2007-2017

Shaping the Future of Long Term Care and Independent Living

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Table of Contents

Executive Summary

~~Every year the Vermont Department of Disabilities, Aging and Independent Living produces this report on the state's long term care system for elders and adults with physical disabilities~~. This report, *Shaping the Future of Long Term Care & Independent Living 2007-2017*, is Vermont's 6th edition ~~and is intended to be a living document, adjusted annually to reflect changing demographics and trends~~. Using a model developed by The Lewin Group that incorporates both demographic and program use data, the Department is able to estimate the need for and use of long term care services in Vermont. Sections of this paragraph were crossed-out in 2017.

The population of the United States is aging along with countries in Europe and Asia. Although Vermont considers itself an aging state, it is not currently one of the oldest in the nation. Maine, Pennsylvania, Florida and others have the highest proportion of people 65 years old and older. Vermont has transitioned from a state that had a majority of younger people in 1990 to one more dominated by older adults. With the lowest birth rate in the nation, Vermonters under the age of 18 years are gradually decreasing while those 55 years old and older continue to grow in number.

Even though Vermont's birth rate is in decline, the state's overall population has been slowly increasing. Vermonters age 65 to 74 are projected to grow a dramatic 63% during this study's 10-year period as a result of the "Baby Boom" cohort. The oldest
"Baby Boomers" turn 62 years old in 2008 and will reach the age of 65 in three years. From 2007 to 2017, Vermonters age 85 and older are projected to increase by 23% (2,700 people). This growth has significant implications for the long term care system given this group's greater need for services.

Vermonters have increasingly expressed their preference to receive long term care services at home as evidenced by a contraction of the state's institutional capacity. Over the last twelve years, 600 Vermont nursing facility beds have closed (from roughly 3,900 to 3,300) shifting care into the home and community-based system. This report embraces this shift and documents current as well as projected use of long term care services. Current utilization of three important home and community based programs is profiled, showing county use rates above and below the state average.

Vermonters are living longer and enjoying better health; however, the number of people with disabilities living in the community is projected to climb due to increased disability rates among younger adults and population growth among older adults. As this number grows, the long-term care system will be challenged to meet the expanding need for a well-trained direct care workforce. Published in 2008, the Direct Care Workforce Study examines a myriad of issues relating to the current and future shortage of caregivers. The Direct Care Workforce Study includes nine valuable recommendations.

Twelve years ago, Vermont passed Act 160 which allowed the State to create a more equal balance between institutional care and home and community based services. This 1996 landmark legislation required Vermont to earmark saved dollars from reduced Medicaid nursing home utilization and invest those funds in the home and community based system. Prior to Act 160, Vermont spent only 12% of its public long term care dollars on home and community based care leaving 88% for nursing facility care. To date, 38% of all public long term care spending goes toward home and community based care while 62% is spent on nursing home care.

The Department's Choices for Care (CFC) 1115 Medicaid Waiver has further advanced Vermont's efforts at rebalancing its long term care system. Begun in 2005, this Waiver offers an entitlement to Vermonters seeking either nursing home care or home and community based services by combining Medicaid costs for both institutional and home based care into a unified budget. Vermont has been able to serve more individuals because people who might otherwise have been served in a nursing facility are now choosing to receive their care at home where costs are generally less.

Vermont's original goal was to serve a minimum of 40 Medicaid home and community based clients for every 60 Medicaid funded nursing home residents in each county (60/40). This year the Department set a new target of serving at least 50% of Medicaid long term care clients in home and community based settings. The following six counties have reached this target: Addison, Chittenden, Franklin, Lamoille, Orange, and Windham. Of Vermont's 14 counties, six have yet to meet this goal and the remaining two do not have any nursing facilities.

Although nursing homes contribute significantly to the state's long term care system, they house only 3.3% of Vermonters age 65 and older and 12.5% of those age 85 and older. Individuals 85 years old and older have shown a precipitous drop in their use of nursing homes over the last 14 years. This is most likely a result of increased use of home based services, declining disability and poverty rates, and greater housing options such as Assisted Living. While the number of Medicaid nursing home days has steadily fallen, Medicaid expenditures have risen. Vermont will need to address this issue of rising Medicaid expenditures amidst falling Medicaid days if it wants to continue shifting the balance from institutional to home and community based care.

Recommendations and New Initiatives:

Progress has been made since the Vermont Department of Disabilities, Aging and Independent Living (DAIL) first issued recommendations in *Shaping the Future of Long Term Care 2000-2010*. The original recommendations from *Shaping the Future of Long Term Care 2000-2010* are in black type while the 2003 updates are in red, the 2004 updates are in blue, the 2005 updates are in green, the 2006 updates are in purple, and the 2007 updates are in brown. These recommendations and new initiatives will help Vermont achieve a balanced and sustainable system of care for elders and adults with physical disabilities.

1. In accordance with consumer preference, continue to decrease reliance on nursing facility 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 goal annually based on utilization and projected need. *Five of 12 counties have met or exceeded this goal in 2003. (Grand Isle and Essex are excluded because they lack nursing homes.) In 2004, no new counties have met this goal although Caledonia and Windsor are close. Caledonia and Windsor Counties have met the 60/40 balance bringing the state total to seven counties. Only five counties have not met the 60/40 ratio, one of which (Bennington) has only 15% of people receiving long term care in home and community based settings. A **50/50** balance may be achievable since Addison, Chittenden, Franklin, Lamoille and Orange Counties have already met or exceeded this goal. The Department's new goal stipulates that at least **50%** of the people needing Medicaid funded nursing home level care receive that care in home and community based settings. All but six Vermont counties with nursing homes have met this goal (Bennington, Caledonia, Orleans, Rutland, Washington, and Windsor).*

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. Only 88 slots were allocated in FY 2004 and 73 are expected in FY 2005. There were 73 slots allocated in FY 2005. With the implementation of Vermont's Choices for Care 1115 Medicaid Waiver, slots no longer exist. Early results indicate an increase in the number of people served in the Choices for Care program. In the first year of Choices for Care, Vermont added twice as many new people (200) to its CFC home and community based service system as would have been possible under the previous 1915(c) Medicaid Waiver. Since its inception in October 2005, Choices for Care has served 720 new people with home and community based services. This translates to 280 new enrollees per year.*

3. Increase the Attendant Services Program to serve an additional 100 people by 2010. In FY 2000, 250 clients were served. *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). The FY 2004 client count (260) is virtually unchanged from FY 2003. Additional funding in FY 2004 paid for an increase in participants' hours of care. The FY 2005 client count increased to 286. Although expenditures actually dropped 4% from FY 2004 to FY 2005, client turnover freed up funds to serve more people (newer clients required less intense services). If Attendant Services maintains its 2005 rate of use and keeps pace with demographics, it would serve 381 people in 2015. The number of people served in FY 2006 increased to 293 although funding remained level for the period ending June 30, 2006. The Attendant Services Program received a wage increase in July 2006. The FY 2007 participant count was 253, far below the FY 2006 count. Some Attendant Services clients have transferred to Choices for Care. The FY 2000 original recommendation is no longer applicable due to Choices for Care.

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 facility wages and home health wages but more needs to be done. Due to budget constraints, there has been little progress on wages in FY 2004. Five of eleven Home Health Agencies have raised their starting wage to $10/hour for personal caregivers and many Agencies provide benefits for caregivers working sufficient hours. The Department is working closely with the Community of Vermont Elders (COVE) on ways to improve recruitment and retention of direct care workers through COVE's Better Jobs Better Care grant and the Vermont Association of Professional Care Providers. Two recently completed studies, one from the Better Jobs Better Care grant and the legislatively mandated Long-Term Care System Sustainability Study recommended annual inflationary increases for all provider rates and wages paid under consumer or surrogate directed programs. The Attendant Services Program received a wage increase in July 2006. DAIL will complete an in-depth study of the direct care workforce by December 2007 which will provide additional information on current wages and benefits. DAIL completed the 18-month Direct Workforce Study and submitted the report to the Legislature in April 2008. Wage increases were at the top of the nine recommendations. In order to bridge the identified gap between caregiver supply and demand, DAIL along with providers and advocates must work together to find solutions that will result in a well-trained reserve of direct care workers. DAIL recognizes the disparity between caregiver wages in the Attendant Services Program and those in the Choices for Care Consumer and Surrogate-directed options and hopes to address this discrepancy in the future.*

5. Develop additional supportive housing such as Enhanced Residential Care, Assisted Living, group-directed congregate housing, and adult family care. Increase funding for home modifications. 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 building design is in progress. There are now 5 licensed Assisted Living Residences in Vermont, with more under development. As of March 2006, there were 6 Assisted Living Residences with 7 in the planning stages. Enhanced Residential Care grew 17% (155 to 182 residents) from FY 2004 to FY 2005 and is projected to serve 311 residents in 2015 at current use rates. The Vermont Center for Independent Living sponsored the state's second Universal Design Conference in April 2006 and is planning a future forum to showcase model home modifications and universal design. The next Universal Design Conference will be held in 2008. Vermont continues to have six Assisted Living Residences with a seventh scheduled to open in December 2007. The Enhanced Residential Care program served 207 residents in FY 2006 and experienced greater expansion during FY 2007 due to Choices for Care. A 24-hour Care option is being developed (similar to shared living arrangements for people with developmental disabilities) which will provide an alternative for individuals who previously had no choice other than a nursing facility or residential care home. For FY 2007, the Enhanced Residential Care program served 264 people, a 28% increase over last year. Vermont now has seven Assisted Living Residences and has created a Vermont Assisted Living Tool Kit for providers and developers. The Tool Kit can be found on the Department's website (also in hard copy) and includes a sample operating policy and procedure manual, and Vermont-specific financial and market feasibility tools. The Real Choice Systems Change Housing grant (#14) provided funds for technical assistance to ten communities/housing providers interested in exploring residential alternatives. DAIL furnished funds for capital improvements to nine residential care and assisted living providers to promote aging in place and improve their capacity to serve people who are nursing home level of care. The renovations ranged from fire/safety upgrades to accessibility improvements.*

6. Increase the daily capacity of adult day centers from 441 in FY 2000 to 720 in FY 2010. *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 by 2013 (i.e., 918 clients in 2013). Daily capacity reached 584 in FY 2004 with expected growth to reach 989 by 2014. Adult Day Services will likely expand as a result of inclusion in the 1115 Waiver. The number of Adult Day clients jumped to 836 in FY 2005, a 43% increase over FY 2004, far exceeding the 2009 projected daily capacity of 785. This gain occurred prior to implementation of Choices for Care and is due to expansions at several sites. If Adult Day Services maintain their 2005 rate of use and keep pace with demographics and the expected decline in nursing facility use, they would serve 1,287 people in 2015. Note: FY 2005 Adult Day counts were cumulative instead*

of point-in-time. For FY 2006, daily capacity totaled 659. Expansion has occurred at a number of sites and additional development is slated for the future. Adult Day daily capacity reached 681 in FY 2007. On-going expansions and relocations will build capacity to serve more people as well as enhance service delivery.

7. Expand the capacity of the Area Agencies on Aging (AAAs) to provide case management to more elders who do not participate in the Medicaid Waiver program. Develop a program to provide case management assistance to adults with physical disabilities between the ages of 18 and 59 who do not qualify for such assistance from any other program. *No progress to date. The Area Agencies on Aging will likely receive substantial new State funding for FY 2006 to help stabilize rather than expand their operations. No additional funding has been identified to develop a case management system for younger adults with physical disabilities. For FY 2006, the AAAs received stabilization funding as well as one-time Global Commitment funding to assist in implementation of the Medicare Modernization Act Part D prescription drug plan. The absence of case management services for people 18-59 has become increasingly problematic and will likely attract more attention in 2006. Plans are underway for two pilot projects which will provide case management services to younger people with disabilities. Other than Choices for Care which provides case management services to people who require nursing home level care or are at risk of institutional placement (CFC Moderate Needs Group), little exists for younger people with disabilities. The AAAs continue to provide Older Americans Act case management to thousands of older Vermonters not eligible for Choices for Care. With the aging of the "Baby Boom" cohort, the AAAs anticipate even greater demands for case management. Two pilot projects that will provide case management services to younger people with disabilities not eligible for Choices for Care will be tested under the Global Commitment Waiver. The AAAs have seen slight increases in the number of older people receiving case management as well as a commensurate increase in services provided.*

8. Expand community-based health promotion and disease prevention programs for elders and adults with physical disabilities. *Expansions include strength training classes predominantly led by elders, the Senior Farmers' Market Nutrition Program, and a quarterly food and nutrition newsletter for providers. Governor Douglas established the Commission on Healthy Aging in 2005. A $48,000 National Governors' Association grant will pay for staffing the Commission this year and procuring additional grants for future work. No additional grants were found. The Department now supports staffing the Commission whose focus this year is developing a Healthy Aging Plan in addition to other statewide initiatives. In FY 2006, Congressional earmark funds targeted to local senior centers will help implement changes to make their services more attractive to "Baby Boomers". The Commodities Supplemental Food Program experienced federal cuts that have resulted in fewer seniors being served. The Governor's Commission on Healthy Aging is addressing two*

key issues: maintain and expand the number of elder Vermonters in the work force; and prevention of falls. Vermont has the nation's highest rate for falls resulting in death www.cdc.gov/aging/saha.htm p.28 *(2007 report). The Department is promoting evidence-based health promotion and disease prevention programs for older adults along with $5,000 community implementation mini-grants. Last year's mini-grants have supported the implementation of a falls prevention program (A Matter of Balance) and a behavioral intervention program for older individuals with mild to moderate depression (Healthy IDEAS). Guidance and instructions for AAAs' area plans specifies using Older Americans Act Part III D funds to maintain, implement or expand evidence based programs. The Governor's Commission on Healthy Aging and the Vermont Department of Labor are spearheading the "Mature Worker Initiative" which focuses on recruitment and retention strategies for the older worker. The Governor's Commission continues to consider fall prevention a top priority. A recent CDC report (March 2008) found Vermont highest in the nation for reported falls although Vermonters were less likely to sustain injury than the national average.* www.cdc.gov/mmwr/preview/mmwrhtml/mm5709a1.htm

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). The 2004 client count (612) is virtually unchanged from 2003 due to level funding. Homemaker Services will likely expand as a result of inclusion in the 1115 Waiver. The Homemaker Program served 648 people in FY 2005, a 6% increase over FY 2004 with no growth in Department funding; however, the Home Health Agencies contributed additional funds of their own. The increase in the number served occurred prior to implementation of Choices for Care and is probably the result of the additional Home Health Agency funds as well as client turnover which freed up funds to serve more people. If the program maintains its 2005 rate of use and keeps pace with demographics, it would serve 998 people in 2015. However, the trend from 2000 to 2005 shows a decline in the number served. The Homemaker Program served 763 people in FY 2006, an 18% increase over FY 2005, due in part to increased funding through the CFC Moderate Needs Group. In FY 2007, the Homemaker Program served 776 clients, an increase over previous years. In order to leverage more funds, 100% of the Homemaker General Fund program was transitioned into the CFC Moderate Needs Group Homemaker Services effective July 2007.*

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. A public education media campaign has been initiated to publicize the Senior HelpLine and the Vermont Center for Independent Living (VCIL) information and referral line—the "I-Line". Additional funding in FY 2005 allowed for continuation of the public information campaign to promote the Senior HelpLine on a limited basis. In 2006, DAIL was awarded a three-year $800,000 grant to develop Aging and Disability Resource Connections (ADRC) which will provide comprehensive and objective information about long term care supports, resources and assistance. See #16. Through the ADRC grant, DAIL provided funding to multiple partner agencies to purchase and provide training on a common database (REFER), already in use by the Champlain Valley Agency on Aging and VT 2-1-1. This initiative has enabled all AAAs to work toward a shared database thereby improving uniform access to and dissemination of resources. In collaboration with the Vermont Agency of Human Services, VT 2-1-1 has developed the State Information, Referral, and Assistance Coordination Council (SIRACC) to enhance the level of information, referral and assistance functions provided statewide by human service agencies.

11. New in 2003: *Obtain permission from the Centers for Medicare and Medicaid Services to implement an 1115 Long Term Care Medicaid Waiver to create equal access to either nursing facility or home and community based care, according to the consumer's preference. As of this printing, the Department expects to receive final approval for the 1115 Medicaid Waiver with an implementation date of September 2005. Vermont began implementation of its Choices for Care 1115 Medicaid Waiver in October 2005, showcasing a remarkably smooth transition. Choices for Care is now serving over 300 new participants in CFC home and community based care and 200 fewer Medicaid nursing home residents, with no waiting list for people who are nursing home level of care. Choices for Care is performing better than anticipated. Nearly three times as many people are receiving services in home and community based settings than would have been expected under the previous 1915 (c) Medicaid Waiver. The number of nursing home residents has decreased by more than 250 and over 1,000 people are receiving preventive services as participants in the Moderate Needs Group. In order to stay within the budgeted amount for FY 2008, a High Needs Group applicant list was started in February 2008 and as of May 15, 2008, there were 38 people on this list. The ability to institute an applicant list to control expenditures was approved by both the federal government and the Vermont Legislature as part of the Choices for Care application.*

12. New in 2005: *DAIL received a $2.1 million Real Choice Systems Change grant—Comprehensive System Reform (Health and Long Term Care Integration Project) from CMS to develop a system that integrates acute, primary and long term care for elders and people with disabilities. This includes capitating Medicare and Medicaid funds into a flexible pool to create a system*

of services more person-centered and responsive to individual needs. The Department has made planning grants available to several provider organizations to further develop the model called "MyCare Vermont". A Core Planning Team and Consumer Advisory Council developed a draft contract agreement and prescriptive recommendations for the to-be-chosen MyCare provider organization. DAIL invited interested entities to submit business plans and requests for funding to develop the necessary infrastructure. At the same time, the federal government put a moratorium on approval of any new Special Needs Plans, the available mechanism to provide capitated Medicare and Medicaid rates to an organization. DAIL did not find a strong candidate for a MyCare organization so plans are currently on hold. Work will continue to finalize a draft contract agreement, set the rates, and promote person-centered care.

13. New in 2005: *DAIL received a Real Choice Systems Change grant—Quality Assurance and Quality Improvement to develop a comprehensive quality management system across the Department's home and community based Medicaid waivers for elders, people with physical disabilities, traumatic brain injury survivors and people with developmental disabilities. Outcomes and indicators of quality services were developed, followed by the dissemination and implementation of the Quality Management Plan in April 2007. The Quality Services Resource Guide was completed and distributed to all Vermont waiver participants in cooperation with service providers. Two participants were hired as part of the State Quality Management Review Team to conduct interviews and focus groups with consumers.*

14. New in 2005: *DAIL received a Real Choice Systems Change grant—Integrating Long Term Supports with Affordable and Accessible Housing to enhance housing capacity and supportive services so that Medicaid-eligible frail elders and adults with physical disabilities can live in the setting of their choice. With grant completion anticipated in September 2008, work is proceeding in three areas: preserving, developing and enhancing 10 supportive housing projects; establishing medication assistance to support elders in congregate housing; and planning for coordination of services with supportive housing projects for the two PACE sites in Colchester and Rutland. (See # 17 for implementation of PACE.) A medication assistance best practices model was developed and will be piloted and evaluated at five congregate housing sites. With regard to coordinating PACE services with affordable housing, the Colchester PACE site has limited potential for future transitional or respite housing; however, the Rutland PACE site is co-located with newly developed affordable housing which creates a nice link between housing and services. The PACE component of the Real Choice Systems Change Housing grant has been completed. For additional supportive housing updates, see # 5.*

15. New in 2005: *DAIL received a Robert Wood Johnson grant to implement a "Cash and Counseling" option for participants in the Choices for Care program. Enrollment in the Flexible Choices program began in July 2006. This program allows people to convert their plans of care for home-based services into a dollar-equivalent allocation, develop a spending plan for that allocation, and then purchase care to more flexibly meet their needs. The initial pilot will serve 50 individuals. Enrollment in Flexible Choices has been slow but steady with approximately 45 enrollees as of April 2008. Evaluations conducted in the summer of 2007 found clients to be satisfied with this option and using their funds creatively. This grant will conclude in July 2008 and Flexible Choices will be subsumed into Choices for Care at that time.*

16. New in 2006: *DAIL was awarded a three-year $800,000 Administration on Aging grant to establish Aging & Disability Resource Connections (ADRC). ADRCs will provide a single point of entry for information on and access to public long term support programs and benefits regardless of age or income. Over the course of the grant, services will become available to older Vermonters, younger people with physical disabilities, individuals with developmental disabilities, and people with a traumatic brain injury. Two pilot sites were formed to enhance a seamless network of regional partnerships among agencies providing long term care information, referral and assistance functions. A statewide ADRC Leadership Team comprised of nine partner agencies was also formed to undertake the development and delivery of cross agency training programs to build greater capacity among the ADRC partner agencies.*

17. New in 2006: *Vermont opened its first PACE center (Program for All-Inclusive Care for the Elderly). PACE is a health care system for frail individuals 55 years and older that provides for all acute, primary, and long-term care needs. Care is provided or coordinated by an interdisciplinary team and services are financed through a combined Medicare and Medicaid rate. Serving Chittenden and southern Grand Isle Counties, the PACE Center in Colchester began actively enrolling participants in April 2007. The Rutland site anticipates opening in the Fall of 2007. In 2007, PACE Vermont enrolled a total of 21 participants at their Colchester site and as of May 2008 was serving 28 participants. The Rutland site, which serves Rutland County as well as northern-most Bennington County, began enrolling participants in March 2008 and was serving four individuals as of May 2008. CMS staff from Baltimore and Boston visited both PACE Vermont sites and offered recommendations in May 2008. CMS will return in December for an official on-site review. PACE Vermont is the only "rural" PACE site operating in the nation.*

18. New in 2007: *The Vermont Traumatic Brain Injury (TBI) Program was awarded a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, for $118,600 per year for three years. The project was developed in response to the limited services for individuals*

with mild to moderate traumatic brain injury. The TBI Program will develop a Neuro-Resource Facilitation Program to establish a continuum of care system for veterans with TBI returning from the Middle East. This system will be based on the proven "best practice" model developed and implemented by the State of New Hampshire and the Brain Injury Association of New Hampshire. In addition, a TBI fund was created by the 2008 Legislature for the benefit of all Vermonters suffering from traumatic brain injuries. The initial funding was $140,000 and will be used to finance services and programs for individuals with TBI.

19. New in 2007: *Vermont was one of twelve states selected by the Administration on Aging (AoA) to receive a Nursing Home Diversion Modernization Grant. The goal of this grant is to transform non-Medicaid funding into flexible, consumer-directed service dollars which support nursing home diversion for those at risk of institutional placement. This grant is also intended to prevent individuals from spending down to the Medicaid level. DAIL will partner with two AAAs, Central Vermont Council on Aging and the Council on Aging for Southeastern Vermont, which serve five of Vermont's 14 counties. This 18-month project will utilize Older Americans Act and other non-Medicaid revenues to divert at least 200 older Vermonters from nursing home admission and "spend down". Case management staff from all five Vermont AAAs will be trained in this model of flexible service delivery.*

20. New in 2007: *DAIL began an initiative to develop a housing model serving young adults who are deaf or hard of hearing (HOH) by working with a diverse planning group of parents, organizations serving the deaf or HOH, and Cathedral Square Corporation. Pre-development activities include conceptual designs for the Vermont Initiative for Deaf Adult Living (VIDAL) which hopes to develop a six to eight unit residence by the close of 2010.*

Methodology

The Vermont Department of Disabilities, Aging and Independent Living contracted with The Lewin Group to project 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 the Lewin model to derive both "need" and "use" projections for the 10-year period 2007 to 2017.

Vermont population data from the U.S. Census 2000 serve as the baseline. The University of Massachusetts Institute for Social and Economic Research (MISER) developed population projections for the period 2000 to 2020. The Lewin Group integrated the population projections with a variety of data sources, including disability data, population characteristics, nursing facility utilization, and the Department's Fiscal Year (FY) 2007 actual program use, to produce a set of tables that describes Vermont's need and use of long term care services by county.[1] (See Appendix, p.23.) Detailed methodology reports from both MISER and The Lewin Group are available upon request.

Two essential state-level assumptions drive the projections in this model: the disability rate trend and the nursing facility use rate trend. The first is a major determinant of long term care need, and the second influences the demand for services in the community. These assumptions can be adjusted over time as expected trends change. (See Appendix, Assumptions Sheet, p.24.)

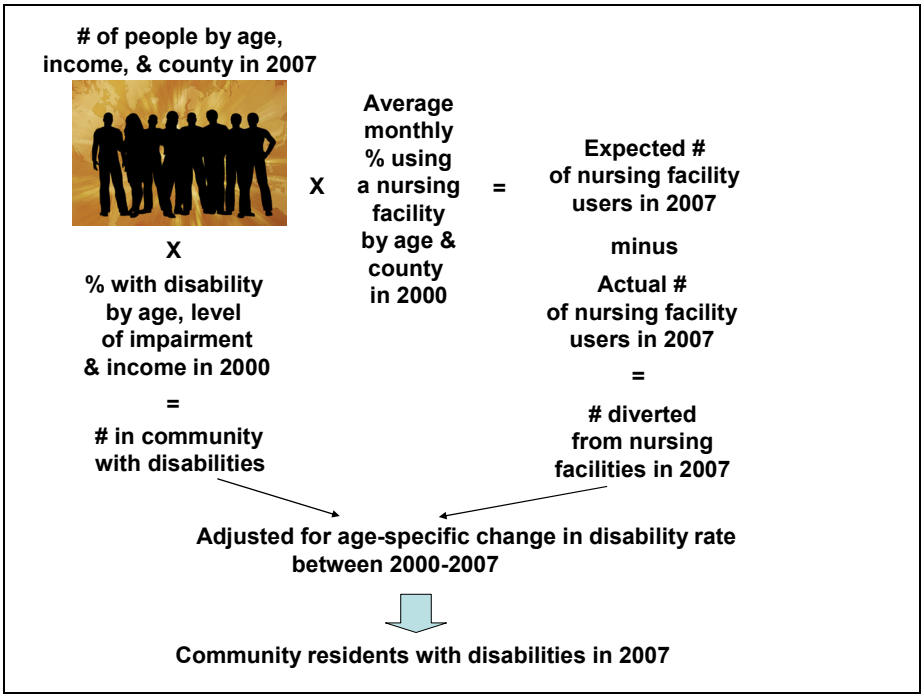
The disability rate trend for individuals age 18-64 uses the Social Security Administration's growth projections on the percentage of workers receiving Disability Insurance benefits. This trend was applied to children as well because projections for individuals younger than age 18 are not available elsewhere. 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. The Lewin model assumes a slightly smaller and flattening decline for the projections because there is debate as to whether these declines will continue into the future.

[1] To produce detailed disability estimates by county, Lewin relied principally on the following sources of data, all from the U.S. Bureau of the Census: (1) for county-level general disability data, the 2000 Public Use Microdata Sample (PUMS); (2) for detailed data on Activities of Daily Living (ADLs), Wave 11 of the 1996 Panel of the Survey of Income and Program Participation (SIPP) conducted during 1999; and (3) for county-level income distribution data, published estimates from the 2000 Census. Because detailed ADL data do not exist at the state or county level, ADL information from the SIPP was statistically matched to the county-level Census disability data to produce ADL estimates for each county.

[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. More recent estimates based on Manton's analysis of the 2004/05 National Long Term Care Survey were not incorporated because weighting issues related to the survey have not yet been fully vetted.

The nursing facility use rate trend assumptions are based on an analysis of Vermont's actual nursing home use during the period FY 1993-2007. These data include all payers, both public and private, and incorporate observed trends in nursing facility use through the second quarter of 2007. The trends show the annual percent change in the per capita nursing facility use rate by age group. The model assumes that the five-year and ten-year trends in nursing facility use (i.e. to 2012 and 2017) will resemble the long-term changes observed from FY 1993 to FY 2007.

The trending assumptions for nursing facility use and for disability rates simultaneously affect the model's projections of both the need for long term care and the use of home and community based services. A decline in the assumed rate of nursing facility use results in a larger proportion of people with disabilities living in the community. This in turn increases the expected use of home and community based services. At the same time, a decrease in the expected disability rate within an age group (as among those age 65 and older) would result in fewer people of that age group with disabilities in the community were it not for the significant growth in the number of older people. Because of this growth, the expected need for and use of home and community based services is projected to increase in 2012 and 2017. The diagram below displays the key calculations involved in estimating the number of community residents with disabilities in 2007.



While the foregoing discussion has focused on the impact of broad, state-level assumptions on projected need for and use of long term care, it is important to understand that the county-level estimates and projections also make use of numerous county-specific data sources. These include county disability data from the 2000 Census, age-specific county demographic data, and actual age-specific county utilization of nursing facilities and home and community based services.

"Disability" is defined as requiring the help of another person to perform two or more activities of daily living (such as dressing, bathing, transferring, toileting, eating). The model excludes people with developmental disabilities. Individuals with mental illness are included only if they have 2 or more ADL limitations. *The numbers in this model represent a "point in time" as opposed to an unduplicated yearly total.* Nursing facility utilization figures represent an average daily census, while use of most other services reflects the average number of users over a one-month period. All "user" data are for the State's fiscal year. As a general rule, county designations for "user" data represent the user's current residence at the time of reporting.

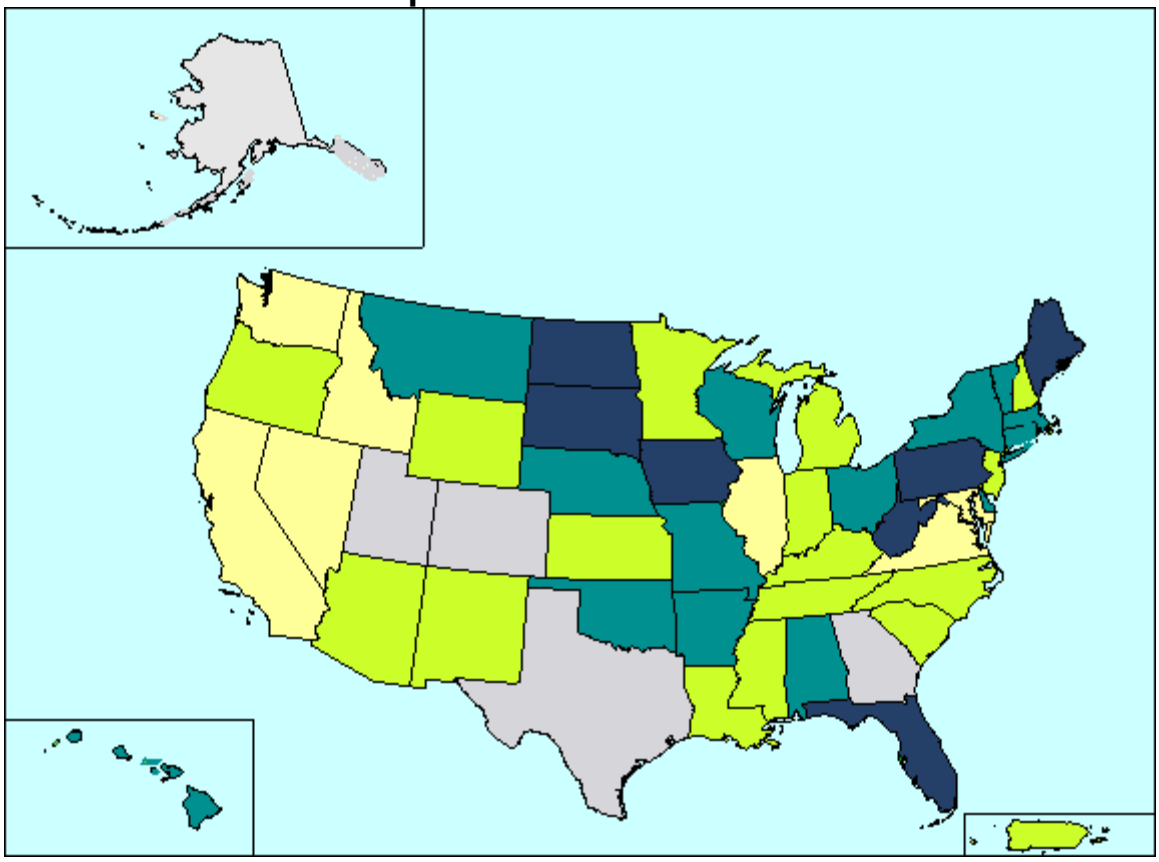
The tables in the Appendix display the results of the model. Tables 2 and 3 (p. 25-29) show the number of Vermonters with long term care needs, employing more detailed population characteristics. The "low-income" delineation refers to people whose income is below 175% of the Federal Poverty Level, roughly capturing the majority of Vermont's publicly funded long term care clients.

Tables 4 and 5 (p. 30, 31) indicate the number of point-in-time "users" for each program or service; "users" in these tables may be served by more than one program. Statewide and county projected use for 2012 and 2017 is based on actual use in FY 2007, projected forward. The projections of use for 2012 and 2017 assume that each county's *rate* of use of each service remains the same as in 2007 within each age and income group. For example, a county with relatively low rates of home and community based service use in 2007 will be projected to have low rates of use in 2017 relative to other counties Thus, use of home and community based services in a county increases *only enough* to accommodate demographic changes in the county (e.g. aging and disability) and the expected shift from nursing facilities, assuming that historical trends in nursing facility use continue. These projections are meant to illustrate how expected changes in the community will affect use of home and community based services in each county.

The Changing Population

The population of the United States is aging along with China, Japan and many European countries. States within the U.S. vary in their degree of “agedness” with Vermont being younger than a handful of states. To measure how old a state is, one needs to look at the percent of the total population that is 65 years old and older. Approximately 12.5% of the United States is comprised of people age 65 years and older. The map below shows the seven states (dark blue) that are older than Vermont. Vermont’s elderly make up 13.3% of the state whereas elders in Maine, Pennsylvania, West Virginia, Florida, Iowa and the Dakotas make up 14.3 to 16.8% of their population. Over time, some states will age faster than others depending upon in-migration, out-migration, the birth rate, and the death rate.

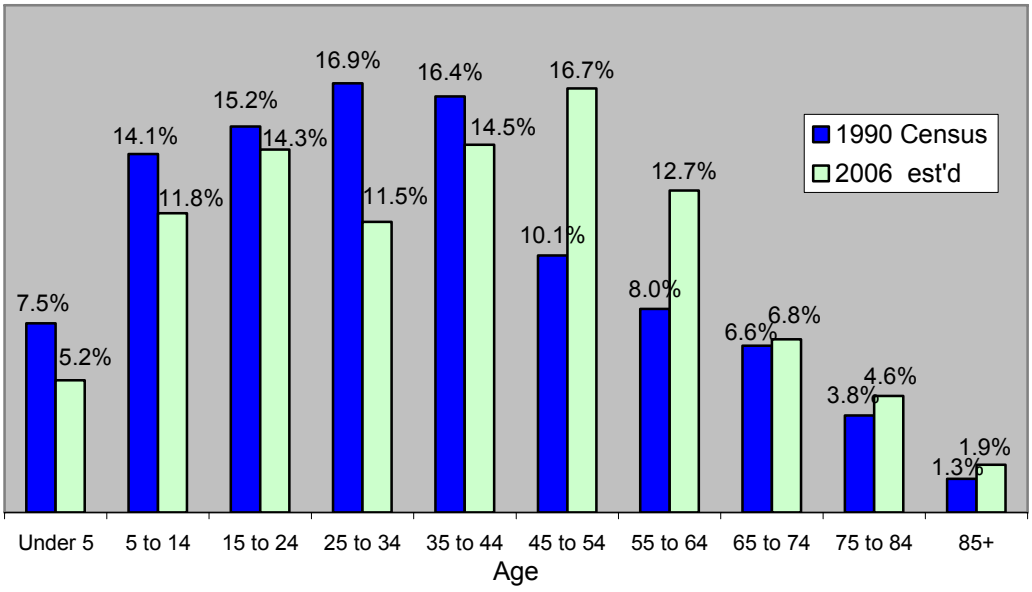
Percent of the Total Population Who Are 65 Years and Over: 2006



U.S. Census, 2006 American Community Survey

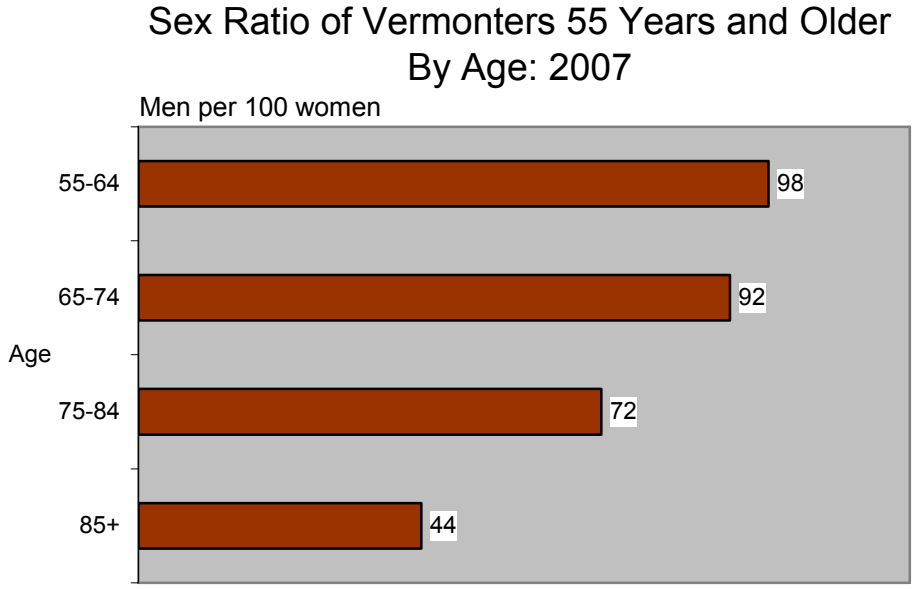
Vermont's population has changed noticeably over the last sixteen years. In 1990, most Vermonters were under the age of 45, however, that has changed. To see this transition, one can compare the size of age groups in 1990 with those in 2006. The chart below shows each age group as a percent of the total population. Younger people clearly dominated the state's demographics in 1990 as shown by the blue bars. By summing the percentages of the blue bars under age 45, one can see that 70% of Vermonters were less than 45 years old. Comparing the two time periods, young adults age 25-34 were almost 17% of the population in 1990 yet in 2006 estimated, that same group dropped to 11.5%. By 2006, the older age groups had grown in size (green bars) and were all larger than those same groups in 1990. The "Baby Boomer" cohort can be easily identified in the 45 to 54 and 55 to 64 year old groups: the 2006 bars are notably larger than their 1990 counterparts. Although this chart portrays changes over a short period of time, it clearly illustrates the aging of Vermont's population.

VT Age Groups as Percent of Total Population
1990 U.S. Census and 2006 Estimated*



* 2006 Estimated Population counts are from the Vermont Department of Health

Among older adults, Vermont women outnumber men. In 2007 projected, there were 78,257 men and 90,312 women age 55 and over, producing a sex ratio (men per 100 women) of 87. The sex ratio steadily drops with age because women live longer than men. For Vermonters 85 years old and over, there were 44 men for every 100 women. (See chart below.) A projected increase in the life expectancy of older men will help narrow this gender gap. As the proportion of men in older age groups grows, women will likely experience greater spousal support and less risk of institutionalization. In addition, there will be more men in our female-dominated nursing homes. Currently, there are more than twice as many women as men in Vermont's nursing homes.



Population

This report focuses on the 10-year period 2007 to 2017. Vermont's population growth for the various age groups during this time period can be seen in the table below. The number of children under 18 years old is projected to decrease each period due to Vermont's declining birth rate. For the last 7 years, Vermont has had the lowest birth rate in the nation, most recently at 10.4 live births per 1,000 people. The 18-34 year old group is projected to increase over the period while 35-54 year olds will decrease. Due to the large size of the "Baby Boomer" cohort, the 65-74 year olds are projected to experience the greatest growth during this 10-year period. The oldest "Baby Boomers" began turning 62 years old in 2008 and will reach the age of 65 in 2011.

Vermont Population Growth*

Age	2000 Actual	2007 Projected	2012 Projected	2017 Projected
Under 18	147,523	137,062	129,941	128,813
18-34	131,153	135,204	143,967	148,241
35-54	195,721	190,424	173,490	155,828
55-64	56,920	81,673	95,284	101,098
65+	**77,510**	**86,894**	**101,743**	**123,755**
65-74	40,683	46,040	58,388	74,940
75-84	26,831	28,968	30,002	34,238
85+	9,996	11,886	13,353	14,578
Total	608,827	631,257	644,424	657,736

* Numbers may not total due to rounding.
U.S. Census 2000 for "Actual"; MISER for "Projected"

The table below depicts the percent change in the projected population growth for each age group. The Vermont population as a whole is projected to grow 4% during this 10-year period. Individuals under 18 years old are projected to decrease 5% during the first 5 years and then another 1% during the second period, ending the 10-year period with a 6% decrease. Although the 18-34 year old group is projected to grow by 10% over the next 10 years, the 35-54 year old group is expected to decrease by 18%. The fastest growing 65-74 year olds are projected to expand a dramatic 63%, however, they are at low risk for needing long term care services. Elders age 85 and older (85+) are projected to grow 12% in the first period and an additional 9% in the second period for a ten year projected increase of 23%. Although the "oldest old" are relatively small in number, they will experience rapid growth and will have the greatest need for long term care services.

Percent Change in Population Growth*

Age	2007 to 2012 Projected	2012 to 2017 Projected	*2007 to 2017 Projected*
Under 18	-5%	-1%	*-6%*
18-34	6%	3%	*10%*
35-54	-9%	-10%	*-18%*
55-64	17%	6%	*24%*
65+	17%	22%	*42%*
65-74	27%	28%	*63%*
75-84	4%	14%	*18%*
85+	12%	9%	*23%*
Total	2%	2%	*4%*

* Growth in the first and second periods does not sum to growth over the 10-year period because growth is compounded over the 10-year period.

The following two pages show the population counts for each county in Vermont. The baseline 2000 Census and projected 2007, 2012, 2017 counts display the demographic changes over time. Each county has its unique distribution of age groups with some counties having a greater proportion of one age group than another. See "Age Groups by County" p.9. In addition, population growth varies markedly from one county to the next with some counties growing faster than others. Rutland is projected to grow 0.5% from 2007 to 2012 whereas Grand Isle will post a 6.6% increase. See "Percent Change in Growth" p.9. With regard to age-specific growth, each age group has a different rate of growth; and the growth rate of an age group in one county may be significantly different than the growth of that same age group in another county. Grand Isle's 31% increase in the number of 85+ during the period 2007 to 2012 is a reflection of its small size and its small number of 85+ year olds.

Vermont Population* for 2000 Census and 2007, 2012, 2017 Projected

2000 Census

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**147,523**	8,949	8,758	7,509	34,513	1,653	12,759	1,712	5,645	7,229	6,608	14,739	13,636	10,412	13,401
18-34	**131,153**	8,483	6,750	5,874	40,436	1,148	9,381	1,137	5,382	5,276	4,889	12,493	12,179	8,136	9,589
35-54	**195,721**	11,304	11,413	9,303	46,499	1,967	14,442	2,408	7,372	9,358	8,042	20,263	19,278	14,966	19,106
55-64	**56,920**	3,173	3,906	2,744	11,343	710	3,831	794	2,196	2,751	2,786	6,425	5,483	4,529	6,249
65+	**77,510**	4,065	6,167	4,272	13,780	981	5,004	850	2,638	3,612	3,952	9,480	7,463	6,173	9,073
65-74	**40,683**	2,146	3,253	2,192	7,364	572	2,765	521	1,391	1,998	2,015	4,850	3,784	3,182	4,650
75-84	**26,831**	1,422	2,066	1,555	4,576	330	1,686	270	900	1,224	1,440	3,398	2,550	2,117	3,297
85+	**9,996**	497	848	525	1,840	79	553	59	347	390	497	1,232	1,129	874	1,126
Total	**608,827**	35,974	36,994	29,702	146,571	6,459	45,417	6,901	23,233	28,226	26,277	63,400	58,039	44,216	57,418

2007 Projected

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**137,062**	8,384	7,847	6,934	33,117	1,513	12,391	1,641	5,432	6,434	6,097	13,309	12,575	9,417	11,970
18-34	**135,204**	8,792	7,137	6,449	40,303	1,221	9,479	1,255	5,671	5,825	5,156	12,851	12,234	8,501	10,329
35-54	**190,424**	10,799	10,544	8,640	48,298	1,929	15,391	2,421	7,437	8,801	7,763	18,893	18,336	13,798	17,373
55-64	**81,673**	4,784	5,122	4,121	16,997	881	5,496	1,155	3,166	3,990	3,673	8,813	8,147	6,665	8,662
65+	**86,894**	4,635	6,696	4,577	15,981	1,102	5,646	1,151	3,199	4,153	4,431	10,198	8,164	6,982	9,980
65-74	**46,040**	2,487	3,359	2,271	8,557	608	3,064	718	1,818	2,291	2,327	5,253	4,343	3,733	5,210
75-84	**28,968**	1,544	2,381	1,660	5,144	377	1,921	347	974	1,378	1,459	3,472	2,622	2,279	3,411
85+	**11,886**	603	956	646	2,279	117	661	86	407	484	645	1,473	1,199	970	1,359
Total	**631,257**	37,394	37,345	30,721	154,696	6,646	48,404	7,623	24,906	29,203	27,120	64,064	59,457	45,363	58,314

2012 Projected

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**129,941**	8,031	7,245	6,704	31,533	1,450	12,065	1,596	5,257	5,974	5,838	12,498	11,880	8,819	11,049
18-34	**143,967**	9,443	7,717	6,946	41,747	1,360	10,468	1,453	5,917	6,380	5,551	13,697	12,845	9,188	11,254
35-54	**173,490**	9,633	9,291	7,740	45,827	1,751	14,612	2,194	7,248	7,820	7,054	16,636	16,523	12,029	15,132
55-64	**95,284**	5,578	5,722	4,796	20,761	941	6,653	1,407	3,714	4,670	4,146	9,992	9,432	7,687	9,786
65+	**101,743**	5,581	7,489	5,212	19,211	1,263	6,632	1,477	3,926	4,931	5,086	11,584	9,534	8,320	11,495
65-74	**58,388**	3,326	4,024	2,879	11,081	722	3,880	943	2,372	2,896	2,867	6,487	5,527	4,865	6,516
75-84	**30,002**	1,564	2,391	1,585	5,478	400	1,981	421	1,107	1,479	1,507	3,488	2,751	2,392	3,458
85+	**13,353**	691	1,074	749	2,652	140	770	112	448	556	712	1,609	1,256	1,063	1,520
Total	**644,424**	38,266	37,464	31,399	159,079	6,766	50,430	8,127	26,063	29,775	27,675	64,407	60,213	46,044	58,716

2017 Projected

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**128,813**	8,066	7,053	6,815	31,029	1,483	12,209	1,646	5,283	5,880	5,835	12,362	11,662	8,670	10,820
18-34	**148,241**	9,774	7,875	7,075	42,930	1,410	11,338	1,567	6,099	6,607	5,659	13,840	13,025	9,456	11,584
35-54	**155,828**	8,625	8,117	7,071	41,827	1,569	13,381	1,962	6,885	6,816	6,479	14,633	14,863	10,485	13,115
55-64	**101,098**	5,761	5,931	4,814	23,397	999	7,626	1,560	4,013	5,019	4,265	10,298	9,639	7,842	9,935
65+	**123,755**	6,982	8,620	6,335	24,036	1,440	8,092	1,907	4,932	6,045	5,992	13,661	11,723	10,289	13,701
65-74	**74,940**	4,395	4,865	3,826	14,687	837	4,998	1,225	3,058	3,734	3,489	8,083	7,258	6,333	8,153
75-84	**34,238**	1,838	2,570	1,710	6,343	437	2,234	543	1,382	1,687	1,742	3,869	3,150	2,807	3,926
85+	**14,578**	749	1,185	799	3,007	166	860	139	493	624	762	1,710	1,315	1,148	1,622
Total	**657,736**	39,208	37,595	32,109	163,220	6,901	52,646	8,643	27,213	30,368	28,230	64,794	60,911	46,742	59,155

Age Groups by County–2007 Projected

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**22%**	22%	21%	23%	21%	23%	26%	22%	22%	22%	22%	21%	21%	21%	21%
18-34	**21%**	24%	19%	21%	26%	18%	20%	16%	23%	20%	19%	20%	21%	19%	18%
35-54	**30%**	29%	28%	28%	31%	29%	32%	32%	30%	30%	29%	29%	31%	30%	30%
55-64	**13%**	13%	14%	13%	11%	13%	11%	15%	13%	14%	14%	14%	14%	15%	15%
65+	**14%**	12%	18%	15%	10%	17%	12%	15%	13%	14%	16%	16%	14%	15%	17%
65-74	**7%**	7%	9%	7%	6%	9%	6%	9%	7%	8%	9%	8%	7%	8%	9%
75-84	**5%**	4%	6%	5%	3%	6%	4%	5%	4%	5%	5%	5%	4%	5%	6%
85+	**2%**	2%	3%	2%	1%	2%	1%	1%	2%	2%	2%	2%	2%	2%	2%
Total	**100%**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percent Change in Growth (projected)

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2007-12	**2.1%**	2.3%	0.3%	2.2%	2.8%	1.8%	4.2%	6.6%	4.6%	2.0%	2.0%	0.5%	1.3%	1.5%	0.7%
2012-17	**2.1%**	2.5%	0.4%	2.3%	2.6%	2.0%	4.4%	6.4%	4.4%	2.0%	2.0%	0.6%	1.2%	1.5%	0.7%

Percent Change in Growth by Age Group—2007 to 2012 (projected)

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**-5%**	-4%	-8%	-3%	-5%	-4%	-3%	-3%	-3%	-7%	-4%	-6%	-6%	-6%	-8%
18-34	**6%**	7%	8%	8%	4%	11%	10%	16%	4%	10%	8%	7%	5%	8%	9%
35-54	**-9%**	-11%	-12%	-10%	-5%	-9%	-5%	-9%	-3%	-11%	-9%	-12%	-10%	-13%	-13%
55-64	**17%**	17%	12%	16%	22%	7%	21%	22%	17%	17%	13%	13%	16%	15%	13%
65+	**17%**	20%	12%	14%	20%	15%	17%	28%	23%	19%	15%	14%	17%	19%	15%
65-74	**27%**	34%	20%	27%	29%	19%	27%	31%	30%	26%	23%	24%	27%	30%	25%
75-84	**4%**	1%	0%	-5%	6%	6%	3%	22%	14%	7%	3%	0%	5%	5%	1%
85+	**12%**	14%	12%	16%	16%	19%	16%	31%	10%	15%	10%	9%	5%	10%	12%
Total	**2%**	2%	0%	2%	3%	2%	4%	7%	5%	2%	2%	1%	1%	1%	1%

Percent Change in Growth by Age Group— 2012 to 2017 (projected)

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
<18	**-1%**	0%	-3%	2%	-2%	2%	1%	3%	0%	-2%	0%	-1%	-2%	-2%	-2%
18-34	**3%**	4%	2%	2%	3%	4%	8%	8%	3%	4%	2%	1%	1%	3%	3%
35-54	**-10%**	-10%	-13%	-9%	-9%	-10%	-8%	-11%	-5%	-13%	-8%	-12%	-10%	-13%	-13%
55-64	**6%**	3%	4%	0%	13%	6%	15%	11%	8%	7%	3%	3%	2%	2%	2%
65+	**22%**	25%	15%	22%	25%	14%	22%	29%	26%	23%	18%	18%	23%	24%	19%
65-74	**28%**	32%	21%	33%	33%	16%	29%	30%	29%	29%	22%	25%	31%	30%	25%
75-84	**14%**	17%	7%	8%	16%	9%	13%	29%	25%	14%	16%	11%	15%	17%	14%
85+	**9%**	8%	10%	7%	13%	18%	12%	24%	10%	12%	7%	6%	5%	8%	7%
Total	**2%**	2%	0%	2%	3%	2%	4%	6%	4%	2%	2%	1%	1%	2%	1%

**** Includes institutionalized. Numbers may not total due to rounding.***

Disability Trends & Long Term Care

Vermonters are living longer and enjoying better health, yet, disability affects young and old alike and is the major determinant of the need for long term care. While disability rates are decreasing in older adults, they are increasing for younger individuals.

This report defines disability as requiring the help of another person to perform two or more activities of daily living. The Department's 10-year model predicts an increase in the disability rate for those younger than 65 years old, although that increase slows during the first five year period 2007-2012 and slows even further during the second five-year period (3.9% to 2.2% to 1.3%). For Vermonters over 65, a decline of almost 1% annually is projected from 2007 to 2017. See Trends table below. (See Appendix, Tables 2 & 3, p.25-29 for detailed disability data.)

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

Age	2000-2007	2007-2012	2012-2017
Birth-64	3.9%	2.2%	1.3%
65+	-0.9%	-0.9%	-0.8%

Vermonters with a disability living in the community are projected to increase 35% over the 10-year period. Younger people with disabilities are predicted to grow 22% while older people with disabilities will expand by 42%. The latter is a result of the increasing number of older people in the population. See table below. (For county disability data with additional age detail, see Appendix, Table 3b, p.28.) It may seem inconsistent for the number of older Vermonters with disabilities to grow while the elder disability rate is declining. However, this results from the population of 65+ Vermonters growing faster than the combined growth of institutionalized and non-institutionalized elders with disabilities. Community based long term care services need to expand in order to accommodate the growing number of people with disabilities.

	People w/ Disabilities in the Community			**Percent Growth**		
Age	**2007**	**2112 proj.**	**2017 proj.**	**2007-2012 proj**	**2012-2017 proj**	***2007-2017 proj***
18-64	1,569	1,809	1,922	15%	6%	*22%*
65+	3,226	3,856	4,568	20%	18%	*42%*
Total	4,796	5,665	6,490	18%	15%	*35%*

The table below shows the county distribution of both younger and older adults with disabilities living in the community.

People w/ Disabilities in the Community−2007

	18-64	65+	Total
Vermont	**1569**	**3226**	**4796**
Addison	91	163	254
Bennington	88	241	329
Caledonia	76	180	255
Chittenden	404	622	1027
Essex	17	39	56
Franklin	115	200	316
Grand Isle	18	35	53
Lamoille	62	93	155
Orange	72	155	227
Orleans	69	171	240
Rutland	161	398	559
Washington	149	292	441
Windham	110	263	373
Windsor	137	374	511

Vermonters increasingly prefer to receive their long term care services at home as evidenced by a contraction of the state's institutional capacity. Over the last twelve years, 600 Vermont nursing facility beds have closed (from roughly 3,900 to 3,300) shifting care into the home and community-based system. Current utilization of home and community based services serves as a benchmark for future growth. See Appendix Tables 4 and 5 (pages 30-31) for the client counts of all programs featured in this report with actual utilization for 2007 and projected utilization for 2012 and 2017. Projected utilization is based on changing demographics, disability trends, the decline in nursing home use, and current home and community based program use patterns.

The following table spotlights three selected programs all of which are essential for a well-balanced system. For each of the three programs, the number of clients served during FY 2007 and the accompanying use rates are displayed. The table compares each county's FY 2007 use rate with that of the state's and highlights in yellow those counties whose use rate is lower than the state average. Four counties have use rates lower than the state average *in all three programs*; Bennington, Chittenden, Rutland and Windham. All counties with use rates below the state average should strive to improve their program participation.

Home & Community-Based Program Use by County
Selected Programs in FY 2007

Personal Care*	**Vermont**	Addison	**Bennington**	Caledonia	**Chittenden**	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	**Rutland**	**Washington**	**Windham**	**Windsor**
Use Rate**	**23.2%**	34%	15%	29%	22%	33%	33%	35%	28%	24%	32%	19%	19%	17%	21%
Avg # Served	1,114	87	50	75	227	19	103	19	44	54	76	109	82	65	106

Adult Day	**Vermont**	Addison	**Bennington**	Caledonia	**Chittenden**	Essex	Franklin	**Grand Isle**	Lamoille	Orange	**Orleans**	**Rutland**	**Washington**	**Windham**	**Windsor**
Use Rate**	**14.2%**	55%	14.0%	31%	6%	18%	17%	9%	32%	15%	12%	5%	10%	12%	11%
Avg # Served	681	139	46	79	63	10	54	5	50	33	30	26	43	46	57

ERC^	**Vermont**	Addison	**Bennington**	**Caledonia**	**Chittenden**	**Essex**	Franklin	**Grand Isle**	**Lamoille**	Orange	**Orleans**	**Rutland**	Washington	**Windham**	Windsor
Use Rate**	**5.5%**	8%	3%	0%	4%	0%	16%	2%	3%	8%	5.0%	5.2%	6%	4%	7%
Avg # Served	264	20	9	0	41	0	51	1	5	19	12	29	26	15	36

* Personal Care = Choices for Care Personal Care services

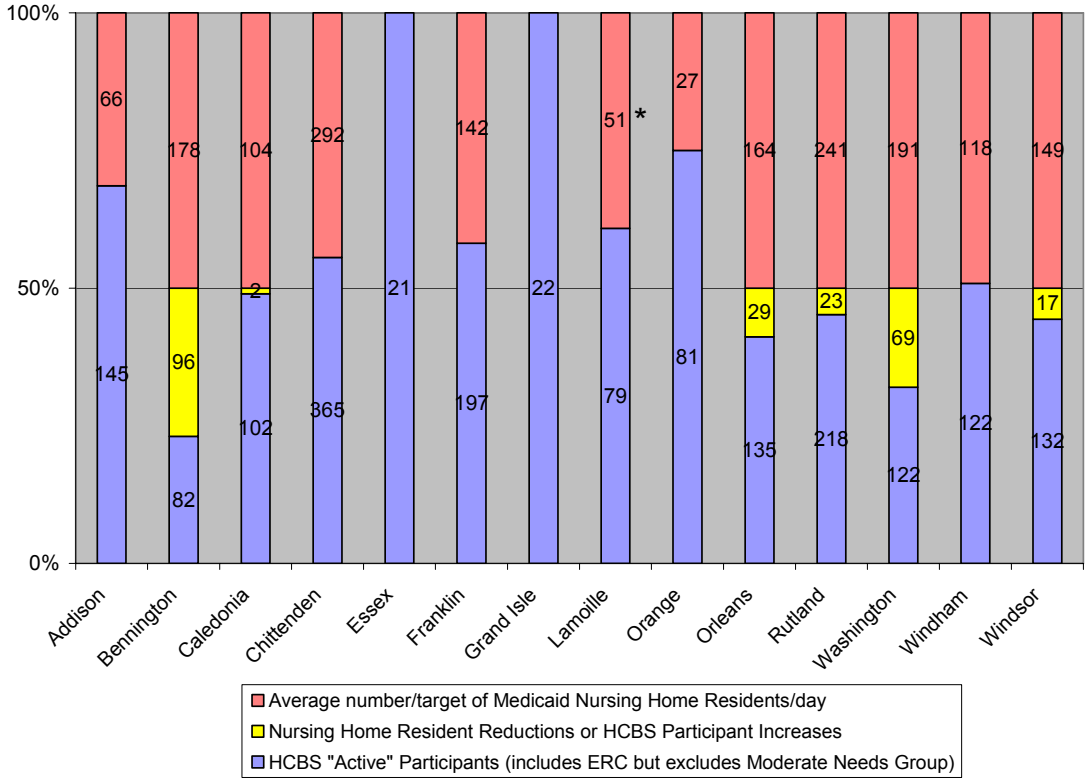
** Use Rate = number of program participants divided by the number of 18+ disabled.

^ ERC = Enhanced Residential Care

= below the Vermont state average

The Department's Choices for Care Medicaid Waiver has boosted efforts to rebalance Vermont's long term care system. While the original goal for each county was to have a minimum of 40 Medicaid home and community based clients for every 60 Medicaid funded nursing home residents (60/40), the Department now believes that serving a minimum of 50% home and community based clients is attainable. This target has already been met by six counties: Addison, Chittenden, Franklin, Lamoille, Orange, and Windham. (See chart below.) Six counties have yet to meet the goal; see yellow bars in chart. Vermont has 14 counties but two do not have any nursing homes (Essex and Grand Isle). *Lamoille County numbers include The Manor's 20 ERC-funded nursing home residents. CFC Moderate Needs Group is excluded.

Medicaid *Choices for Care:* Nursing Home Residents and Home & Community-Based Participants--*April 2008*
Changes (Yellow) Needed to Achieve At Least 50% HCBS

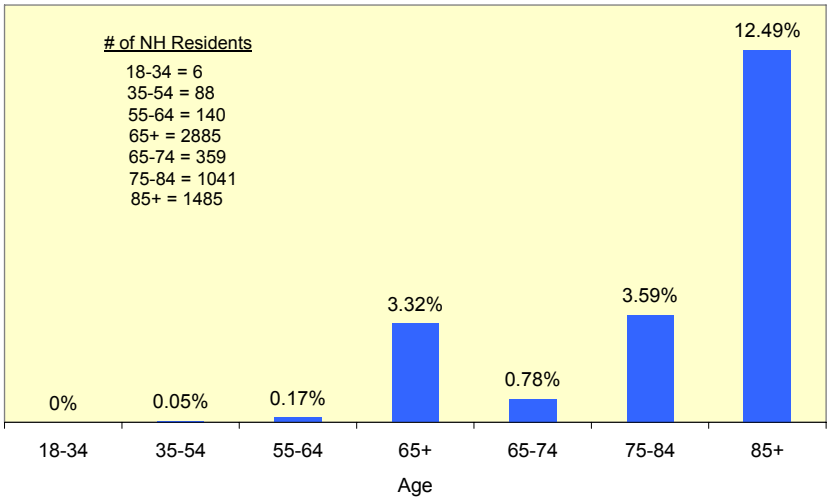


Although this chart gives counties a sense of the proportion of CFC nursing facility residents relative to CFC home and community based clients, it does not necessarily speak to the optimal number of people served in one setting or the other. For example, although Franklin County has more than exceeded the Department's goal of having at least 50% of long term care Medicaid beneficiaries receive their care in home and community based settings, it has a higher than average use of nursing facilities. Franklin County's rebalancing has been accomplished by increasing the number of people served in home and community based settings rather than by reducing nursing facility utilization.

Nursing Facilities

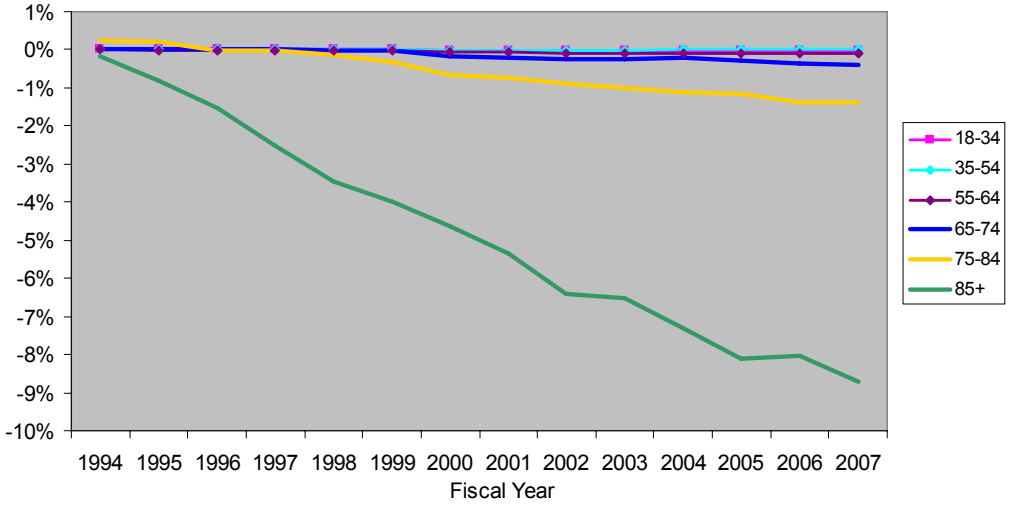
Nursing facilities play a significant role in Vermont's long term care system serving 39% of the state's disabled people age 18 and older. The vast majority of nursing home residents (93%) are over the age of 65. Although nursing homes make a significant contribution to the state's long term care system, they house only 3.3% of Vermonters age 65 and older and 12.5% of those age 85 and over. (See below.)

Percent of Vermonters Residing in Nursing Homes by Age in 2007



Vermonters' utilization of nursing homes has changed over time especially for the older age groups. Individuals 85 years old and older have shown a precipitous drop in their use of nursing homes during the last 14 years (1993 to 2007). See chart below. These decreases are most likely due to increased use of home based services, declining disability and poverty rates, and greater housing options such as Assisted Living.

Change in Nursing Facility Use
Age Adjusted Difference from 1993 Use Rate



Vermont nursing facilities served an average of 3,118 residents during FY 2007. This translates into a use rate of 39% which means that 39% of Vermonters with a disability (requiring help with 2 or more activities of daily living) age 18 and older were served in nursing facilities. The table below ranks Vermont counties above and below the state average use rate. Bennington tops the list with a nursing home use rate of 60%; in other words, 60% of Bennington County's people with a disability were served in nursing homes. Bennington County has the highest number of nursing home beds per population in the state. Orleans, Washington, Rutland, and Franklin Counties also have nursing home use rates above the state average. Orange County has the lowest use rate in the state at 11%.

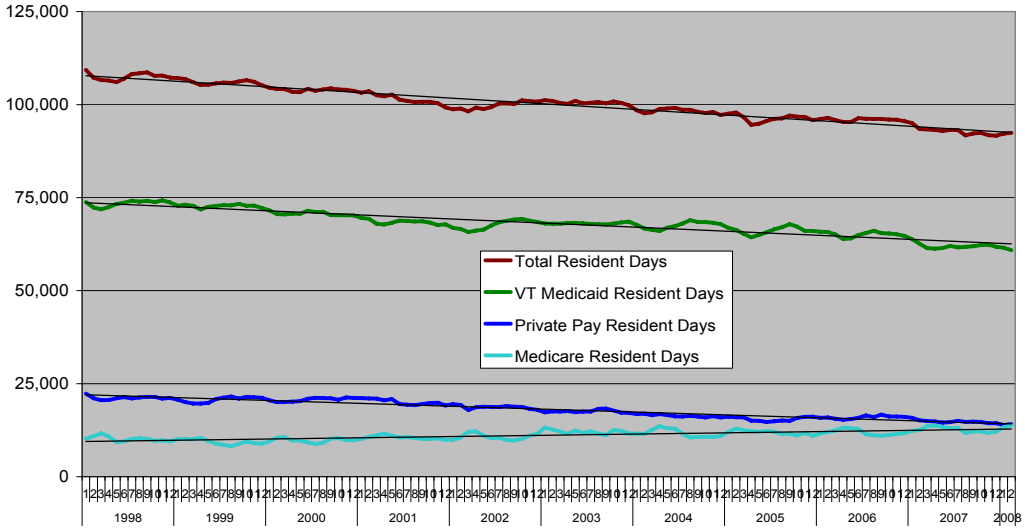
Nursing Facility Use Rates by County

Nursing Facility	Use Rate* FY 2007	Avg Daily Census FY 2007
Bennington	**60%**	**493**
Orleans	**51%**	**246**
Washington	**48%**	**411**
Rutland	**41%**	**388**
Franklin	**40%**	**210**
Vermont	39%	3,118
Caledonia	38%	154
Windham	36%	208
Windsor	35%	278
Lamoille	35%	83
Chittenden	34%	518
Addison	29%	102
Orange	11%	28

* Use Rate = # of NF residents ÷ # of 18+ Disabled

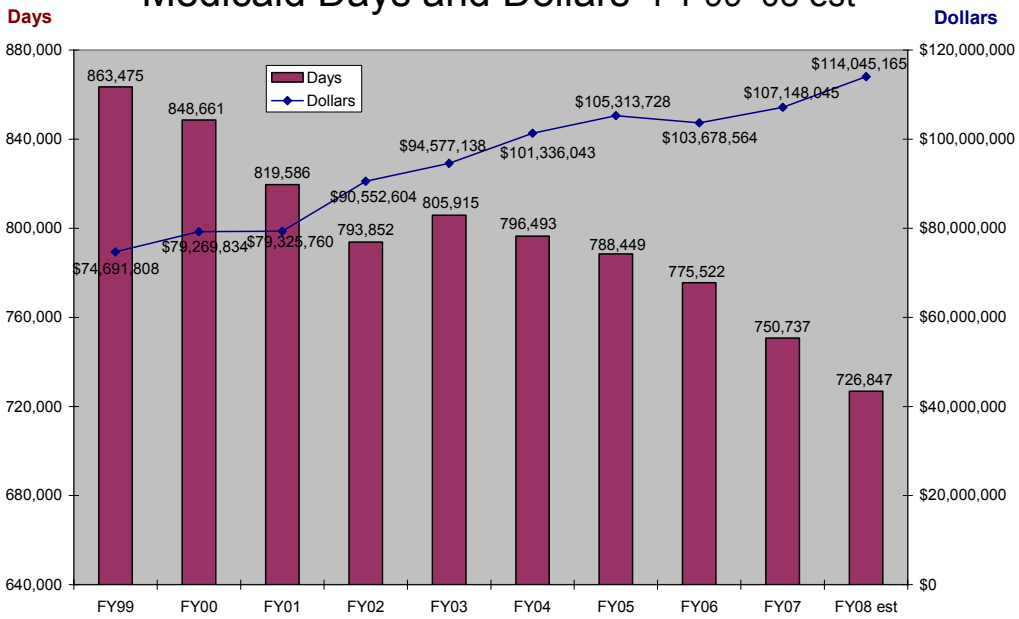
Although the number of older people is growing, Vermonters are spending fewer days in nursing facilities. Over the past ten years, Vermont has seen a continuous decrease in the total number of nursing home days. Vermont Medicaid days have declined as have Private Pay days, although Medicare days have risen slightly. (See chart below.) These resident day changes are attributable to the aforementioned reasons for declining nursing home utilization as well as to the increased emphasis on sub-acute and rehabilitation care in nursing facilities.

Nursing Facility Monthly Resident Days 1998-2008
Total, Medicaid, Private Pay and Medicare
Standardized to 31 day month



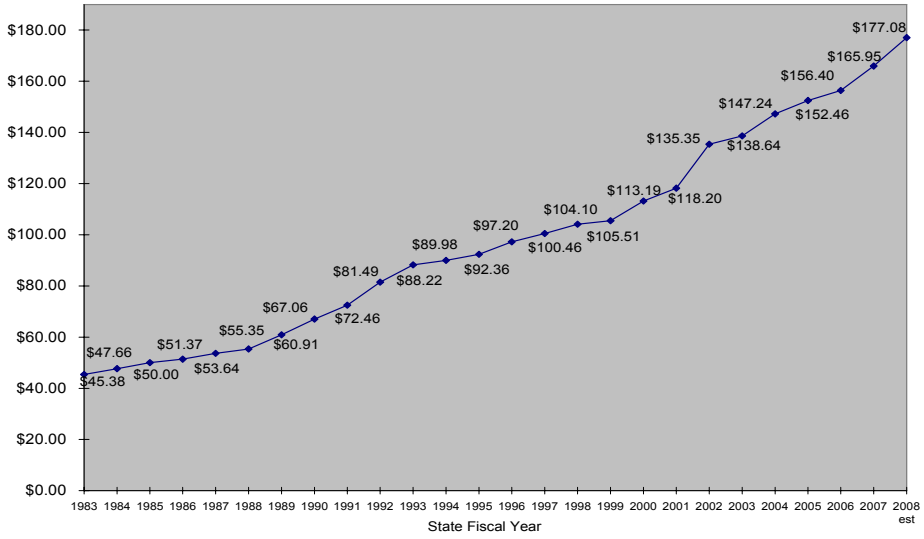
Although the number of Medicaid nursing home days has fallen by more than 136,000 from FY 1999 to FY 2008 est, expenditures have risen by $39 million. In FY 1999, Vermont Medicaid paid approximately $74.7 million for nursing home care; an estimated $114 million will be expended in FY 2008. (See chart below. “Dollars” include out-of-state and swing beds; “Days” do not.) If shifting the balance from institutional to home and community based care is to continue, Vermont will need to address this issue of rising Medicaid expenditures amidst falling Medicaid days.

Nursing Facilities
Medicaid Days and Dollars FY'99-'08 est



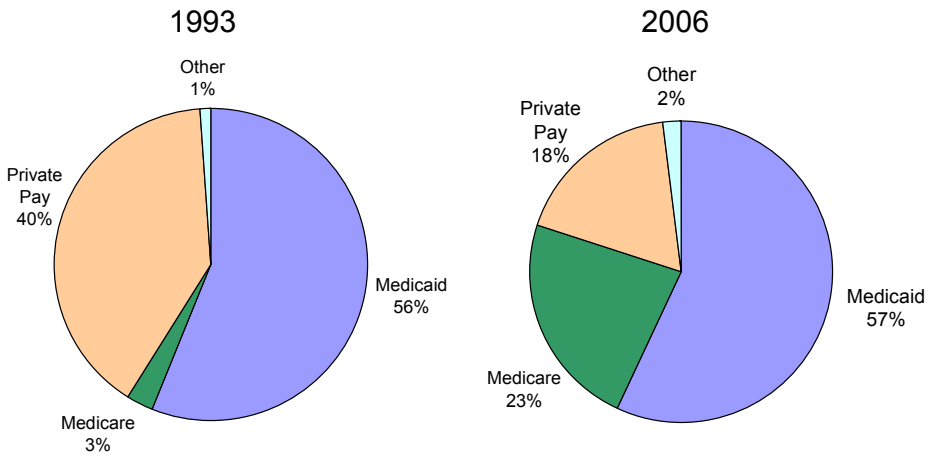
Many factors contribute to the rise in Medicaid expenditures; however, one significant contributor is the daily payment rate. The average daily weighted Medicaid payment rate has risen over the last 25 years to its current $177 per day. The chart below shows the change in Medicaid payment rates since 1983. For FY 2007 and FY 2008 est., the Vermont Veterans Home has been excluded since a different methodology is used for its rate calculation. For FY 2009 only, the nursing facility inflation factor was reduced by 50%.

Average Medicaid Daily Rate
for VT Nursing Home Residents

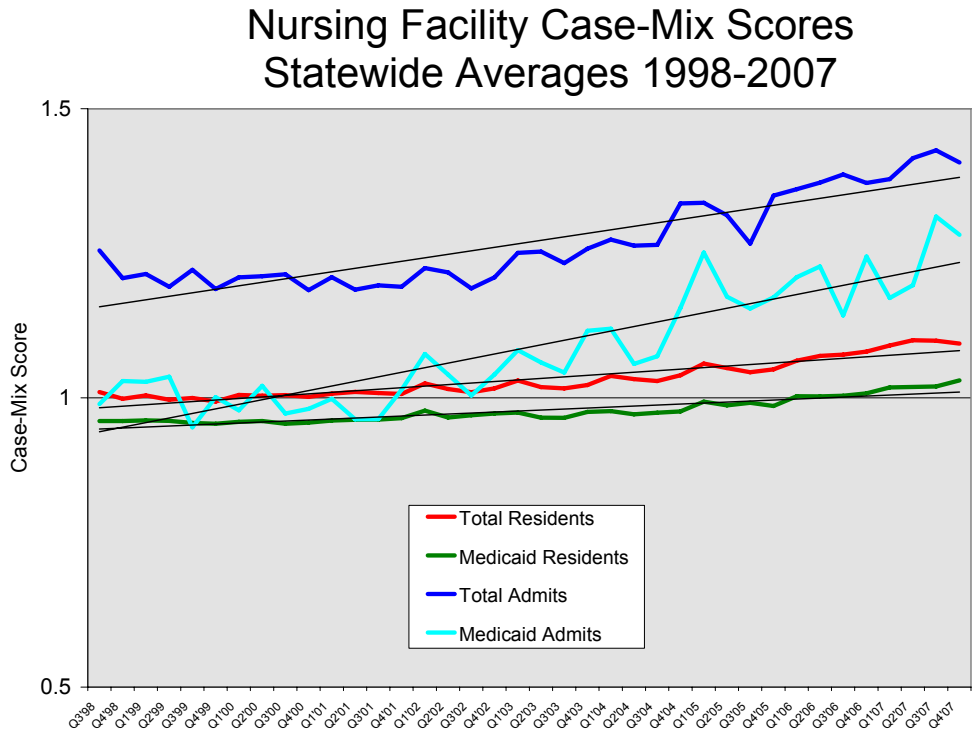


Medicaid provides nursing facilities with their biggest share of revenues, comprising 57% of the total in 2006 (most recent data available). This share appears to be relatively constant over time as Medicaid made up 56% of nursing home revenues in 1993. However, the proportional amount of other payers has shifted. Medicare has grown from 3% in 1993 to 23% in 2006, most likely a result of increased sub-acute and rehabilitation services. Private Pay revenues have shrunk from 40% in 1993 to 18% in 2006. (See pie chart below.)

Vermont Nursing Facility Revenues by Payer



Vermont's long term care system has been successful in serving people at home who might otherwise have been admitted to nursing homes. Nursing facility Case Mix scores have increased over time due to the greater preponderance of higher acuity residents in nursing homes. (See chart below.) The Case Mix reimbursement system takes into account resident acuity by measuring resident characteristics associated with resource use. This chart shows that the acuity level of nursing home



admissions, both Total Admits and Medicaid Admits, has trended upward over the 1998-2007 period reflecting fewer light care admissions and more high acuity admissions. Case mix scores for Total Residents and Medicaid Residents have shown significant gains as well although to a lesser extent.

Looking to the future, this report projects the annual percent change in nursing home use over the next ten years. (See table below.) These projections are derived from actual nursing home use during the period FY 1992 to FY 2007 and then trended forward to 2012 and 2017. This year's model determined use rates for three groups under the age of 65. When taken as a whole in last year's *Shaping the Future of Long Term Care 2006-2016* report, the under 65 year old group showed a projected *increase* in nursing home use. Yet, when separated into three groups, a different picture emerges. Vermonters 18-34 years old are projected to decrease their use of nursing homes by more than 5% as will the 55-64 year old group (by 3.4%). For most all of the age groups, nursing home use is projected to decrease during the 10-year period which translates into more people being diverted to the community where they will receive home and community based services.

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

Age	2007-2012	2012-2017
18-34	-5.1%	-5.1%
35-54	1.1%	1.1%
55-64	-3.4%	-3.4%
65+	-2.6%	-2.6%
65-74	-2.8%	-2.8%
75-84	-2.3%	-2.3%
85+	-3.7%	-3.7%

Shifting the Balance 2008

Twelve years have elapsed since Vermont passed Act 160, the landmark legislation that gave a jump start to the goal of creating a more equal balance between institutional and home and community based care. For the first time, funds that were appropriated for nursing home care, but not needed in that setting, would be invested to further develop the home and community based system. In October 2005, Vermont's 1115 demonstration Medicaid Waiver Choices for Care brought an end to the institutional bias in Vermont by giving participants equal choice between a nursing facility and home & community based care by creating one long term care budget for both settings.

Since Act 160 was passed, Vermont has tracked public expenditures in long term care and the change has been striking. During the last 10 years, the investment in home and community based care has grown from a mere 18% to the current 38%. (See graph below.) Funds have been used to increase caregiver wages and provider rates, improve adult day centers, install sprinklers in residential care homes, provide flexible funds when no other source of funding is available, and support a housing with supportive services program. Most recently, Assistive Community Care Service providers (ACCS) received a $2 per day rate increase beginning July 1, 2008 that will help sustain Medicaid-funded care in residential care homes.

Vermont Public Expenditures for Long Term Care
FY 1999 - FY 2008 est

* Home & Community Based Services include CFC, AAA State funds, Adult Day, Alzheimer/Dementia grants, Commodity Food, Supportive Housing, Flex Funds, Attendant Services, TBI Program, Home Modification, Homemaker, Mental Health & Aging, and other. Excludes DS Program, High Tech, Children's Personal Care Svcs.

As more people choose to receive their care in home and community based settings, DAIL is often challenged to provide appropriate and high quality care to people who need specialized services. These individuals often end up staying longer than necessary in a hospital, including the Vermont State Hospital (VSH) or must be served in an out-of-state setting. These special care situations include: dementia with behaviors that are difficult to control; ventilator care; bariatric care; traumatic brain

injury care; aging sex offenders who have completed their sentences in the correctional system; individuals with mental illness and significant functional limitations due to disabilities or chronic health conditions; and care for patients with rare illnesses such as Huntington's Chorea. During the last year, a handful of people who were not able to find care in a nursing home were able to leave the VSH and live in the community with significant supports. The State will continue to work with providers from both nursing homes and home and community based settings to develop on-going solutions for these individuals.

The State continues to work with Vermont nursing facilities on four major issues: (1) creating incentives for downsizing that are affordable within the Choices for Care Waiver; (2) examining the feasibility of additional special care units; (3) improving quality and advancing the retention of direct care workers; and (4) examining more home-like models of nursing home care (e.g. the Green House model).

As the number of individuals with disabilities grows and people increasingly choose home and community based care, the long-term care system will be challenged to meet the growing need for a well-trained direct care workforce. After 18 months of diligent work by the Statewide Advisory Group, the Direct Care Workforce Study was presented to the Legislature in April 2008. The study examined the following issues:

1. What are workforce quantity and availability issues across care and support settings and consumer populations? Specifically:
    - What is the supply of workers?
    - What is the demand for workers?
    - What are the gaps between supply and demand?
    - What recruitment and retention strategies are currently in use?
    - Can technology be used to bridge gaps between supply and demand?
    - What other strategies can bridge gaps between supply and demand?
2. What are workforce quality issues across care and support settings and consumer populations? Specifically:
    - What is the level of service quality?
    - What skill sets and training are expected of direct care/support workers?
    - How do care and support settings address cultural differences?
    - What is the level of worker satisfaction with work and the workplace?
3. What are workforce stability issues across care and support settings and consumer populations? Specifically:
    - To what extent do consumers of care/support services experience a stable workforce?
    - To what extent do professional caregivers and support providers experience stability in their jobs?
    - To what extent do employers experience stability in the direct care workforce?

4. What are financial issues across care and support settings and consumer populations that will need attention? Specifically:
    - How does compensation compare across programs and services?
    - What administrative policies impact compensation for caregivers?
    - What compensation must professional caregivers receive to establish and maintain a viable workforce?

The study's nine detailed recommendations provide Vermont with a roadmap to ensure the availability of a high quality direct care workforce. Recommendations include increasing direct care worker wages, providing access to health insurance, and promoting recruitment and retention of direct care workers through a variety of creative approaches. Copies of the Direct Care Workforce Study can be obtained from DAIL or found on the Department's website http://dail.vermont.gov.

Vermont is currently faced with a fiscal environment that necessitates slower growth in its long term care programs and fewer new initiatives. DAIL intends to use this time to engage in strategic planning, evaluate program effectiveness, and initiate improvements so that Vermont will be well-positioned to move forward once the economic forecast improves.

APPENDIX

ASSUMPTIONS SHEET

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

Disability Rate Trends (non-MR/DD)

	2000-2007	2007-2012	2012-2017
0-64*	3.9%	2.2%	1.3%
65+**	-0.9%	-0.9%	-0.8%

Default values:

	'00-'07	'07-'12	'12-'17
0-64	3.9%	2.2%	1.3%
65+	-0.9%	-0.9%	-0.8%

*Default disability trends for the 0-64 population assumes the same rate of increase as assumed by the Social Security Administration for projections of Disabled Workers (i.e., individuals receiving Social Security Disability Insurance benefits) from the 2007 Annual Trustees Report for those age 18-64. Lewin applied the trends for those age 18-64 to individuals younger than age 18, because projections for individuals younger than age 18 are not available.

**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, Lewin 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. The projections assume a slight flattening of this trend in the future.

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

Nursing Facility Use Rate Trends***

	2007-2012	2012-2017
18-34	-5.1%	-5.1%
35-54	1.1%	1.1%
55-64	-3.4%	-3.4%
18-64	0.2%	0.2%
65+	-2.6%	-2.6%
65-74	-2.8%	-2.8%
75-84	-2.3%	-2.3%
85+	-3.7%	-3.7%

Note: VT historical trends:

	'93-'07	'93-'00	'00-'07
18-34	-5.1%	-4.2%	-6.0%
35-54	1.1%	-1.1%	3.3%
55-64	-3.4%	-3.4%	-3.4%
18-64	0.2%	-0.7%	1.0%
65+	-2.6%	-2.1%	-3.2%
65-74	-2.8%	-2.2%	-3.4%
75-84	-2.3%	-2.1%	-2.6%
85+	-3.7%	-3.4%	-4.0%

Default values:

	'07-'12	'12-'17
18-34	-5.1%	-5.1%
35-54	1.1%	1.1%
55-64	-3.4%	-3.4%
18-64	0.2%	0.2%
65+	-2.6%	-2.6%
65-74	-2.8%	-2.8%
75-84	-2.3%	-2.3%
85+	-3.7%	-3.7%

***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 calculated on a state fiscal year basis through the second calendar quarter of 2007. Lewin conservatively assumed that the age-specific changes in nursing facility use from 2007 to 2017 will resemble the long term changes observed from 1993 to 2007.

Table 2

Estimated Number of People with any ADL or IADL Need[1] by County, 2007, 2012 proj., and 2017 proj.
By Disability Level and Income, People of All Ages
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2007															
Nursing Facility[2,3]	3,118	102	493	154	518	-	210	-	83	28	246	388	411	208	278
Community[4]	626,413	37,276	36,838	30,316	153,875	6,646	47,933	7,623	24,823	29,144	26,571	63,514	58,831	45,155	57,869
All <175% FPL	135,033	7,571	8,176	7,253	31,971	1,709	10,155	1,552	5,393	6,271	6,788	14,594	11,951	9,761	11,889
2+ ADLs	2,059	109	135	111	445	26	138	22	76	97	110	241	181	163	206
1+ ADLs	3,643	195	240	198	787	47	246	40	137	170	193	423	319	283	364
Any ADL or IADL	7,449	401	500	406	1,575	99	505	85	280	351	391	864	653	576	763
All 175%+ FPL	491,380	29,705	28,661	23,064	121,904	4,937	37,778	6,071	19,430	22,873	19,784	48,920	46,880	35,394	45,980
2+ ADLs	2,830	150	200	149	603	31	186	33	82	135	135	328	268	217	313
1+ ADLs	5,280	291	364	272	1,137	58	354	63	175	251	243	595	500	405	572
Any ADL or IADL	11,613	652	790	588	2,509	129	784	143	416	551	525	1,288	1,098	895	1,245
2012 Projected															
Nursing Facility[2,3]	2,934	97	459	146	509	-	201	-	72	30	232	359	376	195	259
Community[4]	639,701	38,150	36,992	30,998	158,262	6,766	49,955	8,127	25,991	29,709	27,135	63,889	59,587	45,849	58,291
All <175% FPL	138,196	7,775	8,221	7,415	32,987	1,744	10,601	1,665	5,657	6,403	6,931	14,698	12,130	9,934	12,035
2+ ADLs	2,439	127	173	130	528	28	166	26	94	107	134	280	219	189	238
1+ ADLs	4,198	222	287	226	917	52	289	47	164	189	225	477	371	321	411
Any ADL or IADL	8,417	453	568	453	1,811	109	581	101	328	391	442	953	737	646	844
All 175%+ FPL	501,505	30,374	28,771	23,583	125,275	5,022	39,354	6,462	20,334	23,307	20,204	49,191	47,457	35,915	46,256
2+ ADLs	3,326	173	252	171	710	33	223	38	108	148	164	377	322	251	356
1+ ADLs	6,046	330	429	305	1,315	63	412	75	215	277	284	666	577	461	638
Any ADL or IADL	13,116	738	892	651	2,879	141	901	171	493	614	594	1,420	1,240	1,007	1,374
2017 Projected															
Nursing Facility[2,3]	2,822	96	434	138	509	-	197	-	72	29	223	338	356	187	244
Community[4]	653,076	39,091	37,149	31,723	162,401	6,901	52,169	8,643	27,141	30,296	27,702	64,300	60,253	46,555	58,752
All <175% FPL	142,103	8,043	8,312	7,636	34,074	1,791	11,144	1,794	5,947	6,585	7,107	14,881	12,360	10,176	12,255
2+ ADLs	2,774	142	205	147	603	30	193	30	108	118	154	313	253	212	266
1+ ADLs	4,700	248	328	250	1,036	56	330	55	186	208	252	524	418	357	452
Any ADL or IADL	9,387	507	632	500	2,046	117	659	119	374	433	490	1,039	824	720	926
All 175%+ FPL	510,974	31,047	28,837	24,087	128,328	5,110	41,025	6,849	21,195	23,711	20,595	49,419	47,893	36,379	46,498
2+ ADLs	3,821	197	301	193	819	36	259	45	129	163	193	426	375	288	399
1+ ADLs	6,818	372	491	339	1,494	68	471	87	250	306	323	737	655	520	705
Any ADL or IADL	14,656	829	989	721	3,251	151	1,021	200	568	680	664	1,554	1,388	1,130	1,509

[1]Any ADL or IADL Need is defined as requiring the help of another person to perform ADLs and/or IADLs. *Excludes* individuals with mental retardation or developmental disabilities.

[2]Represents 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. Lamoille County: The Manor's ERC-funded nursing facilty residents are included from Feb 1, 2007 forward.

[3]Nursing facility "need" assumes that all individuals in nursing facilities in 2007 "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.

[4]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 2000 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 report.

Table 3

Estimated Number of People with LTC Needs[1] by County, 2007, 2012 proj., and 2017 proj.
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

2007

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Nursing Facility[2,3]	3,118	102	493	154	518	-	210	-	83	28	246	388	411	208	278
Community, Low Income (<175%FPL)[4]	2,059	109	135	111	445	26	138	22	76	97	110	241	181	163	206
<65	834	46	47	43	212	10	60	9	33	38	41	89	76	59	70
<18	39	2	3	3	8	1	3	0	2	2	3	5	3	3	3
18-64	795	44	45	40	204	9	57	9	32	36	39	85	73	56	67
65+	1,225	63	88	69	233	16	77	13	43	59	69	152	104	104	136
65-74	319	17	24	16	56	5	23	5	12	16	18	37	29	26	36
75-84	331	16	25	21	58	5	23	4	11	17	18	41	27	26	39
85+	576	30	39	32	118	6	32	4	19	25	34	74	49	52	62
Community, 175%+ FPL[4]	2,830	150	200	149	603	31	186	33	82	135	135	328	268	217	313
<65	829	50	47	38	214	8	63	10	32	39	33	81	81	58	75
<18	55	3	3	3	13	1	5	1	2	2	2	5	5	4	5
18-64	775	47	43	36	200	7	58	9	30	36	30	76	76	54	70
65+	2,001	100	153	111	389	23	123	23	50	96	102	246	187	158	238
65-74	481	25	37	22	86	6	31	7	16	24	24	57	48	38	58
75-84	860	41	66	50	153	10	54	10	23	42	45	111	82	64	110
85+	660	34	50	39	150	7	38	5	12	30	33	77	57	57	70

[1]LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

[2]Represents 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. Lamoille County: The Manor's ERC-funded nursing facilty residents are included from Feb 1, 2007 forward.

[3]Nursing facility "need" assumes that all individuals in nursing facilities in 2007 "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.

[4]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 2000 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 report.

Table 3

Estimated Number of People with LTC Needs[1] by County, 2007, 2012 proj., and 2017 proj.
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
2012 Projected															
Nursing Facility[2,3]	2,934	97	459	146	509	-	201	-	72	30	232	359	376	195	259
Community, Low Income (<175%FPL)[4]	2,439	127	173	130	528	28	166	26	94	107	134	280	219	189	238
<65	957	52	56	49	245	11	71	11	40	43	48	101	87	66	79
<18	42	2	3	3	8	1	4	0	2	2	3	5	3	3	3
18-64	916	50	53	46	236	10	67	10	38	41	45	96	84	63	76
65+	1,481	74	117	81	283	17	96	15	54	64	86	179	132	123	160
65-74	401	22	30	21	73	6	29	6	16	20	23	46	36	32	43
75-84	359	17	29	20	64	5	25	4	14	17	20	43	31	28	40
85+	722	36	57	40	146	7	42	5	24	28	43	90	65	63	77
Community, 175%+ FPL[4]	3,326	173	252	171	710	33	223	38	108	148	164	377	322	251	356
<65	951	57	55	44	247	9	74	12	38	44	38	92	92	65	84
<18	58	4	3	3	14	1	5	1	2	3	3	6	5	4	5
18-64	893	53	52	41	232	8	69	11	36	41	36	86	87	61	79
65+	2,375	116	197	127	464	24	149	27	70	104	126	285	230	186	271
65-74	601	32	47	29	111	7	39	9	21	28	31	70	60	48	70
75-84	928	43	77	49	168	10	59	11	29	43	50	116	92	68	112
85+	846	41	73	49	185	7	51	6	19	33	44	99	78	70	89

[1]LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

[2]Represents 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. Lamoille County: The Manor's ERC-funded nursing facilty residents are included from Feb 1, 2007

[3]Nursing facility "need" assumes that all individuals in nursing facilities in 2007 "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.

[4]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 2000 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 report.

Table 3

Estimated Number of People with LTC Needs[1] by County, 2007, 2012 proj., and 2017 proj.
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
2017 Projected															
Nursing Facility[2,3]	2,822	96	434	138	509	-	197	-	72	29	223	338	356	187	244
Community, Low Income (<175%FPL)[4]	2,774	142	205	147	603	30	193	30	108	118	154	313	253	212	266
<65	1,017	55	61	52	263	12	77	11	43	45	52	105	92	68	82
<18	44	2	3	3	9	1	4	1	2	2	3	5	4	3	3
18-64	973	52	58	49	254	11	73	11	42	42	49	100	88	65	79
65+	1,757	87	145	95	341	19	115	18	64	73	102	208	161	144	184
65-74	505	28	37	27	95	6	36	7	20	24	28	56	46	41	52
75-84	413	20	35	22	75	5	29	5	17	19	24	49	37	32	45
85+	840	40	73	46	170	7	51	6	28	30	50	103	78	71	88
Community, 175%+ FPL[4]	3,821	197	301	193	819	36	259	45	129	163	193	426	375	288	399
<65	1,010	59	60	47	265	9	81	13	42	46	41	96	97	67	88
<18	61	4	3	3	15	1	6	1	2	3	3	6	6	4	5
18-64	949	55	56	44	250	9	75	12	39	43	39	90	91	63	82
65+	2,811	138	241	146	554	26	178	32	87	118	152	329	278	221	311
65-74	752	41	57	38	144	7	49	11	27	35	39	85	75	60	83
75-84	1,064	50	91	52	194	11	68	14	36	46	60	129	108	80	125
85+	995	46	93	56	216	8	61	7	24	37	54	115	95	81	103

[1]LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

[2]Represents 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. Lamoille County: The Manor's ERC-funded nursing facilty residents are included from Feb 1, 2007

[3]Nursing facility "need" assumes that all individuals in nursing facilities in 2007 "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.

[4]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 2000 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 report.

Table 3a

Percent Distribution of Community Residents with LTC Needs[1] by County, 2007, 2012 proj., and 2017 proj.
Individuals Needing Assistance with 2+ ADLs, by Age Group
People of All Income Levels
Point in Time

	Vermont (100%)	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Age <18															
2007	94	5.8%	5.9%	5.7%	22.5%	1.3%	8.9%	1.2%	4.0%	4.8%	5.4%	10.5%	9.0%	7.0%	8.1%
2012 proj.	99	5.9%	5.8%	5.8%	22.6%	1.3%	9.1%	1.2%	4.1%	4.7%	5.4%	10.5%	9.0%	6.9%	7.9%
2017 proj.	105	6.0%	5.7%	5.9%	22.4%	1.3%	9.3%	1.2%	4.1%	4.7%	5.5%	10.4%	8.9%	6.8%	7.8%
Age 18-64															
2007	1,569	5.8%	5.6%	4.8%	25.8%	1.1%	7.3%	1.2%	3.9%	4.6%	4.4%	10.2%	9.5%	7.0%	8.7%
2012 proj.	1,809	5.7%	5.8%	4.9%	25.9%	1.0%	7.5%	1.2%	4.1%	4.5%	4.5%	10.1%	9.4%	6.9%	8.6%
2017 proj.	1,922	5.6%	5.9%	4.8%	26.2%	1.0%	7.7%	1.2%	4.2%	4.4%	4.5%	9.9%	9.3%	6.7%	8.4%
Age 18+															
2007	4,796	5.3%	6.9%	5.3%	21.4%	1.2%	6.6%	1.1%	3.2%	4.7%	5.0%	11.6%	9.2%	7.8%	10.7%
2012 proj.	5,665	5.2%	7.4%	5.2%	21.5%	1.1%	6.7%	1.1%	3.5%	4.4%	5.2%	11.4%	9.4%	7.6%	10.3%
2017 proj.	6,490	5.1%	7.7%	5.1%	21.5%	1.0%	6.8%	1.1%	3.6%	4.3%	5.3%	11.2%	9.5%	7.6%	10.1%
Age 65+															
2007	3,226	5.1%	7.5%	5.6%	19.3%	1.2%	6.2%	1.1%	2.9%	4.8%	5.3%	12.3%	9.0%	8.1%	11.6%
2012 proj.	3,856	4.9%	8.1%	5.4%	19.4%	1.1%	6.3%	1.1%	3.2%	4.4%	5.5%	12.0%	9.4%	8.0%	11.2%
2017 proj.	4,568	4.9%	8.4%	5.3%	19.6%	1.0%	6.4%	1.1%	3.3%	4.2%	5.6%	11.8%	9.6%	8.0%	10.9%
Age 65-74															
2007	799	5.2%	7.6%	4.8%	17.8%	1.4%	6.8%	1.5%	3.5%	5.1%	5.3%	11.8%	9.6%	8.0%	11.7%
2012 proj.	1,002	5.4%	7.7%	4.9%	18.3%	1.2%	6.7%	1.5%	3.7%	4.8%	5.4%	11.5%	9.6%	8.0%	11.2%
2017 proj.	1,256	5.5%	7.5%	5.2%	19.1%	1.1%	6.7%	1.5%	3.7%	4.7%	5.3%	11.3%	9.7%	8.0%	10.8%
Age 75-84															
2007	1,191	4.8%	7.6%	5.9%	17.8%	1.3%	6.4%	1.2%	2.8%	4.9%	5.3%	12.8%	9.2%	7.5%	12.5%
2012 proj.	1,287	4.6%	8.3%	5.4%	18.0%	1.2%	6.5%	1.2%	3.3%	4.6%	5.5%	12.4%	9.6%	7.5%	11.8%
2017 proj.	1,477	4.8%	8.5%	5.0%	18.2%	1.1%	6.6%	1.3%	3.6%	4.4%	5.7%	12.1%	9.8%	7.6%	11.5%
Age 85+															
2007	1,236	5.2%	7.2%	5.7%	21.7%	1.0%	5.6%	0.8%	2.5%	4.5%	5.4%	12.2%	8.5%	8.9%	10.6%
2012 proj.	1,568	4.9%	8.3%	5.7%	21.1%	0.9%	5.9%	0.7%	2.8%	3.9%	5.6%	12.0%	9.1%	8.5%	10.6%
2017 proj.	1,835	4.7%	9.0%	5.6%	21.0%	0.9%	6.1%	0.7%	2.8%	3.7%	5.7%	11.8%	9.4%	8.3%	10.4%

[1]LTC Needs defined as requiring the help of another person to perform 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:

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Table 3b

Distribution of Community Residents with LTC Needs[1] by County, 2007, 2012 proj., and 2017 proj.
Individuals Needing Assistance with 2+ ADLs, by Age Group
People 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															
2007	94	5	6	5	21	1	8	1	4	5	5	10	8	7	8
2012 proj.	99	6	6	6	22	1	9	1	4	5	5	10	9	7	8
2017 proj.	105	6	6	6	24	1	10	1	4	5	6	11	9	7	8
Age 18-64															
2007	1,569	91	88	76	404	17	115	18	62	72	69	161	149	110	137
2012 proj.	1,809	103	105	88	469	19	135	21	74	82	81	182	171	124	155
2017 proj.	1,922	108	114	93	504	20	148	23	81	85	87	190	179	128	161
Age 18+															
2007	4,796	254	329	255	1,027	56	316	53	155	227	240	559	441	373	511
2012 proj.	5,665	294	419	296	1,216	60	380	63	198	250	292	646	532	433	586
2017 proj.	6,490	333	500	334	1,398	65	442	73	232	276	341	728	618	493	657
Age 65+															
2007	3,226	163	241	180	622	39	200	35	93	155	171	398	292	263	374
2012 proj.	3,856	191	314	208	747	42	244	42	124	168	212	464	362	309	431
2017 proj.	4,568	225	386	241	894	45	294	50	151	191	254	537	439	365	496
Age 65-74															
2007	799	42	61	39	142	11	54	12	28	40	42	94	77	64	94
2012 proj.	1,002	54	77	49	184	12	67	15	37	48	54	116	96	80	113
2017 proj.	1,256	69	95	65	240	14	85	18	47	59	67	142	122	101	135
Age 75-84															
2007	1,191	57	91	70	212	15	77	14	34	58	63	153	109	90	149
2012 proj.	1,287	60	107	69	232	15	84	16	43	60	71	160	123	96	152
2017 proj.	1,477	70	126	74	268	16	97	19	53	65	84	178	145	112	170
Age 85+															
2007	1,236	64	89	71	269	13	69	9	31	56	66	151	106	109	132
2012 proj.	1,568	77	130	90	331	14	93	11	44	61	87	189	143	133	166
2017 proj.	1,835	86	165	102	386	16	112	13	52	67	104	217	173	152	191

[1]LTC Needs defined as requiring the help of another person to perform 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:

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Table 3c

Proportion of Community Residents with LTC Needs[1] of Age-Specific Community Population by County, 2007, 2012 proj, and 2017 proj.
Individuals Needing Assistance with 2+ ADLs, by Age Group
People 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															
2007	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2012 proj.	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
2017 proj.	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Age 18-64															
2007	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
2012 proj.	0.4%	0.4%	0.5%	0.5%	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	0.4%	0.4%	0.4%
2017 proj.	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
Age 18+															
2007	1.0%	0.9%	1.1%	1.1%	0.8%	1.1%	0.9%	0.9%	0.8%	1.0%	1.2%	1.1%	1.0%	1.0%	1.1%
2012 proj.	1.1%	1.0%	1.4%	1.2%	1.0%	1.1%	1.0%	1.0%	1.0%	1.1%	1.4%	1.3%	1.1%	1.2%	1.2%
2017 proj.	1.2%	1.1%	1.7%	1.3%	1.1%	1.2%	1.1%	1.0%	1.1%	1.1%	1.6%	1.4%	1.3%	1.3%	1.4%
Age 65+															
2007	3.8%	3.6%	3.9%	4.0%	4.0%	3.5%	3.7%	3.1%	3.0%	3.8%	4.1%	4.0%	3.8%	3.9%	3.8%
2012 proj.	3.9%	3.5%	4.4%	4.1%	4.0%	3.3%	3.8%	2.8%	3.2%	3.5%	4.4%	4.1%	4.0%	3.8%	3.8%
2017 proj.	3.8%	3.3%	4.7%	3.9%	3.8%	3.1%	3.7%	2.6%	3.1%	3.2%	4.4%	4.0%	3.9%	3.6%	3.7%
Age 65-74															
2007	1.8%	1.7%	1.8%	1.7%	1.7%	1.8%	1.8%	1.7%	1.6%	1.8%	1.8%	1.8%	1.8%	1.7%	1.8%
2012 proj.	1.7%	1.6%	1.9%	1.7%	1.7%	1.7%	1.7%	1.6%	1.6%	1.7%	1.9%	1.8%	1.8%	1.7%	1.7%
2017 proj.	1.7%	1.6%	2.0%	1.7%	1.6%	1.6%	1.7%	1.5%	1.5%	1.6%	1.9%	1.8%	1.7%	1.6%	1.7%
Age 75-84															
2007	4.3%	3.8%	4.1%	4.4%	4.3%	4.0%	4.2%	4.0%	3.6%	4.3%	4.6%	4.6%	4.4%	4.0%	4.5%
2012 proj.	4.4%	3.9%	4.8%	4.4%	4.4%	3.8%	4.4%	3.7%	4.0%	4.1%	4.9%	4.7%	4.7%	4.1%	4.5%
2017 proj.	4.4%	3.9%	5.2%	4.4%	4.3%	3.7%	4.5%	3.5%	3.9%	3.9%	5.0%	4.7%	4.8%	4.1%	4.4%
Age 85+															
2007	11.9%	11.5%	11.8%	12.4%	13.2%	11.0%	12.3%	11.0%	8.6%	12.0%	12.2%	11.7%	10.7%	12.8%	10.9%
2012 proj.	13.1%	11.9%	14.6%	13.2%	13.7%	10.1%	13.7%	10.0%	10.6%	11.3%	14.1%	13.1%	13.3%	13.8%	12.0%
2017 proj.	13.7%	12.1%	16.2%	13.8%	13.8%	9.4%	14.5%	9.3%	11.3%	11.1%	15.3%	13.9%	15.0%	14.4%	12.7%

[1]LTC Needs defined as requiring the help of another person to perform 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 2000 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 report.

Table 4

Actual and Projected Users of Long Term Care Services in Vermont, 2007, 2012, and 2017[1]
Selected Programs/Services, Point in Time

				Growth Rates	
	FY 2007 Actual	FY 2012 Proj.	FY 2017 Proj.	2007-2012	2012-2017
Nursing Facilities (All payers)[2]	3,118	2,934	2,822	-6%	-4%
Enhanced Residential Care--Choices for Care	264	361	454	37%	26%
Residential Care--ACCS (Medicaid State Plan)	588	756	909	28%	20%
Residential Care--Private Pay	1,135	1,467	1,771	29%	21%
Assisted Living (All payers. Incl's 27 ACCS & 11 ERC)	238	324	403	36%	24%
Personal Care--Choices for Care	1,114	1,425	1,727	28%	21%
Respite/Companion--Choices for Care	783	996	1,203	27%	21%
Traumatic Brain Injury Program	63	71	75	13%	5%
Case Management--Choices for Care	1,463	1,884	2,293	29%	22%
Case Management--Older Americans Act	1,783	2,304	3,047	29%	32%
Attendant Services Program (ASP)	253	308	351	22%	14%
Adult Day (All payers)	681	869	1,064	28%	22%
Homemaker Services	776	993	1,205	28%	21%
Home Delivered Meals--VCIL (age < 60)	245	286	307	17%	7%
Mental Health and Aging (Eldercare Clinician Program)	275	355	442	29%	25%

[1]Individuals may use more than one service. Residents of Nursing Facilities, Residential Care-Private Pay and Assisted Living represent an average daily census. The Nursing Facility numbers were derived by averaging quarterly MDS resident counts whereas the numbers of Residential Care-Private Pay and Assisted Living residents were derived from a point-in-time census count done in June 2007. User counts for all other services represent the average number of individuals with use during a month. The FY 2007 Medicaid program data are derived from EDS paid claims on date of service; other FY 2007 program data are derived from reported program use. Age distributions for Adult Day were extrapolated from EDS data; age and county distributions for GF Homemaker were extrapolated from EDS data; both were applied to their respective provider service counts. FY 2005 Adult Day counts were cumulative. From FY 2006 forward, HASS is subsumed into the Homemaker Program, and Case Management-CFC includes Moderate Needs Group. Assisted Living counts include ACCS and ERC. Prior to FY 2006, ACCS counts included ERC. Respite includes Companion Services from FY 2005 forward. Mental Health & Aging counts were cumulative prior to FY 2006. Counts represent the user's current county of residence.

Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

[2]Nursing Facility residents include Wake Robin but exclude Arbors and Mertens. Lamoille County: The Manor's ERC-funded nursing facility residents are included from Feb 1, 2007 forward.

Table 5

Actual and Projected Use[1] of Long Term Care Services in Vermont by Program by County, 2007, 2012, and 2017

Selected Programs/Services

Point in Time

	Vermont[2]	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
FY 2007 Actual															
Number of Users															
Nursing Facilities (All payers)[3]	3,118	102	493	154	518	0	210	0	83	28	246	388	411	208	278
Enhanced Residential Care--Choices for Care	264	20	9	0	41	0	51	1	5	19	12	29	26	15	36
Residential Care--ACCS (Medicaid State Plan)	588	12	33	28	55	18	53	2	27	17	55	116	108	24	40
Residential Care--Private Pay	1,135	31	185	30	325	5	67	0	63	51	45	87	149	61	36
Assisted Living (All payers. Incl's 27 ACCS, 11 ERC)	238	0	0	0	28	0	0	0	0	0	0	57	0	42	111
Personal Care--Choices for Care	1,114	87	50	75	227	19	103	19	44	54	76	109	82	65	106
Respite/Companion--Choices for Care	783	76	30	55	149	17	78	15	20	43	62	74	49	45	70
Traumatic Brain Injury Program	63	2	1	4	3	0	2	1	7	4	4	13	15	2	5
Case Management--Choices for Care	1,463	108	69	87	290	19	167	20	46	64	93	151	109	89	151
Case Management--Older Americans Act	1,783	67	161	127	250	32	113	20	72	69	110	199	195	179	189
Attendant Services Program (ASP)	253	8	9	9	39	0	19	4	13	9	10	62	33	19	19
Adult Day (All payers)	681	139	46	79	63	10	54	5	50	33	30	26	43	46	57
Homemaker Services	776	58	80	29	126	18	40	2	79	15	17	180	75	22	35
Home Delivered Meals--VCIL (age <60)	245	12	15	26	54	2	16	2	9	8	5	31	33	14	18
Mental Health and Aging[4] (Eldercare Clinician Program)	275	29	17	29	46	0	24	0	0	0	0	38	53	39	0

[1]Individuals may use more than one service. Residents of Nursing Facilities, Residential Care-Private Pay and Assisted Living represent an average daily census. The Nursing Facility numbers were derived by averaging quarterly MDS resident counts whereas the numbers of Residential Care-Private Pay and Assisted Living residents were derived from a point-in-time census count done in June 2007. User counts for all other services represent the average number of individuals with use during a month. The FY 2007 Medicaid program data are derived from EDS paid claims on date of service; other FY 2007 program data are derived from reported program use. Age distributions for Adult Day were extrapolated from EDS data; age and county distributions for GF Homemaker were extrapolated from SAMS data; both were applied to their respective provider service counts. FY 2005 Adult Day counts were cumulative. From FY 2006 forward, HASS is subsumed into the Homemaker Program, and Case Management-CFC includes Moderate Needs Group. Assisted Living counts include ACCS and ERC. Prior to FY 2006, ACCS counts included ERC. Respite includes Companion Services from FY 2005 forward. Mental Health & Aging counts were cumulative prior to FY 2006. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

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

[3]Nursing Facility residents include Wake Robin but exclude Arbors and Mertens. Lamoille County: The Manor's ERC-funded NF residents are included from Feb 1, 2007 forward.

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

Table 5

Actual and Projected Use[1] of Long Term Care Services in Vermont by Program by County, 2007, 2012, and 2017

Selected Programs/Services

Point in Time

	Vermont[2]	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
FY 2012 Projected															
Number of Users															
Nursing Facilities (All payers)[3]	2,934	97	459	146	509	0	201	0	72	30	232	359	376	195	259
Enhanced Residential Care--Choices for Care	361	26	16	0	56	0	74	1	7	21	17	40	37	21	47
Residential Care--ACCS (Medicaid State Plan)	756	15	46	34	70	20	72	2	37	19	74	147	140	31	49
Residential Care--Private Pay	1,467	38	253	37	411	6	91	0	87	57	60	110	193	80	44
Assisted Living (All payers)	324	0	0	0	38	0	0	0	0	0	0	81	0	57	149
Personal Care--Choices for Care	1,425	107	74	92	285	20	134	22	63	60	104	138	113	81	132
Respite/Companion--Choices for Care	996	94	46	68	187	19	101	18	29	48	84	94	67	56	88
Traumatic Brain Injury Program	71	2	1	4	3	0	2	1	8	5	5	15	17	2	6
Case Management--Choices for Care	1,884	133	105	108	368	21	214	24	66	71	128	195	149	113	190
Case Management--Older Americans Act	2,304	84	235	155	324	34	150	24	101	76	150	257	259	219	236
Attendant Services Program (ASP)	308	9	12	11	47	0	23	5	17	10	12	75	43	22	22
Adult Day (All payers)	869	166	70	98	80	11	70	6	75	36	41	33	57	58	68
Homemaker Services	993	72	116	36	158	19	48	2	110	17	24	224	96	27	43
Home Delivered Meals--VCIL (age <60)	286	14	19	31	63	2	19	2	11	9	6	36	38	16	21
Mental Health and Aging[4] (Eldercare Clinician Program)	355	35	27	35	59	0	31	0	0	0	0	47	73	49	0

[1]Individuals may use more than one service. Residents of Nursing Facilities, Residential Care-Private Pay and Assisted Living represent an average daily census. The Nursing Facility numbers were derived by averaging quarterly MDS resident counts whereas the numbers of Residential Care-Private Pay and Assisted Living residents were derived from a point-in-time census count done in June 2007. User counts for all other services represent the average number of individuals with use during a month. The FY 2007 Medicaid program data are derived from EDS paid claims on date of service; other FY 2007 program data are derived from reported program use. Age distributions for Adult Day were extrapolated from EDS data; age and county distributions for GF Homemaker were extrapolated from SAMS data; both were applied to their respective provider service counts. FY 2005 Adult Day counts were cumulative. From FY 2006 forward, HASS is subsumed into the Homemaker Program, and Case Management-CFC includes Moderate Needs Group. Assisted Living counts include ACCS and ERC. Prior to FY 2006, ACCS counts included ERC. Respite includes Companion Services from FY 2005 forward. Mental Health & Aging counts were cumulative prior to FY 2006. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

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Table 5
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Selected Programs/Services
Point in Time

	Vermont[2]	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
FY 2017 Projected															
Number of Users															
Nursing Facilities (All payers)[3]	2,822	96	434	138	509	0	197	0	72	29	223	338	356	187	244
Enhanced Residential Care--Choices for Care	454	31	22	0	70	0	95	1	9	24	23	50	47	26	57
Residential Care--ACCS (Medicaid State Plan)	909	18	57	40	84	21	90	3	44	21	91	177	168	39	56
Residential Care--Private Pay	1,771	47	312	43	496	6	114	0	103	62	74	133	232	98	50
Assisted Living (All payers)	403	0	0	0	48	0	0	0	0	0	0	102	0	71	182
Personal Care--Choices for Care	1,727	128	98	110	345	22	165	25	76	68	129	165	142	97	157
Respite/Companion--Choices for Care	1,203	112	60	81	224	20	124	20	36	54	104	112	84	67	105
Traumatic Brain Injury Program	75	2	1	5	4	0	3	1	9	5	5	15	18	2	6
Case Management--Choices for Care	2,293	159	140	129	447	22	261	27	81	81	160	235	188	137	226
Case Management--Older Americans Act	3,047	113	302	203	446	41	201	32	124	100	194	335	350	295	310
Attendant Services Program (ASP)	351	10	13	12	52	0	27	5	20	11	14	86	51	24	24
Adult Day (All payers)	1,064	198	92	117	98	11	87	7	93	42	52	41	72	72	81
Homemaker Services	1,205	87	150	43	192	21	56	3	134	19	31	269	118	32	50
Home Delivered Meals--VCIL (age <60)	307	14	21	33	68	2	21	2	12	9	7	38	41	17	22
Mental Health and Aging[4] (Eldercare Clinician Program)	442	42	36	42	74	0	39	0	0	0	0	56	93	60	0

[1]Individuals may use more than one service. Residents of Nursing Facilities, Residential Care-Private Pay and Assisted Living represent an average daily census. The Nursing Facility numbers were derived by averaging quarterly MDS resident counts whereas the numbers of Residential Care-Private Pay and Assisted Living residents were derived from a point-in-time census count done in June 2007. User counts for all other services represent the average number of individuals with use during a month. The FY 2007 Medicaid program data are derived from EDS paid claims on date of service; other FY 2007 program data are derived from reported program use. Age distributions for Adult Day were extrapolated from EDS data; age and county distributions for GF Homemaker were extrapolated from SAMS data; both were applied to their respective provider service counts. FY 2005 Adult Day counts were cumulative. From FY 2006 forward, HASS is subsumed into the Homemaker Program, and Case Management-CFC includes Moderate Needs Group. Assisted Living counts include ACCS and ERC. Prior to FY 2006, ACCS counts included ERC. Respite includes Companion Services from FY 2005 forward. Mental Health & Aging counts were cumulative prior to FY 2006. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

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