A Profile of Home and Community Based Services in Ohio

March 2024

Robert Applebaum
Matt Nelson
Oksana Dikhtyar
John R. Bowblis

100 Bishop Circle, Upham Hall 396, Oxford, OH 45056
MiamiOH.edu/ScrippsAging.org | 513.529.2914 | Scripps@MiamiOH.edu

ACKNOWLEDGMENTS

In the 30th year of this longitudinal study to track Ohio's long-term services and supports system, we owe a debt of gratitude to many. First, this study would not have occurred without the long-time support of the Ohio Department of Aging (ODA). We have had the support of each of the ODA Directors over the past three decades and Director Ursel McElroy has continued as a champion of this work. At ODA we also received valuable support from Nancy Bucci, Jenny Carlson, and Mina Chang. Our industry partners, including Megan Kelley, Larke Recchie, Chris Murray, Pete Van Runkle, and Susan Wallace, have been great supporters and collaborators in this work. At the Scripps Gerontology Center we thank our research assistants, Makenna McClure and Negar Nik Bakht, for all of their work on the survey, and our communications specialist, Shawn Vanness for her help in producing this report. Finally, we recognize the many providers and consumers in long-term services and supports (LTSS) and hope that this work can in some small way contribute to making Ohio's system the best in the nation.

Robert Applebaum, PhD, MSW

Matt Nelson, MGS

Oksana Dikhtyar, PhD, MBA

John R. Bowblis, PhD

March 2024

This study was funded through by a grant from the Ohio Department of Aging and the Ohio Long-Term Care Research Project supported by the Ohio General Assembly through the Ohio Department of Higher Education.

To download or print additional copies of this report go to:
Scripps.MiamiOH.edu/publications

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

Recognizing that Ohio was facing a growing older population that was likely to need long-term services and supports, in 1993 the Ohio Legislature and the Ohio Department of Aging (ODA) committed to an ongoing research study to generate data to develop future state policies and plans. During the last 30 years, Ohio has made major strides in improving how older people with disability and their caregivers receive long-term services. An independent assessment scorecard of state long-term care systems completed by the AARP Public Policy Institute rated Ohio's overall long-term services system performance the 44th worst in 2014. However, in the 2020 rankings, Ohio had improved its overall standing to 19th out of 50. While Ohio still faces challenges as the size of the population in need of long-term services increases over the next two decades, the state's progress has been considerable.

DEMOGRAPHICS

- Ohio, has the sixth largest older population in the nation. In 2020, Ohio had 2.85 million individuals age 60 and older (24%) and more than 2 million Ohioans (17%) were age 65 and older.
- Over the next 20 years, the state's overall population is projected to decline slightly (-0.9% between 2020-2030 and -3.2%, 2020-2040).
- The population age 65 and older will record a moderate increase from 2.05 million in 2020, to 2.28 million in 2030 (11.1%) However, because of a decline from 2030 to 2040 to 2.12 million, the 2020-2040 increase is just 3.5%.
- Today 466,600 individuals are age 80 and over and 232,800 older persons age 85 and above.
- The population age 80 and 85 is projected to increase between 2020 and 2040 (24.3% and 12.3% respectively).
- Demonstrating the large impact of the COVID-19 pandemic, Ohio's 85 and older population, which had been projected to increase by more than 14% between 2020 and 2030, is now projected to drop by -8.2%. While the 85 plus group will increase by 12.3% by 2040, our pre-pandemic projections were for a more than 50% increase in this group of older Ohioans.
- To put these demographics trends in perspective, in 2020 there were 38.4 Ohioans aged 0 to 59 for every Ohioan aged 85 and over. By 2050, this ratio is projected to be 29.5, a nearly 23% decline.

LONG-TERM SERVICES AND SUPPORT SYSTEM (LTSS) CHANGES

- There have been considerable shifts in how long-term services and supports are financed and delivered in the state, with a shift towards home and community-based services (HCBS).

- In 1993, the first year of the Scripps longitudinal study, nine in ten Ohioans age 60 and older with severe disability who were supported by Medicaid received services in the nursing home setting. By 2021, more than six in ten (62%) of those age 60 and over with severe disability and supported by Medicaid received HCBS, rather than nursing home care.
- In 2021, just over 95,000 Ohioans age 60 and older received long-term services through the Medicaid program. Of these Ohioans, slightly more than 35,000 were in a nursing home and 60,000 where receiving long-terms services in a home and community-based services waiver program.
- Older Ohioans receive these home and community-based services in their own homes, in the home of family or friends, or in an assisted living facility.
- These services are provided through two Medicaid programs. For older Ohioans living in the urban counties of the state, who are dually eligible for Medicaid and Medicare, home and community-based services are provided as part of an integrative care demonstration known as MyCare.
- Older people in non-MyCare counties and those age 60 an over not yet eligible for Medicare, regardless of county, remain in the fee-for-service Medicaid program and receive services through Ohio's PASSPORT and Assisted Living Medicaid Waiver Program.
- The PASSPORT program serves some 26,450 older individuals annually and the assisted living program serves 4,400 Ohioans. MyCare provides care to 32,000 older Ohioans receiving long-term services in a home or assisted living.

RESIDENTIAL CARE FACILITIES (RCFS) IN OHIO

- While the nursing home bed supply has dropped over the last two decades, the number of residential care facilities (RCFs), which include assisted living facilities, has seen considerable growth.
- In 1992, Ohio had 250 licensed RCFs and fewer than 10,000 beds. By the end of 2021, Ohio had 791 RCFs with more than 67,000 beds.
- In 2021, Ohio had more than 50,000 units. Most of Ohio's RCFs operate as assisted living facilities (86%). Four in ten RCFs have a designated memory care unit (42%).
- The average private pay rate in 2021 was $4,800 per month. This rate was $2140 higher per month ($6,940) for residents in a memory care unit.
- Four in ten RCFs (43.4%) participate in the Assisted Living Medicaid Waiver Program and one in three serve residents enrolled in the MyCare demonstration.
- In 2021, 72.1% of RCF units were occupied, a substantial drop from the 81.3% reported in 2019. However, occupancy rates have been dropping slowly since 2015 (88.9%) due to the continued expansion in the number of RCF units.
- Overall more than half of RCF residents (51%) were reported to be age 85 and older. Two-thirds of residents reported needing assistance with bathing (67%) and half (51%) required assistance with dressing.

- Three in ten residents (30%) have a cognitive impairment and just under half (46%) have two or more impairments, which approximates the nursing home level of care admission criteria under Medicaid. One in ten residents is reported to have behavioral problems and/or severe mental illness (11% and 8%, respectively).
- Staffing levels in RCFs showed a resident-to-staff ratio of 14 residents to each direct care worker on the day shift. The night shift had 23 residents to each direct care worker.
- For licensed nursing staff (i.e. registered nurses or licensed practical nurses) on the day shift there was one licensed nurse per 24 residents, while on the night shift, this ratio became 43 residents per nurse.

FUTURE CHALLENGES

Despite Ohio's improvement, the path forward includes a number of challenges. The size of Ohio's older population today is unprecedented in our history, but a 24% increase in those age 80 and older over the next two decades will continue to have an impact. These demographic shifts alone would be difficult, but in combination with additional system complications that have been heightened as a result of the COVID-19 pandemic (workforce, infection control, individual and public funding, quality of care, and family caregiving pressures), the pressures for family and the public sector are considerable. The COVID-19 pandemic shined a spotlight on the need for system changes; policy makers, consumers, family members, advocates, and providers will need to work together to address current issues and future needs. To this end, we offer the following ideas for consideration:

Preventive Actions

As a nation we spend a substantial amount of resources through both the Medicare and Medicaid programs to assist individuals with medical care and long-term services. Evidence-based practices, now supported by the Ohio Department of Aging through the federal Older Americans Act, have been shown to have an impact on disability rates of older people. If Ohio were able to reduce the sheer number of severely disabled older people by just 10%, that could mean 19,500 fewer older people with severe disability and 8,500 fewer individuals needing Medicaid LTSS. The Older Americans Act resources used to support these types of programs for the entire nation totaled $44 million, in comparison to the more than $1.6 billion on Medicare and Medicaid. Strategies to reduce the presence of disability for older people can include individual programs focusing on areas as home modifications that promote the use of safety and adaptive equipment (such as bath grab bars), and social and nutritional activities that enhance independence. The ODA Strategic Action Plan for Aging (SAPA) includes an array of important ideas to address this area. However, because states are heavily

reliant on the federal Older Americans Act to support such activities, the overall investment has not kept pace with the dramatic population increases.

Expanded Support Services

Medicaid is the major state funding source for LTSS, but individuals need to be severely disabled and meet strict income and asset criteria to receive assistance. There are a sizable number of older people (estimated at more than 100,000) in Ohio who experience moderate levels of disability and who are just above Medicaid eligibility. Several recent studies have shown that states with fewer supportive services, such as home-delivered meals and personal care, had a higher proportion of low care residents in nursing homes. Another study found that individuals receiving congregate meals were less likely to be admitted to nursing homes or to be admitted to hospitals when compared to a group of older people not receiving meals. A study of Area Agencies on Aging found that organizations able to have partnerships to link community services with health care organizations had significantly lower hospital readmission rates and significantly fewer low care residents in nursing homes in the regions served.

An approach used by a few states (Minnesota, Washington) to address this issue has been to pursue Medicaid waivers from the Centers for Medicare and Medicaid Services (CMS) that provide federal support to use Medicaid funds for individuals before they actually meet Medicaid eligibility for LTSS. A strategy used in Ohio to provide additional support services to older people has been the use of community supported levies. A recent Scripps study found that very high levy counties had fewer low care residents in nursing homes and a lower utilization rate of Medicaid HCBS. The proposed Healthy Aging Initiative would be an important step in expanding support services in the community.

Better Support of Caregivers, Both Informal and Formal

Studies consistently indicate that for individuals with severe disability, family and friend caregivers provide about 80% of all the assistance received. The pandemic has certainly increased these levels as many more individuals are getting care at home. The major support for caregivers in the United States comes though the National Family Caregiver Support Program under the Older Americans Act. As was the case for prevention and supportive services, this component of the act has limited funding, with $145 million allocated annually nationwide for this program. However, we have learned that it is critical to successfully support older people living independently. In particular, when families, who are providing the bulk of care in this country, can no longer hold up to the pressures of caregiving, nursing home or assisted living care is required for the older adult.

Without question, the number one issue being discussed across the array of long-term settings in Ohio and the nation overall involves the LTSS formal workforce. While worker quality and shortages have been a consistent challenge for the long-term industry for more than 30 years, the pandemic brought this problem to even greater heights. Nursing homes, assisted living facilities, and home care services have all been impacted. Of course, long-term services are not alone, as restaurants, hotels, and retail outlets have all reported worker shortages. RCFs in the Biennial Survey reported limiting admissions when not enough workers are available and home care providers have reported similar issues. States and providers are exploring options to address the worker challenges, but there is no one answer that will solve this problem. There is certainly a clear recognition by state policy makers and the industry that this problem must be addressed. Ohio's recent legislation allocating additional funds to address this challenge in home care and RCFs is an important step. A LTSS system plan to form a short-term and long-term response to the workforce challenge would be a critical next step.

Harnessing Technological Innovation

Even if Ohio makes great advances in the areas previously discussed, the demographic changes of tomorrow will still present significant challenges for the state. One important area that offers room for optimism involves the use of technology to meet future long-term needs. Many of these technological innovations are already in design, such as the Uber transportation and Uber Eats, while others will be tomorrow's new ideas. As an example, Toyota and Honda, in anticipation of Japan's rapidly increasing aging population, have developed robots that are designed to help individuals with personal care. Other technological ideas, such as enhanced communication systems to reduce social isolation, telehealth options for improving health access, and floor sensors in senior centers or retirement communities to identify individuals who are at risk for falling are all in development. Technological development cuts across the public and private sectors but how can state policy makers support these activities? As Ohio's manufacturing profile has decreased, could the state leverage such resources as its universities, Wright Patterson Air Force Base, and many others to design, develop, test, and market such technologies? With a large aging population and a strong research and development community, Ohio could become a leader in technology for an aging society.

Conclusion

Ohio's progress in LTSS system reform has been significant. The changes that have occurred were almost unimaginable three decades ago. However, the demographic and service hurdles of tomorrow will continue. What Ohio's experiences have shown is that the state can respond to these new and never experienced challenges associated with

population aging, but it will take creativity, commitment, and cooperation to succeed. While designing an efficient and effective system of long-term services is no small task, Ohioans are counting on our state to be a good place to grow old.

This page is intentional left blank.

BACKGROUND

Recognizing that Ohio was facing a growing older population that was likely to need long-term services and supports (LTSS), in 1993 the Ohio Legislature and the Ohio Department of Aging (ODA) committed to an ongoing research study to generate data to develop future state policies and plans. During the last 30 years, Ohio has made major strides in improving how older people with disability and their caregivers receive long-term services. An independent assessment scorecard of state long-term care systems completed by the AARP Public Policy Institute ranks states based on a series of criteria focusing on access and affordability, choice, quality, support for family caregivers, and effective transitions across health and long-term services. In the early 2010s, AARP rated Ohio's overall long-term services system performance poorly, ranking 38th worst out of 50 states in 2010 and 44th worst in 2014. However, in the 2020 rankings, Ohio had improved its overall standing to 19th out of 50. While Ohio still faces challenges as the size of the population in need of long-term services increases over the next two decades, Ohio's progress has been considerable.

As had been the case for many states, Ohio's approach thirty years ago emphasized nursing home care for older people because of federal rules surrounding the use of Medicaid funds. However, as a result of a series of public and private changes, the balance in the long-term services system has been altered. Factors contributing to this change include a major expansion of home and community-based services funded through Medicaid, the growth in the private sector home care market, the development of the assisted living industry and the implementation of the Assisted Living Medicaid Waiver, and an increased emphasis on short-term rehabilitative care provision by the nursing home industry. This report examines Ohio's efforts to expand the home and community-based services available to older Ohioans with long-term service needs.

The data used for this study come from an array of sources. The population and disability numbers come from the U.S Census Vintage files, the Ohio Department of Development, Office of Research, and the Scripps Gerontology Center Population Research website. Data describing residential care facilities come from the Biennial Survey of Long-Term Care Facilities. The Biennial Survey has been collected by Scripps since 1997, and was distributed to all residential care facilities who operated in 2021 (82% response rate). Data on the characteristics of PASSPORT, Assisted Living Waiver participants and MyCare enrollees are available through the ODA PIMS data base.

OHIO'S DEMOGRAPHIC CHANGES

Ohio, as is the nation overall, is aging. Three factors have resulted in a growing population age 60 and older: increasing life expectancy, population out-migration, and

lower rates of fertility. In 2020 Ohio had 2.85 million individuals age 60 and older (24.2%) and more than 2 million Ohioans (17.4%) were age 65 and older (See Table 1). In 2020, there were 466,600 individuals age 80 and over and 232,800 older persons age 85 and above living in Ohio.

Over the next 20 years, the state's overall population is projected to decline (-0.9% between 2020-2030, -3.2% between 2020-2040.The population aged 60 and over is projected to have a 2.8% increase from 2020 to 2030, but declines by 4.9% by 2040. For those aged 65 and over, this same pattern of an increase, and subsequent decline in population is also found. From 2020 to 2030, there are projected to be an 11.1% increase in Ohioans aged 65 and over, but by 2050, this age group is projected to be 4.3% smaller.

The most interesting patterns are among those aged 80 or 85 and older, the group most likely to need long-term services and supports either at home, an assisted living, or nursing home. Demonstrating the large impact of the COVID-19 pandemic, Ohio's 85 and older population, which had been projected to increase by more than 14% between 2020 and 2030, is now projected to drop by -8.2%. While the 85 plus group will increase by 12.3% by 2040, our pre-pandemic projections were for a more than 50% increase in this group of older Ohioans. By 2050 we will see a 24% increase in the 85 plus population. Putting these demographics trends in perspective, in 2020 there were 38.4 Ohioans aged 0 to 59 for every Ohioan aged 85 and over. By 2050, this ratio is projected to be 29.5, a nearly 23% decline.

Table 1. Projections of Ohio's Aging Population (2020-2050)											
Year	**2020**	**2030**	**2040**	**2050**	**2020 percent of population**	**2030 percent of population**	**2040 percent of population**	**2050 percent of population**	**Percent Change (2020-2030)**	**Percent Change (2020-2040)**	**Percent Change (2020-2050)**
All Population	11,799,448	11,694,767	11,425,531	11,123,896	100.0	100.0	100.0	100.0	-0.9	-3.2	-5.7
60 and over	2,855,985	2,937,042	2,717,015	2,618,361	24.2	25.1	23.8	23.5	2.8	-4.9	-8.3
65 and over	2,047,720	2,275,493	2,120,160	1,959,822	17.4	19.5	18.6	17.6	11.1	3.5	-4.3
80 and over	466,638	491,511	579,923	547,629	4.0	4.2	5.1	4.9	5.3	24.3	17.4
85 and over	232,833	213,788	261,400	288,627	2.0	1.8	2.3	2.6	-8.2	12.3	24.0

Source: Ohio Department of Development Population Projections, 2020-2050.
https://devresearch.ohio.gov/files/research/p6001.pdf

Led by ODA, Ohio's aging network is divided into 12 regional Area Agencies on Aging, plus one independent PASSPORT Administrative Agency (PAA), established as part of a pilot in 1993 in Sydney. These regional agencies provide the foundation for home and community-based services (HCBS) in the state. Data on Ohio's older population broken down by the 13 regional agencies for 2021 is shown in Table 2. One in four Ohioans are age 60 and older, but those proportions vary across the state. The Youngstown region has the highest proportion of older adults with three in ten individuals age 60 and older, while the central Ohio region surrounding Columbus is the lowest with less than one in five age 60 and older. The actual numbers vary dramatically based on the region. The Cleveland area record more than 550,000 individuals age 60 and older, while the Marietta region has just under 67,000. There is also significant variation in the population age 85 and older. The 227,000 individuals in this age group in 2021 were dispersed across the state, with 47,000 residing in the Cleveland region and just over 4,700 in the Marietta region.

To gain a more in-depth overview of the older population in need of long-term services and supports we examined the older population with severe disability as a result of cognitive or functional limitations (See Table 3). Almost 200,000 Ohioans age 60 and older experience severe levels of long-term disability. About half of these individuals have incomes at or below 300% of the federal poverty level and are thus most likely to need support provided through Ohio's Medicaid program. Prior to experiencing severe levels of disability, nine in ten Ohioans do not use Medicaid services. However, because only about 10% of individuals age 65 and older have private long-term care insurance and Medicare does not cover long-term services, individuals use personal financial resources until depleted and then rely on Medicaid. The regional differences are heavily driven by overall population, but income levels also vary across the state, impacting the number of individuals with severe disability who are below 300% of the federal poverty level. For example, in the Rio Grande and Cambridge regions 61% of those with severe disability fall below 300% of poverty, while the Franklin county rate was 44%. These variations in the size of the at-risk population have an impact on program participation rates across the state.

Table 2. Ohio's Older Population by Region 2021, Ages 60, 65, 80, 85									
PAA Site	**Total Population**	**Total 60+**	**60+ percent**	**Total 65+**	**65+ percent**	**Total 80+**	**Total 80+**	**Total 85+**	**Total 85+**
Cincinnati	1,714,572	388,263	22.6	275,485	16.1	59,049	3.4	28,936	1.7
Dayton	839,885	211,848	25.2	155,249	18.5	35,906	4.3	17,897	2.1
Lima	358,447	90,560	25.3	65,804	18.4	15,044	4.2	7,464	2.1
Toledo	899,053	229,092	25.5	165,759	18.4	36,090	4.0	17,752	2.0
Mansfield	517,585	136,413	26.4	99,936	19.3	22,713	4.4	11,057	2.1
Columbus	2,081,215	408,212	19.6	287,103	13.8	57697	2.8	27,233	1.3
Rio Grande	423,694	109,024	25.7	78,730	18.6	17,085	4.0	7,673	1.8
Marietta	248,272	66,976	27.0	48,559	19.6	10,479	4.2	4,722	1.9
Cambridge	469,890	128,041	27.2	93,501	19.9	21,330	4.5	10,341	2.2
Cleveland	2,075,662	554,095	26.7	402,587	19.4	93,264	4.5	47,096	2.3
Youngstown	626,744	183,104	29.2	135,170	21.6	30,804	4.9	15,425	2.5
Akron	1,190,559	312,896	26.3	227,398	19.1	50,192	4.2	24,788	2.1
Sydney (CSS)*	334,439	87,696	26.2	63,718	19.1	13,973	4.2	6,491	1.9
Ohio	11,780,017	2,906,220	24.7	2,098,999	17.8	463,626	3.9	226,875	1.9

Source: U.S. Census Bureau, Population Division, Vintage file 2021, Release date: June 2022

* Catholic Social Services (CSS)

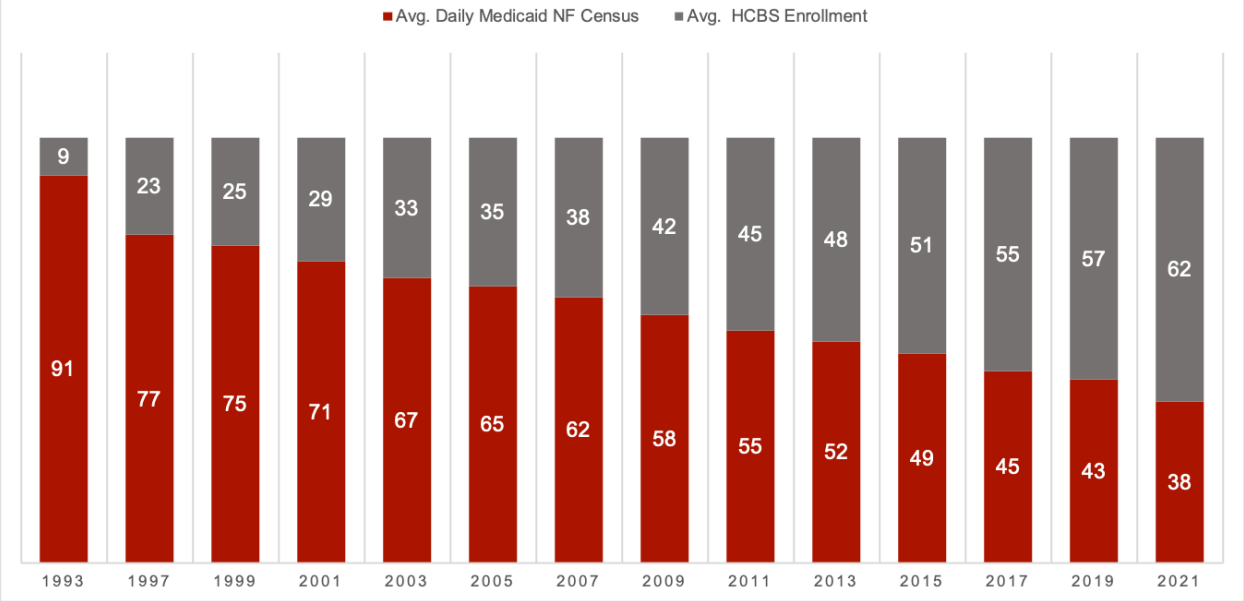
Table 3. Ohio's Older Population with Severe Disability and at 300% of Poverty by Region			
PAA Site	**Total 60+**	**Estimated Population 60+ with Severe Disability**	**Estimated Population 60+ with Severe and/or Cognitive Disability with Income at or below 300% of Poverty**
Cincinnati	388,263	25,878	12,254
Dayton	211,848	14,961	7,362
Lima	90,560	6,447	3,390
Toledo	229,092	15,623	8,222
Mansfield	136,413	9,490	5,320
Columbus	408,212	25,726	11,441
Rio Grande	109,024	7,116	4,379
Marietta	66,976	4,335	2,686
Cambridge	128,041	8,940	5,533
Cleveland	554,095	39,628	20,401
Youngstown	183,104	13,119	7,485
Akron	312,896	21,679	11,147
Sydney (CSS)*	87,696	5,826	3,224
Total	**2,906,220**	**197,623**	**102,843**

Source: U.S. Census Bureau, Population Division, Vintage file 2021, Release date: June 2022. Mehdizadeh, S. Kunkel, S. and Nelson, I. (2014). Projections of Ohio's Population with Disability by County, 2010-2030. Scripps Gerontology Center, Miami University, Oxford, OH.
* Catholic Social Services is also a PASSPORT provider in the Dayton region.

THE CHANGING LONG-TERM SERVICES SYSTEM

The major demographic changes experienced in Ohio have been accompanied by considerable shifts in how long-term services and supports are financed and delivered. In 1993, the first year of the Scripps longitudinal study, nine in ten Ohioans age 60 and older with severe disability were supported by Medicaid received services in the nursing home setting (See Figure 1). With policy changes and new expectations by consumers and families, Ohio has shifted its approach towards providing more of this care in the community. By 2021, more than six in ten (62%) of those age 60 and over with severe disability and supported by Medicaid received home and community-based services (HCBS), rather than nursing home care. In the mid 1990s Ohio was ranked as the 47th least balanced state in the nation (i.e., providing mostly care in nursing homes), Ohio's 2020 ranking of 19th was largely driven by its expansion of HCBS.

Figure 1.
Distribution of Ohio's Long-Term Care Services and Supports Use by People Age 60 and Older, 1997-2015

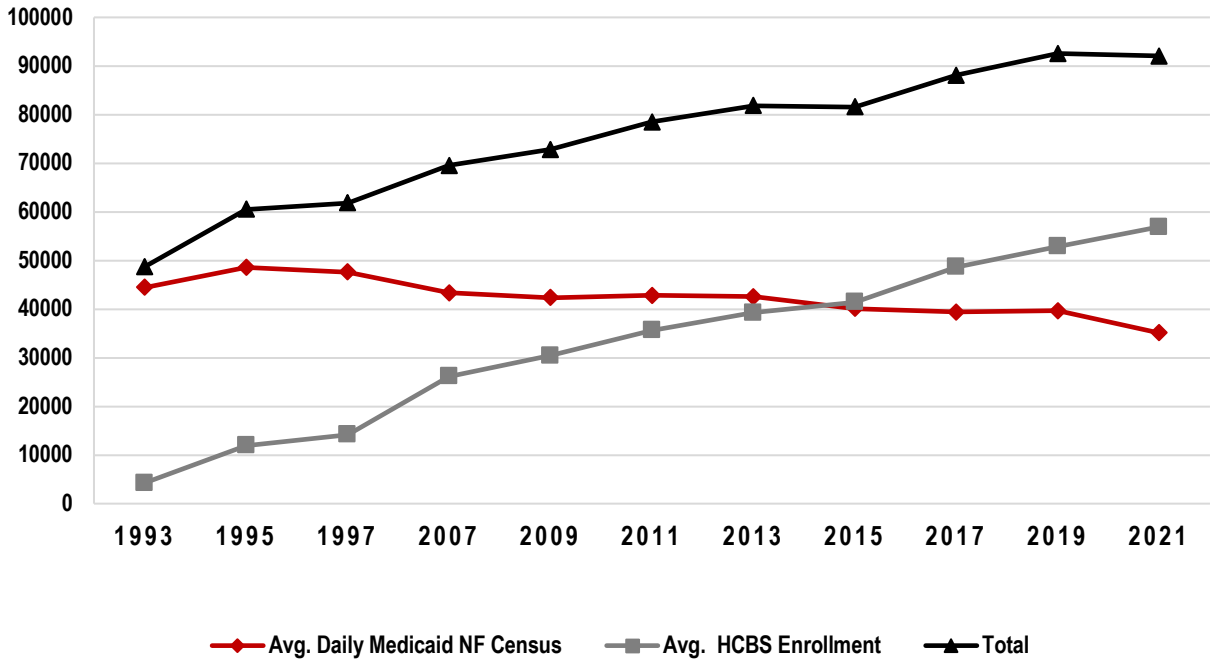


Source: Unpublished Medicaid Claims data, Ohio Department of Medicaid SFY 2005- 2013.
Health Policy Institute of Ohio, '*Ohio Medicaid Basics 2015.*
PASSPORT Information Management System (PIMS) 1993-2017
Ohio Department of Medicaid, 'Waiver Comparison Charts – Enrollment Figures for May 2019
Ohio Department of Medicaid, 'Caseload Report: Actual versus Estimated Medicaid Eligibles

In 2021, just over 92,000 Ohioans age 60 and older received long-term services and supports (LTSS) through the federal/state Medicaid program (See Figure 2). Slightly more than 35,000 older Ohioans were nursing home residents using Medicaid supported care. Ohio's HCBS waiver programs served just under 60,000 individuals age 60 and older, accounting for 62% of older people receiving Medicaid LTSS. Older Ohioans receive these HCBS in their own homes, in the home of family or friends, or in an assisted living facility, which is also considered a community-based living arrangement. These services are provided through two Medicaid programs. For older Ohioans living in the urban counties of the state, who are dually eligible for Medicaid and Medicare, HCBS are provided as part of an integrative care demonstration known as MyCare. In the MyCare program, five health plans across the state's urban counties receive a capitated reimbursement from both Medicaid and Medicare and are required to fund a comprehensive package of acute and long-term services. Older people in non-MyCare counties and those age 60 an over not yet eligible for Medicare, regardless of county, remain in the fee-for-service Medicaid program and receive services through Ohio's PASSPORT and Assisted Living Medicaid Waiver Program. The PASSPORT program serves some 26,450 older individuals annually and the assisted living program serves 4,400 Ohioans. MyCare provides care to 32,000 older Ohioans receiving HCBS.

Ohio has one PACE site, which is a national program designed to integrate acute and long-term services organized around an adult day care setting, that serves about 500 individuals.

FIGURE 2. MEDICAID LONG-TERM SERVICES AND SUPPORTS FOR INDIVIDUALS AGE 60 AND OLDER, 1993-2021

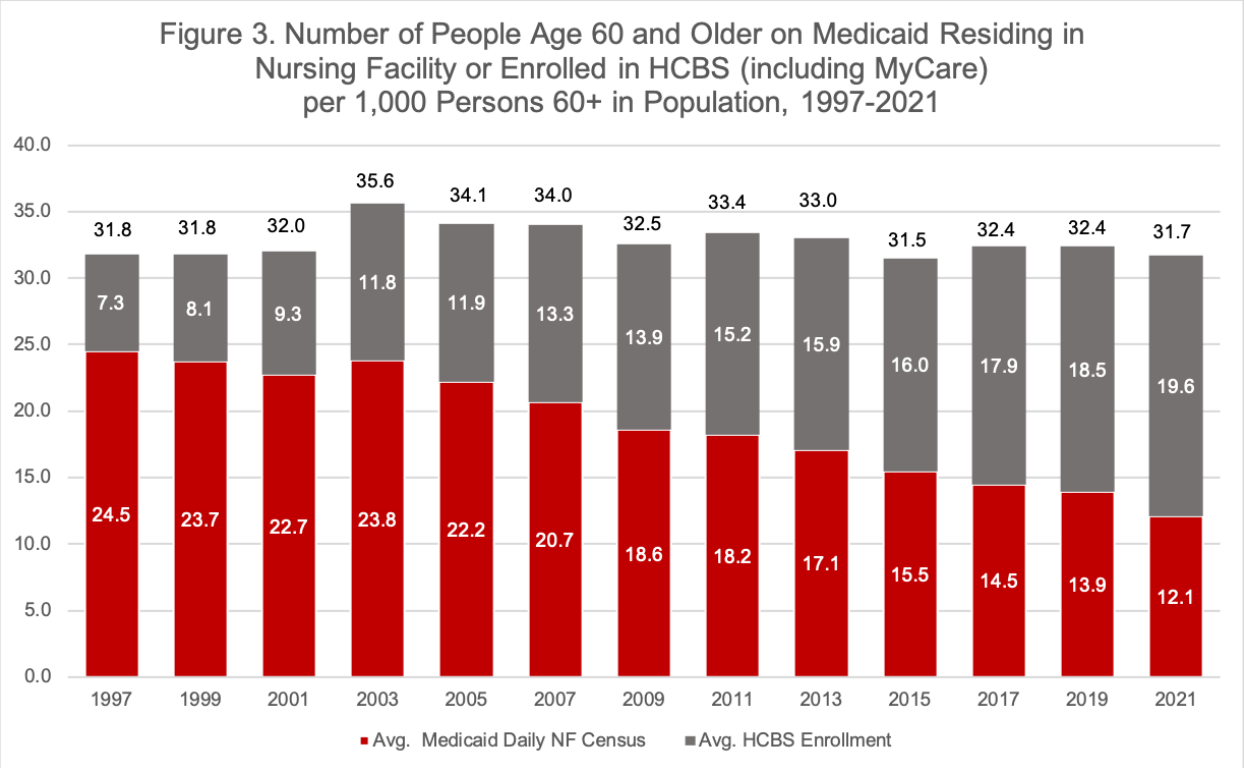


Source: Unpublished Medicaid Claims data, Ohio Department of Medicaid SFY 2005- 2013.
Health Policy Institute of Ohio, '*Ohio Medicaid Basics 2015.*
PASSPORT Information Management System (PIMS) 1993-2017
Ohio Department of Medicaid, 'Waiver Comparison Charts – Enrollment Figures for May 2019
Ohio Department of Medicaid, 'Caseload Report: Actual versus Estimated Medicaid Eligibles

The expansion of HCBS was widely supported by policy makers in Ohio, because HCBS are generally less expensive than nursing home care. However, these initial policy changes were accompanied by budget concerns, particularly that providing a new service would induce demand among Ohioans who would otherwise not receive care in a nursing home. These "add-ons" would increase the state's expenditure on the Medicaid program. The debate about "add- on" costs received considerable attention, but limited empirical evidence existed to address the question.

As noted, the number of Ohioans receiving long-term services increased from just under 49,000 in 1993 to 92,000 in 2021. The total number of Ohioans supported by Medicaid in nursing homes declined by about 10,000 from 1993 to 2021, while those enrolled in HCBS increased from 4,000 to 57,000 over the same period. This might suggest an

inducement of demand, but the number of older Ohioans during this period also increased. To account for the aging of the population, the number of Medicaid enrollees using nursing home or home care can be divided by the population aged 60 and older to assess if demand increased. Figure 3 provides longitudinal data examining this utilization from 1997 to 2021. In 1997, the proportion of Ohioans age 60 and older using Medicaid long-term services was 31.8 per 1,000 individuals age 60 and over. In that year, the majority of use occurred in the nursing home setting, 24.5/1,000, compared to 7.3/1,000 for HCBS. As Ohio expanded the use of HCBS the overall utilization rate did not change. In 2021, the proportion of Ohioans age 60 and older using Medicaid long-term services was almost identical to 1997 at 31.7 per 1,000. However, the nursing home utilization rate was cut in half, dropping to 12.1 per 1,000 (from 24.5 per 1000), while the HCBS use rate increased to 19.6 per 1,000. The constant overall utilization rate but the changing ratio of use of nursing home care and home care from 1997 to 2021, indicates that the HCBS expansion was offset by a reduction in nursing home use, rather than representing a service add-on.



Source: Annual and Biennial Survey of Long-Term Care Facilities, 1995-2019. Health Policy Institute of Ohio. 2015 *Ohio Medicaid Basics 2015.;* PASSPORT Information Management System (PIMS) 1993-2015.; United States Census Bureau 2013-2017 American Community Survey, 5 Year Summary File; Integrated Public Use Microdata Sample, National Historic Geographic Information Systems (IPUMS NHGIS); Unpublished Medicaid Claims data, Ohio Department of Medicaid SFY 2005-2013.
Ohio Department of Medicaid, 'Waiver Comparison Charts – Enrollment Figures for 2019
Ohio Department of Medicaid, 'Caseload Report: Actual versus Estimated Medicaid Eligible.

HCBS Participant Characteristics

With the large expansion of home and community-based services under Medicaid, Ohio now has one of the largest waiver programs in the nation. PASSPORT, which was expanded across the state in 1993, serves individuals age 60 and older who meet the nursing home level of care and Medicaid financial eligibility criteria. To implement the program, the state receives a waiver under Medicaid from CMS to serve nursing home eligible individuals with home and community-based services. The Assisted Living Waiver Program implemented in 2007, serves individuals age 18 and older who meet the Medicaid nursing home and financial eligibility criteria. In 2014, Ohio implemented the MyCare demonstration as part of the CMS Financial Alignment Initiative. MyCare provides HCBS to individuals who are dually eligible for Medicare and Medicaid who meet the nursing home level of care criteria and live in one of 29 urban counties of the state. The MyCare demonstration will end in 2025 and the state is now planning the next phase of this work. Table 4 presents an overview of the characteristics of participants in the three programs.

A review of participant characteristics shows some differences across programs. The AL waiver program serves an older population with half of the participants (50.7%) age 80 and older, compared to one in four in the PASSPORT and MyCare programs. AL waiver participants are more likely to be widowed (44% vs. 27% and 29%), also reflecting the differences in age and the residential nature of that option. For out of five MyCare and PASSPORT participants live in their own home or apartment and seven in ten are female. A higher proportion of MyCare participants were Black compared to PASSPORT and the AL waiver (37% vs. 20% and 9%).

Table 4. Characteristics of HCBS Participants in PASSPORT, MyCare and Assisted Living Waiver Programs			
	PASSPORT (%)	**MyCare (%)**	**AL Waiver (%)**
Age			
46-59	0.0	13.8	9.1
60-64	20.0	11.0	9.9
65-69	21.8	17.7	7.9
70-79	33.6	31.4	21.4
80-89	19.7	19.7	29.5
90-plus	4.9	6.3	21.2
Average Age	73.2	71.6	78.1
Gender			
Female	70.2	71.2	72.2
Race			
White	66.1	55.5	88.9
Black	19.6	37.4	9.0
Other	14.3	7.1	2.1
Marital Status			
Never Married	16.6	26.7	20.4
Widowed	29.3	26.5	44.6
Divorced/Separated	31.2	31.4	26.2
Married	23.0	15.3	8.9
Usual Living Arrangement			
Own home/apartment (1)	78.4	79.4	NA
Relative or friend (2)	19.5	20.5	3.2
Nursing Home	0.5	0.1	4.3
Number of Consumers Served	N = 26457	N = 32066	N = 4388

Source: PASSPORT Information Management System (PIMS) 1993-2021. Ohio Department of Medicaid, 'Waiver Comparison Charts – Enrollment Figures for 2021. Ohio Department of Medicaid, 'Caseload Report: Actual versus Estimated Medicaid Eligible.

RESIDENTIAL CARE FACILITIES IN OHIO

While the nursing home bed supply has dropped over the last two decades, the number of residential care facilities (RCFs), which includes assisted living facilities, and the supply of RCF beds has seen considerable growth. In 1992, Ohio had 250 licensed RCFs and fewer than 10,000 beds. By 1997, Ohio had 327 licensed RCFs, and by 1999, the number had grown to 438, with 27,052 beds. By the end of 2021, Ohio had 791 RCFs with more than 67,000 beds (See Table 5). While RCFs are typically licensed for dual occupancy, most rooms or units are used by one person, so RCF's are examined at the unit level. In 2021, Ohio had more than 50,000 units.

Most of Ohio's RCFs operate as assisted living facilities (94%), with the remaining RCFs (6%) not meeting the state's definition of an assisted living residence. An assisted living residence is required to have a private room and bathroom, locking door, and temperature controls. Four in ten RCFs (43.4%) participate in the Assisted Living Medicaid Waiver Program and one in three serve residents enrolled in the MyCare demonstration. One in five RCFs (20.7%) are part of a continuing care retirement community (CCRC) and more than half (51.9%) provide only RCF or assisted living care. Three in four RCFs are for profit (73%) and are located in an urban environment (77%). Almost six in ten RCFs (56.4%) are part of a chain. Six in ten RCFs (57.2%) report having residents using the telehealth care option and seven in ten report having an infection control preventionist at the facility. Eight in ten (83%) report an organized resident group. The average private pay rate in 2021 was $4,800 per month.

Occupancy rates were calculated as the proportion of occupied RCF units (See Table 6). In 2021, the overall unit RCF occupancy rate was 72.1%, a substantial drop from the 81.3% reported in 2019. RCF occupancy rates had been dropping prior to the pandemic, from 88.9% in 2015 to 85.3% in 2017 and 81.3% in 2019 as a result of the continued expansion in RCF units. While the substantial drop in occupancy from 2019 to 2021 is in part a result of the continued expansion of the industry (more than 4,000 new units added from 2019 to 2021) it primarily reflects the considerable impact of the pandemic, which was also felt in the nursing home industry.

Table 5. Profile of Residential Care Facilities in Ohio, 2021	
Facility characteristic	**Number or percent**
Number of RCF facilities	791
Number of units	50,124
Number of licensed beds	67,403
Facilities meeting the assisted living definitions (%)	94
Facilities participating in AL Medicaid Waiver program (%)	43.4
Facilities part of a continuing care retirement community (CCRC) (%)	20.7
Participate in MyCare demonstration	33.9
Free-standing facilities without independent living and nursing homes (%)	51.9
Facility has a specific memory care unit or only serves residents with dementia (%)	42.3
Some facility residents use telehealth	57.2
Facility reports having an organized resident group	83.0
For-profit Ownership (%)	73.0
Part of chain (multiple facilities not on site) (%)	56.4
Facility has an Infection Preventionist (%)	70.4
Facility in urban location (%)	77.5
Private monthly pay rate (dollars)	4,803

Source: Biennial Survey of Residential Care Facilities, 2021.

Table 6. Occupancy Rates in Ohio's Residential Care Facilities, 2013-2021					
	2013	**2015**	**2017**	**2019**	**2021**
Number of facilities	606	655	708	759	791
Number of units	33,182	35,979	40,450	45,931	50,124
Unit occupancy rate (%)	87.8	88.9	85.3	81.3	72.1

Source: Biennial Survey of Residential Care Facilities, 2021.

Characteristics of RCF Residents

RCFs do not have the same requirement to conduct and provide federally mandated resident assessments as nursing homes, so there is no systematic information on the characteristics of RCF residents. The Biennial Survey asks RCFs to provide a snap shot of their resident profile on the day the survey is completed and those findings are reported in this section. Data for the RCF industry are presented overall and broken down by whether a RCF met the assisted living waiver criteria (See Table 7). Overall more than half of the residents (51%) were reported to be age 85 and older, with the next largest grouping between 71 and 84 (36%). Seven in ten residents were female (71%). Two-thirds of residents reported needing assistance with bathing (67%) and half (51%) required assistance with dressing. Three in ten residents (30%) have a cognitive impairment and just under half (46%) have two or more impairments, which approximates the nursing home level of care admission criteria under Medicaid. One in ten residents is reported to have behavioral problems and/or severe mental illness (11% and 8%, respectively).

There are some notable differences between the facilities that are classified as assisted living and those categorized as a traditional RCF that does not meet the state's definition of being an assisted living. To be an assisted living facility under Ohio's Medicaid waiver program, residents must have a private room, a private bathroom, locking doors, temperature controls, and a food preparation area. Traditional RCF residents, relative to those that meet the assisted living criteria, are more likely to be under age 60 (16% vs. 4%), male (37% vs. 29%), and much more likely to experience a cognitive impairment (47% vs. 30%). Traditional RCF facilities are also more likely to have residents with behavioral health problems (25% vs. 10%) and severe mental illness (23% vs. 8%).

Staffing Levels, Challenges, and Strategies

As shown previously, about half of residents in assisted livings and traditional RCFs met the nursing home level of care criteria, with about one in three having cognitive impairment and one in ten having behavioral health problems. While these prevalence rates are lower than in nursing homes, residents in these communities still have a high need for direct care services. Providing high quality care requires having a strong, stable workforce, but recruiting and retaining staff across the long-term services spectrum has been a consistent challenge.

In 2021, the one-year retention rate, measured as the proportion of employees working on January 1st who were still employed on December 31, for direct care workers was 66% for full-time employees and 55% for part-time employees (See Table 8). The LPN/RN retention rate for 2021 was 75% for full-time employees and 68% for part-timers. When asked to rate the seriousness of retaining and recruiting DCWs, LPNs,

and RNs, administrators identified all three as a challenge, with ratings of 7 out 10 (10 being the worst challenge). RNs were rated as the most difficult to recruit and retain.

Table 7. Functional Characteristics of Ohio's Residential Care Facilities Residents, 2021

	Overall (Percentages)	RCF not AL	Meet Assisted Living Requirements
Number of Facilities	791	47	744
Under 60	4.8	16.3	4.1
Between 60 and 70	10.3	8.2	10.5
Between 71 and 84	35.8	40.2	35.6
85+	51.3	41.5	51.9
Gender			
Female	70.5	63.1	71.0
Functioning			
Bathing	67.0	68.8	66.9
Dressing	50.6	62.0	50.0
Transferring	31.3	33.8	31.2
Toileting	41.0	51.2	40.5
Eating	11.1	23.6	10.4
Medication	83.6	82.1	83.6
Walking	27.6	37.5	27.1
Cognitive Impairment	30.4	47.0	29.5
With two or more activities of daily living impairments or cognitive impairment*	45.5	51.3	45.1
Behavior Problems	10.8	25.1	10.1
Severe mental illness (SMI)	8.0	23.1	7.5

Source: Biennial Survey of Residential Care Facilities, 2021.
*Percentages are provided by facilities. The numbers are averaged for all facilities that provided a response to each question.

Table 8 also reports the staffing levels in RCFs as resident-to-staff ratios and the proportion of staff present on the day, evening, and night shifts. For direct care workers, 40% were present on the day shift with a staffing level of 14 residents to each direct care worker. The night shift had 25% of direct care workers with a staffing level of 23 residents to each direct care worker. For licensed nursing staff (i.e. registered nurses or licensed practical nurses), 46% were present during the day shift, 33% during the

evening shift, and 21% during the night shift. During the day shift there was one licensed nurse per 24 residents, while on the night shift, this ratio became 43 residents per nurse. Given the average number of units in a RCF and a 72% occupancy rate, the

Table 8. Direct Care Staffing in Ohio's Residential Care Facilities 2021		
Retention Rates	**Full-time Staff**	**Part-time Staff**
DCWs (%)	66.0	55.0
LPNs/RNs (%)	74.7	67.6
	Resident-to -Staff Ratio (mean)	**Proportion of Nursing Staff Type by Shift (%)**
DCWs		
10 am	14:1	40
7 pm	16:1	35
4 am	23:1	24
LPNs/RNs		
10 am	24:1	46
7 pm	32:1	33
4 am	43:1	21
Hourly wages (dollars)	**Starting**	**Highest**
DCWs	$13.20	$16.20
LPNs	$23.30	$27.20
RNs	$28.60	$33.30
	DCW	**LPNs/RNs**
Rate seriousness of retention problems (1-10 with 10 worst)	7.1	6.3/8.5
Rate seriousness of recruitment problems (1-10 with 10 worst)	7.5	8.1/9.1

Source: Biennial Survey of Residential Care Facilities, 2021.
DCW-direct care workers, LPN-licensed practical nurse, RN- registered nurse

average RCF has approximately two licensed nurses on duty during the day shift and one during the night shift.

Direct care workers are critical to the care provided in RCFs, and the Biennial Survey asked a series of questions about the strategies used by facilities to retain these individuals. Strategies were classified into two major groups; financial and workplace environmental strategies (See Table 9). For financial strategies, nine in ten facilities offered health insurance (95%) and vacation (89%), although the health insurance take-up rate averaged 37%. Three in four facilities reported offering a 401K or other retirement plan and two-thirds reported offering paid sick leave. Six in ten facilities

offered extra pay for shift differentials and to recognize merit and supported tuition reimbursement for staff. About half offered longevity pay increases, extra work perks such as free meals, and bonuses for good attendance. Four in ten offered longevity bonuses and bonuses for extra training. Finally, one in five (17%) offered extra financial support such as gas cards or assistance with auto repair.

Facilities also used a series of workplace environmental strategies to better retain workers. Eight in ten RCFs had staff work together to cover shifts and three in four attempted to provide scheduling flexibility for workers. Seven in ten cross-trained staff and used formal employee recognition programs to reward staff. Six in ten facilities reported assigning staff to the same residents and informing direct care workers at least one day before a change in care plan. There was more variation in the use of strategies that attempted to more actively involve direct care workers in the care process. For example, four in ten facilities involved direct care workers in resident care plan meetings, three in ten used direct care workers on quality improvement teams, one in four had direct care workers involved with scheduling, and 15% had direct care workers participate in hiring interviews. Fewer than 3% of facilities reported that their direct care workers were unionized and two-thirds of administrators reported knowing all of their direct care workers by name.

Table 9. Strategies Utilized to Retain Direct Care Workers in Ohio, 2021	
Strategy	**(%)**
Financial Strategies for Retention	
Offer health insurance (Take up rate 37.4%)	94.6
Provide paid vacation	88.6
Offer 401K or other retirement plan	76.0
Paid sick leave	66.2
Extra pay for shift differential	62.3
Provide merit wage increases	60.4
Offer tuition reimbursement	57.2
Offer other work perks (free meals)	52.2
Provide longevity wage increases	50.7
Offer career ladders	48.8
Offer bonuses for attendance	48.7
Offer hiring bonus after time on the job	43.3
Offer bonuses, raises, for completing extra training	42.2
Offer financial assistance (gas cards, help with car repair)	17.9
Workplace Environment Strategies for Retention	
Staff work together to cover shifts	80.7
Offer scheduling flexibility	73.6
Staff are cross-trained to perform tasks outside their regular duties	69.6
Offer employee recognition programs	69.6
DCWs are consistently assigned to the same group of residents	63.7
DCWs are informed within one day when a resident's care plan is changed	56.3
CNAs participate in resident care planning meetings	38.5
DCWs participate on quality improvement teams	31.2
Staff scheduling is managed by staff teams	24.9
DCWs participate in interviews of direct care applicants	15.1
DCWs choose which residents they care for	7.0
Residents participate on hiring teams for selecting new staff	5.4
Other Factors Related to Retention	
Facilities with unionized DCWs	2.7
Administrator knows all DCWs by name	
All	66.7
90 – 99%	20.1
75 – 89%	7.5
50 – 75%	4.5
Fewer than half	1.3

Source: Biennial Survey of Residential Care Facilities, 2021.

Successful recruitment of direct care workers is also critical to meet the staffing challenges faced by RCFs (Table 10). Nine in ten facilities reported using online platforms, such as Monster.com, seven in ten participate in job fairs and one-third work with employment agencies. More than eight in ten report offering referral bonuses to existing staff and six in ten do offer signing bonuses. Seven in ten facilities reported partnering with community colleges and offering flexible scheduling options. About half now offer tuition reimbursement programs. One in five offer same day pay, and have stopped requiring drug tests.

Table 10. Recruitment Strategies for Direct Care Workers in Ohio, 2021

Strategy	**(%)**
Work with online platforms (e.g., Monster, Indeed)	91.8
Offer staff referrals bonuses	83.2
Participate in job fairs	68.2
Partner with community colleges and/or vocational schools	68.0
Offer flexible scheduling	66.3
Offer bonuses to new employees	62.6
Offer tuition reimbursement	53.6
Work with employment agencies	34.0
Provide same-day pay	17.9
Stopped or do not require drug testing	17.9

Source: Biennial Survey of Residential Care Facilities, 2021.

When asked about strategies for addressing staffing shortages facilities there were several commonly used approaches (See Table 11). The most prevalent strategies were to ask current staff to pick up more hours or to offer financial incentives. More than half of facilities reported relying on agency staff. Sharing staff with a partner nursing home or assisted living facilities was used in about one-quarter of RCFs. Finally, more than one in ten facilities reported having to limit admissions because of staffing shortages.

Table 11. Strategies Used When Short Staffed in Ohio, 2021 (%)		
Strategy	**DCWs**	**LPNs/RNs**
Ask existing staff to pick up additional hours (e.g., double shifts, overtime)	92.3	87.2
Offer financial incentives (e.g., bonuses, shift differentials)	86.7	81.9
Use agency/pool staff	53.8	56.4
Use our own "on-call" staff	49.5	50.5
Share staff with our nursing homes (NH)	29.8	28.9
Share staff with an affiliated residential care facility (RCF)	23.0	22.9
Limit admissions	13.0	12.7

Source: Biennial Survey of Residential Care Facilities, 2021.
DCW-direct care workers, LPN-licensed practical nurse, RN- registered nurse

Memory Care Facilities and Special Care Units

With the growth in the number of individuals with Alzheimer's and other forms of dementia there has been an increase in the number of RCFs offering specialty memory care in dedicated units (See Table 12). In 2021, more than four in ten RCFs (43%) reported being 100% memory care or having a special memory care unit within the facility. Memory care units represent 25% of Ohio's RCF system capacity. On average, facilities charged an additional $2,144 per month for care in the Memory Unit. One in five facilities (18%) take only individuals with advanced dementia and three-quarters do require a recommendation from a physician. The approaches used to deliver memory care services vary by facility in such areas as consistent assignment, higher staffing levels, use of a locked unit or a secured outside area.

Staffing levels in memory care units were found to be slightly better than RCFs as a whole for direct care workers. For the day, evening, and night shifts, resident-to-staff ratios for direct care workers were 13 to 1, 15 to 1, and 20 to 1, respectively (See Table 13). The averages reported earlier for the entire facility in Table 8 had 1 to 3 additional residents per direct care staff member. Memory care units have about equal proportion of direct care staff devoted to the day and evening shifts (45% and 41%, respectively), but the fewest staff on the evening shift (14%). This is in contrast to all RCFs which have 24% of their direct care workers devoted to the evening shift. A review of licensed nurse staffing for memory care units found comparable or lower resident-to-staff ratios when compared to the typical RCF (See Table 8 and 13). There was less variation across shifts for licensed nurse staffing. This suggests that the memory care residents require more and different care than the typical RCF residents and may have implications for future staffing patterns.

Table 12. Description of Dedicated Memory Care Facilities and Units in Ohio, 2021	
Characteristics	**Number or Percent**
Number of memory care units	11,967
Facilities serving only memory care or with memory care units (%)	42.7
Proportion of all assisted living units in the state in memory care units.	23.9
Number of residents in memory care	8,863
Statewide memory care units occupancy rate (%)	74.0
Additional private pay payment per month for memory care ($)	2,144
Additional Medicaid payment per month for memory care ($)	0.0
Admission criteria (%)	
Facility only takes individuals with advanced dementia	17.5
Physician recommendation required for admission	75.0
Characteristics of the memory care facility/unit (%)	
Individualized therapeutic recreation plan	29.2
Written procedures to follow in the event of resident elopement	38.6
Visual cues or landmarks in the physical environment to assist with wayfinding	31.4
Environmental triggers are studied and eliminated	28.9
Display (or encouraging residents to display) meaningful objects in resident/patient personal areas	36.0
Consistent nursing staff assigned to memory care unit	38.3
Consistent nursing staff assigned for each resident within memory care unit	24.3
Higher staffing levels within memory care	33.5
Locked unit	38.0
Secured outdoor area	36.3
Room/unit alarms	19.5
Elopement alarms	30.8
Strength-based vs. deficit-based approaches	20.4

Source: Biennial Survey of Residential Care Facilities, 2021.

Table 13. Resident-to-Staff Ratios in Ohio's Memory Care Facilities/Units, 2021		
Nursing Staff (Shifts)	**Resident-to-Staff Ratio Average**	**Proportion of Nursing Staff Type on Shift (%)**
Direct care workers		
10:00 AM	13 to 1	45
7:00 PM	15 to 1	41
4:00 AM	20 to 1	14
Licensed practical nurses/registered nurses		
10:00 AM	25 to 1	41
7:00 PM	30 to 1	31
4:00 AM	33 to 1	28

Source: Biennial Survey of Residential Care Facilities, 2021.

Many experts have identified the need for specialized training for staff working with individuals with dementia. The majority of RCFs with memory care units have incorporated such specialized training for memory care employees (See Table 14). Two in three require training before individuals start their work in memory care units, and eight in ten require that training be done within the first 14 days. Almost all (97%) require ongoing in-service training for memory care staff. Approaches to physician monitoring varies by RCF with three in ten requiring weekly or more frequent monitoring checks for those on psychotropic medications, four in ten monthly and one in five quarterly. The most common behavior monitoring by physicians occurs either weekly (40%) or monthly (33%).

Table 14. Training and Monitoring in Ohio's Memory Care Facilities/Units, 2021	
Characteristics	**(%)**
Nursing staff training requirements	
Required special memory care training to start work on unit	64.2
Special training is required in first 14-days	81.1
Requires continuing education and training on best practices	96.6
Frequency of a physician monitoring of psychotropic medications	
At least 2-3 times per week	5.0
Weekly	23.9
Monthly	43.9
Quarterly	19.2
Semi-annually	2.7
Yearly	1.2
No monitoring is done by a physician	4.2
Frequency of a physician monitoring of behavioral symptoms	
At least 2-3 times per week	9.3
Weekly	39.9
Monthly	33.3
Quarterly	8.5
Semi-annually	0.4
Yearly	1.6
No monitoring done by a physician	7.0

Source: Biennial Survey of Residential Care Facilities, 2021.

TELEHEALTH

One of the changes in response to the COVID-19 pandemic was an increase in Telehealth opportunities. The Biennial Survey asked RCFs about their experience in this area (See Table 15). Six in ten facilities reported using telehealth most often with video and almost always in the resident's room. About half the time resident's used telehealth with their personal physician with the next common use, about one in four, for a visit with a mental health professional. Evaluation or therapy visits were the next most used category of telehealth (8%). The telehealth visits were most likely arranged and monitored by the facility's licensed nurse (70% of RCFs).

RCFs identified a series of barriers to the use of telehealth (See Table 16). About half of the facilities identified physical or cognitive limitations and limited resident interest as a moderate or substantial barrier to use of telehealth. Another one quarter identified family resistance. Lack of facility staff and reimbursement to support telehealth was also seen

as a moderate or substantial barrier in 20-25% of facilities. One in five facilities identified internet bandwidth and equipment as a moderate or substantial barrier. Only 5% of facilities reported physician resistance as a substantial barrier to telehealth.

Table 15. Characteristics of Telehealth Use in Ohio, 2021	
	(%)
Proportion of facilities using telehealth	57.2
Telehealth use prior to the COVID-19 pandemic	17.8
Telehealth method used	
Telephone (audio only)	14.3
Video	81.7
Other method	3.9
Location of telehealth visit	
Residents go to a dedicated room	9.8
Telehealth is brought to the resident's room	88.5
Other location	1.7
How telehealth is used	
Resident's personal physician or physician chosen by resident/family	47.0
Behavioral or mental health professional	27.4
Evaluation by therapist (speech, physical, occupational therapy)	4.9
Therapy visit (by speech, physical, occupational therapist)	3.4
Emergency department	0.9
Other use	2.8
Scheduling a telehealth visit involves:	
Registered nurse or licensed practical nurse	71.1
Direct care worker	10.3
Family/friend	18.6
Telehealth visit technical assistance involves:	
Registered nurse or licensed practical nurse	70.9
Direct care worker	22.2
Family/friend	6.9
Participates in the telehealth visit (e.g., blood pressure check)	
Registered nurse or licensed practical nurse	86.9
Direct care worker	9.3
Family/other	3.8

Source: Biennial Survey of Residential Care Facilities, 2021.

INFECTION PREVENTION

Given the impact that the COVID-19 pandemic had on long-term residential settings, the survey also asked about infection prevention (See Table 17). Seven in ten RCFs reported having an infection preventionist, who in almost all cases was a licensed nurse (RN/LPN). Facilities reported that these individuals spend 31% of their time allocated to this task. For comparison, in the nursing home setting, 42% of an infection preventionist's time was allocated to this task.

Table 16. Barriers to Using Telehealth in Ohio, 2021

	Barrier Levels (%)			
Barrier	**Not a Barrier**	**Somewhat**	**Moderate**	**Substantial**
Hard to find physicians offering telehealth	63.7	19.1	12.2	5.0
Residents don't want telehealth	31.9	22.4	20.5	25.2
Residents have a hard time participating (cognitive/physical limitations)	25.1	22.0	20.8	32.0
Family members resistant to telehealth	53.3	21.9	14.1	10.8
Internet bandwidth	63.6	16.1	10.1	10.1
Privacy and legal concerns regarding personal health information (i.e. HIPAA)	80.4	11.7	5.6	2.4
Lack of access to proper technology or equipment	69.0	14.7	10.2	6.1
Lack of reimbursement to the facility for technology and equipment	69.0	11.8	7.7	11.5
Lack of facility staff to support telehealth	53.7	21.5	12.5	12.3
Lack of reimbursement to the facility for staff to assist residents	66.6	11.3	7.8	14.3
Ownership/management of facility resistant to telehealth	89.2	5.6	3.7	1.6

Source: Biennial Survey of Residential Care Facilities, 2021.

Table 17. Characteristics of Infection Preventionists in RCFs, 2021	
	Percentage/ Number
Proportion that has infection preventionist	70.4
Primary professional background of infection preventionist	
Registered nurse	56.6
Licensed practical nurse	38.9
Medical training (non-nurse)	0.5
Other	4.1
Infection preventionist receives special training	81.4
Proportion of time per week infection preventionist spends on:	
Infection prevention tasks	31
All other task	69

Source: Biennial Survey of Residential Care Facilities, 2021.

A Path Forward

When this research effort began three decades ago, Ohio was ranked 47th out of 50 states (50 being lowest) in a national study of long-term care services system access and balancing. The most recent AARP Public Policy Institute Scorecard ranks Ohio 19th out of 50 on overall system performance, indicating substantial progress in creating more options for older people with severe disability. Despite Ohio's improvement, the path forward includes a number of challenges. The size of Ohio's older population today is unprecedented in our history, but a 24% increase in those age 80 and older over the next two decades will continue to have an impact, especially as the overall population is projected to decline. These demographic shifts alone would be difficult, but in combination with additional system complications that have been heightened as a result of the COVID-19 pandemic (workforce, infection control, individual and public funding, quality of care, and family caregiving pressures), the challenges are considerable. The COVID-19 pandemic shined a spotlight on the need for system changes; policy makers, consumers, family members, advocates, and providers will need to work together to address current issues and future needs.

Ohio's long-term services system has been very much shaped by the federal/state Medicaid program. Medicaid is typically the largest single expenditure in almost every state in the nation and so it naturally takes up considerable space at the policy table. However, it is critical to recognize that nine in ten older people in Ohio are not eligible for the Medicaid program. Very few older Ohioans have private long-term care insurance. Many of them end up on Medicaid when severe health and disability occurs, and after these individuals have depleted savings because of high expenditures. That is why more than half of older people in Ohio with severe disability currently use Medicaid

to support their long-term services either in their home, an assisted living, or a nursing home. Today 197,000 older people have severe disability and that number is projected to grow by 25%. The question is whether Ohio can do anything to lower the rate of disability or the high rate of use of Medicaid long-term services among those with a disability. A number of ideas have been brought forward by national experts in the long-term services arena to address this question including: (1) preventive actions, (2) expanded support services, (3) better support for caregivers, both informal and formal, (4) harnessing technological innovation, and (5) encouraging both community and individual responsibility for LTSS.

Preventive Actions

As a nation we spend a substantial amount of resources through both the Medicare and Medicaid programs to assist individuals with medical care and long-term services. As a caring society, we recognize the importance of helping older people in need, but assistance to individuals prior to a crisis could pay dividends. Evidence-based practices, now supported by the Ohio Department of Aging through the federal Older Americans Act, have been shown to have an impact on disability rates of older people. If Ohio were able to reduce the sheer number of severely disabled older people by just 10%, that could mean 19,500 fewer older people with severe disability and 8,500 fewer individuals needing Medicaid supported long-term services. The Older Americans Act resources used to support these types of programs for the entire nation totaled $44 million, in comparison to the more than $1.6 billion on Medicare and Medicaid.

Strategies to reduce the presence of disability for older people can include individual programs focusing on areas such as individual movement and exercise. A second area to emphasize is fall prevention, which more broadly includes the removal of environmental hazards and home modifications that promote the use of safety and adaptive equipment (such as bath grab bars). A third area is social and nutritional activities that enhance independence. The ODA Strategic Action Plan for Aging (SAPA) includes an array of important ideas to address this area. However, because states are heavily reliant on the federal Older Americans Act to support such activities, the overall investment has not kept pace with the dramatic population increases that have occurred.

Expanded Support Services

A second problem area that is partially linked to the preventive action discussion involves the availability of support services. Because Medicaid is the major state funding source for long-term services and supports, individuals need to be severely disabled and meet strict income and asset criteria to receive assistance. There are a sizable number of older people (estimated at more than 100,000) in Ohio who experience moderate levels of disability and who are just above Medicaid eligibility. As an example, about 40% of older people rely on Social Security for the majority of their

retirement income and the average benefit is just over $1,500 per month. Several recent studies have shown that states with fewer supportive services, such as home-delivered meals and personal care, had a higher proportion of low care residents in nursing homes. Another study found that individuals receiving congregate meals were less likely to be admitted to nursing homes or to be admitted to hospitals when compared to a group of older people not receiving meals. Finally, some recent work has highlighted the success of combining supportive services in partnership with health care services. Area Agencies on Aging that were able to have partnerships to link community services with health care organizations had significantly lower hospital readmission rates and significantly fewer low care residents in nursing homes in the regions served.

An approach used by a few states (Minnesota, Washington) to address this issue has been to pursue Medicaid waivers from the Centers for Medicare and Medicaid Services (CMS) that provide federal support to use Medicaid funds for individuals before they actually meet Medicaid eligibility for long-term services. As noted under current rules, an individual must meet the state's nursing home level of care to receive home and community-based services funded by Medicaid. These pilot states have identified individuals who are close to functional eligibility and found by intervening earlier they can keep individuals from ending up on Medicaid and ultimately receiving a much higher level of care.

Finally, a strategy used in Ohio to provide additional support services to older people has been the use of community supported levies. A recent Scripps study found that very high levy counties had fewer low care residents in nursing homes and a lower utilization rate of Medicaid home and community-based services. While these programs provide valuable support services, they vary widely across the state and often the poorest counties have small or no levy supported programs. A second problem is that because the levy programs are most often funded at the county level, the programs report facing local pressure to shift participants to the state Medicaid program whenever possible. There are many cost and programmatic reasons why this strategy is not in the best interest of older people, their families, and the state overall. But, because these shifts currently exist, efforts to incentivize counties to use local funds differently could result in better care and lower costs for both the state and county programs. The proposed Healthy Aging Initiative would be an important step in expanding support services in the community.

Better Support of Caregivers, Both Informal and Formal

While we celebrate increased longevity and the unprecedented number of older people in Ohio, we also recognize that families and friends have never been called upon to provide more long-term services assistance. Studies consistently indicate that for individuals with severe disability, family and friend caregivers provide about 80% of all the assistance received. The pandemic has certainly increased these levels as many more individuals are getting care at home. Older people and their family members grew

concerned about the high impact of COVID-19 on congregate living settings (including nursing homes and assisted living facilities). During much of the pandemic, older people who had been hospitalized often went directly home, rather than using the nursing home as a place to receive rehabilitation services. This meant that more of the care responsibilities were shifted to family and friend caregivers and in some instances, this required a high level of health-related care in addition to hands-on long-term services. The rise in dual worker households and lower fertility rates has placed rising pressure on informal caregivers.

The major support for caregivers in the United States comes though the National Family Caregiver Support Program under the Older Americans Act. As was the case for prevention and supportive services, this component of the act has limited funding, with $145 million allocated annually nationwide for this program. However, we have learned that it is critical to successfully support older people living independently. In particular, when families, who are providing the bulk of care in this country, can no longer hold up to the pressures of caregiving, nursing home or assisted living care is required for the older adult. Our critical question is what can local communities and state policy makers do to support but not supplant the work of caregivers? As an example, recent state and local programs have begun to assess caregiver needs, in addition to the normal assessment of the older person that is traditionally completed. Such an approach allows care managers and home care providers to better match services to family needs from a scheduling and task perspective.

Without question, the number one issue being discussed across the array of long-term settings in Ohio and the nation overall involves the formal workforce for long-term services. While worker quality and shortages have been a consistent challenge for the long-term industry for more than 30 years, the pandemic brought this problem to even greater heights. Nursing homes, assisted living facilities, and home care services have all been impacted. Of course, long-term services are not alone, as restaurants, hotels, and retail outlets have all reported worker shortages. But for a long-term service provider, a missing worker does not just mean patrons can only be served at the fast food drive-thru rather than the dine-in area of the restaurant; it means that individuals with severe disability will not receive the needed service, or services will be delivered with longer wait times, or services will be limited in amount or type. RCFs in the Biennial Survey have also reported limiting admissions when not enough workers are available and home care providers have reported similar issues. States and providers are exploring options to address the worker challenges, but there is no one answer that will solve this problem. There is certainly a clear recognition by state policy makers and the industry that this problem must be addressed. Ohio's recent legislation allocating additional funds to address this challenge in home care and RCFs is an important step.

A series of options are now being explored by states. For example, a number of states are much more involved in the provision of consumer directed services, where friends

and families can be hired by older people to provide the needed personal care assistance. Other states are exploring alternative financing methods such as wage pass through mechanisms to directly raise the compensation of direct care workers. Still other states are working with their state boards of higher education or the community college network to explore career building options. A plan to form a short-term and long-term response to the workforce challenge would be an important step.

Harnessing Technological Innovation

Even if Ohio makes great advances in the areas previously discussed, the demographic changes of tomorrow will still present significant challenges for the state. One important area that offers much room for optimism involves the use of technology to meet future long-term needs. Many of these technological innovations are already in design, such as the Uber transportation and Uber Eats, while others will be tomorrow's new ideas. As an example, Toyota and Honda, in anticipation of Japan's rapidly increasing aging population, have developed robots that are designed to help individuals with personal care. While some object to the use of robotics in place of human assistance, others see it as an innovation that will enhance independence and the potential to live at home longer. Other technological ideas, such as enhanced communication systems to reduce social isolation, telehealth options for improving health access, and floor sensors in senior centers or retirement communities to identify individuals who are at risk for falling are all in development. One of the area agencies in Ohio is working on a software to better link potential independent care workers with older people in need of in-home care.

Technological development cuts across the public and private sectors but how can state policy makers support these activities? As Ohio's manufacturing profile has decreased, could the state leverage such resources as its universities, Wright Patterson Air Force Base, and many others to design, develop, test, and market such technologies? With a large aging population and a strong research and development community, Ohio could become a leader in technology for an aging society.

Conclusion

Ohio's progress in long-term services and support system reform has been significant. The changes that have occurred were almost unimaginable three decades ago. However, the demographic and service hurdles of tomorrow will continue. What Ohio's experiences have taught is that Ohio can respond to these new and never experienced challenges associated with population aging, but it will take creativity, commitment, and cooperation to succeed. While designing an efficient and effective system of long-term services is no small task, the large number of Ohioans, our family, our friends, and we are counting on Ohio being a good place to grow old.