Special Report on
Residential Options for Long-Term Care Services for Moderate and Low Income Seniors

In Accordance with 162 V.S.A. §E.308.2:
Long-term Care Continuum of Residential Services

Submitted to: Senator Jane Kitchel

Submitted by: Douglas Racine, Secretary, AHS
Susan Wehry, Commissioner, DAIL

Prepared by: Camille George
Deputy Commissioner, DAIL

Report Date: April 2013
TABLE OF CONTENTS

Introduction
   The Charge 1
   Staff and Stakeholder Engagement 1-2

Executive Summary
   Overview 3
   Demographics 3
   The Continuum of Long-term Services and Housing Options 3-4
   Highlighted Themes and Recommendations 4-5

Demographics 6-8

The Continuum of Long-term Services and Housing Options 9-14
   Alternative Models 13-14

Principles 15-16
   Stakeholder Suggestions 16

Resources 17
INTRODUCTION

The Charge:

Act 162 of the 2012 Vermont legislature contained a charge for AHS and DAIL to deliver this report regarding long-term care continuum of residential services. The request seeks a better understanding of the continuum of long-term care housing models in Vermont, and its ability to meet the needs of moderate and low income seniors now and in the future:

Sec. E.308.2 LONG-TERM CARE CONTINUUM OF RESIDENTIAL SERVICES
(a) The agency of human services and department of disabilities, aging, and independent living shall prepare a report in consultation with consumer and provider groups on the continuum of residential options for long-term care services that are currently available to moderate and low income seniors. The report shall identify the appropriate range of residential options that will be needed to meet the needs of moderate and low income seniors over the next 10, 15, and 20 years. The report shall also include the reimbursement rates across the continuum of residential options identified and the potential sources of funding for such options.

Staff and Stakeholder Engagement:

The Agency of Human Services (AHS) and the Department of Disabilities, Aging and Independent Living (DAIL) prepared this report, in consultation with consumers and providers.

AHS and DAIL staff persons assigned to this project are:

Angus Chaney, Director of Housing, Agency of Human Services
Bard Hill, Director, Data and Planning Unit, DAIL/DDAS
Lora Nielsen, Assistant Division Director, Aging Services Unit, DAIL/DDAS
Linda Martinez, Program Director, Money Follows the Person, DAIL/DDAS
Will Rowe, Operations Team Leader, DAIL

A series of internal planning meetings were held in late 2012 through early 2013 to gather background and data related to the charge. A broad group of stakeholders met on
December 7th, 2012 to review and discuss initial data that presented current residential options and long-term services for moderate to low income seniors. Following this meeting, stakeholders were asked to contribute feedback on content, data and the final report draft. This stakeholder group included:

Attending the December 7th, 2012 Stakeholders Meeting were:

Laura Wilson--- Cathedral Square Corporation
Molly Dugan--- Cathedral Square Corporation
Christina Goodwin--- Homeshare NOW
Jackie Majoros--- Vermont Legal Aide
Laura Pelosi--- Vermont Health Care Association
Sarah Carpenter--- Vermont Housing Finance Agency
Nancy Owens--- Housing Vermont
Robert Crego --- Valley Cares
Eileen Peltier--- Central Vermont Community Land Trust
John Broderick--- Regional Affordable Housing Corporation
David Mickenberg--- AARP and Community of Vermont Elders
Jeanne Hutchins--- Center on Aging at UVM
Will Rowe--- DAIL
Bard Hill--- DAIL
Linda Martinez--- DAIL
Lora Nielsen--- DAIL
Colleen Forkas---- DAIL
Angus Chaney--- AHS

Others invited to the Stakeholder meeting included:

Jennifer Wallace-Brodeur--- AARP
Peter Cobb--- Vermont Assembly of Home Health Agencies
Arthur Hamlin--- Agency of Commerce and Community Development
Rick DeAngelis--- Vermont Housing and Conservation Board
Brian Smith--- Vermont Department of Mental Health
Sarah Launderville--- Vermont Center for Independent Living
EXECUTIVE SUMMARY

Overview:

This study provides information about the current continuum of long-term care residential options along with recommendations based on current and limited data regarding anticipated future demographics, resources and needs of older persons and persons with disabilities in Vermont. Several major factors confound making reliable projections including: lack of clarity about future federal funding resources and support for both housing and services; the future impact of health care reform in the nation and in the state; the future eligibility, benefits, and funding in Medicare and Medicaid; possible advances in medical treatments for common ailments that affect older persons; changes in the state economy including housing affordability; eligibility for and benefits available through social security; and the detailed consequences associated with the gradual shift to an older state population.

Projections of the future demographic age profile of the state are available, showing an older Vermont population in 10, 15 and 20 years. However, the available projections do not include estimates of future disability, income, or assets among the older population. Because these are major factors in the need for and use of long term care services, it is difficult to estimate future long-term care needs. If desirable, it would be possible to pursue the development of estimates of future demographics (including age, disability, income, and assets) but this would require resources that are not currently available.

Demographics:

Vermont is an “old” state and getting older. In 2012, 15.9% of the state’s population was over the age of 65, ranking Vermont fourth ‘oldest’ state in the United States. By 2032, it is projected that 23.8% of the Vermont population will be over the age of 65, with Vermont having the highest percent of persons older than age 65 in the US. Projections about the ‘oldest’ population, people 85 and older, rank Vermont second in the nation by 2050.

The demand for an array of long term support services and appropriate housing for older people and adults with physical disabilities will grow with the increasing numbers of people over 65. Because the prevalence of dementia increases quite significantly among people over the age of 85, Vermont can expect a steady increase in demand for services for people with dementia over the next thirty years.

The Continuum of Long Term Care Services and Housing Options:

The Mission of the Department of Disabilities, Aging and Independent Living is to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence. Since the passage of Act 160 in 1996 substantial progress has been made in supporting the choices of older Vermonters to remain in their homes, even as they need more assistance.

In 2005 Vermont implemented the “Choices for Care” (CFC) effort, a first-in-the-nation federal 1115 Medicaid Long-term Care Waiver that provides an entitlement to home and
community-based services. The flexibility of the CFC waiver created new opportunities for expansion of the home and community based system. “Housing options” for long term care and support may be understood as the availability, accessibility, and affordability of an array of care and support services, from which individuals and families can choose. Many in the independent living community appropriately express the strong position that housing management issues and services issues need to be separate and not controlled by the same person or entity. The appropriate array of “home and community based services” (HCBS) can allow many individuals to remain in community settings, achieving “aging in place.” HCBS currently includes case management, personal care, respite, personal emergency response, homemaker services, companion services, assistive devices, home modifications, adult day services and 24 hour individualized residential support services. HCBS can be flexible, person-centered, and person-directed, supporting both independence and autonomy.

This study includes a matrix that describes levels of individual need and the housing/service options that can meet these needs. As the matrix illustrates, comprehensive and flexible HCBS can support many different long-term housing/service options. In many respects the “housing challenge” is a challenge of availability, accessibility, and affordability of HCBS. A need for staffed and licensed settings remains, including “Enhanced Residential Care Homes” and Nursing Homes.

This section of the report also includes a discussion of promising models that are not currently available in Vermont. Innovations and experiments in community living options are taking place throughout the country, including some promising models that may have value in Vermont.

**Highlighted Themes:**

All stakeholders stressed the importance of

- An optimum continuum of long term care options that would be needed to support Vermonter’s expressed desire to age-in-place at home or in their communities both now and in the future
- Housing and service options that are person-centered and person-directed, supporting individual choices and preferences
- Consumer outcomes and consumer preferences driving public investments in long-term services, supports, and residential options.
- A Results Based Accountability framework with consumer-centered outcome and performance measures would help to insure that services are both desirable and effective.
- Support for family caregivers
- An integrated model of service delivery. Such integration may occur through changes in service coordination, the Dual Eligibles demonstration, Accountable Care Organizations, Blueprint Community Health Teams, the “Support and Services at Home” (SASH) demonstration, and/or other models that seek to integrate care, improve quality, and control costs.
Recommendations:

Too little data exists for us to recommend any of the suggestions generated by the group. The following were most often endorsed:

- Optimize existing housing stock: increase resources for housing modification and utilization of universal design to improve accessibility and support aging in place
- Expand Home Sharing options around the state
- Implement Adult Family Care option and expand around the state
- Expand Assisted Living Residences and Residential Care homes to meet the demands of the expanding elder population and the demand for alternatives to nursing homes
- Explore piloting a ‘Greenhouse’ nursing home model in Vermont
- Promote full-integration of the Aging and Disability Resource Connections (ADRC) effort within aging, disabilities, and medical care networks to optimize public awareness, understanding and utilization of long-term care and support options
- Expand HUD supported housing options through aggressive, collaborative applications with the housing and provider networks; for example, pursue HUD Section 811 applications for an increase in rental housing vouchers for people with disabilities and similar HUD Section 202 applications for elderly households
- Encourage development of affordable supportive senior housing by providing tax breaks or reductions in building fees for developers who create service enriched affordable senior housing or affordable assisted living communities
- Explore pilots of “alternative housing” options utilized in other parts of the country but not yet active in Vermont, e.g. cohousing efforts that promote “active neighboring” and allow professional caregivers to live among residents

(For a complete list see page 15-16 of this report)
DEMOGRAPHICS

Vermont’s population is small. In 2012, Vermont’s total population of about 625,000 people was ranked fiftieth in the United States. However, Vermont is also an ‘old’ state. In 2012, 15.9% of the Vermont population was over the age of 65, ranking #4 in the US. By 2032, 23.8% of the Vermont population is predicted to be over the age of 65, ranking #1 in the US.

Vermont’s ‘oldest’ population is relatively large, and growing larger. In 2012, 2.3% of the population was aged 85 and over, ranking #10. This age group is estimated to increase to 3.5% of the population in 2032 (rank #3) and to 5.8% of the population in 2050 (rank #2). The increase in this age group is noteworthy, due to the increased prevalence of dementia in this age group, as high as 40%. We can expect many more Vermonters to survive past age 85, which means that we can expect about three times as many people with dementia to need both housing and support services in the future. Figure 1 illustrates projected population growth by age group:

Figure 1
Projected Growth in the Older Population in Vermont as a Percentage of 2012 Population, by Age Group


Figure 2 below provides Vermont population projections for several age groups: 50 to 64; 65+; 65 to 74; 75 to 84; and 85+. Projections for 2032 and 2050 are compared to 2012, producing percentages of change from 2012. The table also compares Vermont’s projected future population with the projected future populations of other states.

The table depicts the aging of the baby-boomers which, combined with the fact that people are generally living longer, contributes to the growth in the older population. Just as society needed to adjust school capacities in communities from the 50s to the
80s, society needs to adjust capacities to meet the needs of older people from 2013 to 2050.

**Figure 2:**

<table>
<thead>
<tr>
<th>Vermont Population &amp; Projections Year</th>
<th>State Pop. (1,000s)</th>
<th>% of Total Populatio n Rank</th>
<th>U.S.</th>
<th>% Change from 2012 Rank</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages 2012</td>
<td>620</td>
<td>50</td>
<td>315,311</td>
<td>+16%</td>
<td>36</td>
</tr>
<tr>
<td>2032</td>
<td>722</td>
<td>51</td>
<td>376,660</td>
<td>+29%</td>
<td>38</td>
</tr>
<tr>
<td>2050</td>
<td>803</td>
<td></td>
<td>434,447</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 50-64 2012</td>
<td>144</td>
<td>23.2%</td>
<td>19.2%</td>
<td>50</td>
<td>+2%</td>
</tr>
<tr>
<td>2032</td>
<td>114</td>
<td>15.8%</td>
<td>16.4%</td>
<td>-21%</td>
<td>36</td>
</tr>
<tr>
<td>2050</td>
<td>161</td>
<td>20.0%</td>
<td>16.6%</td>
<td>+12%</td>
<td>39</td>
</tr>
<tr>
<td>Age 65+ 2012</td>
<td>99</td>
<td>15.9%</td>
<td>13.6%</td>
<td>18</td>
<td>+74%</td>
</tr>
<tr>
<td>2032</td>
<td>172</td>
<td>23.8%</td>
<td>19.8%</td>
<td>+73%</td>
<td>31</td>
</tr>
<tr>
<td>2050</td>
<td>175</td>
<td>21.8%</td>
<td>20.4%</td>
<td>+77%</td>
<td>44</td>
</tr>
<tr>
<td>Age 65-74 2012</td>
<td>55</td>
<td>8.9%</td>
<td>7.4%</td>
<td>44</td>
<td>+107%</td>
</tr>
<tr>
<td>2032</td>
<td>85</td>
<td>11.8%</td>
<td>10.1%</td>
<td>+53%</td>
<td>31</td>
</tr>
<tr>
<td>2050</td>
<td>73</td>
<td>9.1%</td>
<td>9.1%</td>
<td>+32%</td>
<td>49</td>
</tr>
<tr>
<td>Age 75-84 2012</td>
<td>29</td>
<td>4.7%</td>
<td>4.2%</td>
<td>13</td>
<td>+94%</td>
</tr>
<tr>
<td>2032</td>
<td>62</td>
<td>8.6%</td>
<td>6.8%</td>
<td>+111%</td>
<td>31</td>
</tr>
<tr>
<td>2050</td>
<td>55</td>
<td>6.9%</td>
<td>6.6%</td>
<td>+89%</td>
<td>49</td>
</tr>
<tr>
<td>Age 85+ 2012</td>
<td>14</td>
<td>2.3%</td>
<td>2.0%</td>
<td>19</td>
<td>+69%</td>
</tr>
<tr>
<td>2032</td>
<td>25</td>
<td>3.5%</td>
<td>2.9%</td>
<td>+77%</td>
<td>20</td>
</tr>
<tr>
<td>2050</td>
<td>47</td>
<td>5.8%</td>
<td>4.8%</td>
<td>+230%</td>
<td>20</td>
</tr>
</tbody>
</table>


Vermont currently provides a high percentage of long term support services (ltss) in the community. For older people and adults with physical disabilities, 41% of Vermont ltss spending is in home and community based settings, ranking #14 in the US. For all populations, 65% of Vermont ltss spending is in home and community based settings, ranking #5 in the US. The people who want services in the community also need housing in the community, which means that the demand for combinations of housing and support services in the community is higher than the national average, and can be expected to continue to grow. Vermont’s increasingly ‘old’ population, coupled with people’s general desire to ‘age in place’ and Vermont’s efforts to provide home and community based services, is expected to increase future demand for both affordable, accessible housing and support services in HCBS settings.

**Figure 3** below shows current estimates of disability rates in the 65+ population and the 18 to 64 population in Vermont. If current prevalence and incidence rates continue, as the proportions and numbers of population 65 and older, 75 and older, and 85 and older increases, the numbers of individuals with self-care and cognitive disabilities will also increase.

- Applying the Self-Care Difficulty rate of 6.9% in Table 3 to the 2012 and 2032 populations in Table 1 the numbers of individuals with Self-Care Difficulties in 2012 were 6,831. In 2032 these numbers would increase to 11,868.
• Applying the Cognitive Difficulty rate of 8.9% to the 2012 and 2032 populations in Table 1, the numbers of individuals with Cognitive Difficulties in 2012 were 8,811. In 2032 these numbers would increase to 15,308.

Figure 3:

<table>
<thead>
<tr>
<th>Disability Rates</th>
<th>Number (1,000s)</th>
<th>Percent</th>
<th>Rank</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>People age 65+ with disabilities, 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care difficulty</td>
<td>6</td>
<td>6.9%</td>
<td>37</td>
<td>8.8%</td>
</tr>
<tr>
<td>Cognitive difficulty</td>
<td>8</td>
<td>8.9%</td>
<td>26</td>
<td>9.5%</td>
</tr>
<tr>
<td>Any disability</td>
<td>30</td>
<td>34%</td>
<td>35</td>
<td>37%</td>
</tr>
<tr>
<td>People age 18-64 with disabilities, 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care difficulty</td>
<td>7</td>
<td>1.8%</td>
<td>21</td>
<td>1.8%</td>
</tr>
<tr>
<td>Cognitive difficulty</td>
<td>22</td>
<td>5.5%</td>
<td>11</td>
<td>4.2%</td>
</tr>
<tr>
<td>Any disability</td>
<td>45</td>
<td>11.2%</td>
<td>17</td>
<td>10.0%</td>
</tr>
</tbody>
</table>


Unfortunately, these population projections do not directly answer the question of future demand for publicly funded long term care services, which will be directly affected by future levels of disability, income and assets. Combined projections of age, disability, income and assets are not currently available, and the capacity to complete such projections does not exist within the Agency of Human Services. It would be possible to pursue the development of estimates of future demographics (including age, disability, income, and assets) through contracts with external entities, but this would require resources that are not currently available. Connecticut recently completed such work for their state through such contracts an approach that could be replicated in Vermont, if adequate financial resources are made available. (Consistent with Vermont contracting rules, the actual cost of this work could be determined by competitive bidding.) (http://www.ct.gov/dss/lib/dss/pdfs/frontpage/ct_ltc_report_final.pdf)
**THE CONTINUUM OF LONG-TERM CARE SERVICES AND HOUSING OPTIONS**

**Figure 4** (below) represents a residential continuum of twelve options and relates the capacity of those options to meeting different levels of individual need. The twelve residential options range from a person living in his or her own home or apartment to a person living in a nursing home. The levels of need range from independent to intense/complex needs. The needs hierarchy reflects a conceptual combination of:

- functional independence based on ADLs, Activities of Daily Living, IADLs, Instrumental Activities of Daily Living
- cognitive status including dementia and intellectual disability
- mental health
- substance abuse
- medical/health conditions

Home and Community-Based Services (HCBS) or long-term care services and supports refers to a broad range of services designed to assist people over a prolonged period of time to compensate for loss of function. The type, frequency and intensity of services vary depending upon need. The flexibility of type, frequency and intensity allows for the wide range of housing options. Services provided via HCBS may include care coordination or case management, personal care assistant service, personal attendant service, homemaker services, home-delivered meals, home reconfiguration or modification, medication management, skilled nursing, emergency helplines, equipment rental and exchange, and transportation. Some services provided through HCBS are considered as respite care meant to relieve family caregivers. At some levels, the services provided through HCBS resemble the services provided in staffed housing like nursing homes. However, HCBS services may need to be pieced together from multiple agencies and independent providers, with or without overall coordination or management.

In order to achieve the optimal continuum of long-term care residential options it is important to embed planning and program development work in the Results Based Accountability (RBA) planning and management approach. This approach coupled with a person-centered philosophy of service planning and implementation will keep the planning and management processes true to achieving outcomes reflecting the needs and desires of people needing care. The increased focus on HCBS is not only fueled by the apparent cost-saving compared to nursing home care. It is also fueled by the predominant preference of consumers for long-term care in homes and in the community.

Long-term care needs are most often met by a combination of unpaid services provided by family members and paid assistance. More than three-quarters of community-dwelling adults rely exclusively on unpaid long-term assistance from family members. Paid long-term care services are financed through both public and private means. Medicaid is the largest source of public funding for long-term care. HCBS Medicaid dollars for long-term community residential care are restricted to the service component and generally exclude payments for room and board. The Older Americans Act, administered through the state, provides support of some long-term care services such
as case management, home-delivered meals, caregiver support, dementia respite, and other services for individuals 60 and older.

The effective delivery of HCBS in the home or community requires a special focus on assessment, planning and coordination of services. Support to families caring for loved ones should be enhanced with more assistance in assessing needs, planning and coordinating services. Emerging models of care integration – integration of primary care, acute care, chronic care, long term care, and preventive care, through interdisciplinary care – are currently under development in Vermont as well as in other states. These new models show promise in improving the quality of care and individual outcomes while controlling costs. In Vermont, integration could occur through changes in existing service coordination/case management practices, the Dual Eligibles demonstration, Accountable Care Organizations, Blueprint Community Health Teams, the “Support and Services at Home” (SASH) demonstration, and/or other models that seek to integrate care, improve quality, and control costs.

The brief presentation of demographics projected a major increase in the proportion and numbers of individuals 85+. Given the increased prevalence of dementia and cognitive disorders in this oldest population, Vermont can anticipate a demand for more services for people with dementia across the spectrum of need, from initial family caregiver training and support to the most intensive and costly levels of support for people with end-stage dementia. Absent a significant break-through in prevention or treatment of dementia, Vermont should expand service funding and capacity to address this growing need.
Figure 4: Person-Centered Long Term Care Housing and Services Continuum for People with Low or Moderate Income

Level of Need reflects conceptual combination of functional independence (IADLs and ADLs), cognitive status including dementia and intellectual disability, mental health, substance abuse, medical/health conditions.

<table>
<thead>
<tr>
<th>Level of Need</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>Certified</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Low needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intense/Complex needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other current factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Licensed?</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>Certified</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>2 Housing and Services ‘blended’?</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>varies</td>
<td>no</td>
<td>YES</td>
<td>no</td>
<td>no</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Rates/costs</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Varies</td>
<td>Broad range; DS average sfy2012 Medicaid payment app $86/day (not including room and board, service coordination, respite, etc.), CFC HCBS 24 hour care sfy2102</td>
<td>Broad range in private pay rates; avg sfy2012 Medicaid ACCS payment app $35/day (not including room and board)</td>
<td>Broad range in private pay rates; avg sfy2012 Medicaid CFC ERC payment app $59/day (not including ACCS or room and board)</td>
<td>Broad range; average sfy2012 Medicaid GDAC payment app $158/day, DS TCR app. $227/day, ICF/ID app. $551/day (not including room and board)</td>
</tr>
</tbody>
</table>

11
<table>
<thead>
<tr>
<th></th>
<th>Funding source(s) for rent</th>
<th>self, housing subsidy</th>
<th>self, housing subsidy</th>
<th>self, housing subsidy</th>
<th>self</th>
<th>self</th>
<th>self</th>
<th>self</th>
<th>including room and board</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>self</td>
<td>self</td>
<td>self, Medicare, private insurance</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
</tr>
<tr>
<td>5</td>
<td>Funding source(s) for services</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
<td>self, Medicare, private insurance, Medicaid, OAA, other</td>
</tr>
<tr>
<td>6</td>
<td>Inclusionary/exclusionary criteria?</td>
<td>na</td>
<td>na</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>na</td>
<td>YES</td>
</tr>
</tbody>
</table>

**Payments**
- $270/day (not including room and board)

**Including room and board**
- self, Medicare, Medicaid
Alternative Models:

There are alternative models of housing that are not widely utilized in Vermont at this time. This brief overview serves as a reminder of a broader spectrum of potential solutions that may be relevant in meeting the needs of our aging population. These models that have been in the recent press are: 1) the Granny Pod (http://www.medcottage.com/); 2) pocket housing, (http://www.pocket-neighborhoods.net/); 3) intentional communities, (http://www.cohousing.org/); 4) remote video monitoring and 5) small-home models of elderly living. There are surely many more examples that could be examined in future research if deemed useful.

The Granny Pod concept is being developed by companies such as N2Care MEDCottage to extend what is available in a caregiver’s home to support family-managed health care. “MEDCottage” is a mobile, modular medical home designed to be temporarily placed on a caregiver’s property for rehabilitation and extended care. Simply stated, it’s a state-of-the-art hospital room with remote monitoring..., when medical treatment and rehabilitation might otherwise require leaving the home. The flexibility and medical intensity of this option is a compelling characteristic.

Pocket housing is primarily being developed in the Pacific Northwest. Similar to cluster housing models but with a smaller design focus, pocket housing builds neighborhoods of cottage-like homes with design elements that ensure privacy while encouraging community interaction. These developments may feature individual gardens, shared green space, front porches and common walkways. Homes are designed with small footprints and flexibly accommodate visiting family and friends, reduce maintenance, and minimize car use. Pocket housing neighborhoods of a few dozen homes represent a possible development opportunity in Vermont, meeting the needs of elders seeking a community-oriented option as they choose to downsize.

Cohousing, cluster housing, intentional communities, and communes are variations on elder and intergenerational social contract models. These settings typically include active participation in creating and operating the community structure. Contrasted to pocket housing or other residential design models, these intentional communities require more involvement than simply purchasing a home in a neighborhood designed to encourage interaction. Vermont has successful examples of intentional communities and this model may become more prominent in the coming years.

Full Circle America, developed by Dr. Allen Teel of Maine, presents a virtual assisted living model using technology to supplement home care to keep elders in their homes. They offer a variety of services, from transportation, errands and advocacy, to phone checks and video spot-checking. The latter option has perhaps generated the most interest and may be a beneficial supplement to the robust long-term services and supports already found in Vermont. (http://www.fullcircleamerica.com/index.html)

The small-home model of elderly living is really three distinct models, and is still so new that it is mostly ill-defined and often unregulated. Younger, healthier seniors can simply live cooperatively in multi-bedroom apartments, à la The Golden Girls television show. That's happening in an organized fashion in several spots around the country, says Jacqueline Grossman of the national Shared Housing Resource Center, which offers
referrals to projects nationwide. In Chicago, for example, the nonprofit group Senior Home Sharing buys small ranch homes, retrofits them for group living, and rents rooms to unrelated seniors.

The second small-home model is a more formal and institutional alternative to long-term or nursing-home care, run in small houses that are often on larger campuses and built specifically for this purpose. A good example here is the Green House Project, founded in 2001 by Bill Thomas, a geriatrician who wanted to develop a more personalized approach to eldercare. Funded by the Robert Wood Johnson Foundation, the Green House project now takes a franchise-like approach to spreading its model, with plans to create at least one Green House in every state. The typical Green House offers nursing-home-like care to groups of 10 to 12 seniors in standardized homes that include central dining and living rooms complete with fireplaces. Residents—called "elders"—each have their own bedrooms and bathrooms, may help with meal preparation, can eat when they want instead of at prescribed times, and enjoy other amenities that make it seem like a private home. But institutionalized small homes like this often are subject to state nursing-home regulations, and the costs involved in meeting the regulations and offering high-level care may have impeded the construction of Green Homes and similar projects. Despite a lot of enthusiasm for the concept, there are currently only 50 Green House homes operating in 12 states. (http://thegreenhouseproject.org/ or http://www.aarp.org/relationships/caregiving/info-01-2011/green_house_homes_a_model_for_aging_that_promotes_growth.html)

The third model of small-home living for the elderly involves one individual caretaker opening up her home (women make up the majority of these caretakers) to boarders who need looking after. Termed the "board and care" model, this is more popular in some states, such as Washington State, than others and subject to different licensing requirements, depending on the services offered and the state."

This short review of alternative housing models suggests that Vermont may benefit from a broader examination of housing and service models to meet the needs of our aging population. While these models may be developed by private and/or public and non-profit entities, they may present a welcome addition in an innovative marketplace.
PRINCIPLES

The Agency of Human Services (AHS) has developed principles expressed in the AHS Housing Stability Policy. These principles provide the foundation for planning an optimum long-term care housing continuum and are consistent with the themes and recommendations above:

- Stable, safe, affordable housing is critical to all of the clients of the Agency of Human Services.
- All departments shall be attuned to the housing needs of clients and ensure that their programs support housing stability.
- AHS will – to the maximum extent possible – provide supported housing that is integrated into non-specialized residential buildings or settings.
- AHS supports the efforts of partner agencies to create permanently affordable and mixed income housing, particularly housing which is affordable to persons at or below 30% of Area Median Income.
- Applicants requesting AHS funding to support services in a new shelter, transitional, or supportive housing project shall demonstrate, at a minimum:
  - That there is both a short-term and long-term local need for the project supported by data acceptable to the Agency of Human Services.
  - That the program design is best suited to provide the appropriate housing and/or supports to the local population identified.
  - The suitability of the proposed location and building to meet resident needs and efficiently provide services.
  - That the applicant has sufficient expertise and capacity to develop and manage the project and provide the needed supportive services.
  - That the proposal is integrated with, or informed by, the local homeless continuum of care and fills an identified gap in services or capacity.
  - That there is a viable back-up plan for reuse of the project in the event that the need or project funding changes.

In order to address our citizens’ expressed desire to age-in-place at home or in the community, the workgroup endorses adding these principles:

- Housing and service options, primary medical care, care for chronic conditions, and social services should be person-centered and person-directed, supporting individual choices and preferences.
- Housing and service options should support “Aging in place”, which is widely endorsed by older persons and persons with disabilities.
- Consumer outcomes and consumer preferences should drive public investments in long-term services, supports, and residential options. The use of a Results Based Accountability framework with consumer-centered outcome and performance measures would help to insure that services are both desirable and effective.
- Whereas family caregivers provide a majority of long-term support services, family caregiver support should be strengthened to help sustain this caregiving.
- Optimize existing housing stock: increase resources for housing modification and utilization of universal design to improve accessibility and support aging in place.
Stakeholder Suggestions:

- Encourage development of affordable supportive senior housing by providing tax breaks or reductions in building fees for developers who create service enriched affordable senior housing or affordable assisted living communities
- Explore pilots of “alternative housing” options utilized in other parts of the country but not yet active in Vermont, e.g. cohousing efforts that promote “active neighboring” and allow professional caregivers to live among residents
- Support understanding of the future and planning for the needs of the future by funding a study that develops projections for the future demand for and supply of Long-term Care services (see Connecticut study at http://www.ct.gov/dss/lib/dss/pdfs/frontpage/ct_ltc_report_final.pdf)
- Explore piloting a ‘Green House’ model in Vermont
- Promote full-integration of the Aging and Disability Resource Connections (ADRC) effort within aging, disabilities, and medical care networks to optimize public awareness, understanding and utilization of long-term care and support options
- Expand HUD supported housing options through aggressive, collaborative applications with the housing and provider networks; for example, pursue HUD Section 811 applications for an increase in rental housing vouchers for people with disabilities and similar HUD Section 202 applications for elderly households
- Provide educational support for appropriate utilization of “reverse mortgages” by people who own their own homes
RESOURCES

3. “Long-Term Care System Sustainability Study” Vermont Department of Disabilities, Aging and Independent Living (2007)
7. “How Housing Matters, Meeting the Health Care Needs of Aging Residents of Multifamily Affordable Housing, Case Study, Cathedral Square” Center for Housing Policy (2011)
   http://www.nhc.org/media/files/How_Housing_Matters_-Health_Case_Study.pdf
8. “Across the States: Profiles of Long-Term Care and Supports—Vermont” AARP (2012)
    http://www.dlp.vermont.gov/regs