RESIDENTIAL ALTERNATIVES
FOR PEOPLE ACCESSING HOME & COMMUNITY-BASED SERVICES

A Report Prepared by
Aspire Living & Learning
2096 Airport Rd., Barre, VT 05641

For the
Vermont Department of Disabilities, Aging and Independent Living

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Executive Summary

Vermont was one of the earliest states to offer community-based residential services for people with disabilities. Today, through the Global Commitment to Health 1115 Waiver, thousands of older Vermonters and those who experience disabilities are supported in their own homes, or in small home settings, to a larger extent than in many other states. The waiver authorizes Medicaid funded long-term care services in community-based settings (HCBS).

At the same time, gaps remain. Self-advocates, their families, and those who support them are seeking new housing models that support the full community engagement, choice, and control that federal regulations require, and that Vermonters envision for themselves.

At the request of Vermont's Department of Disabilities, Aging, and Independent Living (DAIL), Aspire Living & Learning undertook research on alternative residential options that could fill those gaps in the settings and services available to people accessing residential services through the Global Commitment to Health 1115 Waiver.

Three residential pilots for people experiencing intellectual or developmental disabilities (IDD) are being tested at this time. We anticipate that they will provide additional guidance about the feasibility of different types of models for this population. However, Aspire's research encompasses not just those with (IDD), but older people, people experiencing physical disabilities, people with brain injuries, and people who are Deaf, Hard of Hearing, or DeafBlind who also seek to have more and different housing options to meet their needs and goals.

Aspire began our work by collecting input from stakeholders. We conducted an online survey and held in-person as well as virtual meetings. We interviewed stakeholders, including advocates, individuals, families, service providers, and DAIL employees in both individual and small group meetings. The findings included the need for housing for people with IDD who want to live more independently in their own homes, people with IDD with significant support needs who want a more permanent housing/support solution than shared living, housing that is accessible for people with sensory challenges and supported by people with communication/ASL skills, options specialized for people with brain injury, and emergency or transitional housing for older adults and people with physical disabilities.

A team of 20 Aspire subject matter professionals employed a variety of methods to identify alternatives to meet these need areas. Some potential alternative programs and best practices were identified in the stakeholder interviews. All team members reached out to their networks, as well as leaders of innovative programs already known to Aspire, to identify additional alternative residential models. Aspire also conducted a literature review of published research to gain more insight into evidence-based alternatives. These efforts identified recently recognized best practices and promising practices in residential services for each population.

Leaders at each of the potential alternatives were contacted. Only a small number did not respond to our request to meet. Aspire interviewed leaders from 22 providers of potential residential alternatives using a standard set of questions. Based on their responses, a rubric was completed outlining the most important features that would indicate a program would meet the needs of Vermonters. Elements were scored for each program as to whether it likely does, possibly does, or likely does not meet a Vermont need. Based on this rubric, Aspire is recommending several programs and best practices for DAIL's consideration.

Given Vermont's demographics and significant workforce shortage, new workers need to be attracted to the state to fill in the position that will be created, not only by an aging population, but also the increasing numbers of students with autism who will be reaching adulthood and needing services. We outline a number of strategies for doing so and recommend that the workforce task force pursue this option. Aspire recommends that DAIL examine the feasibility of technical assistance to hire foreign nationals into the workforce.

Aspire's recommendations include the following. First, incorporate a number of best practices into the design and implementation of current shared living models. While it is clear that alternatives are also needed, with 75% of people with IDD and 5% of older adults receiving Medicaid long-term care in adult family care, this model is going to be a significant part of the Vermont landscape moving forward. Compared to other states, Vermont funding may be under-invested in this option. Additional funding will be needed to increase provider compensation and also to strengthen the system to address the concerns of service participants.

Aspire also recommends that DAIL join forces at every possible juncture with the housing community to advocate for as much funding, flexibility, and partnership as possible to increase the supply of housing in Vermont. There is no alternative program that will address the needs of people accessing HCBS without additional housing for both participants and direct support staff. We recommend bringing Universal Design to the forefront of housing conversation to ensure that new and renovated housing is accessible to and inclusive of as many people as possible.

To this end, Aspire's primary housing recommendation is for a model called Main Street Apartments located in Rockville Maryland. This project separates housing from services. The project was built using universal design and was funded through public and private means. It is tied to the Main Street Connect program, which is an inclusive membership organization that operates programs and public spaces on site and is open to anyone, not just residents. Within this setting, any type of support model is possible – including supportive housing, shared living, staffed living, or remote supports – for any waiver population.

Aspire also recommends that DAIL actively pursue remote supports and smart technology as a Technology First state. This approach is being used by a number of states to ensure that teams are considering the role that technology could play in each person's supports. Remote supports are the only alternative to current services that would not be more expensive or require a more direct support workforce than is currently offered.

For all people seeking services that involve living with another person, whether paid or unpaid, Aspire urges DAIL to consider a roommate matching process statewide. Integrating a support for matching and choice across the system would be a truly innovative step forward for the people served. It would also break down the silos between programs, and remove the

inappropriate assumption that people are best sorted by disability instead of interest and compatibility.

Finally, Aspire identifies and describes programs for each waiver population that would likely increase choice for these groups and fit within the current regulatory environment. Some require more investment than others, whether because of the associated costs or regulatory variances needed. In an appendix, we include a listing and description of all models explored, including those we did not recommend because they did not appear to address Vermonters' needs or because they presented regulatory or other challenges.

It has been our pleasure and privilege to get to know Vermont better and to explore innovation nationwide. We thank DAIL and every stakeholder and provider for their contributions to this project.

Le'Ann Milinder

Senior Director of Strategic Initiatives

Rebecca Hamilton

Chief of Adult Services

Lou Giramma

CEO

Organization of the Report

This report is organized into several sections. We begin by describing our methods and findings with regard to stakeholder input. We then describe our process for identifying alternative residential options and best practices. The full list of all alternatives can be found in Appendix A. We then present our findings, including both best practices and specific programs for consideration. Specific programs are divided into several categories: those that apply to all populations, and those that apply to each of the four populations identified by DAIL.

Some Key Take-Aways Detailed in This Report

- DAIL should support access to technical assistance to providers interested in employing foreign nationals. Legal assistance and fees add up quickly, so having a state resource would assist providers looking to determine the feasibility of this approach for their situation.

- New models of service are not likely to be viable, scalable, or sustainable if they add significantly to the demands on the direct support workforce without providing either the housing or living wages that would support new workers coming to Vermont. Some employers are responding directly to this need by developing workforce housing.

- DAIL should continue to join forces at every possible juncture with the housing community to advocate for increased funding, flexibility, and partnership to increase the supply of housing in Vermont.

- Universal Design should come to the forefront of the housing conversation to ensure that new and renovated housing is accessible and inclusive of as many people as possible.

- Vermont should become a Technology First state to ensure that all who can benefit from remote supports and enabling technology have access to them; support the expansion of Howard Center's Safety Connection model.

Recommended Alternative Residential Models

Aspire recommends that DAIL support the following services and models. Full recommendations begin on p. 25.

- For All Groups
  - Facilitate a statewide housemate matching process
  - Strengthen the shared living model to address stakeholder concerns
  - Coordinate the development of a statewide inclusive social network
  - Offer technical assistance for replication of the Main Street Apartments in Maryland
- For people who are Deaf, Hard of Hearing, or DeafBlind
  - Fund continuation of the SSP program at Vancro
  - Consult with Life Connections in New Hampshire to create a specialty within shared living
  - Explore with providers the possible replication of PAHrtners Deaf Services in Pennsylvania
- For people experiencing Intellectual or Developmental Disabilities
  - Support the replication of the individualized housing model offered by KFI in Maine
- For people with brain injury
  - Explore with providers the possible replication of the ABI home model operated by Aspire and others in Massachusetts
- For older people and people with physical disabilities
  - Facilitate a partnership that could replicate the CASS supportive shelter in Arizona
  - Explore with providers the development of a Green House Project home for interim housing

Table of Contents

Stakeholder Input

Methods

Aspire utilized a variety of methods to collect input from stakeholders.

To kick off the project, Aspire interviewed DAIL staff on 8/7/23 regarding the specific aims of the project. Interview questions for stakeholders were developed, and these were piloted with DAIL staff in an interview on 9/15/23.

Six in-person public input sessions were offered across the state: Brattleboro, Rutland, Bennington, Barre, Burlington, and Newport. All meetings were held in public libraries with accessible facilities, except for Barre, which occurred at Aspire's accessible offices. Accessibility options including ASL interpretation and live captioning were offered. The meetings were publicized through direct email to all email addresses provided by DAIL, as well as in social media posts. Plain language emails were sent on 9/7/23 with encouragement to share the email widely to recipient networks. Two follow-up emails were sent as well, on 9/13/23 and on 9/18/23, and the meeting notice was posted on LinkedIn, Twitter/X, and Facebook on 9/15/23, with a reminder on 9/18/23. Paid social media ads ran 9/13/23 to 9/28/23 for the public input meeting. The meetings were not well attended, with two having no attendees at all.

Included in all emails and social posts were links to an online survey, which remained open until 11/21/23. Survey questions can be found in Appendix A.The survey was re-opened in December with no additional respondents. Social media ads promoting the survey also ran October 27 to November 10. Survey participants were asked if they wanted to participate in a focus group. The 11 who responded yes were invited to participate in an online session, which occurred on 11/14/23. A handful of other respondents were identified by referral and interviewed individually in virtual meetings.

Aspire also held a series of six virtual meetings for providers from 9/21/23 to 10/4/23. A total of 15 providers attended these sessions. They were organized by population focus: older adults and physical disabilities, IDD, Deaf, Hard of Hearing, and DeafBlind and brain injury. Two meetings were designated "all providers" as well.

Survey Results

A total of 66 people responded to the online survey. The respondents were evenly split between providers (33) and individuals or their friends/family members (33).

ANSWER CHOICES	RESPONSES	
I have residential services now	9.09%	6
I want residential services in the future	9.09%	6
I have a friend or family member who has or wants residential services	31.82%	21
I provide services	50.00%	33
TOTAL		66

While there was some overlap in questions, the survey routed respondents to separate question sets based on this distinction. Results for each group are reported separately. Respondents who identified as a friend or family member were asked to answer based on the experience of the person with a disability.

Individuals, Family Members and Friends

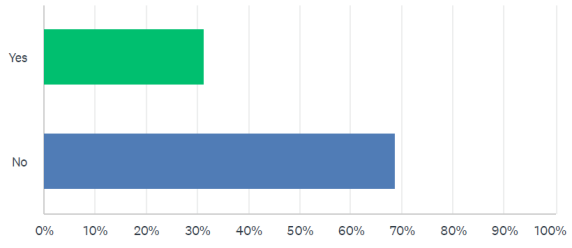
The large majority of individuals described their interest in the survey as people experiencing intellectual or developmental disability. There were a handful of people expressing interest in each of the other populations. Data for each population is described later in this report in the description of each recommended model. Combined results are reported here.

ANSWER CHOICES	RESPONSES	
Older people (age 65+)	9.09%	3
People experiencing Intellectual or Developmental Disability	84.85%	28
People who have a Brain Injury	12.12%	4
Deaf, Hard of Hearing, or Deaf-Blind	18.18%	6
People experiencing Physical Disability	24.24%	8
Total Respondents: 33		

Most respondents selected the family home as the current residential setting. A small number lived in their own home, in a staffed home, or in shared living. A majority of respondents wanted a different residential choice for the future.

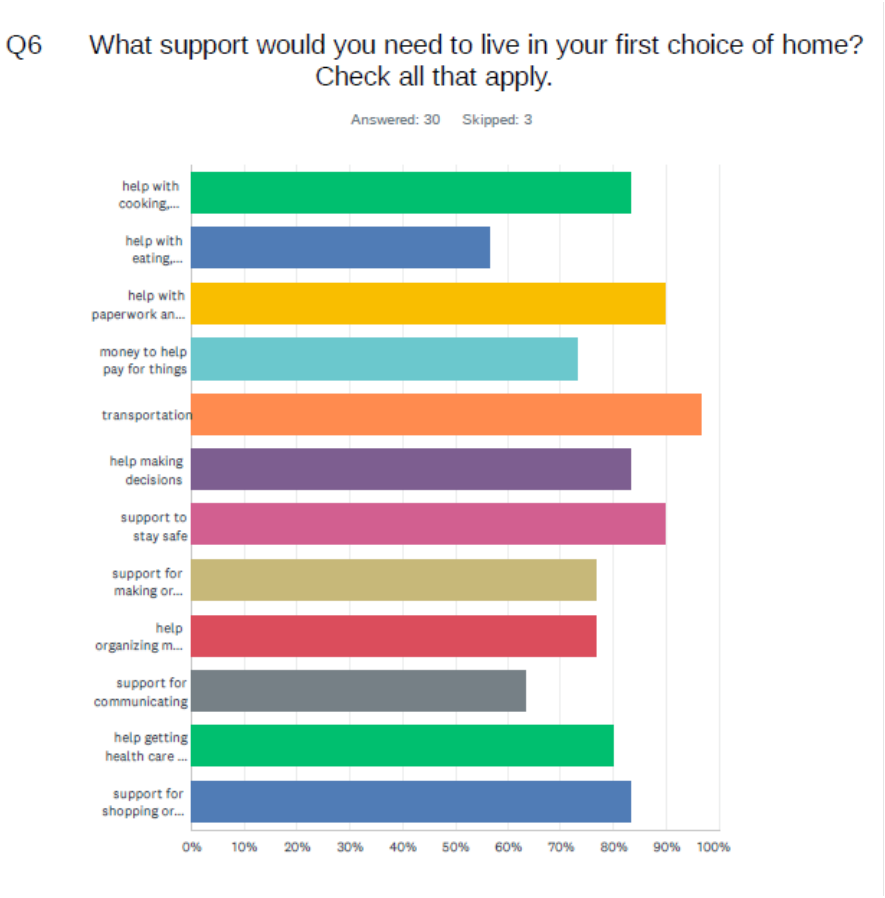
Q4 Is your current home your first choice for where to live in the future?

Answered: 32 Skipped: 1

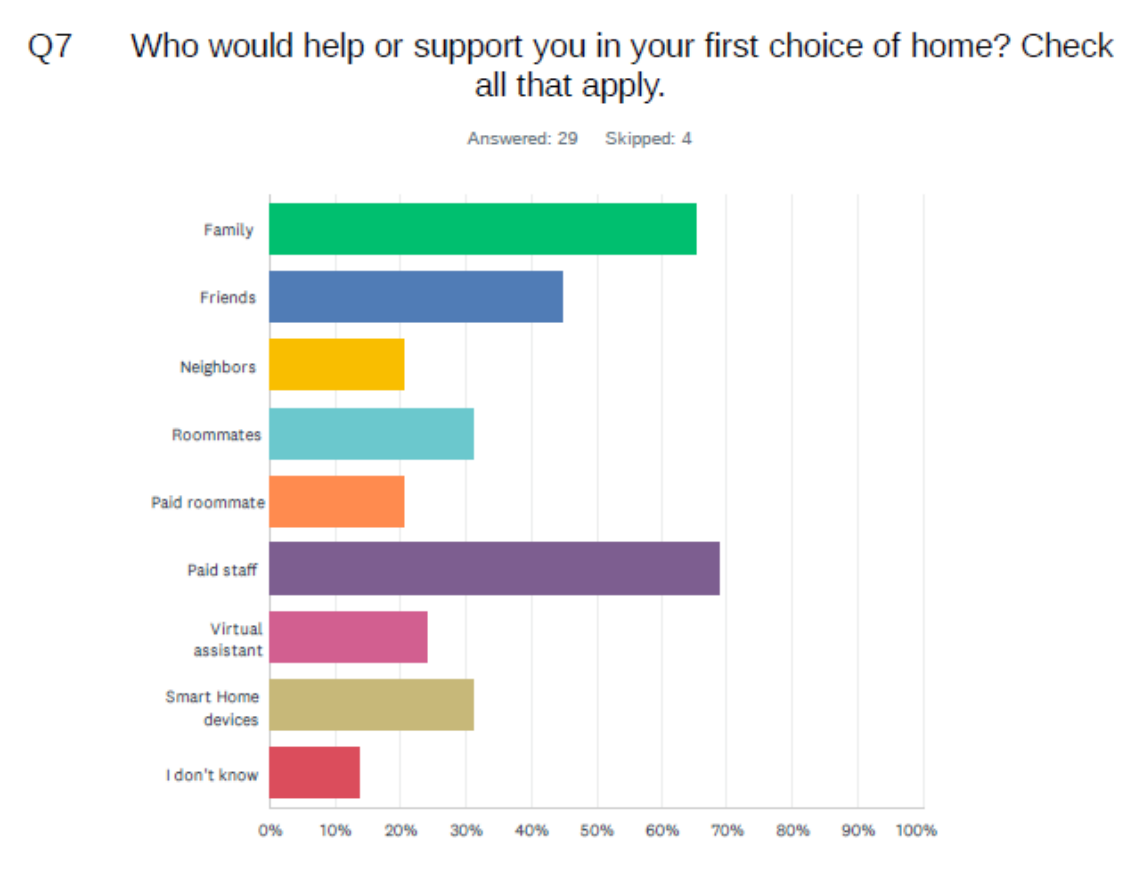


The 23 respondents who answered “no” to their current residence as a first choice were asked about their first choice for housing, and 19 answered the question. Of these, four focused on having their own place, either independent or semi-independent. Twelve mentioned living in a setting with friends, peers, or other people with disabilities. The three other responses were: with family, Burlington, and having options to choose from.

Respondents endorsed a full range of support needs. For 90% or more of respondents, supports to stay safe, help with paperwork/forms, and transportation were needed. Even the least reported need (help with eating, bathing, or dressing) was selected by more than half.



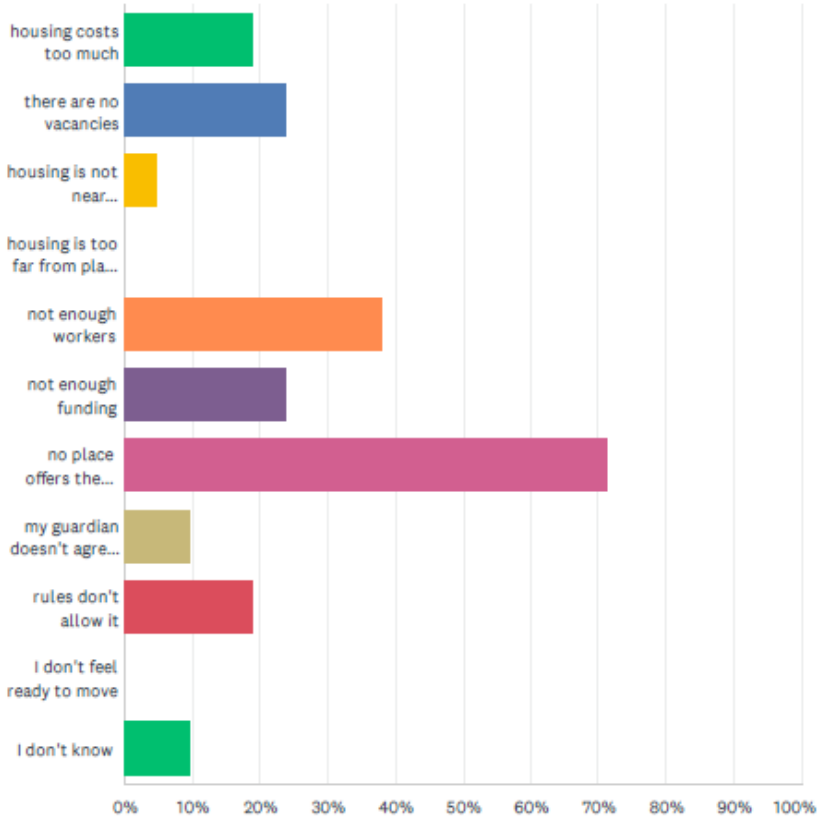
Paid staff and family members were the top choices of respondents for who they would want to support them in their preferred home.



By a large margin, respondents felt that no provider offered the residential option - they were looking for. A smaller number felt that a lack of staff was preventing them from accessing their preferred option.

Q9 Why isn't your first choice of home available now?Check all that apply.

Answered: 21 Skipped: 12



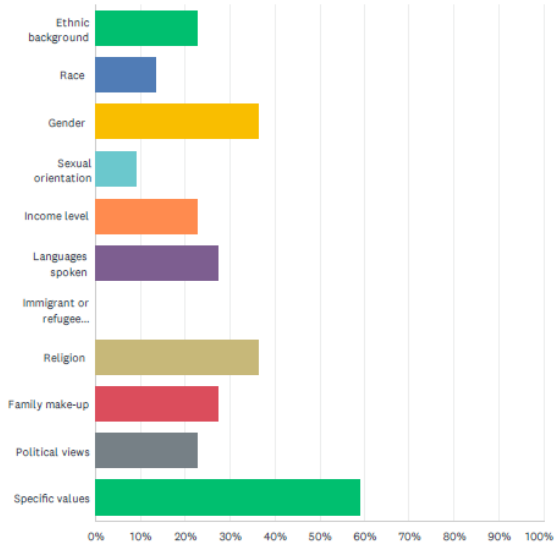
When asked what accommodations they would need in their preferred home, respondents selected a variety of supports. The most common were written materials read aloud and assistive technology to access the phone, computer, or internet. Every option was selected by at least two people.

ANSWER CHOICES	RESPONSES	
None of the above	23.08%	6
interpreter	7.69%	2
supporters who are fluent signers	15.38%	4
assistive technology to access the phone, computer or internet	38.46%	10
other assistive technology	30.77%	8
translation of written materials	19.23%	5
written materials read aloud	46.15%	12
wheelchair or mobility accessibility	26.92%	7
modified appliances	11.54%	3
modified smoke or gas alarms	11.54%	3
Total Respondents: 26		

Cultural factors endorsed most frequently as being important in their home were specific values, gender, and religion. All factors were endorsed by at least two people, except immigrant or refugee status.

Q11 What parts of culture are important to you in your home?Check all that apply.

Answered: 22 Skipped: 11



A composite of responses can be characterized by the following: People with IDD prefer a residential setting with peers that is not currently offered in Vermont, that is sensitive to their specific values, where they would have family and paid staff support them, and where they could access assistive technology. This does not capture the full range of responses, but it is a meaningful pattern within the data.

DDC provides a more detailed perspective in their report (p.15), “The Arc and the Council on Quality and Leadership (CQL) released a housing report in 2019 that underscores the need for more independent housing options in the community that are accessible and affordable. Another theme echoed by the findings in this research brief is that often parents and family caregivers are looking for more secluded, disability-only living environments, where adults with I/DD are more interested in living in their own homes.”

Providers

Thirty-three people identified themselves as providers. Providers serving all populations were represented, with the smallest number from the Deaf, Hard-of-Hearing, DeafBlind category (DHHDB)

ANSWER CHOICES	RESPONSES	
Older people (age 65+)	45.45%	15
People experiencing Intellectual or Developmental Disability	63.64%	21
People who have a Brain Injury	30.30%	10
Deaf, Hard of Hearing, or Deaf-Blind	18.18%	6
People experiencing Physical Disability	39.39%	13
Total Respondents: 33		

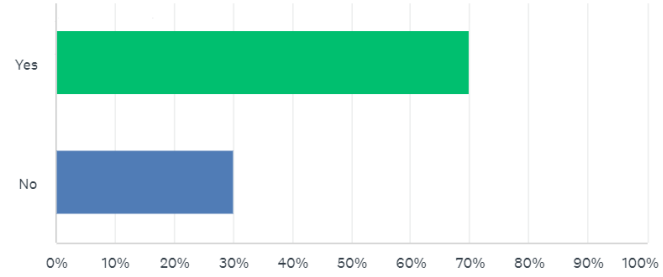
More providers than not chose not to identify the type of agency they represented, with only 15 of 33 answering this question.

ANSWER CHOICES	RESPONSES	
Designated Agency	60.00%	9
Specialized Services Agency	13.33%	2
Provider Agency	0.00%	0
Case Management	13.33%	2
Other (please specify)	13.33%	2
TOTAL		15

Of the 11 designated and specialized service agencies who responded, only seven indicated that their organization wanted to provide new housing options.

Does your organization want to provide new housing options?

Answered: 10 Skipped: 1



The remaining survey questions for providers were open-ended. Themes in the answers are summarized below.

What are the biggest gaps? There were 12 responses to this question. Providers identified the need for: Services for disabled people who are homeless or at risk of being homeless, i.e. living in a hotel or living in an unhealthy situation.

More access to services in a variety of housing situations, including emergency services; accessible locations; services for people who pose a risk to self or others; intensive case management; and as needed services (not 24/7).

More independent and permanent housing options, both rural and urban, where people receive support to increase independence.

More affordable and available housing

More choice of service models, including supporting more than three people in an unlicensed setting, alternatives to shared living, paid family caregivers, options for Deaf and Hard-of-Hearing; assistive technology, Pod housing, and a home of your own.

Accessing housing resources by partnering with housing organizations, accessing funds for low-income housing, accessing federal housing funds.

How does the VT system create opportunities to try new models? There were 10 responses to this question, six of which were “unknown” or “does not.” The remaining responses acknowledged DAIL’s openness to, and recognition of, the need for change and creativity. Funding for pilots was appreciated, and ongoing funding identified as a need. One agency noted that they are developing new models now with their “housing partners.”

Meeting results - DAIL

On 9/15/23, Aspire met with representatives of DAIL. These included Jennifer Garabedian, Angela Smith-Dieng, Angela McMann, Laura Siegel, Julie Abrahamson, and Carolyn Bowen. They identified the gaps in Vermont's residential HCBS options.

Deaf, Hard-of-Hearing, Deaf-Blind. There is only one program in the state of Vermont for people who are deaf. There is a new sensory program coming online in a few weeks. A big gap is the availability for American Sign Language (ASL) interpreters and ASL classes for Direct Support Professionals (DSPs) and other direct care workers. Deafness is often a hidden disability, and there is no good data about the population in Vermont. There is no pay differential for direct support staff who are proficient in ASL.

Choices for Care. There is a need for temporary and transitional housing, especially for people who are homeless and in need of personal care and disability support. There is a need for a place between the hospital or rehabilitation and home where they can be temporarily for stabilization. This situation is needed if a provider terminates shared living without giving notice or if the person is in an emergency situation such as fleeing abuse.

Intellectual & Developmental Disabilities (IDD). Shared living makes up the bulk of services, at 75% of residential placements, but doesn't serve everyone well. Other alternatives have been developed in unique situations that are costly and time consuming to create. People want more independent options. There has been work done in this area: The housing report from the Vermont Developmental Disabilities Council and Green Mountain Self-Advocates identified a number of possible models, including supportive housing and intentional communities.

Brain Injury. The issues of this population are similar to those of the IDD population. Shared Living is the only option if you are not living on your own. This is accessed through Choices for Care if the injury is significant enough. People with brain injuries would like to see permanent supportive housing with more ongoing rehabilitation.

Barriers to address. There are barriers that make it difficult to implement both existing and innovative models. The most significant of these is the workforce shortage of direct care workers, where the crisis is at a critical level in Vermont. Additionally, it is a long, complicated process to build new services into the waiver, so generally they are relying on pilots, which can become more costly than if these services were built into the waiver. Fee-for-service models are more difficult to implement when individuals share staff and with new federal requirements for electronic visit verification. Licensing can be a barrier as well when meeting the requirements for licensing requires many additional expenses. Finally, given the population numbers and rural settings in Vermont, it can be difficult to achieve economy of scale.

Focus of the Aspire report. DAIL requested that Aspire provide specific input to inform their movement forward. While cost effectiveness is important, they did not want cost to limit the solutions we propose. DAIL expressed their commitment to finding solutions by reviewing and revising the system of care. The project goal is to identify sustainable solutions that can be replicated across the state, that are less reliant on a strained workforce, and are manageable in terms of policy and fiscal impacts.

Meeting results – People Accessing Services, Families and Advocates

Seven people were interviewed in person and four were interviewed virtually. Those interviewed included family members and advocates for the IDD, and older adults and physically disabled populations. One individual who utilized assistive technology attended a meeting but did not comment. The main themes of these conversations were aligned with what DAIL presented as areas of need and system change: housing affordability, housing availability, as well as accessibility and regulatory barriers. Because these themes also appear in the provider interviews, we combined these comments across stakeholder groups and discuss them in the sections on p. 19.

There were additional concerns that were more specific to individuals with IDD. One person commented about the number of people with IDD who are living with elderly parents who may not be connected to the service system. . The person talked about how their sibling had been living independently until their mother, who was the primary support, died. They had no knowledge of services available, and ultimately the sibling quit their job and became the home provider. Others reported a fear of being homeless because of shared living being their only choice.

Two types of housing alternatives were mentioned by people with lived experience: 1) living in their own apartment alongside people without disabilities with sufficient supports for autonomy and safety; and 2) being able to live in a more intentional community focused on support for complex needs and building social connection. Two people specifically mentioned that technology was not helpful in their family member’s situation.

The individuals whose interest was older adults and people with physical disabilities shared some of the concerns of those reported in the Age Strong VT Listening Sessions 2023 report. Because of the limited number of individuals responding in this category, this project relied on the findings in this report to inform our choice of models that could meet the needs of Vermonters.

One difference in the comments between these two projects was the strong focus on older adults being able to afford care among those we spoke to. One concern was that eligibility for benefits and services causes significant hardship to the spouse prior to receiving any help. A system that included a sliding scale and not just a cut-off for benefits was suggested. The isolation and difficulty of being a caregiver was also paramount. Another suggestion was to offer the option of assisted living for couples when only one person is disabled to relieve some of the caregiving burden while keeping the couple together.

At one session, which no family members or individuals attended, the interpreter observed that there are several gaps that need to be addressed for people who are deaf or use ASL. They reported a need for more complete data on this community, more interpreters in the state, better access to training for the general public and caregivers to learn sign language, and increased awareness of a newer tactile sign language approach, Protactile, for people who are DeafBlind.

There were no family members or individuals identifying with the brain injury population in attendance at in person or virtual interviews. For the purposes of this report, we relied on the input of the brain injury service providers and the online survey results.

Meeting Results – Service Providers

Representatives of the Designated Agencies, as well as providers of services to all the target populations, attended these interviews. A total of 12 of these stakeholders were interviewed, all virtually.

Across all providers two themes were clear. First, their capacity to respond to the need for alternative housing models is hampered by the lack of affordable, accessible housing across the state of Vermont: “The housing crisis is insane.” Second, the ongoing workforce crisis is just as difficult: “Program staffing is at 50%.” Both of these issues are well known to DAIL and policy-makers in Vermont. As a result, some providers are less willing to take risks in developing new models and programs: “The overhead and conflicts to providing new services is not sustainable most of the time.” “Staffing would be a huge problem in providing new services.” Additional details around these and other themes are described in the relevant sections below, where comments were similar across stakeholders.

There were some differences in concerns by provider types. Providers of brain injury services shared the concerns above but were also tied directly to concerns about homelessness and service eligibility. They report that with the end of the hotel voucher program some people with brain injury have been “lost” and are currently unhoused. “This population can be very

dysregulated and sensory overload and become loud and agitated and can be deemed an issue." Shelters may not be an option for some with sensory issues resulting from their injury: "Shelters are not an option because of the environment of a shelter – too loud, too many people, too bright, too chaotic." Despite their brain injury preventing them from accessing independently the housing and services they need, they don't meet the eligibility for residential services, either financially, clinically, or due to the timeframe for the injury. When they do qualify, the choices are extremely limited, with only shared living options or just one 5-bed group home for people with brain injury. They are not seeing people coming off the waiting list. Case management for the brain injury program is paid at a lower rate than case management for other populations, reducing the availability of this service as well. There is also significant overlap with other needs, such as substance use, suicidality and other mental health issues, that can make navigating services more difficult.

Common Themes Across All Stakeholder Groups

Lack of Housing

The lack of housing units across the state affects service delivery from many angles. When housing is available, the cost is out of reach for people with disabilities who rely on SSI. Medicaid does not normally pay for room and board costs. Available housing is also out of reach for the people who provide the services, whether they are direct care employees or shared living providers. As one provider said, "We share a bedroom because we can't afford a bigger place. Even if we could afford it, we couldn't find one."

Parents spoke of wanting children to keep their community and have housing that supports their complex needs enables them to live with or near friends they have from high school. This desire is indicative of the need for varied, affordable housing in communities throughout the state. People do not want to move for care.

Providers had numerous comments about affordable housing:

- "Programs are more reactive than proactive. It's years for section 8 and a mad dash when opened. We need more low-income housing."
- "Please designate housing money for our folks."
- "2nd & 3rd homes are compounding the problem."
- "Towns don't want to lose tourist room & meal tax if a hotel is converted."
- "Many places have few services available, especially in the south of the state."
- "Depending on where you live infrastructure would be a huge deterrent."
- "There is funding for homeless populations – the people we serve will never meet the standards of 'homeless' if we are doing our job."
- "There is no funding to renovate a house to be supportive of the aging IDD population."

Providers are unable to locate housing for people they already serve with existing models of support. Providers are unable to develop alternative models without access to additional housing. A report prepared by the Vermont Developmental Disabilities Council and Green Mountain Self-Advocates estimated that as many as 600 new units of housing are needed for the IDD population alone. This is an area that many are reluctant to enter: “The provider needs to focus on what they are designed to do. “We do not want to be all of the entities (landlord, purchasing properties, managing the infrastructure of the property) we just want to provide the service.” Many partnerships will be needed to bring service providers and housing developers together. As one stakeholder put it, we “need some intermediary organizations to bridge housing and providers.”

Some providers are more open to partnering and have a number of observations about housing. One said, “There is a good housing organization in Burlington however, IDD is not on their radar. It’s a gap.” “Downstreet has affordable housing in Waterbury offering a sliding scale.” Providers also see potential in accessory dwelling units and the conversion of commercial spaces like malls and hotels. Stakeholders would like to see easier access to subsidized housing partnerships with local housing authorities in conjunction with DAIL. “As a provider we need to see that the creative ideas are supported and financially sustainable.”

Accessibility

Stakeholder concerns with accessibility and cultural competence were varied and intertwined.

Transportation was consistently identified as an issue that impacted both. Services cannot be accessed in many cases without transportation. Additionally, people may require access to transportation to culturally important activities and communities. “Transportation is an issue – even in shared living when providers won’t drive them – to cultural events, music, church, special Olympics.

ADA-compliant housing is scarce and if found may be unaffordable. “If we have 20 [shared living] providers who might be available, only 2 or 3 will have accessible homes.” One strength of the system is that all individuals have an accessibility assessment done.

Regarding culturally and linguistically appropriate services, VT excels at striving to be person-centered. This is part of various agencies’ strategic plans. Vermont participates in a national initiative building a Community of Practice on Cultural and Linguistic Competence in Developmental Disabilities. Challenges in ensuring the use of plain language and the availability of translated written materials remain.

Stakeholders report that it’s hard to find and access ASL interpreters. “This is a high-cost service, which is a burden. This is not supported through the waiver.”

Stakeholders don’t feel their cultural values are always centered. For example, “Faith is very important to her – sometimes she gets shut down when she brings it up instead of guiding her to

talk about it." This person's religious community is very supportive of them, but the family member was not aware of any connections between the faith community and the designated agency. Another stakeholder pointed out that when people's sensory needs can be seen as an issue instead of an important component of the environment for that person.

Regulatory Factors

On the positive side, stakeholders report that "there has been a lot of turn-over in leadership. This has created an openness in change and open to new ideas" and "there is a supportive legislature for our community." So there is some optimism that change to address their concerns is possible. Others are concerned that change will be slow in coming.

Some providers would like to see opportunities in the next waiver renewal for remote and virtual services. Good internet is still a struggle in the northeast kingdom and far south, but the situation is improving. DAIL has contracted with a person who conducts accessibility assessment and provides referrals for assistive technology for the individual.

Providers reported that funding is an issue in several ways. Funding for many current services is not high enough to adequately compensate staff and providers. Some models won't qualify for funding at all. Other desired models will be more expensive and require more funding throughout the system.

Regulations can sometimes be a barrier: if an individual in a licensed house needs more medical intervention but want to remain there; authority to pay parents to support their sons and daughters; the restrictiveness of local zoning around the state; narrow eligibility for services.

A few providers mentioned the need for immigration reform at the federal level and state support for looking at the VISA process to bring people to work in programs in Vermont.

Shared Living Concerns

Virtually everyone interviewed agreed that the shared living model is overused in Vermont for I/DD services.

The most prominent concern about shared living is that the person accessing services is typically the one who moves when the provider gives notice. However, it was noted by one parent, that a group of parents had set up a non-profit to lease properties to their children's home providers, where they had now lived in a stable housing situation for 25 years despite changing providers.

However, problems with shared living can start from the beginning. Good home providers can be difficult to recruit. Those who would like to come to Vermont to become providers, or who need a bigger home, face the same housing shortage as everyone else.

As a result, there may be little choice and minimal preparation. "There's no help for making good matches" and "Matching is wholly inadequate." Another said "Shared living is not being

practiced in an individualized way. There are people who section off the house and create lots of restrictions. A non-vegan in a vegan household. No friends allowed to visit. It's critically important to have the checks and balances."

One provider reported that shared living works better when there were clear expectations for all prior to the move about what sort of relationship there would be and how everyday life would work, but that this does not happen often enough. Training for providers is reported to be less than adequate. One provider noted, "I need more training as a home provider – after seven years, I'm still not entirely sure who is supposed to do what."

Family members of people with significant needs noted that shared living can be warehousing of people with higher support needs without actually teaching them. "These adults could be doing more."

Some stakeholders reported that shared living providers need more support, "they're not a part of something – they need community. They're just out there in the breeze." The impression was that provided are monitored for compliance more than supported. Incentives and education, or special bonuses, were suggested, as was creating a network for providers and giving them a voice in the system.

Finally, one person reported the person they support "didn't want goals – just to do what she does. There's lots of paperwork, and the goals don't always make sense. It's just not a natural way to talk."

Selection of Providers of Alternative Residential Services

Provider Selection Process

A team of 20 Aspire professionals used a variety of methods to identify residential alternatives that might meet the needs and gaps described by stakeholders. A few potential alternative program and best practices were identified in the stakeholder interviews.

Aspire team members also reached out to their networks, as well as to leaders of innovative programs already known to Aspire for their input. Aspire conducted a literature review of published articles relevant to each waiver program to gain more insight into evidence-based alternatives. The literature review included a number of Vermont reports on the extensive work that has been done previously in this area, as well as state plans and reports that would provide context for the comparison rubric.

These efforts identified potential best practices and promising practices in residential services for each population. Aspire then contacted or followed up with these providers to collect the data needed to complete the comparison rubric. Interview questions can be found in Appendix B, and provider interview contacts in Appendix C.

Rubric

Based on the needs, interests, gaps, challenges, practices and opportunities discovered during the research, Aspire developed a rubric for categorizing and prioritizing alternative programs to enable comparison across models. The spreadsheet can be found in Appendix D. This rubric includes four broad categories: Model Parameters, Participant Experience, Workforce, Provider Experience, and Regulatory & Legal Factors.

“Model Parameters” includes population served, years of operation, type of housing, funding source, number served, number of locations, and utilization of existing housing stock. This was the simplest section to score and all programs reported on this section.

“Participant Experience” includes whether the program addressed unmet needs, was in compliance with the setting rule, offered a choice of roommates, offered a choice of staff/supporters, control of the daily routine, environmental accommodations, and availability of outcome data. This section was of highest importance to quality of life for people served, and most programs reported on this section. However, certain questions were not applicable in all cases.

“Workforce” reports the number of Direct Support Professionals (DSPs) for each person served, whether additional training is required above the standard, current vacancy rates and turnover,

impact on workforce shortage, DSP wage versus median in the state versus other DSPs, recruiting DSPs out of state, whether housing is offered to DSPs, and whether wages are sufficient for DSP housing. Many providers did not answer these questions as directly or specifically as they did questions in the previous sections, although a few did.

“Provider Experience” describes whether there is sufficient margin for stability and investment, whether expenses are predictable, whether revenue is predictable, whether any special management or infrastructure is required, start-up costs, atypical expenses, and whether the program fit within the states existing payment models. Response completeness to these questions varied, with most providers not commenting specifically on margin. Aspire examined individual 990s for non-profits when available to gain some sense of the financial footing of each provider.

“Regulatory & Legal Factors” notes whether any new rules or laws led to the program’s development, whether regulations, laws, or funding models were changed to accommodate the program, and whether the program has been replicated outside their state. In most cases, programs were developed without requiring modification to existing rules or laws, and within the funding sources available in their state. Some programs were the direct result of rule changes made previously.

The rubric is laid out visually in a spreadsheet to enable the reader to see broadly how different providers scored in each category, as well as look more closely at the detailed distinctions. Each question in each category was scored as one of four colors, with one question/aspect per row:

- Gray – insufficient data. The provider did not answer the question or did not know the answer
- Red – may not meet VT needs. **It is very important to note that this is not a judgment of the value or appropriateness of the program’s practice,** only that it appears unlikely to address the stated needs of Vermonters based on the information provided
- Yellow – may meet VT needs. This aspect of the program may address stated needs, but not completely or not in a demonstrated way
- Green – likely meets VT needs. This aspect of the program likely addresses the needs or concerns presented by stakeholders.

By organizing categories in sections of rows on the spreadsheet, the reader can look across the provider columns and see in a broad way which programs might best address Vermont needs within a particular category. Programs that are predominantly green would be the strongest. Those with significant red and gray colors would be less of a good fit. The spreadsheet shows the entire rubric. Programs are shown in columns organized by the populations they serve. Note that models that appear in the rubric but are not highlighted in the next sections of this report are described in Appendix E.

Recommendations that Support All Models

In the course of our work it has become apparent that there are three factors which will play a role in the success of the service system moving forward. As such, we felt it was important to address these in our findings before introducing the specific models.

Workforce

Vermont is looking to reduce its reliance on shared living, but few models are less demanding on the workforce overall than shared living. As such, expansion of the workforce will be a foundation on which the expansion of residential options will stand. We present our findings related to workforce for consideration by the workgroups tasked with strengthening Vermont's workforce across the state.

Vermont's State Plan on Aging stated the problem succinctly: "Across the LTSS system, service providers report serious staffing shortages, limiting their ability to serve current participants or new participants. Shortages are impacting long-term care facilities' ability to admit new residents, home health agencies' ability to provide personal care and homemaker services, Authorized Agencies' ability to find shared living home providers, and Adult Days' ability to increase census capacity. People self-directing services also have difficulty hiring independent caregivers." (p.40)

The demand for workers in this field is likely increasing as Vermonters age. Vermont has the third highest percentage of residents over the age of 65, at 21.7% in 2022 (KFF State Health Facts). In 2021,13.5% of Vermont's population had a disability according to the Annual Disability Statistics Compendium.

The workforce shortage in human services has been well documented both nationally (see ANCOR's State of the American Direct Support Workforce Crisis) and in Vermont (Vermont Care Partners 2023 brief). Workforce is both a long-standing issue (for example, see 2019 NCI staff stability report – 30% turnover among DSPs in VT) and an accelerating crisis when combined with an unemployment rate that continues to track below the national average at 2.1% (see Vermont labor market data).

Employing Foreign Nationals

Virtually all of Aspire's proposed models require access to a workforce to implement. While the reasons for the workforce shortage are multi-faceted, one challenge is simply that the number of workers in Vermont is less than the number of positions available. According to the U.S. Bureau of Labor Statistics, there were 0.3 people looking for work for each job opening in Vermont as of July 2023.

Lack of affordable workforce housing and competitive wages will need to be addressed also, but one solution is to increase the number of foreign nationals eligible to work in the U.S. who are living and working in Vermont.

Nationally, business leaders and some states are calling for a reduction in the time asylum applicants must wait before being eligible for a work permit. Federal legislation, the H.R.1325 - Asylum Seeker Work Authorization Act of 2023, has been proposed (see Pingree) to make this change. A number of other immigration reforms could address the DSP workforce crisis as well (see Clark, 2021).

In our work, Aspire is increasingly seeing interest among providers in employing foreign nationals as an element of a workforce solution. However, provider agencies have little or no expertise in navigating this area of employment law. Aspire recommends that DAIL examine how it might support technical assistance to providers interested in employing foreign nationals. Legal assistance and fees add up quickly, so having a state resource would assist providers looking to determine the feasibility of this approach for their situation. While each employer will need to seek its own legal counsel, an introduction to the topic is included in Apprendix F.

The Housing Shortage

Both the person accessing services and the workforce needed to support them are affected by Vermont's severe shortage of affordable housing. Vermont's housing vacancy rate is among the lowest nationwide, ranging from 0.5% to 3% across the state at the start of 2023, according to Vermont's point-in-time-count report by Chittenden County Homeless Alliance and the Vermont Coalition to End Homelessness. Aspire recommends that DAIL join forces at every possible juncture with the housing community to advocate for increased funding, flexibility, and partnership to increase the supply of housing in Vermont. *There is no alternative residential program that will address the needs of people accessing residential services without additional housing stock for both participants and direct support staff.*

We applaud the creation of the Residential Program Director position to focus on the coordination and technical assistance for expanding housing and residential services options for individuals with developmental disabilities. One resource in this domain that may be a model for Vermont is the Maryland Inclusive Housing organization, https://mih-inc.org/. As a result of a Maryland Department of Developmental Disabilities initiative, this nonprofit was formed to help "people with Intellectual and Developmental Disabilities (IDD) successfully access and maintain inclusive, affordable, and accessible housing of their choice by creating opportunities, identifying resources, connecting people and providing services." The Maryland Inclusive Housing organization provides a comprehensive online platform of resources as well as community housing case managers to people with IDD and their families.

At the same time, there are a number of housing opportunities and practices that apply to all populations (see our recommendations starting on p. 25). We urge DAIL to consider how the new position can facilitate innovation across departments—both to avoid duplication and to develop models and practices that provide universal access.

Housing for Workers

Beyond demographics, low direct care wages deepen the crisis. With DSP wages averaging $17 to $23 per hour statewide (based on figures from Indeed) many DSPs would fall below 50% of AMI in wealthier areas such as Burlington, where $19.12/hour puts you below the very low-income limit for a single person. A wage of $21.84 does so for a two-person household (see Burlington HUD income limits). According to a recent Harvard report on housing for older adults (p. 28) in 2022 nationwide “43 percent of these [direct care] workers, mostly women of color and immigrants, relied on public assistance such as Medicaid, food and nutrition assistance, or cash assistance that year.”

New models of service are not likely to be viable, scalable, or sustainable if they add significantly to the demands on the direct support workforce without providing either housing or living wages that would support new workers coming to Vermont.

Some employers are responding directly to this need by developing their own workforce housing. This housing may be integral to the model or separate housing dedicated to the workforce.

Waypoint - Maine

Waypoint in Maine has begun providing housing for their workforce of direct support professionals. Waypoint has served adults with autism and intellectual or developmental disabilities for over five decades throughout southern Maine. Their adult programs include residential and day program services, remote support, employment support, adult case management and outpatient therapy. Residential programs provide services from shared living to intermittent in-home support, to group homes offering care 24/7.

Waypoint’s housing initiative began a few years ago when properties the organization owned, but was not using for services, were converted to housing for DSPs and shared living arrangements. These first opportunities worked out well. Waypoint then bought an eight-unit apartment building and gradually moved in DSPs. They worked with existing tenants to transition slowly, along with an early return of security deposits and waiving of the last month’s rent to ease the move. In August of 2023, they bought a 24-unit building and have transitioned about a third of the units to workforce housing. It’s been 18 months since they began this initiative, and they have had zero turnover among DSPs renting their units.

The rents are established at low market rates to avoid being taxed as a benefit. Waypoint includes all utilities in the rent, so tenants have only one predictable housing cost per month. They have helped some employees match up to become roommates, to lower their individual rents. Currently, Waypoint manages the properties. Their business manager oversees the financial side, and a director of maintenance lives on-site, rent-free. They are vigilant about keeping the landlord and supervisor roles separate—and this can be a challenge.

Waypoint worked with the city of Sanford, where the units are located, to keep them apprised of their projects. They would have preferred to have built a new property, but the cost far exceeded what they could spend. They purchased the properties with cash from their reserves, but otherwise would have used market financing. They did not want to work with a developer to create low-income housing because of the restrictive requirements.

Gateways Community Services – New Hampshire

Gateways Community Services in Nashua, NH, is a large non-profit serving nearly 3,000 children and adults with disabilities, children with Autism, and aging adults in need of long-term care. Gateways is partnering with the city of Nashua to develop a site that will offer apartments in the same building to DSPs and individuals accessing services .

Gateways owns a property near downtown Nashua that has been used as a group home for 23 years. The property requires significant maintenance and upgrades that are not financially viable even in the current real estate market. However, the location is near the city center, allowing residents to walk to many activities and easily interact with other people.

The plan for the property involves demolishing the current structure and constructing an apartment building with a capacity of six to 10 units, pending zoning modifications. Gateways is working on this project with NeighborWorks Southern New Hampshire to assist with project development. The preliminary development budget is $2–3 million, depending on the number of apartments. Gateways aims to address the apartment cost issue by allocating a percentage of units to clients and offering another portion to its workforce at lower market rental rates. Gateways has committed to raising the funds needed through grants, government programs, loans, and development activities.

PadSplit – 15 States

Another housing option for workers is now available in 15 states through a new app-based service called PadSplit. https://www.padsplit.com/

Living in a PadSplit is different from traditional rentals. Members only pay one bill each week, and it covers a private furnished room, all utilities, and free credit reporting. To be approved, a person doesn't need a minimum credit score, and doesn't have to pay a big security deposit. PadSplit reports membership payments to help members build their credit histories and improve their credit scores. According to the website, 95% of PadSplit members have seen an

improvement in their credit score. On average, members save $420 a month while living in a PadSplit, allowing members to purchase a car, and pay off their credit cards.

PadSplit does not currently have listings in Vermont. However, their model is one that could benefit low wage workers by providing another income option for homeowners who currently use their property for short-term rentals.

Housing for People Accessing Services

There is substantial variability in the willingness and ability of provider organizations to address the need for additional affordable housing units for people accessing services. Some agencies have already developed successful partnerships with housing agencies, utilizing a variety of approaches.

Housing vouchers are a key piece of the puzzle. The DDC report (p. 34) noted that “Importantly, half of the respondents (4) [nonprofit affordable housing providers] reported that they already provide housing “set asides,” which is a key strategy used in other states to support the development of supportive housing; and all but one said that they would be willing to do this. In the comments, one respondent said they would be willing to “master lease” affordable units to their local designated agency. In this scenario, the master lease would give the agency control over who rents the units, as well as the responsibility of supporting those tenants.”

One program on which DAIL could consider partnering with housing authorities is incentivizing landlords to make existing units available for project-based rental assistance vouchers. Contracts can be made for up to a 20-year timeframe, a period which may address individual and family concerns about permanency.

The DDC report also notes that “individuals with IDD and housing support through Section 811 vouchers can successfully share an apartment, an approach Vermonter self-advocates expressed interest in.” (p.69) The Vermont State Housing Authority confirms that people accessing rental assistance can share an apartment, albeit subject to different formulas. When people can choose to live together, there is more efficient use of staff and resources.

Partnerships for bringing new housing on line will also be an essential feature of a successful plan for expanding residential housing options. As was mentioned earlier, the DDC report estimated about 600 units would be needed just for people with IDD. Significant numbers of units for people transitioning from the COVID-era hotel program will also be needed. Building bridges between the provider community and the many housing organizations in Vermont will be essential to ensuring that the Low-Income Housing Tax Credit (LIHTC) is prioritized for people with disabilities.

Additionally, cultivating a variety of partnerships will build awareness and momentum for accessing both governmental and non-governmental opportunities. These include programs such as 504 home repair projects and construction of Accessory Dwelling Units. Expanding awareness of the availability of private capital from non-profit partners such as CIL

(https://www.cil.org/) may also facilitate construction projects. CIL is a Connecticut-based nonprofit that partners with other nonprofits to construct accessible, community-based housing that has recently expanded its geographic reach. CIL builds or renovates homes to agency specifications and then leases to service providers under long-term capital lease arrangements. CIL secures all of the financing, and service agencies are not required to contribute any equity towards the development. At the end of the lease term, CIL donates the property to the service provider.

Universal Design

We recommend bringing Universal Design to the forefront of the housing conversation to ensure that new and renovated housing is accessible and inclusive of as many people as possible. Universal Design is the creation of an environment so that it can be accessed, understood and used to the greatest extent possible by all people regardless of their age, size, ability or disability.

While individual projects specific to disability can fill some gaps, focusing on disability specific locations ultimately limits choice. To the extent that developers and homebuilders incorporate universal design in all they do, people have the flexibility to live where and how they choose. Universal Design is referenced in Vermont's Age Strong roadmap (p.39).

Vermont ACCD's Homes for All toolkit project honors the traditions of Vermont towns and how they have traditionally been designed and organized (see the Homes for All 2024 report). The toolkit will highlight "Missing Middle" homes that are rooted in historical development patterns and diverse and affordable housing choices in existing, walkable neighborhoods. These homes designs include accessory dwelling units (ADUs), duplexes, multi-household buildings, and neighborhood-scale mixed-use buildings. This diversity of housing in a walkable community is exactly what many people with disabilities are looking for. We urge DAIL to work with project leaders to center Universal Design in its priorities to ensure that all people can be included in these settings and age in place as their needs change.

A design option that may provide some urgently needed accessibility to existing homes is the use of add-on accessible spaces, including bedrooms, bathrooms and kitchens. Wheel Pad is an award-winning Vermont-based business that offers fully accessible dwellings that can attach to an existing home or can stand alone. The dwellings are built off-site and can be installed quickly. DAIL is currently incorporating Wheel Pad into one project for people experiencing homelessness, and Aspire recommends that DAIL consider how Wheel Pad could expand accessibility more broadly. https://www.wheelpad.com/

Shared Living and Adult Family Care

Stakeholders frequently mentioned that they see shared living as an overused option in I/DD services. More precise data is needed about the number of people who would continue to choose shared living if the model were updated to address stakeholder concerns, versus how many would pursue a different option regardless. Overuse was not a concern raised about Adult Family Care. Given the similarity of the two programs, however, Aspire's recommendations may benefit both services.

The DDC report (p. 25) noted that some service providers believed that 20-50% of those they work with would choose a less restrictive living arrangement than shared living. However, even if half of those currently utilizing shared living chose other options when they become available, many people will still be utilizing shared living to take advantage of the stable relationships, typical life experiences, and strong community connections that can form in this setting. The shared living model is going to be a significant part of the Vermont landscape moving forward. Ensuring the enduring strength of this model is essential to a successful, high quality service system.

Who moves?

As previously mentioned, one expressed concern is that when a shared living provider quits, the person with a disability has to move. When these moves happen suddenly or repeatedly, the person with a disability experiences significant disruption. According to the DDSD FY22 Report (p. 36), 293 safety reviews were conducted that year (a number equivalent to about 20% of the DD population residing in shared living). Not all of these would have been disrupted placements--new people come into services, and sometimes households move together. Reducing this turnover may occur if certain quality issues are addressed. Providing more options for how providers and those they support choose their housing can also make a difference.

The Developmental Disabilities Housing Initiative report noted that Black Mountain Assisted Family Living provides permanent housing for people with developmental disabilities (p. 17). The residents live with Shared Living Providers (SLP) who rent the housing from BMAFL for as long as they are willing and able to provide the needed care. If a SLP is no longer willing to provide the needed care for a resident, the providers leave. With the consent of the guardian, new SLPs move in to support the resident in their permanent BMAFL home. The SLPs are screened and supervised by the local agencies serving the residents with developmental disabilities.

Because stability is one of the biggest concerns regarding shared living, Aspire recommends that DAIL explore the BMAFL model for its scalability to other providers. In the context of a workforce crisis, increasing the viability of shared living by making it more stable will prevent unnecessary demands on an already over-taxed workforce when people move from a foster care arrangement to staffed arrangements.

Aspire also has several recommendations to improve the shared living experience--to make it an attractive choice that meets the needs and expectations for as many people as possible. If the quality of shared living is not maintained, more and more people will migrate to other, potentially more expensive and staff-intensive, options.

Aspire's survey responses and interview participants were primarily family members and advocates for people with disabilities, rather than self-advocates. We therefore relied heavily on the input collected from individuals with developmental disabilities in the DDC report (compiled

by the DDC Council and Green Mountain Self-Advocates) to understand what individuals who advocate for themselves are saying about housing.

Shared Expectations

Self-advocates' comments indicated mismatches in expectations about the placement between the person with the disability and the provider. This was echoed by the providers in the Aspire interviews. The DDC reported:

- “Some felt rules in the place where they live are unfair. Though many of the adults liked living with their shared living provider and had lived there for some time, others reported that they felt they did not have privacy in Shared Living.” (p.6)
- “There seems to be a troubling power imbalance between residents and home providers that surfaces in many different ways, particularly when navigating conflicting interests. (p. 32)

To address this concern, Aspire recommends that DAIL expand upon the lease requirement of the CMS settings rule to include a frank, detailed, and documented discussion of expectations for the relationship and for conflict resolution within the home. Among stakeholders, the same circumstance was reported as desirable by one person, and a real problem for another. For example, some people felt excluded if they lived in an in-law apartment, while others are seeking this kind of arrangement for more independence. Some people are looking to be part of a family--one parent was upset that the provider didn’t take her on vacation with them. Others already have a strong connection to their own family and friends and aren’t looking to become one of the provider’s family. Expectations for the relationship that are shared by both parties are likely more important than which particular expectations are at play. Being careful to set social expectations, as well as discussing how conflicts will be resolved, before the person moves in may prevent unwise matches from occurring.

Even before the lease stage, initial matching of potential providers with people looking for support is a process that can set up the situation for success. Stakeholders reported to us that there is no consistent matching process and that providers are generally hard to find. Aspire recommends that Vermont develop a statewide option for having potential providers (along with all roommates, whether paid and unpaid), participate in the formal matching process we describe in the section below on recommendations for all populations (p.36).

Oversight

Other experiences described by self-advocates indicate a lack of training and oversight. The described behaviors would not be acceptable in any circumstance (DDC report, p.29).

- “My brother was not treated the best…he gets punished a lot, and then he is not allowed to do certain things.”

- A family member described how a shared living provider never learned sign language for a resident who is deaf.
- A resident was not allowed to have sex while living in a shared living placement.

There needs to be a specific expectation regarding the frequency, type, and intensity of oversight that happens in shared living. Additional training in provider responsibilities and how to carry them out is essential.

Social Support

Compliance needs to occur in the context of support for providers. Their 24/7 role can be extremely stressful, especially when supporting people with complex needs. As our stakeholders pointed out, providers often feel like they do not have a voice or a network to rely on. Facilitating contact among providers for networking, socializing, sharing experiences, and respite will help these providers do their best work. Regular gatherings, a dedicated intranet, or other virtual connections could all be utilized.

Finally, even with improvements to their supports, providers are going to end their contract from time to time. This event has the most impact on people for whom the provider is their housing, their DSP, and their social network. If people have the chance to separate those roles, a move is less traumatic. Moving is a very typical life experience in the U.S. According to the U.S. Census, it is estimated that a person in the United States can expect to move 11.7 times in their lifetime. At age 18, a person can expect to move another 9.1 times in their remaining lifetime, but by age 45, the expected number of moves is only 2.7. The Harvard report noted that between 2016 and 2021 (omitting 2020), just 5 percent of households ages 65 and older reported that they had relocated in the previous year, as compared to 16 percent of those under 65 (p.10).

While moving can be difficult for anyone, for people without disabilities it doesn't always mean losing everything and everyone when you go.

One way to normalize the impact of moving would be to ensure that the person has access to a social network that does not necessarily involve the provider. For this purpose, Aspire recommends the Main Street Connect program, which brings together community members of all ages and abilities to socialize, learn, and network. This is described in the section below on recommendations for all populations (p.36). People with a rich circle of friends and supporters will experience the loss of a provider in a different way from people for whom the provider and their family are the whole social network.

Provider Specialization

Another approach is to strengthen shared living is to create the opportunity for providers to become specialists who can provide more expertise that addresses specific needs.

For example, a transitional placement could be dedicated to teaching skills intensively and helping the person create the network they will need to move to the next desired living situation (see for example the Essentials for Living Curriculum). For those looking to move from shared living to their own home, this kind of intensive teaching placement could also make it more likely the person would be ready to move to supervised living. Cost Savings from transitions to a less expensive supervised living arrangement could support investment in other models that serve people with more complex needs. Some providers may wish to become specialists in behavioral support for those with severe and challenging behavior. The specialty provider could be given financial incentives for their expertise and effectiveness. This type of program may be a good pilot for value-based payments that provide an incentive for achieving specified outcomes.

Another provider specialization is suggested in the section on models for people who are Deaf, Hard of Hearing and DeafBlind (see p. 49).

Rates

Cost effectiveness is an important value in the Vermont system, and ensuring that tax dollars are spent on necessary, high-quality services is a vital responsibility.

Shared living for people with IDD had an average cost of $41,575 annually in FY2022. This is far more cost effective than group or staffed living as it exists in Vermont today. Adult Family Care rates in Vermont's Choices for Care program have a range of $90.89 to $184.16 per day. If the provider is able to bill 365 days in a year, that is $33,175 to $67,218 annually.

At the same time, services must be funded at a level that enables them to be effective. The waiver (p.16, 3.11) requires "Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment…"

For comparison, Maine's published rates are significantly higher. Even at Maine's lower rate, 325 days of service in a year would be $53,206. At the higher rate, this would be $78,569 (see MaineCare manual). Note also that Vermont has a slightly higher cost of living than Maine, approximately 3%, but its shared living rate is 22% lower than the lowest Maine rate. (see https://worldpopulationreview.com/state-rankings/cost-of-living-index-by-state) In Massachusetts, a FY2021 report noted that the average cost of a shared living placement was $59,099. Note that the cost of living in Massachusetts is 29% higher than in Vermont, but the FY21 average rate is 42% higher than Vermont's average in FY22.

This contrast may be even greater if the level of need of people who are served in shared living is taken into account. Maine and Massachusetts rely heavily on staffed residences for people with high levels of need, an option that has limited beds in Vermont. As rates are reviewed, consideration should be given to the possibility that the higher shared living rates in Maine and Massachusetts are supporting people with fewer needs than some of the people in shared living in Vermont.

Given these comparisons, Vermont may have room to increase its investment in the shared living model. Additional investments should be made to build on the model's proven effectiveness and to address provider retention and other concerns of service participants.

Recommended Alternative Residential Models

Because of the ADA, the Olmstead ruling, and the settings rule, people seeking Medicaid services in the communities have the right to a range of choices of services that can meet their needs. Based on these requirements, the input from stakeholders, and our review of the literature, Aspire offers the following vision.

The Ideal System

The ideal system of care is one where an adult can select the setting of their choice, whether their own home or one with housemates; where they can choose the location that they like; with access to needed supports that range from intermittent to continuous. These services empower a full range of activities of daily living, community engagement, and social connection through communication assistance, physical support, skill teaching, rights advocacy, medical and behavioral health care, and reliable transportation.

The system is envisioned as supporting a life journey, rather than parking people in a destination. The system directs resources to programs that advance measurable, functional skills that enable people to reduce reliance on paid staff whenever possible. By offering a full range of options, people can envision what they want for their lives and move in any direction on a continuum over time as their needs change, just as people without disabilities do. People will not fear reducing their reliance on services on the chance they may need additional services again in the future.

The ideal system offers a full range of choices to all participants for housing provider and service provider. The system allows for the separation of housing choices from provider choices if desired. The system incentivizes partnerships across departments and organizations to create universal, coordinated supports. For all who can benefit from them, the system incentivizes the use of low-staffing models, models that maximize housing stock, and models that provide remote supports.

Based on this vision and the model comparison rubric, Aspire has identified several practices and models that could be utilized with all of the identified populations, which we describe in the next section. Additionally, Aspire has selected programs for each waiver population that could likely increase choice for these groups and fit within the current regulatory environment.

Models for All Populations

Roommate Matching

For all people seeking services that involve living with another person, whether paid or unpaid, Aspire recommends DAIL consider a statewide housemate matching process.

One of the drawbacks of nearly all the programs where housemates are involved is the lack of choice and control by the person over who they will be sharing space with. Few people without disabilities would consent to live with people they did not choose, except as children or in temporary situations like a school dormitory.

Integrating a system for housemate choice and matching across the state would be a real step forward for the people with disabilities. It would also help bridge barriers between programs and remove the inappropriate assumption that people are best sorted by disability, instead of interest and compatibility. Matching people first, then understanding how this match might be supported by the available services, privileges the people involved and their relationship rather than separating them into service system silos.

There are several models for matching people that could be a starting point for Vermonters.

HomeShare -Vermont

Since 1982, the HomeShare program has matched potential housemates with seniors or people with disabilities willing to offer a room in their home at reduced rent in exchange for household help. Home sharing situations are of mutual benefit to both parties.

Of all the models that Aspire has researched, HomeShare offers the most efficient use of existing resources, including best ROI of public funding, maximizing existing housing and reducing the demand on the caregiving workforce. (The program also offers meaningful volunteer staff opportunities. According to their Strategic plan, a 2010 study found that the key benefits for staff volunteers were learning, self-growth and satisfaction. Most of the volunteers are retired professionals, such as social workers, guidance counselors or teachers. This kind of connection is a goal of the Age Strong Vermont plan, see p.17.)

The program currently supports 224 matched participants (including both hosts and guests). HomeShare operates in Chittenden, Addison, Franklin, Grand Isle, Lamoille, Washington, and Orange counties. Expansion into Windsor County is occurring this year.

In FY 2023, the State of Vermont provided $123,200 in state funds and $156,800 of matching federal funds to HomeShare. The rest of HomeShare's $631,809 in revenue came from grants, individual gifts, fees and donated services. HomeShare provided approximately 28,600 hours of assistance to their hosts, allowing Vermonters to save a total of over $991,000. The average rent in a home sharing match was only $378, with 23% of matches paying no rent at all. Homehare guests saved an estimated $510,000 in rental expenses this year.

HomeShare conducts an annual survey of its participants. Last year 95% of hosts were satisfied with the program, and 100% would recommend it to others.

Housemates do not provide all aspects of personal care, but rather they perform household tasks (instrumental activities of daily living) that would be difficult for their host, such as yard work, caring for animals, rides or cleaning. Guests typically do not have disabilities, but there is nothing precluding that if it's a good match. This is a potential area for growth in the model, where people with disabilities use their abilities and strengths to access affordable housing.

The rent goes down as the services offered by the guest go up. The cap on rent is $500-650 depending on location. For a no-rent situation, a reasonable service exchange would be a maximum of 10-12 hours weekly. This works as a landlord tenant relationship, not an employment relationship, and HomeShare is careful to educate all parties in the requirements. However, the model is unique, and a clearer legal status could be helpful. Tenants have housing protections, and employees have labor protections. Legal clarity about the relationship between hosts and guests, protects both by providing guidance specific to home sharing. HomeShare also takes on organizational risk because of the potential for disputes in a match that they facilitate.

HomeShare provides support for the match in a variety of ways. They screen potential guests and hosts with several background checks and interviews to build a resume about key lifestyle factors such as smoking, pets, and interests/passions. They introduce potential matches based on the data collected, who can then choose to meet. After feedback from both sides, the participants may decide to move forward with a match agreement.

The HomeShare case manager creates the agreement to assist the participants to be clear about the expectations of each party. This includes expectations regarding private/common areas of home, rent/utilities to be paid, guests, time away, services to be performed, and notice for termination. The guest starts a two-week trial match (without moving in) prior to signing the agreement and a final decision on the move. The timeframe goal for the whole process is typically six weeks, and therefore, home sharing is not typically an emergency option. An area for growth for the model may be to build program capacity around emergency respite options.

Once the homeshare begins, case managers check-in weekly, then gradually fade out, stopping when participants say they no longer need the support. The average match length is 13 months. Typically, the guest moves away, or the host moves to assisted living or passes away. Hosts can request a new guest when their current guests leave.

HomeShare's stated goal is to expand to the entire state. However, they plan to move cautiously to ensure they continue to have the resources to ensure good matches. They would like to see hosts come on board earlier, before they need a lot of assistance, to develop the relationship with a guest. The model faces some cultural barriers, such as the belief that having a boarder indicates a failure or loss of autonomy, that they hope to overcome with a marketing effort and increasing partnerships with other organizations. Additionally, recruiting hosts in more populated areas is a challenge, with typically three to five times as many potential guests as

hosts in more urban areas. The opposite is true in rural areas that offer fewer jobs and transportation options.

According to their strategic plan, geographic expansion would require:

- a 2-year staffing and funding plan to serve any new geographic area and dedicated funding
- an office, staff and/or volunteers within a reasonable distance to meet with potential hosts and guests
- a local partner such as a non-profit organization in, business, religious group or government agency to invite them into the new area and be willing to offer some type of support such as funding, office space, or help with outreach or volunteer recruitment.

Aspire recommends that DAIL

- Continue to increase funding to HomeShare as needed to support thoughtful expansion. The SFY24 budget includes $200,000 to support expansion this year
- Ensure that all state services for older and disabled adults are aware of HomeShare and know how to refer; and/or consider additional formal referral agreements
- Explore whether there are individuals with disabilities and low incomes who may be interested in home sharing as an alternative to shared living or their own apartments. Given the average length of stay, this could be an interesting transitional option while waiting for a housing voucher or as an intermediate step out of the family home
- Explore whether HomeShare could potentially support more urgent situations, given the number of potential guests waiting for a match. The program could partner with hospital or rehabilitation facility social workers who connect the host's loved ones with vetted guests, such as current direct care workers, who may have relevant experience. Those guests who are good matches could be ready to take over household tasks when family members need to return to work/home after supporting the host's transition and initial recovery
- Talk with the HomeShare team about what sort of legal status for this arrangement would be most protective of its success and flexibility. Consider whether pursuing this through regulation or law would make sense and how DAIL could support the effort.

Rumi - Minnesota

Rumi is a provider agency that connects people with disabilities with a compatible supportive roommate in shared living arrangements through an app and website. The company was recently acquired by Dungarvin, a multi-state service provider, but continues to operate only in Minnesota.

Rumi facilitates the match between a supportive roommate and a person who is at least 18 years old and has access to waiver services: Minnesota's CADI waiver, DD waiver, or Brain Injury waiver.

The website is Meet My Rumi • Disability Roommate Matching Service.

The process starts when the person or a potential roommate fills out a profile on the website or app. Rumi requires a full legal name and phone numbers to create a profile, so that information can be verified. There is a team of Rumi connectors to support the person to interact with potential caregiver roommates on the platform. They help the person start conversations and ask the right questions. Users can search the desired living location, age, gender, pets, and what they are looking for in a roommate or roommates. A person with a disability can become a supportive roommate.

Rumi conducts background checks and provides training to all eligible supportive roommates before they provide support, as would be true in any shared living arrangement. Background checks are run through the state criminal court system as well as a sex offender database. Guidance is provided on how to engage with connections while ensuring safety. There is zero tolerance for behavior that breaks site rules; those that do engage in inappropriate behavior are flagged and banned from the system.

The Rumi team takes a case-by-case look at each situation to make sure it has the proper supports in place before parties sign a lease. Rumi does not provide housing or take part in any of the leasing or rental arrangements. However, they do become the service provider agency for the arrangement.

They support the arrangement as tax-exempt shared living whether the person moves into the roommate's home, the roommate moves into the person's home, or they move together to a new home. The requirement for shared living is that both people live in that home. As a result, the individual with a disability can stay in the home if the relationship is terminated. The Rumi team provides fill-in support while a new long-term roommate is identified. As a service provider, Rumi can provide additional training and supports beyond what is offered by the supportive roommate.

Easter Seals - Arkansas

Easter Seal's Roommate Housing and Matching program in Arkansas is a community housing model for individuals accessing Arkansas' Community and Employment Supports Waiver. Like Rumi, they are using technology to start the matching process.

After trying and abandoning a time-consuming process based on Survey Monkey, they have started piloting an app called RoomSync, https://www.roomsync.com/. The software was developed for use by colleges to assign dormitory roommates. College roommate matching is a relatively well studied area, and that background drives the matching algorithm. However, Easter Seals has custom questions on their version.

The company has marketing and training videos to support users. Users must have a social media account to log in. Once a user fills out a profile, they can match in a number of ways. Users can browse profiles and swipe left/right, or they can match via the provider, or the

software. A match on the app initiates the process for potential roommates to then meet and get to know one another before making a final decision.

Roommates who agree to move in together access either a developer-owned or Easter Seals-owned apartment. About 15 people have been matched so far. Easter Seals provides support services to the roommates. They utilize shared staff across apartments and are currently building out a remote supports model with the help of the Ohio provider, LADD.

Remote Supports and Smart Technology

Aspire recommends that DAIL actively pursue remote supports and smart technology as a Technology First state. This approach is being used by a number of states to ensure that teams are considering the role that technology can play for each person. Technology First can be defined as a "framework for systems change where technology is considered first in the discussion of support options available to individuals and families through person-centered approaches to promote meaningful participation, social inclusion, self-determination and quality of life." (Tanis, 2020)

For example, Maryland became a Technology First state for developmental disabilities in 2022. They offer both remote supports and assistive technology through the waiver. Maryland is spreading the word about this type of support through regular community events, presentations at other state agencies, and at their annual technology celebration and conference. All colleagues are invited, including those serving older adults, people with brain injury, and Deaf, Hard of Hearing, and DeafBlind. The task force overseeing Technology First is a collaborative effort that seeks to bring people together, although turnover at the other agencies has slowed progress some.

Remote supports and smart technology can be less expensive than in-person support options and place less demand on the direct support workforce than current service offerings. Given the investments that will be needed to implement new models for people who cannot benefit from remote supports, providing an option for person-centered, efficient, effective technology-based supports that will meet the needs of as many Vermonters as possible will be helpful in the allocation of funding.

Assistive technology is increasingly being referred to as enabling technology and can work hand-in-hand with remote supervision to maximize a person's autonomy. Where remote supports are a direct substitute for in-person support, other technology may indirectly have that effect by helping the person do more for themselves. These types of smart technologies are rapidly proliferating. Examples include (to name just a few) handheld devices that read almost any text, alternative and augmentative communication devices, cooking appliances with motion detectors and automatic shut-offs, scheduling and reminder apps, smart medication dispensers, and even a cane that has built-in GPS.

Given how rapidly this field advances, having professionals dedicated to keeping up with technological advances is essential. We understand that Vermont has contracted with an

assessor, and this is an excellent start. To ensure that every person has the access to enabling technology, local experts are essential. A 2020 study concluded that soft-technology supports, including assessment, training and evaluation of technology implementation, may play just as important a role in shaping outcomes as the technology itself (Jamwal, Jarman, Roseingrave, & Winkler, 2020).

Professionals with a variety of backgrounds can be trained to be assessors. Maryland currently requires specific training for qualified professionals and utilizes training provided by SHIFT for all provider staff who implement this service. Their curriculum and accreditation process were created to support organizations within the intellectual and developmental disabilities field as they work to adopt a Technology First culture, see Shift (techfirstshift.com). However, Maryland also limits authorized assessors to those with an SLP, OT, RSNA, or CSUN credential, resulting in slow access to assessments. We recommend not restricting qualifications too narrowly, since this can reduce opportunities to benefit from technology.

Whether or not a state adopts a technology first approach, the use of technology is spreading. Friedman (2023, CQL)) found that in FY2021,10 states with 1915c waivers allocated $22.4 million for remote support services for 3,039 people with IDD, with plans to expand. For example, Alabama projected providing almost 10% of its waiver recipients with remote supports. The study cites Blauwet et al, (2020) and WHO United Nations Children's Fund (2022) to report that assistive technology has a return on investment of $9 for every $1 spent. According to the study, remote supports helped promote self-determination, independence, and autonomy, while also helping people feel safer and more secure. They found that states provided remote support services to promote independence, health, and welfare, and reduce and/or replace services. Rules and requirements to help keep people safe while remote support services were being used included informed consent, encryption, emergency backup plans, and the prohibition of use in private spaces.

Tass, Wagner, and Kim (2020) found that the introduction of remote support services meant that staff members could be distributed to other situations that needed hands-on support, while reducing the overall need for staff presence. Remote support technologies met a wide range of support needs, including those of people with substantial healthcare care needs. Adoption of remote support enabled provider agencies to serve more individuals without increasing personnel or overtime hours.

Remote support need not apply only to DSP roles. Case management was provided remotely successfully during the COVID-19 pandemic. At least one designated agency is considering using remote workers to fill case management roles, utilizing workers who live in other states to expand Vermont's capacity.

Safety Connection – Vermont

Vermont's Howard Center has operated a remote support model since 2006 for individuals living in their own homes. Each person has a Personal Emergency Response System (PERS) device

in their home that connects them to the system. A combination of telephone check-ins and sensor alarms (such as smoke alarms, fall detection, or a PERS pendant activation) are used to provide support 11 hours each day during the evenings and overnights for more than 100 people. Those served are primarily young adults with IDD, but also some older adults. Each person's plan specifies how often they check in. If a check-in is missed or a sensor is triggered, a phone operator calls and attempts to locate the person or isolate the problem. Two operators work during the high-volume evening hours and one overnight. Back up staff, who are located close by, are available to go to the site or provide phone support. Participants can call in at any time during the 11 hours if they need assistance. Typically, the backup staff are well known to the people served in this program.

Howard Center also contracts with four other designated agencies to provide operator support, but each DA provides the local back up staff. There are two backup staff in each region. The program is billed through the waiver under two separate home modification billing codes: one for the technology and one for the daily rate for monitoring/support. The annual cost is $7,000 regardless of the frequency of check-ins, number of sensors. or use of back up staff. Staffing for this program has been quite stable, with operators having no turnover for several years. The backup staff are typically employees with other positions at the agency who are paid a stipend to stand by overnight and paid hourly for any in-person time and some types of calls. Compared to other staffed programs, they do not have any difficulty filling these roles.

The program has been used to support young adults transitioning into their own apartments as part of their Succeed college/independent living program. The awake overnight component of the program was successfully faded out and replaced with Safety Connection. Howard Center is also introducing this program as a transition for people returning from intensive treatment programs to community living.

A pilot would be needed to determine the cost of a 24-hour option for this service. There is also potential for this type of service to provide transitional support for someone looking to practice prior to moving out of a placement with 24-hour support, or to reduce the respite needs of shared living providers. However, offering this service to someone who has a shared living arrangement would be considered duplicative currently. A pilot might be considered for how this type of service could be offered on a more part-time or intermittent basis.

LADD - Ohio

The Safety Connection program at Howard Center is a relatively passive monitoring system. In Ohio, the remote supports waiver service funds more active monitoring using a wide range of technology in a smart home.

LADD, an Ohio provider organization for people with IDD, initiated a pilot of a comprehensive support home in 2020. This model is currently being explored by one of Vermont's residential pilot projects.

LADD developed a purpose-built 4-bed home with nearly 130 different devices or apps placed into use, including home automation, platform technology, remote home monitoring, adaptive equipment, external tracking, and health/wellness. The total cost of technology was $97,238: $85,278 to purchase and $11,960 to install. The pilot was conducted in partnership with the Occupational Therapy department with Xavier University and resulted in a research brief which can be found at https://laddinc.org/program/smart-living/ .

The smart home set-up allowed active monitoring and two-way interaction on large screens to facilitate remote supervision, as well as more passive monitoring through sensor devices. The features enabled these individuals with somewhat higher needs (than might be typical in supervised or independent living) to take more control over their daily lives.

Four men, with an average age of 26 and a variety of disabilities including Down syndrome, autism and seizure disorder, moved into the home in 2021. The assessed level of disability for each person was not noted in the research brief. However, their reported performance on essential life skills such as cooking, laundry, and planning/following the day's schedule, indicated the need for ongoing staff assistance at the time they moved into the smart home.

Technology for the home was selected based on the assessment outcomes. Over a two-year period, the residents' independence and satisfaction with performance of their targeted skills increased substantially. Direct staff assistance to each resident decreased from 33.8 minutes to only 5.33 minutes.

While LADD continued to provide some in-person assistance to the residents, these hours were significantly reduced. Prior to the initiation of the smart home pilot, LADD spent $5,260 per week on staff for these four individuals. After two years, thecosts totaled $2,607 per week ($1,290 for the remote caregiver and $1,317 for the in-person caregiver.) This is a total savings of $137,941 annually, resulting in a full return on investment of start-up technology equipment expected in 37 weeks when converting from a staffed model.

It's not clear how many Vermonters looking to transition from shared living or Adult Family Care would be best served by this model. Some individuals and their families are seeking a model where people can live with friends or socialize with peers in a permanent home—a group arrangement in this model might be cost effective. Based on LADD's numbers, caregiving costs would be $33,891 annually per person for four people or $45,188 for three people. These costs would need to be compared to provider contract payments to fully understand the fiscal impact of this model. It should be noted that there are ongoing costs of technology, including tech support, equipment maintenance, and replacement costs that would need to be addressed.

Another way this active remote support and smart home model might be used cost effectively would be to keep people who are currently living independently (or in supervised living) in their own homes when their needs increase. Moving to a staffed situation, such as staffed or group living, assisted living, or a nursing home would be significantly more expensive than the smart

home option. Supporting people to stay in their own homes as they age is also a stated objective of Vermont's Age Strong plan (p.19).

As of July 1, 2024, the rates in Ohio for remote support services will be $9.48 hourly per site when back up support is unpaid (family or others designated by the person) and $14.12 hourly when back up support is paid. When more than one person lives at the site, they split the cost. Technology devices can be purchased through the wavier for the lesser of the provider's usual and customary charge or the MSRP plus a reasonable percentage for the provider's responsibilities with monthly fees of no more than $75. To accommodate a more cost-effective group size, Vermont rules would need to be changed to allow more than two people living in the same home to access the remote support system.

Social Connection

Increasingly the social determinants of health are being recognized as essential components of the healthcare landscape. According to a recent summary of the research, (https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/social-cohesion) relationships are key to physical health and well-being. Relationships offer social cohesion, social capital, social networks, and social support. Social cohesion refers to the strength of relationships and the sense of solidarity among members of a community. One indicator of social cohesion is the amount of social capital, or shared group resources a community has—such as a friend-of-a-friend's knowledge of a job opening. Individuals have access to social capital through their social networks, which provide social support, emotional support (e.g., encouragement) and instrumental support (e.g., a ride).

Full inclusion in the life of the community has long been a goal of the disability community. One of the primary concerns of families of people with IDD who are seeking intentional communities specifically for IDD is to combat social isolation. Vermont's draft Age Strong Roadmap (p.17) lists a goal to "increase the number of intergenerational engagement opportunities – with the goal of implementing at least 5 new models by 2023." In that same roadmap, objective 4 (p.36) is to "create social hubs at schools, libraries, churches and other locations to increase social connection and engagement." The roadmap notes (p.49) what people do to keep connected and engaged: "• Spaces to gather, and the activities put on by the organizations that run them • Zoom, and other platforms for on-line/virtual connection • Interacting with younger people • Volunteering (in general, with children) • Sharing a meal with like-minded people, people you don't already know." In our report, Aspiremakes the argument that a stronger social network, independent of a shared living provider, would strengthen participants willingness to risk the potential moves inherent in choosing to reside in a shared living provider's home.

Main Street Connect - Maryland

Given the agreement on the importance of social connection, Aspire recommends that DAIL promote the development of a statewide social network that incorporates the principles that drive a program called Main Street Connect in Maryland.

Main Street Connect is a nonprofit organization that runs a social membership program housed at the Main Street Apartments in Rockville Maryland (see housing description below.) Main Street Connect offers a robust calendar of daily, weekly and monthly classes, programs, events and community engagement opportunities at the Main Street Community Center. Membership is open to anyone, whether or not they live in the Main Street Apartments, including disabled and non-disabled community members. Information can be found at https://mainstreetconnect.org/membership/ .

Full memberships with access to all programs cost $75 per month. Financial assistance is available. Lower price options are available for single events and programs. Professional memberships are also available that offer networking events, opportunities to present to the community, write for the newsletter, and provide discounted memberships to employees.

Programming is developed in collaboration with members, professional partners, and the larger community. They focus on wellness, personal development, and social, cultural, and educational engagement at special events, weekly events, and in member directed clubs. The have an art gallery with a three-month rotation of artists, both disabled and non-disabled. In addition, Soulfull Cafe, a coffee shop partnered with Main Street Connect, is located in the Main Street building and open to the public. Soulfull Cafe provides employment to people with and without disabilities.

Main Street Connect has partners and presenters from large companies, nonprofit organizations, and small businesses—they are a hub for community partnership. Started in 2020, the program now offers about 20 programs or events each week. Currently, 99 people have individual memberships and 33 have professional memberships at this one site. In one recent month, there were 298 different attendees at 74 events.

Social programming to create community is a common feature of the intentional communities put forward by the recent DDHI and DDC reports – including L'Arche, Heartbeet, and Visions. However, what Aspire sees as uniquely valuable about the Main Street Connect model is its invitation to the larger community to create a broad network that benefits everyone, disabled and non-disabled alike, including older and younger adults. In an independent 2021 survey of their members, 75% said they felt healthier, 88% felt more like they belonged in this community; 82% felt their overall life had improved because of membership; and 86% said they felt more connected to others. Their most recent numbers are at 100%.

There is an entrepreneurial focus in the program that can harness the considerable energy of Vermont's small communities and tradition of engagement with local initiatives. Smaller, local

programs modeled on Main Street Connect could be fostered around the state to provide in-person programs and events to those close at hand. Local religious organizations could be recruited as partners for these programs, ensuring that this support that is crucial to families is both recognized and strengthened. Linking these groups together in a larger network would provide additional opportunities, expertise and talents that may not be available in the smallest locales. For example, communities that already embrace the Village Model could be linked to this new program. The Village Model utilizes community-based organizations to coordinate access to affordable services like transportation, home repairs, and social and educational activities. Vermont has a small cohort of established villages.

In addition to in-person events, these groups could gather for shared events and programming virtually. As we learned during the pandemic, virtual connections can bridge geographic divides. We saw this phenomenon at Aspire with our Aspire Online program. Started during the pandemic to replace community participation services that could not be delivered during lockdown, people with IDD from across the state began meeting up for the first time to take and offer classes, run game days, exercise together, tell stories, and share meals. People who had never used a computer before learned to log on themselves and use the features of a virtual platform. To this day some of these folks continue to run a lunch group and get together for book club or a game online.

Such a network provides a missing link for the various service offerings that might otherwise be isolating, whether people are moving to their own apartments, using remote supports, or moving to a rural shared living home. Importantly, it does not require that participants choose any particular housing model to enjoy its benefits. Effectively, the person's social network can become separate from the service provider and the housing choice. Beyond the social determinants of health, a portable, independent social network changes a person's relationship to the service system: they become free to choose among many options, to respond to changes in service or housing quality, and to move among those choices throughout their lives.

Any of the co-housing and intentional community models suggested by the DDC and DDHI reports would be strengthened by hosting or linking to a social membership group like Main Street Connect.

Housing Model

Main Street Apartments - Maryland

Main Street Connect's home base is the Main Street Apartments. Aspire's primary housing recommendation is for replication of this housing model. The building is an innovative, multi-purpose building that is also an affordable, accessible and inclusive apartment complex and community center. The building is located steps from a subway stop and adjacent to the town center in Rockville, Maryland. The building opened its doors in August 2020.

Seventy-five percent of the 70 apartments in the building are affordable – serving households earning 30%, 50% and 60% of the Area Medium Income (AMI) – and 25% of the units are specifically designated for individuals with varying special needs. Apartments range in size from studios to 1, 2, and 3-bedroom. The ground floor of the Main Street building has a 10,000-square-foot community center that includes a fitness center, teaching kitchen, multimedia room and a classroom. The building offers the convenience of having all the amenities under one roof–an important factor for older people and those with mobility concerns during Vermont winters. Office space is available on upper floors. The apartments are managed by a property management company, and the building is owned jointly by Main Street Connect and Main Street Apartments (the developer).

The project design is in many ways similar to the Kelsey, which was recommended by the DDC report; however, Main Street has the distinct advantage of having already started operations. This project was built using Universal Design and funding through federal, state, and local housing programs. Main Street Connect offers recorded webinars describing the process by which they created the program. Their leaders are available for consultation.

Main Street is not a service provider and does not provide care giving or support staff to meet individualized, customized, one-on-one needs. Main Street's approach is based on a philosophy of inclusion they call "Bring Your Own Independence." Residents and members are encouraged to bring with them whatever and whomever they need to access the benefits of living at Main Street and/or being a member of the community center.

Within the Main Street context, any type of support model is possible – including SASH, supportive housing, shared living, staffed living, remote supports, or even group living – for any waiver or non-waiver population. Theirs is a deliberate choice to separate the choice for housing from the choice for services. This separation can be a key feature for those who want to maintain service provider choice while still having stable housing.

Main Street residents have the option to hire a Main Street Community Coach. These are life coaches who provide limited types of assistance, mostly in group meetings. There are 12 employees at Main Street, including leadership, administration, coaches and concierges.

As is the case with many innovative projects, the parents of a person with IDD started Main Street Connect in 2017 when they did not find any potential housing that met their son's needs and vision for his life. This comports with the responses in Aspire's online survey, more than 70% of which indicated that respondents weren't living where they wanted because no one offered the option they wanted.

The Main Street project was organized around three pillars: 1) affordability, 2) inclusivity, and 3) financial, physical and programmatic sustainability. These comport with DAIL's charge to Aspire to evaluate models on similar dimensions. The founders began the project by starting the membership organization and networking--talking to state and local officials, donors, and community leaders, starting with the commissioner of Maryland's DDA. One of the founders happened to be a general contractor and developer of both low income and market rate

housing. As a result, the organization was well positioned to apply thoughtfully and competitively for LIHTC funding and to construct the building. They also worked with a local bank for financing, received grants from the city and county, and solicited donations, which allowed them to get all their cash in place before applying for LIHTC. Their capital sources, totaling $30,273,492, broke down as follows:

Permanent Mortgage: $6,200,000

Montgomery County (HIF): $2,500,000

MD Department of Health: $2,335,472

Tax Credit Syndicator: $14,963,560

Deferred Developer Fee: $1,574,002

Main Street Connect Equity: $2,700,437

Mixed income apartments and mixed uses in the building help make the project financially sustainable. As a 70-unit apartment building, this design may be appropriate in just a handful of Vermont communities. At the same time, the concepts of a multi-use property incorporating universal design that serves as a hub for a vibrant social community might be applied to co-housing communities of various sizes, whether configured as an apartment building, a campus of townhouses or a neighborhood with a variety of housing types. For example, there could be synergy between the Main Street approach and the Winston Prouty project vision in Brattleboro. Any version of this building project is going to require partnership between the state and local government, housing organizations, providers, families and community members to bring an ambitious vision to fruition. We recommend that DAIL partner with VSHA, VHFA, and other state departments to offer technical assistance for developing strong partnerships and accessing needed resources. A toolkit that builds on the existing resources for housing, such as the Housing Ready Toolbox and the work that is underway on the Homes for All 'Design & Do' Toolkit might be helpful. Adding strategies such as those found in the can provide strategies for motivated families and providers to work cooperatively with DAIL and VHFA to bring local versions of an inclusive model to life. (See https://independentfutures.com/housing-options/ for one example of how training and technical support might be offered to individuals, families and community members.

Models for Deaf, Hard of Hearing, DeafBlind Services

Stakeholder input through Aspire's online survey was limited for people who are Deaf, Hard of Hearing, and DeafBlind (DHHDB). Six stakeholders who were not providers said their primary

interest was DHHDB, and five identified as having or wanting services. Of the six, three live with family, two with a shared living provider, and one in their own home. Five of the six said that this was not their first choice for the future, and that their first choice was not available. These individuals described having numerous support needs, including support to stay safe, help with cooking, access to an interpreter or supporters fluent in sign. They wanted to live in a group house or with friends/peers in their community. They wanted help from friends or staff. Their cultural concerns related to specific values and language, religion, and family make-up.

The DDC report (p. 25) reported gaps as well, particularly regarding communication: “parents and caregivers of adults whose disability includes being deaf or non-verbal struggled to find settings where sign language or other preferred modes of communication are offered… parents spoke of the lack of ASL- trained support staff and an unwillingness of shared living providers to learn sign language. They expressed a general dissatisfaction with the lack of state resources for deaf and non-verbal adults.”

DAIL’s stated top priority to expand ASL services to Vermonters will be essential to implementing the recommendations that Aspire has for serving DHHDB people.

In addition to increased access to enabling technology as noted previously in this report, Aspire has three recommendations regarding support and access for people who a Deaf, Hard of Hearing or DeafBlind:

- Expand the SSP/Co-navigator program to help individuals who are DeafBlind access community services and public spaces
- Develop of a new staffed home focused on the needs for DHHDB Vermonters in central Vermont
- Add support for people who are DHHDB to the provider specializations proposed by Aspire for shared living (see p. 33 of this report) based on the work that is being done in shared living in other states

SSP/Co-Navigators

According to Deeming, Gabry, Gasaway, Jordan, Pope, & Spiers (2021), “People who are deafblind [sic] face unique and complex challenges every day in accessing information, communication, transportation, and their communities. Without readily available access to these foundations of everyday life, the ability to make informed decisions, remain independent, and perform daily living tasks may be compromised. Basic human needs may go unmet…”

The Support Service Provider (SSP), also known as a Co-Navigator, facilitates access to these foundations for DeafBlind individuals through guiding and providing visual, environmental, and social information. The SSP facilitates brief casual exchanges of spoken and/or signed conversations but is not an interpreter. As a result of the SSP’s support, the person who is DeafBlind is better able to make informed choices and decisions. Deeming, et al reported that

DeafBlind people using SSPs are “better able to enjoy life with greater self-confidence, independence, and self-sufficiency.”

Vancro Integrated Interpreting Services is a nationwide company that provides interpreting and SSP services. Vancro, with assistance from DAIL, has piloted a grant-funded statewide SSP program in Vermont, increasing its assistance from three to 31 people in 2023. This service provides an SSP to facilitate community access, such as shopping and doctor’s appointments. This project is currently just a two-year pilot, with the potential to extend to four years.

Deeming et al reported that the World Federation of the DeafBlind estimated in 2018 that 0.85% of people over the age of five in the U.S. are DeafBlind. Assuming a similar prevalence in Vermont, that would mean that 0.85% of the estimated 532,863 adults, or 4,529 adults in Vermont are DeafBlind. This estimate indicates there are likely many more than 31 people who could benefit from SSP support.

Aspire recommends that Vermont continue to pursue a more complete understanding of how many DeafBlind people have health or safety risks that could be alleviated by this service. We recommend that DAIL provide funding for Vancro to expand and extend the current pilot as service needs and the supply of SSPs warrants. It should be noted that a recent want ad for the SSP role offered $16.75 per hour employee wage or $22 hourly as a contractor. This rate is below what is reported on Indeed for other types of direct support workers. If SSP availability is a limiting factor in this service, funding for a higher wage would be advantageous.

PAHrtners Deaf Services – Pennsylvania

Aspire recommends DAIL consider replication of the PAHrtners program as a model for specialized staffed or group living homes for DHHDB people with more complex needs. Vermont currently only has one group residence for people who are DHHDB in the northwestern part of the state. Creating a small community of linked staffed/group homes more centrally will allow those with complex needs to access services closer to or in their preferred communities. The PAHrtners model is similar to the proposed VIDAL staffed multi-unit building described in DDHI Housing Models Report.

PAHrtners offers support programs to Deaf, Hard of Hearing, and DeafBlind individuals in an environment free of cultural or language barriers. Adults with psychological, behavioral health and/or intellectual challenges live in a supportive atmosphere amongst peers. The residential program provides Deaf individuals with a community-based home that offers the level of care they need, promotes independence and teaches living skills in a communication-rich environment. Daily routines are controlled by the residents.

Most staff members are Deaf or Hard of Hearing themselves. Nearly all employees are fluent in American Sign Language and versed in Deaf culture. Non-signers can start work but are assigned to overnight shifts where they focus on online ASL training. (They are considering bonuses for peer ASL tutoring to augment this training.) DSPs who work in this program are

paid a differential wage, starting at $16.50 for nonsigners--$15 is typical in their other programs. Staff who are fluent signers start at $18. They would like to offer a choice of staff to residents, but they remain too short-staffed for that, although the shortage has eased since the pandemic days.

Apartments with one, two or three bedrooms are available, so individuals can live with peers or in their own home. Units are in multi-family homes or townhomes. Ownership varies between PAHrtners, their former founder, and private landlords. There is always at least one member of staff on site 24/7. Additional staffing is based on individual needs. Ideally, they have two staff on if someone in the home is DeafBlind. They try to match roommates carefully but will move people to a different unit if they request. There is a robust grievance procedure. All units are equipped with Deaf-friendly technology, strobe lights, videophones, etc. Some homes are barrier-free for residents with mobility needs. There are two service areas, one near Philadelphia, and a satellite location near Pittsburgh.

PAHrtners has operated since 2001 and was acquired by another provider, RHA Health Services, a few years ago. The program operates in the black. Providers of deaf services in Pennsylvania do receive enhanced rates that vary with the person's level of need. As a 24/7 staffed program, this model is one of two high-cost programs that Aspire is recommending and would require considerable investment with a provider partner. These costs include start-up of the program to build, purchase or lease properties, installation of appropriate technology; recruiting, ASL training and possibly assisting with housing to attached DHHDB staff--and higher operating costs above current averages because of the rate differential. If the regulatory requirement for licensing for three individuals under one roof could be addressed, then the additional cost associated with that level of compliance could be avoided in the larger homes.

Life Connections – New Hampshire

Aspire recommends that DAIL consult with Life Connections in New Hampshire to develop a model for shared living homes specializing in people who are DHHDB. To create efficiencies, these shared living homes could be part of the same network of services offered in the staffed model described above. Shared staff and resources could ease some of the demands on the workforce.

Life Connections has developed a robust hybrid shared living program that is successfully addressing the communication and behavioral health needs of people with intellectual and developmental disabilities who are Deaf and Hard of Hearing. They offer accessible communication, education and advocacy to all individuals receiving services. Services are provided by DSPs who are Deaf and/or fluent in American Sign Language. All individuals have access to Certified ASL interpreters, state of the art video relay, internet and email. Accessibility in homes includes wake up alarms, door lights, interconnected flashing smoke alarms, carbon monoxide detectors and doorbell and phone signalers, and telecommunication equipment.

They use a specialized shared living model. It's an alternative to staffed services for people who don't need group homes, but may be unable to live with a family. Individuals gain greater independence and have opportunities to participate in activities in their local communities, while receiving the support and companionship of a shared living provider at home. Life Connections uses a person-centered approach to understand each person's history, preferences, and vision. Each person has a choice of where they wish to live, the type of person they want to live with, the type of activities they wish to participate in, and their cultural preferences and goals.

There are multi-disciplinary teams that wrap around the individual and weekly meetings of staff. Individuals are matched with a seasoned provider and a residential counselor who gives additional support following an extensive screening process. There is also a therapist and psychiatrist, and medical providers, on their teams. Services could occur in an apartment for the individual, or providers' homes, depending on the situation. The goal is for the person to transition out of the program.

Clinical services are provided by professionals trained to provide culturally and linguistically competent services Pro-active crisis support services are offered to all individuals referred to the program. Their clinical response team and urgent response line is available 24 hours per day, 7 days per week. These enhanced supports will increase the cost of these shared living arrangements well over Vermont's average, to rates more typical of staffed or group living. However, the transitional, treatment focus of these services would appear to offer a return on investment as the person moves to a less restrictive and presumably less costly setting.

Models for People Experiencing Developmental Disabilities

According to the DDC report (p.6) "Adults, family members, and providers all expressed frustration that there are not more housing options available. Providers felt there is not enough of any option to meet the housing needs of adults with IDD. Many families and caregivers shared that their adult family members lived at home because there aren't suitable alternatives. All stakeholders agreed that staffing and support services are stretched thin, and this lack of support limits the amount and effectiveness of existing housing options."

These sentiments were echoed in Aspire's survey and interview findings. In the survey, half of the stakeholders who identified as people accessing services or their families indicated that they lived at home. Seventy percent were not living in their first choice of home for the future, and of those, 80% said that the first choice was not available. Nearly 80% said that no place offered the service they needed.

There were two divergent types of models nominated by the DDHI and DDC reports. One direction was to create intentional communities where people could live with peers and become a part of a social group. Aspire feels the Main Street Apartment model addresses this need. We recognize that the IDD-specific intentional community models put forward by both the DDC and DDHI may be the best choice for some individuals. We support the piloting of these programs.

The other direction desired by people with lived experience was the creation of more supervised/staffed housing, where people live in a place they rent or own with staff support.

For this option, Aspire recommends the individualized housing model offered by KFI in Maine.

KFI - Maine

KFI serves people with IDD who wish to live in a home of their own (with or without a roommate) who want more permanence for themselves than shared or group living. KFI provides flexible supports individualized to each person. They operate out of four different offices in Maine. One important advantage of the KFI program is that their model can support people with complex needs. KFI's model is designed to include everyone, from those who require minimal assistance to people who require up to 24 hours of support daily.

Based on a deep knowledge of the communities where they operate and a commitment to listening closely to the person, KFI staff assist each person to identify and access all resources and benefits they need to live in their own place. With support, the person finds the home that is right for them in their chosen community and transitions to their home.

Housing selected by people KFI supports includes manufactured homes purchased by the person with a HUD loan, apartments in a senior apartment building, low-income townhouses, and rental assistance vouchers for all types of units. All homes are rented or owned by the individual(s) who lives there.

A key facet of KFI's ongoing services is to help the person seek out and develop a network of friends and acquaintances who provide ongoing support. Each person takes control of their own life with assistance from paid staff, friends, family, neighbors, and others in the community. Individuals always choose their housemates. Individuals learn how to manage and care for their home and pay their bills, alongside other skills of daily living. Many are working. Staff are recruited based on what the person is asking for, and "meet and greets" occur before a final assignment. KFI holds true to this approach even when the person has limited communication skills.

As a result, each home and support system is unique and reflects the person's interests, strengths and preferences. The model creates control and stability for the person and promotes economic independence. KFI transitioned to this approach more than 30 years ago. They currently serve 57 people in this model.

In Vermont, KFI's programs contain elements of different services under Vermont's waiver. These include supportive housing, supervised living, and staffed living. KFI achieves a typical 24-hour staffing schedule utilizing three full-time staff who work 2-3 days at a time. Asleep hours are excluded from payment. (KFI does provide some people with awake overnight as well.) Staff are paid $18.00 to $19.63 to start. Their vacancy rates vary by location – they did close their Portland location due to the workforce shortage and rising prices. Overall, they've been fortunate in terms of vacancy and turnover. They are a lean agency with a flat management

structure, working mostly as a team. Each Support Coordinator is responsible for about 10 individuals and their staff.

The DDC report (p. 8) provided an estimate of 602 new units of supportive housing would be needed for adults with IDD who receive HCBS. This estimate was extrapolated from national data. However, estimates for the cost to create and support these units will be most accurate if DAIL undertakes data collection that goes beyond survey data. Despite calls for this type of housing, consider that the Howard Center's program to help young adults transition into their own apartments operates without the need for a waiting list. This is in the most populous area of the state.

Aspire recommends DAIL undertake direct data collection on the housing needs of people with IDD. Ensuring that teams have full discussions of the person's vision for their future housing during person-centered planning and then collecting data directly from these documents, should yield a more complete picture of the need for services like KFI's.

Models for People with Brain Injury

The Brain Injury Alliance of Vermont estimates that 9,000 Vermonters are living with a traumatic brain injury. Only four respondents to Aspire's online survey identified as people receiving or wanting services for brain injury. Of these, two were friends or family. All categories of assistance were endorsed by at least three people, except support for eating (2) and communication (1), indicating a high level of support need. Two people said they were not living in their first-choice arrangement. Both said that their first choice was not available because no place offered the support needed. One wanted to live in the community with friends, and the other wanted to live with family. Friends and staff were the preferred sources of help for three people, and unpaid roommates and family for two.

Waiver services specifically for people with brain injury in Vermont include crisis support, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive adaptations, and self-directed care. (GCH waiver (p. 23). For an adult to access community-based residential habilitation services, they must qualify clinically and financially for Choices for Care with a physical disability.

Service providers also reported that people with brain injury were becoming homeless because of stringent eligibility criteria to access case management and supportive services. Aspire recommends DAIL expand waiver eligibility for non-residential services to better prevent homelessness, and its consequences for the person, as well as the need for more costly residential interventions. The expansion of these services could be considered an investment under the current waiver. DAIL may also consider how the shelter model described in the section for adults and people with physical disabilities may be appropriate for people with brain injury as well.

Vermont has successfully transitioned virtually everyone with brain injury who had been living in a nursing home to home and community-based services, an important achievement. Younger adults with brain injury living with older adults in a nursing home do not find the right social environment for growth. For example, a study in Ireland (Dwyer, Heary, Ward & MacNeela, 2019) concluded that "young adults with acquired brain injury can experience aged care as an existential prison in which their lives feel at a standstill."

Yet people with TBI may find access to appropriate medical care and TBI expertise in Adult Family Care and Enhanced Residential Care homes difficult, depending on where they live. As provider stakeholders put it, "Access to solid medical care is very important and difficult at times given the landscape of VT."

Vermont does have one five-bed Residential Care Home focused on people with brain injury, but additional services are needed to enable more individuals to access supports for complex needs. In particular, those that are looking to return from out of state neurorehabilitation and step down into a lower level of care have limited options for programs that specialize in brain injury.

Other states have chosen to offer a comprehensive waiver for people with acquired brain injury, for example Colorado. Eligibility is limited to individuals aged 16 and older whose brain injury occurred prior to the individual's 65th birthday. Services offered include Supported Living Program and Transitional Living Program. See https://hcpf.colorado.gov/sites/hcpf/files/Brain%20Injury%20%28BI%29%20Waiver-Approved-Effective%201.1.2024.PDF.

Massachusetts created two Acquired Brain Injury waivers. The waivers were designed to help persons with an acquired brain injury (ABI) move from a nursing facility or chronic disease or rehabilitation hospital back to their community. ABI–Residential Habilitation is for people who need supervision and staffing 24 hours a day, seven days a week in a provider-operated residence. ABI–Non-residential Habilitation is for people who can move to their own home or apartment or to the home of someone else and receive services in the community. See https://www.mass.gov/info-details/acquired-brain-injury-abi-waivers. The waiver funding in these states has led to the development of residential programs specializing in support to people with brain injury.

ABI homes, Aspire Living & Learning - Massachusetts

In response to Massachusetts' ABI waivers, Aspire Living & Learning opened two five-bed staffed residences serving people with ABI who had been living in nursing homes. This group living model enabled these individuals to leave nursing homes and return to community life, despite their behavioral and medical fragility.

The two purpose-built homes opened in 2017 and 2018 near Fitchburg in central Massachusetts. Both are fully ADA-compliant, single-story buildings. They were both financed

with commercial loans; however, approximately $100,000 per home in start-up costs (e.g. overhead lifts, staff training) were recovered from the state. The total cost to open each home was about $600,000. Before these two homes opened, there were no community beds specific to people with ABI in this area of Massachusetts. At the time, Aspire was participating in CQL's accreditation process. Because of these high standards, neither home required heightened scrutiny under the settings rule.

Residents do not have a direct choice of their housemates, although everyone meets before the move to test whether it's a good fit. No residents have requested a change or said no to a potential housemate. Massachusetts requires that residents interview potential DSPs, and residents do participate in this process.

The Positive Behavior Support universal protocol is followed in both homes. The people who live there are in control of their daily routines and schedules. One home has an LPN who also works as a DSP. The other program has a shared nurse. Service planning and data reviews are also more intensive in these homes. Staffing is based on the needs and the census of the home, with a workforce of approximately 12 DSPs for each home.

DSPs are paid the same rates as other Aspire Massachusetts staff, $18.50-$19.50. Most DSPs live in the immediate surrounding communities where some housing is affordable at this wage. Vacancies are common, with current vacancies at an average of 16%. DSPs are trained in brain injury and have more medical training than other DSPs. Given the severe workforce and housing shortages in Vermont, higher wages are likely to be necessary to retain adequate staffing for a similar program.

The programs are generally operating in the black, except when staff vacancies have gone higher and resulted in overtime use. Some overtime use was also due to the closure of day programs in the area during the pandemic that never reopened. The residents are medically fragile and extended hospital stays can make revenue unpredictable.

Costs per person for this service are substantially higher than even the average staffed living cost in Vermont. It'slikely that this type of program would be appropriate for those with the very highest needs due to both behavioral and medical complexity. Other options for this population may be an alternative nursing home model, such as Green Houses, which is described in the section in this report on models for older adults and physical disabilities. For individuals with ABI with fewer needs, the KFI and supportive housing models, described in the section on models for IDD, may also be appropriate.

Models for Older Adults and People with Physical Disabilities

Only three individuals from the online survey identified as an older person. All lived in their own homes, and two were looking to remain there. One was looking for subsidized housing but said there were no vacancies. All three endorsed the need for assistance with household tasks, paperwork/forms, money to pay for things and transportation. Two of the three wanted help from

family and friends, and one endorsed neighbors, roommate or paid roommate. No one selected paid staff as a preferred source of help.

Aspire's interview with DAIL, as well as provider stakeholder input, indicated that there is also a significant need in Vermont for emergency and interim housing for older adults. A recent U.S. DHHS report addressing homelessness among older adults concluded (p.27) that "adults who have not previously experienced homelessness, but have experienced adverse events that threaten their housing stability, tend to need lighter touch or prevention-focused services to regain housing stability. Critical services for this population are those that help identify them before they become homeless so that they may be prevented or diverted from homelessness through various systems' efforts to connect them to income supports, medical insurance, rental and utility assistance, nutrition assistance, and transportation assistance."

The GCH waiver funds a pilot of permanent supportive housing, a model which has been successful nationwide in addressing homelessness. The CHS report *Strengthening the Housing and Services System: Recommendations and Strategies for Vermont* in 2021 report made clear that this pilot would need to be scaled to address the need statewide. Identifying people who need supportive housing and what sort of housing best suits their needs is a key factor in the success of scaling up.

Services such as SASH can help identify and address adults' changing personal needs over time. CHS's report noted (p,17) that "the SASH program has been successful in helping participants remain in their homes, both in terms of aging in place as their health and functional needs increase and in helping participants avoid eviction." SASH's reach has increased across the state of Vermont since the publication of that report; however, access remains limited due to funding and workforce constraints.

Expanding the reach of SASH, which can screen for risk of homelessness, is one way to address this for older adults. Homeless persons experience disabilities that are more like housed people who are 10-20 years older. DAIL may want to consider whether supporting the expansion of SASH to older adults starting at age 50 for those eligible for Medicaid or for HCBS services would make sense.

The Main Street-type model may work well for those adults whose first experience of homelessness is after age 50 with transitional supports. However, those with a more chronic experience will likely need something more intensive.

Older adults who first experienced homelessness before the age of 50 tend to be homeless longer, have more disabilities, mental health diagnoses, substance use, and service needs than people who experience homelessness for the first time after age 50. People in the former group will need more intensive supports for longer periods of time (see US DHHS report p. 9). Because they have such different service needs, DAIL may want to collect data on how many older homeless Vermonters fall into each group as service options are explored.

One model for an organization that supports older adults to avoid homelessness and rehouse is Hearth, Inc. in Boston. Hearth operates seven buildings, six with affordable supportive housing units and one assisted living facility, that house 240 older adults. They serve a similar number of outreach clients. They employ 80+ staff and have operated for more than 30 years. Hearth, Inc. is funded through both public and private sources, and provides prevention, placement, and housing programs and services that address medical, mental health, and social needs. A team of case managers, registered nurses, social workers, licensed mental health clinicians, and program managers, supports residents in maintaining their health and housing. They offer additional specialized services for residents requiring more intensive support to address their unique needs. Services include a representative payee to assist with financial management, personal care attendants/homemakers, a resource specialist, a peer specialist, and a substance abuse specialist. A team of case managers partners with local shelters and provides community outreach to identify homeless older adults and those at risk. They assist people to obtain housing, stabilize in that housing, and build networks to sustain them. Prevention services are offered to those who don't meet the definition of homeless but are at risk.

To bring such a program to Vermont would require significant cross-systems alignment and braiding of resources and funding across existing departments. This was clearly outlined in the CHS 2021 report. This report also provided an excellent overview of the process of collaboration for this type of initiative (p.22).

The September 2023 Assisted Living Residence and Residential Care Home Capacity report explored where more intensive needs could be met through open beds at Vermont's assisted living and residential care homes. The intake and transition process appeared to be a significant roadblock for people who are homeless. Typically, a housed person has a network of family and social support to help them. According to the report, "a critical question is to identify who will provide support through the LTC residential review & admissions process and will provide this support after taking residence. This problem is twofold. On one side, regulations assume an adequate network of family /social support and a legal arrangement for external representation as needed. On the other side, the complexity of the financial, medical, and other reviews required to successfully connect an individual to an appropriate LTC residential placement are taxing for anyone without specialized knowledge. In both the survey and follow up interviews, providers expressed this burden as a major concern." (p. 7) They further identify connection to community physicians and ongoing support for 3-6 months as essential.

The US DHHS report called for crisis and interim housing tailored to older adults. They identified is a need for emergency shelter accommodations that include beds that are on the first floor or bottom bunk, 24-hour access to bedrooms and bathrooms, and refrigeration or locked storage for medications and medical supplies, as well as crisis or interim housing accessible to older adults with limited mobility, difficulties with ADLs, and needing assistance with limited health care and medication management. This type of shelter could fill the transitional gap for older adults who are homeless.

CASS - Arizona

Aspire recommends that DAIL explore a partnership that could replicate the CASS shelter model. With support from the City of Phoenix, CASS offered support and private shelter from June 2020 through September 2021 in a pilot program for older adults. The temporary Project Haven program has 60 beds at a hotel site, but will become a housing facility for older adults in 2024 as the Haven Senior Shelter at a hotel that CASS has purchased and renovated. It is slated to open in April 2024.

The pilot program was started to address the specific and unique needs of the older and medically vulnerable populations. Project Haven will have 170 beds in single and double rooms for 24/7 emergency supportive housing for older adults. Double rooms will be utilized by couples and also for hospital-placed individuals who are being discharged from acute care but have no place to go.

The program is a closed campus, meaning there are no walk-in services or tenting permitted, with a 1:15 case management ratio. They have partnered with other local organizations to provide workshops and skills training for participants. They have contracted with an OT and other geriatric service providers. They have been approved as an outpatient Medicaid provider, and they will also be billing hospitals for the discharge beds (the hospitals have a financial incentive to keep participants from needing to return to the hospital).

Operating funds also include emergency housing support from Phoenix and other municipalities, as well as private donations. The former hotel was purchased and renovated with a $30 million start-up capital budget. This included ARPA grants, state funds, and private donations. They have also partnered with ASU to conduct research using a dementia screening tool, which will help guide their referrals to additional services and permanent housing. They are working on introducing a screening tool to assess vulnerability during meals-on-wheels visits to try to catch folks who are struggling before they lose their housing.

They do struggle with staffing, often finding that people leave within days of starting at their large 600-bed shelter. They are finding, however, that the staff at the 60-bed program for older adults are having a much better experience, and they hope this will produce longer tenures at the Senior Haven facility. They pay competitively compared to other programs for frontline workers, with some lower and some higher. They expect to be able to pay those who engage in more training higher wages over time. They do not provide workforce housing at this time, but may consider doing so when they convert some of their pandemic era housing into paid transitional housing.

The unhoused older population in Vermont faces a very different landscape than do those living in Phoenix. Senior Haven is a large facility that might reasonably be scalable as two facilities, one for Chittenden County and one for coordinated entry from the rest of the state. Given the workforce shortage across the healthcare sector, it is unlikely that the model could be scaled to

just a few beds scattered locally. However, some older individuals may have moderate needs that could be addressed with a less workforce-intensive approach that focuses on the physical environment – such as first floor accommodations, 24-hour bedroom/bathroom access, and medication storage. Shelters that currently offer 24-hour services could be partners in the creation of these beds in more communities.

Funding to support such an initiative may be possible under the waiver. According to recent correspondence from ANCOR, the Biden administration's "recent actions have created two major opportunities to improve this. First, there is recent willingness to approve Section 1115 demonstrations that authorize limited temporary housing services within Medicaid as a health-related social need (HRSN) as described in CMS guidance, with additional funding for capacity building and successful implementation. Second, the administration's recent guidance permits states and Medicaid managed care plans to offer short-term housing supports using the 'in lieu of' services approach. These changes open the door for states to propose housing services targeting various populations, including those at risk of homelessness."

It is likely that the needs of some individuals would exceed even what could be offered in a shelter with specialized supports. A longer term, but still temporary, option for evaluation and stabilization may be needed. The assisted living reports suggest a temporary facility option: "Having access to a lower barrier and non-permanent facility option, up to RCH Level III care, could offer a transitional option for individuals who either are not sure if residential LTC is the best next step or lack some of the pre-requisites for admission, such as established PCP relationship. This type of facility could support developing an existing & stable care network in a region, time for observing responsiveness to treatment plans (where applicable), reconciling medical records and medication lists, reviewing long term financing plans, and ensuring comfort with a highly structured community environment. (p.17)" Development of a network that could assist with supported decision-making for people with cognitive difficulties could also be addressed at this time.

For these individuals, Aspire recommends that DAIL consider supporting the development of a Green House model.

Green Houses –National/Colorado

Green House homes offer a non-institutional model of care as an alternative to a traditional nursing home. In addition to having an organizational structure that is radically different from other settings, Green House homes are small in scale, self-contained, and self-sufficient, with older adults at the center. Each home includes private rooms and bathrooms for each person, a kitchen, living room with a fireplace, and outdoor spaces that are easy to access and navigate. Ten to 12 people live in each home. Residents are empowered to engage with the environment and direct their activities. Direct care staff have broader roles than traditional CNAs to facilitate participation and enhance the quality of life for both residents and workers. An important goal is the development of relationships built on equality and respect that make a Green House home a

place where people want to live and to work. The small scale and participatory opportunities make the model a good one for evaluation, as well as rebuilding of skills and relationships in a home-like environment.

The majority of Green House homes are licensed skilled nursing facilities (SNFs). However, organizations are running successful Green House homes as skilled nursing, assisted living, short-term rehabilitation, memory care settings, and homes for people living with intellectual and developmental disabilities, as well as veterans' homes. Since the Green House model's inception 20 years ago, nearly 400 homes have been built in 32 states. In Vermont, such a home could be licensed as skilled nursing or a residential care home to offer short-term rehabilitation.

The Green House model is backed by ongoing research that evaluates quality of care, quality of life, and financial viability. See https://thegreenhouseproject.org/resources/research/. For example, during the pandemic, Green House homes saw significantly fewer COVID cases and deaths.

While workforce remains a challenge, staffing in Green House homes has fared better than other models. Between 2017 and 2018, the overall nursing home workforce had a mean turnover rate of 94%, with 140.7% mean turnover for registered nurses (RNs), 129.1% for certified nursing assistants (CNAs), and 114.1% for licensed practical nurses (LPNs). Even during the pandemic, Green House homes reported substantially lower turnover rates: 33.5% for Shahbazim (the model's term for CNAs), 41.6% for LPNs, and 63.2% for RNs.

The Green House model has been shown to increase occupancy rates and revenues, while maintaining operating costs equivalent to a traditional nursing home. The Green House® Project (GHP) is a not-for-profit organization that offers an expert team to provide consultation for start-up of the Green House model, including design recommendations, regulatory analyses, research on staffing and clinical outcomes, and financial feasibility modeling.

One example of a Green House community is the Green House homes at Mirasol in Loveland, Colorado. The Loveland Housing Authority owns and operates a 55+ campus of affordable housing. Based on the market needs of the community, they created a subsidiary nonprofit to build six Green House homes on their campus initially, and recently added three more to meet the demand. One of the newer homes is licensed as a rehabilitation facility. They contract with an agency experienced in nursing home management to administer the properties and services. LHA was able to finance the buildings through innovative combinations of federal programs and market financing. Financially, the homes were stable until the pandemic. With the workforce crisis that began during the pandemic, they have struggled with losses due to overtime and use of agency staffing. They did bring in a new management company this year, who is expected to better manage staffing while also adhering to the strict guidelines of the Green House model.

Conclusions

Vermont has already undertaken a wide range of initiatives to address the components that make the development of effective, inclusive models of residential services possible. The current workforce and housing crises have received widespread attention among the public and lawmakers. As DAIL's efforts coalesce with those of others within state government and across Vermont communities, there is a powerful opportunity to create system change. At the same time, with every sector clamoring for workers and every part of the population short on housing, the potential for unproductive competition for resources is strong. With this in mind, our findings have led us to three conclusions.

Strengthening and expanding the most efficient models already in use will have the best return on investment.

Leveraging housing programs through public-private partnerships to access new housing should center on inclusive models that welcome people with and without disabilities.

Targeted investment of new funds on models for people with the most complex needs will be necessary.

The models we have recommended form an interlocking vision for these findings. When taken together the models provide a person-driven, inclusive experience that would be harder to achieve with a more piecemeal approach. Remote support and individual apartments without additional avenues for social networking and roommate matching would risk leaving people more isolated and vulnerable than they are now. Focusing on only the most cost-effective options would leave those with higher support needs without the expert services they need to thrive. Developing staffing-intensive service models providing that expertise without an increase in workforce capacity and workforce housing would mean few programs could actually be implemented. The broad scope of the work that was asked of Aspire speaks to DAIL's understanding of this interdependence.

Aspire is deeply appreciative of the opportunity to serve the people of Vermont through this project. We are hopeful that the work has revealed some favorable paths forward for DAIL and the people who rely on and deliver home and community-based services. The energy and commitment of everyone we met during our research are remarkable. The Aspire team is confident that DAIL is moving the service system in the direction Vermonters need it to go.

Appendix A – Stakeholder Survey/Interview Questions

See Attached PDF file

Appendix B – Provider Interview Questions

Script for Interviewing Providers of Alternative Residential Services

Program Name_____

Provider Organization_____

Name/Title of Person Interviewed_____

Contact Information (phone/email)_____

Interviewer_____

Date of Interview_____

Section I. Model Parameters

1. What population does this program serve? (age, diagnosis, eligibility criteria)
2. Describe the intensity of supports (i.e. 24 hour, as needed, limited)
3. Describe the housing utilized by the program
    a. Physical set-up and location
    b. Type of community: large city, rural/farm, small town, etc.
    c. Number of individuals served in the location
    d. Who owns the site?
    e. How is the site paid for?
    f. How many locations for this program (your agency, other agencies in your state)?
4. How long has the program been in operation?

Section II. Participant Experience

1. How does your program meet a previously unmet service need in your state?
    a. Whose need was it: participants', providers', state's?
    b. Is the need now met?

2. How does your program meet the requirements of the HCBS settings rule?

3. How does your program increase autonomy/choice for participants?
    a. How does this program increase or better utilize the existing housing stock?
    b. Do people have a choice of roommates?
    c. Do people have a choice of staff/supporters?
    d. Who controls the daily schedule or routine?
    e. How do you accommodate physical disabilities, sensory disabilities?

f. How do you address cultural competence/responsiveness in the program?
g. Do you have outcome data on program success? Will you share?

Section III. Workforce

1.What is the direct support workforce requirement for this program?
   a. How many DSPs for each person served?
   b. What special training is required for this program?
   c. What are your current vacancy rates and turnover?
   d. How does this program impact the workforce shortage?
   e. How does the DSP rate of pay for this program compare to the median wage in your state? To DSPs in other programs?
   f. Do people come from out of state to take DSP positions in this program?

2.How does this program impact workforce housing?
   a. Is the rate of DSP pay sufficient to pay for local housing?
   b. Does the program offer housing to DSPs?

Section IV. Provider Experience

1. Is this model of service appealing for a provider agency?
   a. Is there sufficient margin for stability and investment?
   b. Are expenses predictable? Why or why not?
   c. Are revenues stable/predictable? Why or why not?
2. What is the management structure required for this program?
3. What infrastructure is required for this program?
4. What were the start-up costs and how were these addressed?
5. Are there atypical expenses in this program that must be billed separately or built into rates?
6. How does this program fit into the payment model used in your state?

Section V. Regulatory and Legal Factors

1. Were there particular regulations, laws, or state programs that led to the development of this program?
2. What regulations had to be changed to enable this program to operate?
3. What laws had to be enacted or changed to enable this program to operate?
4. What changes to funding or payment models had to be changed to enable this program to operate?
5. Has this program been replicated in outside your state?

Appendix C – Provider Interview Contact List

Alternative Provider	Website	Interview Date	Contact Information
Aspire Living & Learning	Aspire Living & Learning - a private, nonprofit human service & educational organization. (allinc.org)	12.20.23	Steve Mendoza smendoza@allinc.org
Central Arizona Shelter Services	https://www.cassaz.org/	12.29.23	Lisa Glow lglow@cassaz.org
Easter Seals Arkansas	https://www.easterseals.com/arkansas/	11.6.23	Brad Hagan bhagan@EasterSealsAR.com
Farmsteads New England	https://www.farmsteads-ne.org/	11.30.23	Deb Descenza deborah@farmsteads-ne.org
Green House Homes at Mirasol	https://mirasolgreenhousehomes.org/	11.29.23	Jeff Feneis JFeneis@lovelandhousing.org
Hands on Huntington	https://huntingtonny.gov/hands-on-huntington	11.1.23	Joyce Little, 631-351-6610
HomeShare	https://www.homesharevermont.org/	10.30.23	Connor Timmons connor@homesharevermont.org
Howard Center - Safety Connection	https://howardcenter.org/safety-connection/	12.13.23	Delaina Norton DelainaN@howardcenter.org
Kallimos	https://kallimos.com/	12.7.23	Megan Marama megan@kallimos.com
KFI	https://www.kfimaine.org/	10.30.23	LyAnn Grogan lgrogan@kfimaine.org
Life Connections	https://www.lifeconnectionsusa.org/	11.15.23	Jennifer Cordaro jennifer.cordaro@lifeconnectionsusa.org
Main Street Connect	https://mainstreetconnect.org/	1.9.24	Sharon Cichy sharonc@mainstreetconnect.org

Mainstay	https://www.mainstayliving.org/	10.31.23	Doreen Cummings doreen.cummings@mainstayliving.org
MDTAP	https://mdod.maryland.gov/mdtap/Pages/MDTAP-Home.aspx	12.15.23	Lori Berrong lori.berrong@maryland.gov
Nascentria Health	https://nascentiahealth.org/	10.26.23	Andrea LaQuay 315-725-0130
PAHrtners	https://pahrtners.com/	12.20.23	Melissa Watson melissa.watson@rhanet.org
Provail	https://provail.org/	11.11.23	Amal Bennani Grabinski amalg@provail.org
The Kelsey	https://thekelsey.org/	10.31.23	Tom Hespod, Kyle Gaughan 617-631-6885
Visions	https://www.visionsnh.org/	11.15.23	Sylvia Dow sdow@visionsnh.org
Waypoint	https://waypointmaine.org/	12.18.23	Jennifer Putnam jputnam@waypointmaine.org
Waystone Health & Human Services	https://waystonehhs.org/	10.30.23	Josh Ryder jryder@waystonehhs.org
Winston Prouty Center	https://winstonprouty.org/housing-development-project/	12.12.23	Chloe Learey chloe@winstonprouty.org

Appendix D – Rubric Spreadsheet

See Attached Excel file

Appendix E - Descriptions of Additional Providers

All Populations

The Kelsy – California

https://thekelsey.org/

The Kelsy has two urban housing communities currently under development. The Kelsey Ayer Station is a fully inclusive mixed-ability, mixed-income housing community located in a transit-oriented neighborhood blocks north of downtown San Jose. The 115 apartment homes include a mix of 2-bedrooms and studios for individuals with and without disabilities across various incomes. The project features community amenities and outdoor spaces. The Inclusion Concierges™ connects residents, the community, and desired services and supports. The Kelsey Civic Center will be a vibrant urban co-living community offering 112 homes for people of all abilities, incomes, and backgrounds. This project addresses the global impacts of climate change alongside the affordable housing crisis.

Mainstay – Massachusetts

https://www.mainstayliving.org/

Mainstay provides human service and housing programs across Massachusetts, including permanent supportive housing. Their mandate covers a variety of vulnerable populations, including low-income elders; people with intellectual, developmental, and physical disabilities; and the recently homeless.

They manage and provide supportive housing services at numerous privately-owned homes for people with a range disabilities. These homes are affordable and located in desirable residential neighborhoods. Each home offers overnight live-in staff and an evening support staff. Each resident has their own private room, with a shared bath and ample common space, including fully equipped kitchen and laundry. The model is a Collaborative Living Support program that combines family and staff support.

Waystone Health & Human Services – Massachusetts

https://waystonehhs.org/

Waystone offers congregate care in staffed homes that address the needs of several different populations. These include medically compromised individuals, young adults with Autism Specturm Disorder turning 22, people with intensive behavioral needs, and people with acquired brain injury. For people with less intensive needs they operate the following services: Adult

Family Care for adults with disabilities; Shared Living for adults with IDD; Individualized Support Services (case management, nursing oversight, and financial management) for older adults

Winston Prouty – Vermont

https://winstonprouty.org/housing-development-project/

The Winston Prouty Center is embarking on project to building housing on it's 180 acre campus to be a part of the solution to the housing crisis our community is facing. The ultimate outcome of this project to develop up to 300 units of diverse housing. The goal is to create a neighborhood that reflects all the different kinds of people and needs that exist in the community. This includes multiple types of housing, from apartments to condos to duplexes, in a variety of structures. It will be affordable for many, not just those who are the lowest income brackets.

People Who Are Deaf, Hard of Hearing, DeafBlind

People Incorporated – Minnesota

https://www.peopleincorporated.org/

The mission of People Incorporated is to transform the health of communities through innovative solutions by providing a system of care predicated on excellence and inclusivity in behavioral health treatment, community support, and education. People Incorporated offers supported living services for people who are Deaf or Hard of Hearing that emphasize cultural accessibility, with the primary mode of communication being American Sign Language who have mental concerns. From inpatient, drop-in, or in-home health services, they have a system of care, helping individuals find support within the deaf community and wherever they are in their mental health journey.

People Experiencing Intellectual and Developmental Disabilities

Farmsteads – New Hampshire

In 2003, Farmsteads provides residential services on a working farm in Hillsborough, NH and Epping, NH. Farmsteads is a residential model that provides each person with his/her own one bedroom apartment within a cluster of apartments on a working farm. Each building is designed with four one-bedroom apartments surrounding a common room and are ADA compliant and handicap accessible. Each building is staffed in accordance with the needs of the individuals living there; most have live-in staff who help with over-night supervision. These apartments give each person maximum privacy and the chance to be as independent as they are able while also having as much support as is needed for safety and the companionship of friends nearby.

L'Arche Boston North – Massachusetts

https://larchebostonnorth.org/

L'Arche Boston North is a community where people with developmental disabilities ("core members") and those who assist them live together as family. Daily life is centered around four communal homes and the 20 core members who live there. They are an inter-denominational faith community where the gifts of core members are revealed through mutually transforming relationships. L'Arche also offers shared living. Community life for all includes weekly and monthly community events, prayer and spiritual gatherings, retreats, inclusion in L'Arche regional, national, and international gatherings and travel opportunities, and a support network for shared living providers.

Visions for Creative Housing Solutions– New Hampshire

https://www.visionsnh.org/

Visions for Creative Housing Solutions provides permanent, secure homes for Upper Valley adults with developmental and similar disabilities. People live among a caring circle of friends, with individualized wrap-around support services. Sunrise Farm in Enfield is an 80-acre setting with a built-in pool, hiking trails, and flower and vegetable gardens supporting eleven adults. The Green Street Commons site encompasses newly renovated apartments with supported housing for another eleven adults in the heart of Lebanon. Each location includes common areas and a family-style evening meal is offered at each site. Visions offers 24/7 oversight of with a wide range of support services.

People With Brain Injury

ADEO - Colorado

ADEO offers an alternative to nursing homes focused on wellness and connection. Stephens Farm features 19 affordable, accessible private studio apartments with common spaces for recreation and dining and 24/7 staff support. Support is tailored to each resident's unique physical, behavioral, and health needs. Opening in 2025, Hope Apartments are undergoing renovation to offer more individual living options for people with brain injuries. There will be 28 affordable, accessible one-bedroom apartments, also with common spaces for recreation and dining and 24/7 staff support

Provail – Washington

https://provail.org/

PROVAIL's s Brainspace facility houses low-income adult TBI survivors who are unable to live independently. In addition to 24-hour support services, residents also have access to specialized therapy and nursing services as needed. The space is designed to be as home-like

as possible with a living room, fireplace, warm finishes, lots of natural light, outdoor patios, and garden areas.

Older Adults and Adults with Physical Disabilities

Hands on Huntington – New York

https://huntingtonny.gov/hands-on-huntington

Hands on Huntington is a Neighborhood Naturally Occurring Retirement Community (NNORC) that helps people aged 60 and over age in place. NNORC staff includes two social workers and a registered nurse. They coordinate services and community resources that help seniors maintain their quality of life and independence in their home. Hands on Huntington is a grant-based program funded through the New York State Office of Aging and supported by the Town of Huntington, The Suffolk Y JCC and community partners and serves the local community. They work mostly in the local senior citizen complex, but see people living in their own homes elsewhere in the community as well.

Kallimos – Colorado

https://kallimos.com/

Kallimos a for-profit mission driven public benefit corporation providing technical support to develop an intentional community design being developed by the Green House Project's originator as a multi-ability, multi-generational inclusive community. The Kallimos model brings generations together to create a community of good neighbors who know and help each other. Compact houses are clustered around a Commons area, along with tiny homes with lofts and studio apartments. Homes and common spaces employ universal design concepts to welcome all abilities and extend independence. Kallimos Commons are shared spaces within each pocket neighborhood where neighbors can enjoy food, fellowship and arts & wellness.
The people who live in Kallimos self-govern because it is their home. Development of Kallimos neighborhoods are in the planning stages in Colorado and another state.

Nascentria Health – New York

https://nascentiahealth.org/

Nascentria Health is a healthcare system without walls that provides both health care services and health insurance plans for people who live nursing homes or people who live at home and have long term care needs and qualify for Medicaid. They serve the same patients in different lines of business – better coordination and identification of needs. They also operate a low-income apartment building for older adults, with another in development. The Gardens at St. Anthony is a newly renovated building with modern, accessible apartments in Syracuse, NY, available to low-income older adults (age 55+) eligible for Medicaid who are currently homeless

or at risk of becoming homeless and meet specific qualifications. There are 27 one-bedroom units available to individuals or couples.

Nascentia arranges for all the support services to be coordinated and provided and receives a capitated rate to cover all services. Nascentria manages the providers through a contract they have directly with providers. There is a contract that outlines everything Nascentia is responsible. They oversee 48 counties Northwest of NYC.

Appendix F – Employing Foreign Nationals

Aspire consulted a law firm that specializes in immigration law employing 60 immigration attorneys nationwide and 100+ paralegals. They help identify visa options for a particular position, evaluate the work authorization status of potential candidates, conduct market evaluations, and file documents at all stages in the process. Based on their extensive experience, including working on behalf of a service provider previously, they provided the following preliminary information about options for employing people who are foreign-born as direct support professionals and personal care attendants in Vermont.

The minimum qualifications required for the position determine which work authorization options may be available. The most popular temporary work visa, H1B, demands that the position requires at least a bachelor's degree as a qualification, with some specialized skill. Twelve years of experience with this specialized skill may qualify as an equivalent. This requirement would likely exclude direct support professionals and personal care attendants.

However, roles that require the degree and some certification might qualify, such as behavior technicians/therapists, mental health professionals, nurses with special expertise, QIDPs, or managers. The H1B visa is valid for up to six years, and generally employers who want to retain this work would apply for a green card on the workers behalf a couple of years into employment.

The employer identifies a qualified candidate and then starts the visa process, which can take six to nine months. The identified candidate can apply from within the U.S. if they are here with valid status on another type of visa, or from outside the U.S. Employees with an H1B visa can transfer the visa from one employer to another.

Because H1B visas are subject to an annual cap, the opportunity to file a petition for one is offered by lottery. There is a lottery process in March, where candidates can register. The lottery occurs in April. The percentage of success varies each year, but about 20% of registrants are typically selected. Those who are selected can file a petition for the H1B visa. There is no guarantee that the petition will be approved. If it is, employment would start October 1 unless there was a request for additional evidence.

There is an option that allows for bypassing the lottery process. Nonprofit organizations that have a formal internship program/partnership with a college or university can become exempt from the annual cap. This would allow the nonprofit to apply for an H1B visa for a potential employee (even if that candidate was involved with the internship program). This process could take as little as two to three months.

The cost of the H1B visa process is borne by the employer. The cost of the lottery is $1,010, and additional fees of $1,710 to $4,960 to complete the process, depending on the size of the employer and speed of processing. Most employers utilize legal services to shepherd this process. While rates will vary across the market for legal services, one estimate for this process was $3,200.

Employing people who are in the U.S. with Temporary Protected Status (TPS) or have an asylum application in place is likely the only temporary visa situation that would apply to a DSP or personal care position. People with TPS are generally authorized to work to the TPS program end date, which is one to two years. Depending on the country they came from, the programs and work authorizations may be extended for many years. Ensuring that equitable and broad recruitment efforts include communities of immigrants from countries where TPS is in place may result in people with TPS applying for employment. Legal advice may be helpful for sorting through the status of any particular applicant.

Asylum seekers are eligible to file for work authorization six months after filing an asylum application. Since candidates with TPS or asylum applications would already have work authorizations, there is no additional cost to the employer. However, employers who want to retain these workers may choose to help pay for TPS extension filings or to sponsor them for a green card. An extension could cost about $1,000 for legal services, $410 for the work authorization fee, and $85 for the filing fee. Green card costs are discussed below.

If a spouse or family member sponsors an individual for a green card, the person will be issued a temporary work authorization for up to five years. This would not involve the employer. The employer can also sponsor employees or candidates for a green card. This is a long process, around two years. This is a long-term plan that, over several years, can create a pipeline of employees for the future.

To start the green card process, the employer files a Prevailing Wage Request with the Department of Labor (DOL). It is currently taking six to nine months for the Department of Labor to issue Prevailing Wage Determinations. One challenge in this process is the fact that DSPs don’t have a standard occupational classification. Therefore, providing enough information for DOL to select the correct wage information is essential.

Provided the employer is willing to pay the prospective green card holder at least the prevailing wage, the employer engages in the process of testing the U.S. labor market for qualified U.S. workers by running a series of legally required ads and reviewing candidates. If there are many openings for the same position in the same location, the employer can run one set of advertisements for all the openings, rather than separate advertisements for each opening. Provided no qualified candidates are found in response to the advertising, the employer then files a Labor Certification Application with the Department of Labor. These applications take up to a year to certify.

Once the Labor Certification Application is certified, the employer can file a green card petition on behalf of the employee. Once a green card number is available to the employee, he/she can either apply for a green card from within the U.S., or an immigrant visa at a U.S. consulate abroad and then enter the U.S. as an immigrant. Note that nurses have a fast-track process for green cards. The market analysis is not needed. If they have an Associate's degree and have passed a test making them eligible to practice in the U.S., they can apply for a green card.

If a shortage of a certain type of worker is documented, the employer can contract with an agency that specializes in recruiting international candidates. However, the field is rife with fraud, and due diligence is essential in selecting a recruiting agency. If an employer is sponsoring someone for a green card, they are responsible for most but not all of the costs. The first two steps are the DOL certification and the petition for immigration. The employer is obligated to pay for these first two steps. This could range from $3,000 to$5,600 per person for legal fees and $2,500 for each petition. The legal costs vary with the number of people for whom application is sought. The third step is the application for adjustment of status or the visa process, which could be about $3,200 per person, plus additional costs for family members. The employer must pay for the I-140 petition. The employee can pay for the cost of the I-485 application.

Employment agreements can protect the employer from employees who leave before a certain length of employment and require repayment of the investment in the green card process. (However, if the employer terminates the employee, there is no recoupment.) These agreements are subject to applicable contract law. Be aware this may make the employer less appealing in a competitive environment.

To understand whether a particular immigration strategy is a worthwhile investment, compare the fees and administrative costs of obtaining the work authorization (spread over the likely time the position would be filled) to the expenses of overtime pay, onboarding and training a succession of new workers, and the opportunity cost of limiting expansion of services during the period when no workers are found. These both should be compared to simply raising the wage of the position.

Appendix G – List of Sources

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Addressing the Direct Care Workforce Shortage: A Bipartisan Call to Action

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https://biavt.org/education/statistics/#tab-vermontstatistics

Burlington HUD income limits

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Choices for Care - rules

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DAIL Adult Services Division Quality Management Overview for Medicaid Funded Services April 2022

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DAIL Budget Testimony SFY2024

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DAIL Scorecard

https://embed.clearimpact.com/Scorecard/Embed/27950

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