ ADLs	2,252	132	141	114	458	24	143	24	77	89	101	279	218	218	233
1+ ADLs	3,902	226	253	198	813	42	255	43	138	165	174	463	377	345	409
Any ADL or IADL	9,697	557	649	493	2,054	105	641	108	349	433	432	1,114	937	794	1,031
2008															
Nursing Facility ^{2,3}	3,089	97	445	150	532	-	196	-	119	84	239	359	372	210	285
Community ⁴	629,090	37,451	36,911	30,451	154,785	6,668	48,336	7,723	25,018	29,201	26,687	63,607	59,022	45,289	57,941
All <175% FPL	146,691	8,256	8,967	7,830	34,446	1,842	11,060	1,712	5,832	6,796	7,312	15,836	13,047	10,637	13,116
2+ ADLs	2,164	117	154	113	431	24	139	22	78	84	113	268	203	201	218
1+ ADLs	3,382	183	237	179	687	40	221	37	124	141	175	408	312	294	344
Any ADL or IADL	8,251	446	570	444	1,724	104	546	92	304	364	426	973	746	666	847
All 175%+ FPL	482,399	29,195	27,944	22,621	120,338	4,826	37,276	6,010	19,187	22,405	19,375	47,771	45,975	34,651	44,824
2+ ADLs	2,674	149	187	134	546	26	173	28	96	105	128	322	260	247	272
1+ ADLs	4,444	251	306	223	933	46	295	50	162	188	206	515	428	382	458
Any ADL or IADL	10,720	610	729	539	2,301	116	720	128	397	481	486	1,204	1,022	866	1,122
2013															
Nursing Facility ^{2,3}	2,967	94	423	143	529	-	191	-	117	83	229	338	350	201	269
Community ⁴	642,248	38,332	37,049	31,140	159,046	6,793	50,387	8,229	26,177	29,770	27,250	63,987	59,743	45,980	58,364
All <175% FPL	150,772	8,524	9,055	8,042	35,631	1,889	11,575	1,851	6,146	6,980	7,499	16,025	13,308	10,898	13,349
2+ ADLs	2,562	135	191	132	519	27	167	27	96	101	136	307	243	229	253
1+ ADLs	3,917	209	282	204	811	44	260	44	149	164	205	459	363	333	391
Any ADL or IADL	9,333	504	644	495	1,994	115	629	110	356	415	482	1,070	837	744	938
All 175%+ FPL	491,476	29,808	27,995	23,098	123,415	4,905	38,812	6,377	20,031	22,791	19,751	47,962	46,435	35,082	45,015
2+ ADLs	3,137	170	230	155	650	29	206	34	117	124	154	366	307	279	314
1+ ADLs	5,102	284	358	253	1,090	51	345	60	194	216	241	574	491	429	516
Any ADL or IADL	12,117	688	820	599	2,655	127	830	153	466	546	550	1,322	1,149	968	1,243

¹LTC needs are defined as requiring "hands on" assistance with ADLs and/or IADLs. *Excludes* individuals with mental retardation or developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2003 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3
Estimated Number of People with LTC Needs¹ by County, 2003, 2008, and 2013
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2003															
Nursing Facility ^{2,3}	3,274	101	477	158	545	-	204	-	125	87	253	386	411	226	304
Community, Low Income (<175%FPL) ⁴	1,802	102	115	96	356	22	114	19	63	71	89	230	168	175	184
<65	520	27	31	26	128	6	35	5	22	23	27	56	51	39	45
<18	65	4	4	3	15	1	6	1	2	3	3	7	6	5	6
18-64	455	23	27	23	113	5	30	5	19	19	24	49	45	35	39
65+	1,282	75	85	69	228	16	78	13	41	48	62	175	117	136	139
65-74	348	20	30	17	54	5	26	5	15	17	14	38	33	31	43
75-84	492	28	30	32	86	6	33	5	14	18	21	75	38	49	55
85+	442	27	25	20	88	4	20	3	11	13	27	61	46	57	41
Community, 175%+ FPL ⁴	2,252	132	141	114	458	24	143	24	77	89	101	279	218	218	233
<65	773	45	44	35	191	7	56	9	31	35	32	75	81	58	71
<18	155	9	9	7	38	2	14	2	6	7	7	16	15	11	14
18-64	618	35	36	28	154	6	43	7	26	28	26	60	66	48	57
65+	1,479	87	97	79	267	17	87	15	46	54	68	204	138	160	162
65-74	312	18	27	14	49	4	22	4	14	15	12	34	31	28	40
75-84	653	38	41	42	115	8	42	7	19	24	26	100	53	66	74
85+	514	31	29	23	102	5	23	4	13	15	31	71	54	66	48

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2003 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3
Estimated Number of People with LTC Needs¹ by County, 2003, 2008, and 2013
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2008															
Nursing Facility ^{2,3}	3,089	97	445	150	532	-	196	-	119	84	239	359	372	210	285
Community, Low Income (<175%FPL) ⁴	2,164	117	154	113	431	24	139	22	78	84	113	268	203	201	218
<65	565	29	33	29	140	7	39	6	24	24	30	60	55	42	47
<18	64	4	4	3	15	1	6	1	3	3	3	7	6	4	5
18-64	501	25	30	26	125	6	33	5	21	21	26	53	49	37	42
65+	1,599	87	120	84	291	18	99	16	54	60	83	208	148	159	170
65-74	412	24	35	19	67	5	30	6	19	19	19	45	40	36	49
75-84	558	30	42	34	100	7	38	6	18	21	25	80	45	53	59
85+	629	34	44	31	124	5	32	4	18	19	39	84	63	70	62
Community, 175%+ FPL ⁴	2,674	149	187	134	546	26	173	28	96	105	128	322	260	247	272
<65	832	48	48	39	207	8	62	10	35	37	35	80	87	62	75
<18	152	9	8	7	37	2	14	2	6	7	7	15	14	10	13
18-64	680	39	40	31	170	6	48	8	29	31	29	65	72	51	61
65+	1,842	101	139	96	339	19	111	19	61	68	92	242	174	185	197
65-74	370	21	32	16	61	4	25	6	17	17	16	40	37	33	45
75-84	741	40	56	44	133	8	49	8	24	28	32	105	62	71	80
85+	731	39	51	36	145	6	36	5	21	23	45	97	74	82	72

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2003 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3
Estimated Number of People with LTC Needs¹ by County, 2003, 2008, and 2013
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2013															
Nursing Facility ^{2,3}	2,967	94	423	143	529	-	191	-	117	83	229	338	350	201	269
Community, Low Income (<175%FPL) ⁴	2,562	135	191	132	519	27	167	27	96	101	136	307	243	229	253
<65	648	34	38	34	162	7	46	7	28	28	34	67	63	47	53
<18	69	4	4	4	16	1	6	1	3	3	4	7	6	5	6
18-64	579	29	34	30	145	7	40	6	25	25	31	60	57	42	48
65+	1,914	101	153	98	357	19	120	20	68	73	102	240	180	182	200
65-74	529	31	44	25	92	6	37	8	23	25	25	57	51	46	60
75-84	601	31	47	33	109	7	41	7	22	23	29	82	52	55	63
85+	783	40	62	40	156	6	43	5	23	25	48	101	77	81	78
Community, 175%+ FPL ⁴	3,137	170	230	155	650	29	206	34	117	124	154	366	307	279	314
<65	952	55	55	44	239	9	73	12	41	43	41	90	99	69	84
<18	166	10	9	8	41	2	15	2	7	7	7	16	16	11	14
18-64	786	45	46	37	198	7	58	9	34	35	33	73	83	58	69
65+	2,185	116	175	111	411	20	133	23	77	82	113	276	209	210	230
65-74	475	28	40	21	83	5	32	7	21	22	21	51	48	42	55
75-84	799	42	63	43	146	9	53	10	29	31	37	108	71	74	85
85+	911	46	72	46	182	7	49	6	27	29	55	117	90	94	91

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2003 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3a

Percent Distribution of Community Residents with LTC Needs¹ by County, 2003, 2008, and 2013
Individuals Needing Assistance with 2+ ADLs, by Age Group
Persons of All Income Levels
Point in Time

		<i>Vermont (100%)</i>	<i>Addison</i>	<i>Bennington</i>	<i>Caledonia</i>	<i>Chittenden</i>	<i>Essex</i>	<i>Franklin</i>	<i>Grand Isle</i>	<i>Lamoille</i>	<i>Orange</i>	<i>Orleans</i>	<i>Rutland</i>	<i>Washington</i>	<i>Windham</i>	<i>Windsor</i>
Age <18																
2003	220	6.1%	5.7%	4.8%	23.9%	1.1%	8.7%	1.2%	3.8%	4.7%	4.6%	10.2%	9.4%	6.8%	9.0%	
2008	216	6.1%	5.5%	4.8%	24.3%	1.0%	9.0%	1.2%	3.9%	4.6%	4.6%	10.1%	9.4%	6.7%	8.7%	
2013	235	6.2%	5.4%	5.0%	24.3%	1.1%	9.2%	1.2%	4.0%	4.5%	4.7%	10.0%	9.3%	6.6%	8.5%	
Age 18-64																
2003	1,073	5.5%	5.8%	4.7%	24.8%	1.1%	6.8%	1.1%	4.2%	4.4%	4.6%	10.1%	10.4%	7.6%	8.9%	
2008	1,181	5.4%	5.9%	4.8%	24.9%	1.0%	6.9%	1.1%	4.2%	4.4%	4.7%	9.9%	10.3%	7.5%	8.8%	
2013	1,365	5.4%	5.9%	4.9%	25.2%	1.0%	7.2%	1.1%	4.3%	4.4%	4.7%	9.8%	10.2%	7.4%	8.6%	
Age 18+																
2003	3,835	5.7%	6.4%	5.2%	19.9%	1.1%	6.2%	1.0%	3.4%	3.9%	4.7%	12.7%	9.5%	9.9%	10.3%	
2008	4,622	5.5%	7.1%	5.1%	20.0%	1.0%	6.3%	1.0%	3.6%	3.9%	5.0%	12.3%	9.6%	9.4%	10.2%	
2013	5,464	5.3%	7.5%	5.0%	20.3%	1.0%	6.4%	1.1%	3.7%	3.9%	5.1%	11.9%	9.7%	9.0%	10.0%	
Age 65+																
2003	2,762	5.9%	6.6%	5.4%	17.9%	1.2%	6.0%	1.0%	3.1%	3.7%	4.7%	13.7%	9.2%	10.7%	10.9%	
2008	3,441	5.5%	7.5%	5.2%	18.3%	1.1%	6.1%	1.0%	3.4%	3.7%	5.1%	13.1%	9.4%	10.0%	10.7%	
2013	4,099	5.3%	8.0%	5.1%	18.7%	1.0%	6.2%	1.0%	3.5%	3.8%	5.3%	12.6%	9.5%	9.6%	10.5%	

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities. Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3b

Distribution of Community Residents with LTC Needs¹ by County, 2003, 2008, and 2013

Individuals Needing Assistance with 2+ ADLs, by Age Group

Persons of All Income Levels

Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Age <18															
2003	220	13	13	11	53	2	19	3	8	10	10	22	21	15	20
2008	216	13	12	10	52	2	19	3	8	10	10	22	20	14	19
2013	235	14	13	12	57	3	22	3	9	11	11	24	22	16	20
Age 18-64															
2003	1,073	59	62	51	267	11	72	12	45	47	49	109	111	82	96
2008	1,181	64	69	57	294	12	82	13	50	52	55	118	122	89	103
2013	1,365	74	80	66	343	14	98	16	59	60	64	133	140	101	117
Age 18+															
2003	3,835	220	244	199	762	44	237	40	132	150	179	487	366	378	397
2008	4,622	253	329	237	924	48	292	48	165	180	230	568	444	433	471
2013	5,464	291	408	275	1,112	53	352	58	204	214	280	649	528	493	547
Age 65+															
2003	2,762	162	182	148	495	32	165	28	87	102	130	379	255	296	301
2008	3,441	189	259	179	630	36	210	35	115	128	175	451	322	344	368
2013	4,099	217	328	209	768	40	254	42	145	155	215	516	388	392	430

¹LTC Needs defined as requiring "hands on" assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities. Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 4**Actual and Projected Users of Long Term Care Services in Vermont by Program, 2003, 2008, and 2013¹ Selected Programs/Services Point in Time**

	FY 2003 Actual	FY 2008	FY 2013	Growth Rates	
				2003-2008	2008-2013
Nursing Facilities (Public and Private) ²	3,274	3,089	2,967	-6%	-4%
Medicaid Waiver Enhanced Residential Care	149	229	312	54%	36%
ACCS (Medicaid State Plan) Residential Care	625	831	1,047	33%	26%
Residential Care Homes -- Private Pay	1,132	1,492	1,872	32%	26%
Congregate Housing with Supportive Services (HASS)	797	951	1,159	19%	22%
Assisted Living	ND	ND	ND		
Medicaid Waiver Personal Care	897	1,167	1,469	30%	26%
Medicaid Waiver Respite	133	355	441	167%	24%
Medicaid Waiver Traumatic Brain Injury	39	40	41	3%	0%
Medicaid Waiver Case Management	871	1,129	1,421	30%	26%
OAA Non-Medicaid Waiver Case Management	1,567	2,045	2,635	31%	29%
Attendant Services Program (ASP)	261	290	319	11%	10%
Adult day	565	726	918	29%	26%
Homemaker Services	614	805	1,018	31%	26%
VCIL Home Delivered Meals (disabled clients)	287	297	299	4%	0%
Mental Health and Aging	509	628	797	23%	27%

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2003 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2003 number of Residential Care-Private Pay users was derived from a point-in-time census count done at various times during FY 2003. User counts for all other services represent the average number of individuals with use during a month. The FY 2003 Medicaid Program data is derived from EDS paid claims; other FY 2003 program data is derived from reported program use. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

²Nursing facility residents include Wake Robin but exclude Arbors and Mertens.

ND = no data available

Table 5

Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2003, 2008, and 2013

Selected Programs/Services

Point in Time

	Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
FY 2003 Actual															
Number of Users															
Nursing Facilities (Public and Private) ³	3,274	101	477	158	545	0	204	0	125	87	253	386	411	226	304
Medicaid Waiver Enhanced Residential Care	149	15	4	0	19	0	25	0	0	9	8	24	19	12	14
ACCS (Medicaid State Plan) Residential Care	625	26	28	44	57	0	70	0	23	22	45	118	112	21	59
Residential Care Homes -- Private Pay	1,132	31	173	40	231	0	33	0	30	26	72	154	145	72	125
Congregate Housing with Supportive Services (HASS)	797	45	57	10	196	19	19	0	124	1	7	219	66	30	4
Medicaid Waiver Personal Care	897	88	27	51	193	7	85	11	30	44	32	90	75	56	108
Medicaid Waiver Respite	133	19	4	4	39	1	3	3	3	5	12	12	10	5	13
Medicaid Waiver Traumatic Brain Injury	39	0	2	0	2	5	3	0	6	0	1	8	11	0	1
Medicaid Waiver Case Management	871	88	28	39	196	8	93	11	23	40	28	89	70	55	103
OAA Non-Medicaid Waiver Case Management	1,567	34	162	77	281	27	124	33	33	61	78	189	78	201	189
Attendant Services Program (ASP)	261	13	11	15	36	0	24	3	17	14	10	58	23	17	20
Adult Day	565	117	41	61	65	5	35	5	38	23	29	39	39	27	41
Homemaker Services	614	57	38	36	53	10	35	0	38	24	53	72	108	52	38
VCIL Home Delivered Meals (disabled clients)	287	14	15	15	60	6	20	5	9	7	5	43	37	21	30
Mental Health and Aging ⁴	509	68	40	72	37	0	67	0	0	0	0	82	83	60	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2003 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2003 number of Residential Care-Private Pay users was derived from a point-in-time census count done at various times during FY 2003. User counts for all other services represent the average number of individuals with use during a month. The FY 2003 Medicaid Program data is derived from EDS paid claims; other FY 2003 program data is derived from reported program use. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

²County estimates may not sum to state total because the State provides some services to Vermont residents with mailing addresses outside of Vermont.

³Nursing facility residents include Wake Robin but exclude Arbors and Mertens.

⁴Some counties report Mental Health & Aging clients in groups of counties: Caledonia/Essex/Orleans are listed under Caledonia; Washington/Orange/Lamoille are listed under Washington; and Windham/Windsor are listed under Windham.

Table 5

Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2003, 2008, and 2013

Selected Programs/Services

Point in Time

FY 2008 Projected

Number of Users

	Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Nursing Facilities (Public and Private) ³	3,089	97	445	150	532	0	196	0	119	84	239	359	372	210	285
Medicaid Waiver Enhanced Residential Care	229	21	9	0	31	0	38	0	0	14	11	38	29	20	19
ACCS (Medicaid State Plan) Residential Care	831	34	40	51	78	0	104	0	26	29	60	159	143	30	75
Residential Care Homes -- Private Pay	1,492	40	224	47	314	0	49	0	35	34	96	207	185	102	159
Congregate Housing with Supportive Services (HASS)	951	52	73	11	234	21	21	0	159	1	9	252	77	36	4
Medicaid Waiver Personal Care	1,167	110	36	65	248	7	116	13	39	56	44	119	101	75	137
Medicaid Waiver Respite	355	41	14	28	87	4	18	5	15	23	18	34	31	14	22
Medicaid Waiver Traumatic Brain Injury	40	0	2	0	2	5	3	0	6	0	1	8	11	0	1
Medicaid Waiver Case Management	1,129	109	37	51	253	9	124	13	30	51	38	117	94	74	129
OAA Non-Medicaid Waiver Case Management	2,045	42	224	98	367	31	163	42	44	77	112	249	103	252	244
Attendant Services Program (ASP)	290	15	11	17	39	0	27	3	19	16	11	66	25	18	22
Adult Day	726	144	56	75	85	5	44	6	55	28	38	49	49	37	55
Homemaker Services	805	72	53	43	69	11	49	0	52	32	78	93	143	64	46
VCIL Home Delivered Meals (disabled clients)	297	15	15	16	63	6	21	5	10	7	5	44	38	22	31
Mental Health and Aging ⁴	628	82	53	85	47	0	84	0	0	0	0	99	105	74	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2003 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2003 number of Residential Care-Private Pay users was derived from a point-in-time census count done at various times during FY 2003. User counts for all other services represent the average number of individuals with use during a month. The FY 2003 Medicaid Program data is derived from EDS paid claims; other FY 2003 program data is derived from reported program use. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

²County estimates may not sum to state total because the State provides some services to Vermont residents with mailing addresses outside of Vermont.

³Nursing facility counts include Wake Robin but exclude Arbors and Mertens.

⁴Some counties report Mental Health & Aging clients in groups of counties: Caledonia/Essex/Orleans are listed under Caledonia; Washington/Orange/Lamoille are listed under Washington; and Windham/Windsor are listed under Windham.

Table 5

Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2003, 2008, and 2013

Selected Programs/Services

Point in Time

FY 2013 Projected**Number of Users**

	Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Nursing Facilities (Public and Private) ³	2,967	94	423	143	529	0	191	0	117	83	229	338	350	201	269
Medicaid Waiver Enhanced Residential Care	312	27	13	0	43	0	53	0	0	19	14	51	39	28	25
ACCS (Medicaid State Plan) Residential Care	1,047	43	53	59	101	0	141	0	30	36	74	203	176	39	91
Residential Care Homes -- Private Pay	1,872	51	277	54	406	0	67	0	40	43	119	262	228	133	193
Congregate Housing with Supportive Services (HASS)	1,159	64	92	14	288	23	23	0	205	2	10	296	93	45	5
Medicaid Waiver Personal Care	1,469	139	46	82	312	8	151	15	48	70	56	149	129	97	168
Medicaid Waiver Respite	441	51	19	35	108	5	23	6	19	29	22	41	39	19	26
Medicaid Waiver Traumatic Brain Injury	41	0	2	0	2	5	3	0	7	0	1	8	11	0	1
Medicaid Waiver Case Management	1,421	137	47	63	321	9	160	15	37	64	48	146	120	96	157
OAA Non-Medicaid Waiver Case Management	2,635	53	293	126	482	36	211	54	58	97	148	317	134	319	309
Attendant Services Program (ASP)	319	18	12	19	41	0	30	4	22	17	12	74	28	20	24
Adult Day	918	179	72	94	110	5	56	8	72	34	48	60	61	48	71
Homemaker Services	1,018	91	69	51	89	13	64	0	68	41	102	114	181	79	56
VCIL Home Delivered Meals (disabled clients)	299	15	15	16	64	6	22	6	10	7	5	43	38	21	30
Mental Health and Aging ⁴	797	104	67	106	61	0	106	0	0	0	0	123	135	95	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2003 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2003 number of Residential Care-Private Pay users was derived from a point-in-time census count done at various times during FY 2003. User counts for all other services represent the average number of individuals with use during a month. The FY 2003 Medicaid Program data is derived from EDS paid claims; other FY 2003 program data is derived from reported program use. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

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