

Ohio Long-Term Care Factbook



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During the 20th century, unprecedented increases in life expectancy resulted in dramatic growth in the world's older population. While an aging society is a hallmark of improvements in public health, public hygiene, and medical advances, these improvements have led us to another set of challenges to be met. As the U.S. population has aged, the need for care services and assistance for increasing numbers of older adults has grown. These noteworthy changes have brought increased public expenditures, greater obligations for families and friends of older adults, and a complex amalgam of services, service providers, and systems of care.

Around the nation, planners and policymakers are giving increased attention to meeting the needs of older citizens. The same is true in Ohio. Older adults and their families are attentive to the issues of planning for care, paying for care, and managing assistance for themselves and their loved ones. Service providers are working to improve the quality of the services they provide, modifying them to meet the changing preferences of older adults, both now and in the future. Recognizing that growing numbers of Ohioans are seeking information about long-term care, this factbook is designed to provide a basic introduction to long-term care, with an emphasis on Ohio. It provides an introductory look at Ohio's long-term care services, the people who are served, and the public and private sources that support them.

A list of sources is included, along with a list of websites that provide additional long-term care information. Terms in **bold** are included in a glossary in the back of the volume. Although long-term care is a topic of importance for all ages, this book focuses on long-term care for older adults.

About Long-term care in Ohio

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Fast Facts

- At the turn of the 21st century, Ohio had 1.6 million people 65 years or older.
- 486,450 of these individuals have moderate or severe disability.
- About 80,930 Ohioans (5.4% of 65+ persons) lived in nursing homes in 2001.
- Approximately 23,000 Ohioans 60+ received PASSPORT home & community based services in 2000.
- In 1999, Ohio had 727 freestanding nursing homes, 218 nursing home/residential care facilities, 59 hospital-based nursing homes, and 39 county homes.
- The typical nursing home in Ohio has between 90 and 100 beds.
- 5% of Ohio's nursing homes were cited in 2000 for substandard or immediate jeopardy quality of care.
- Ohio has 220 freestanding residential care facilities and 218 residential care facilities attached to nursing homes.
- There is an average of 62 beds per residential care facility.
- In 2000, the state spent \$2.5 billion on long-term care services for Medicaid recipients.
- 43% of Ohio's 2000 Medicaid budget was spent on long-term care.
- The average cost for nursing home care in the state in 2002 was \$4345/month.
- The average cost for PASSPORT (Medicaid) home care services in 2000 was \$933/month.
- In 1999, Ohio nursing homes had an occupancy rate of 83%.
- More than half of nursing home residents stay three months or less.

Long-term care (LTC) is a collection of services provided to people who have physical or cognitive limitations in their daily activities. Services can be home or community based, ranging from occasional transportation to daily help with bathing and dressing. Services may also be delivered in facilities such as **assisted living** or **nursing homes**. Family members and friends provide most of the care, particularly for those older adults living in the community. Formal service providers supply care services in the home and in facilities.

Each person's use of and experience with **long-term care** is unique, depending on their individual needs and situation. Because people need differing types and amounts of assistance, **long-term care** is really a continuum of care ranging from infrequent assistance with one or two activities to constant assistance with all activities. Although about 17% of Ohio residents have disabilities, this publication will focus only on older adults, those over age 60.



Who Uses Long-Term Care?

Those who use **long-term care** services include older adults with disabilities and their **caregivers**. Older adults use services to help them manage or accomplish day-to-day activities. Caregiving families and friends use services to supplement the care they provide for their loved ones and to receive respite from caregiving.

The **Activities of Daily Living** are often referred to as **ADLs**. They are the most basic personal tasks of daily life (see box). **ADL** impairments make living independently without assistance difficult. **IADLs** are the **Instrumental Activities of Daily Living**. These tasks are used in the management of one's everyday life. **ADLs** and **IADLs** are often used for assessing what kind and how much care a person needs. Although many researchers classify disability by counting the number of **ADL** impairments, people with the same number of impairments do not always have the same need for assistance.

Disability occurs at all ages. However, the older a person is, the more likely they are to be disabled. Also, as a person grows older, the number of activity limitations generally increases, along with the degree of limitation. Figure 1 shows the gradual, but marked, increase in levels of disability for people 65 and over in Ohio. In Figure 1, disability is classified as severe, moderate or little/none. People with moderate disability are impaired in one **ADL** or at least two **IADLs**; severely impaired people need help with two or more **ADLs**.

ADLs	IADLs
• Eating	• Shopping
• Getting in or out of bed or a chair	• Preparing meals
• Getting to the toilet	• Housekeeping
• Dressing	• Using transportation
• Bathing	• Handling finances
• Walking/Getting around	• Taking medication
	• Using the telephone

(Wiener, Hanley, Clark, & Van Nostrand, 1990).

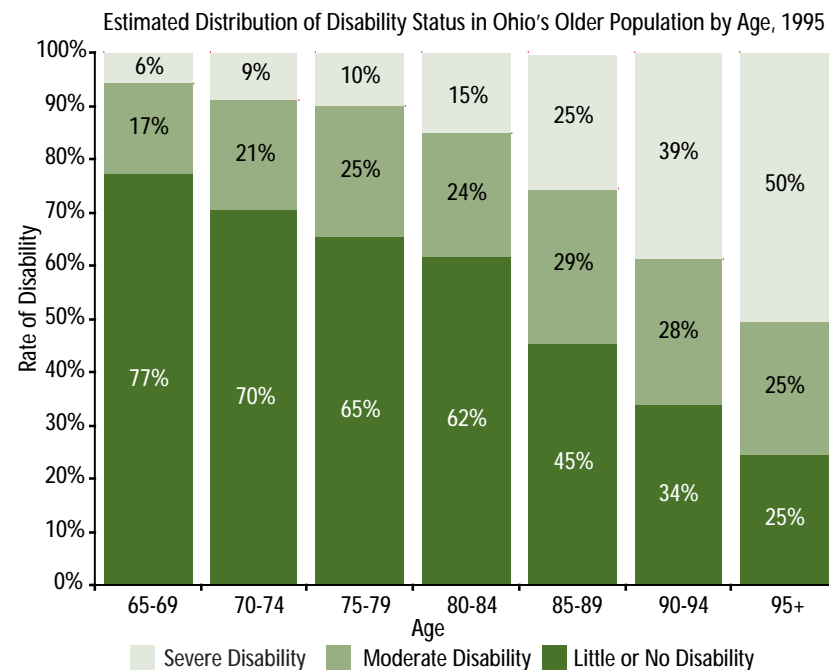


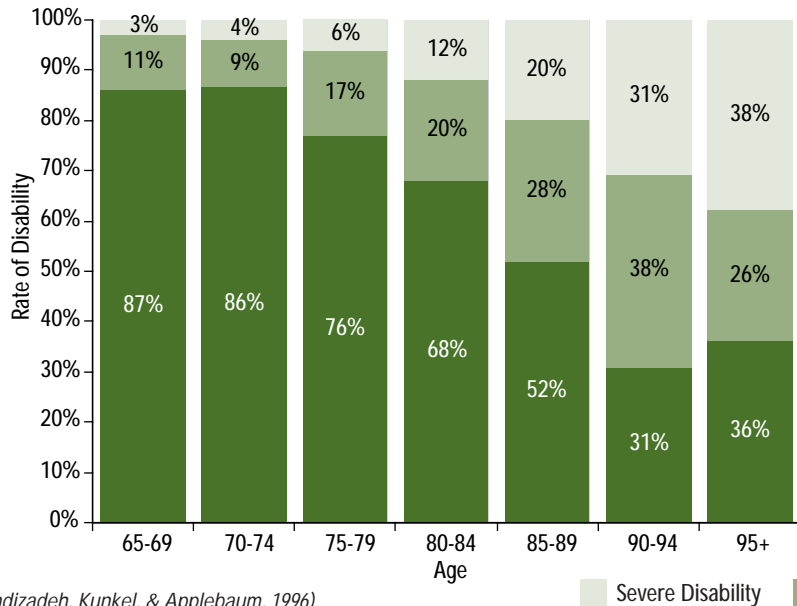
Figure 1

(Mehdzadeh, Kunkel, & Applebaum, 1996).

Gender, ethnicity, marital status, living arrangements and poverty are all associated with disability. As a group, older women are more likely to be disabled than men, as illustrated in Figures 2 and 3. Often, minority persons and those with lower educational levels and/or lower than average incomes are in poorer health and have higher levels of disability as they age (Cantor & Brennan, 2000). Until recently, the older African American population had higher rates of disability than Whites. Chronic disability among this group has declined over the past decade and is now similar to the rate of disability among Whites (Manton & Gu, 2001). Lack of exercise, chronic disease and mental impairment also increase the likelihood of disability.

Figure 2

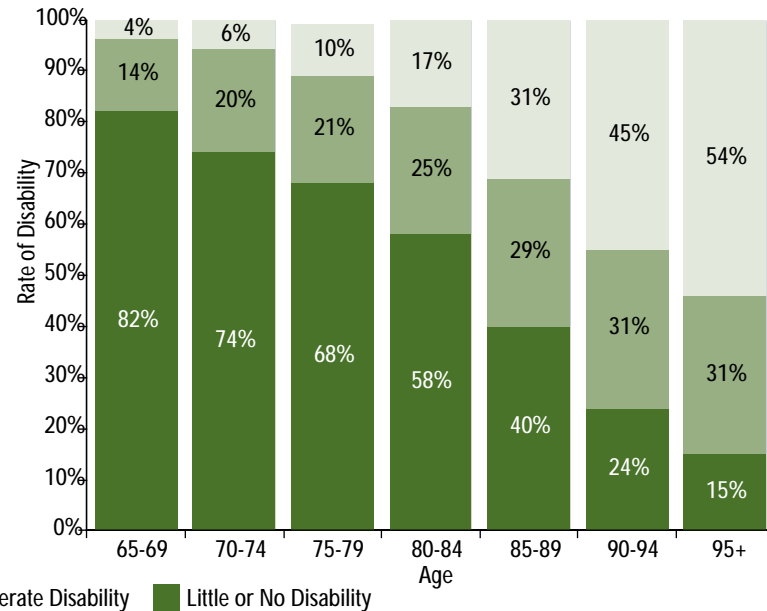
Estimated Distribution of Disability Status in Ohio's Older Male Population by Age, 1995



(Mehdizadeh, Kunkel, & Applebaum, 1996).

Figure 3

Estimated Distribution of Disability Status in Ohio's Older Female Population by Age, 1995



Across the state, **long-term care** service recipients have varying needs for care. When looked at as a group, **nursing home** residents are more impaired than community dwelling older people. For example, over half of Ohio **nursing home** residents have some form of **dementia** (Nursing Home Statistical Yearbook, 2001). Figures 4 and 5 show that, in 1999, about three-fourths of **nursing home** residents in Ohio had limitations with four or more **ADLs**, compared to one-fourth of **Medicaid** clients receiving **home-based services** (Applebaum & Mehdizadeh, 2001). The typical **Medicaid** home care client requires help with an average of 3 **ADLs** and 6 **IADLs** (Applebaum & Mehdizadeh, 2001). Most disabled, older adults prefer to remain in the community. Therefore, for every one person in a **nursing home**, there are 2 people equally impaired who live in the community (Mehdizadeh, Kunkel, & Ritchey, 2001).

The typical Ohio resident in **assisted living** is about 83 years old and female (OALA, 2002). These residents typically need help with **ADLs** such as bathing, dressing and grooming, although 19% need no help with **ADLs** (MetLife Mature Market Group, 2002a).

Percentage of Ohio PASSPORT Clients with ADL Impairments, 1999

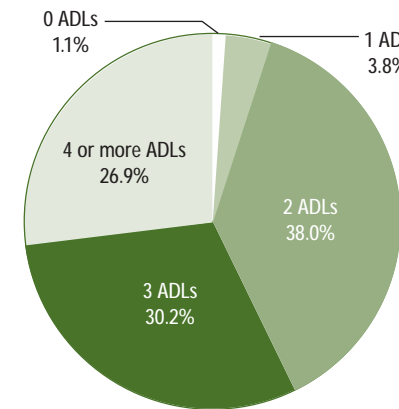


Figure 4

Percentage of Ohio Nursing Home Residents with ADL Impairments, 1999

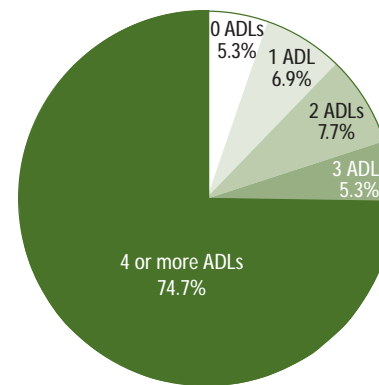


Figure 5

Note: PASSPORT ADL impairment includes only clients receiving hands on assistance while impairment counts of nursing home residents include those receiving supervision as well as more extensive assistance.

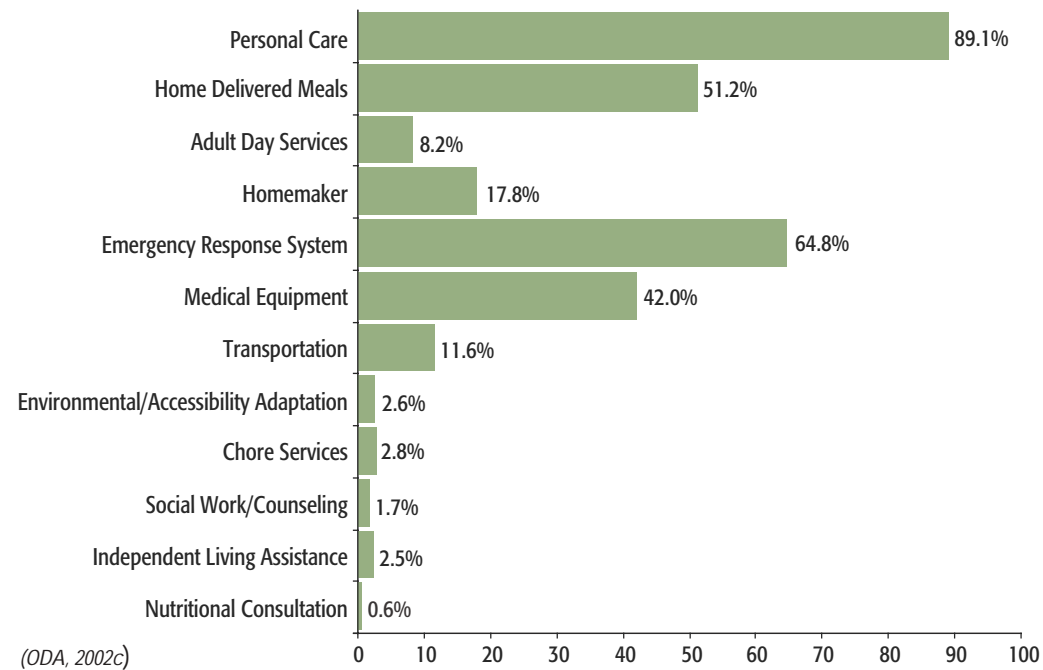
(Applebaum & Mehdizadeh, 2001)

Service Use

Among the nearly 23,000 Ohioans served by the **PASSPORT** program in 2000, the most commonly used services are **personal care, respite care, homemaker, home delivered meals, home medical equipment, and emergency response systems** (see Figure 6).

Figure 6

Percentage of PASSPORT Clients Receiving Each Service in Ohio, 2000

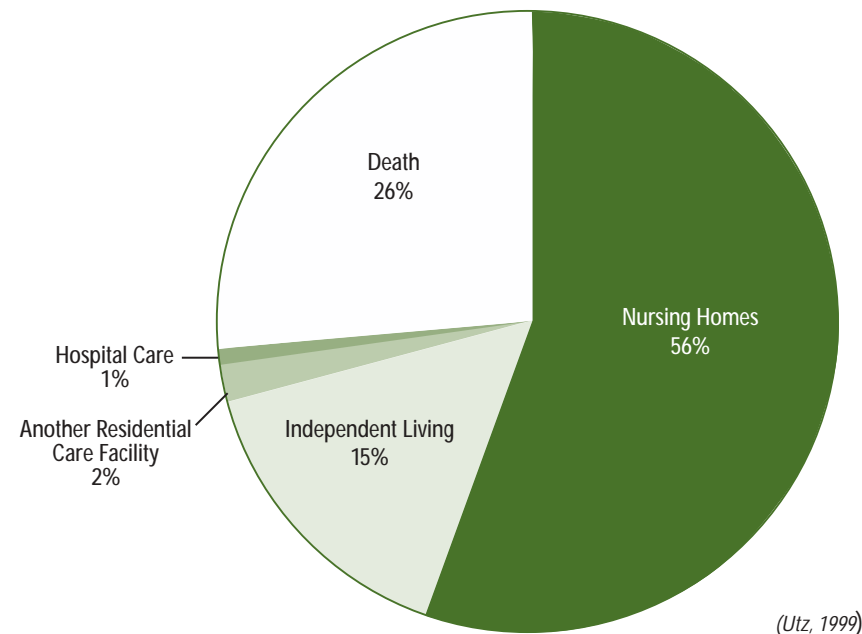


In institutional settings, service use is usually reported as the number of days a person lived in the facility, commonly called “length of stay.” In a survey of 100 **assisted living (residential care)** facilities in Ohio, Utz (1999) found that the average length of stay for residents in these types of facilities is 750 days, or a little over 2 years. The most common reason for leaving an **assisted living** facility is a move to a **nursing home** (see Figure 7).

In Ohio in 1995, 63.3% of those entering **nursing homes** stayed less than six months. However, the proportion of short-stay residents in **nursing homes** at any one point in time is relatively small (about 17%) (Mehdizadeh, Applebaum, & Straker, 1998). Many residents are there for at least one year (AHCA, 2001a).

Discharge Disposition of Assisted Living Residents (Ohio, 1999)

Figure 7





Who Provides Long-Term Care Services?

Informal Caregivers

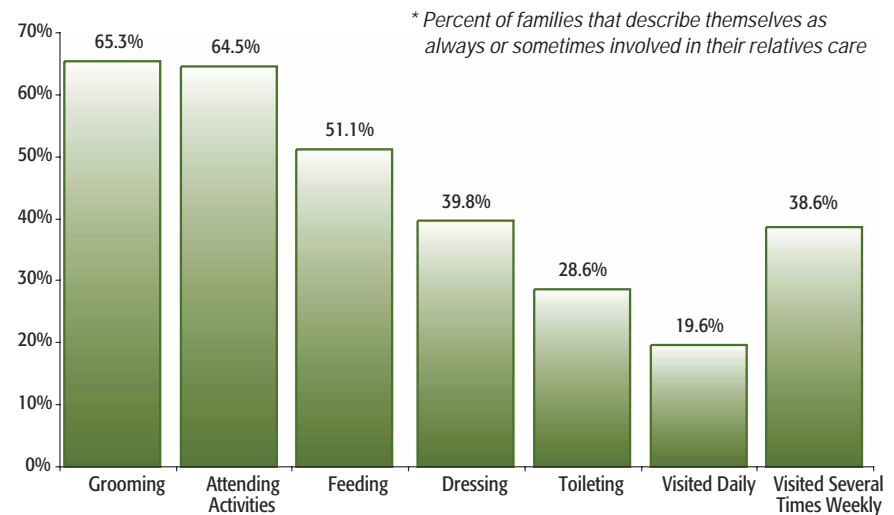
Services are provided by both informal (non-paid) or formal (paid) service providers in private homes, the community, and in a variety of facilities.

Informal **caregivers** are family members, friends, or neighbors who provide care without receiving pay for these services. These individuals care for community-dwelling older adults and they provide supplemental care to family and friends living in facilities such as **nursing homes** or **assisted living** centers. In 2000 in Ohio, an estimated 28,582 full-time equivalent unpaid **caregivers** provided help with **ADLs** and another 122,683 provided assistance with **IADLs** (Even, Ghosal, & Kunkel, 1998). About 80% of care provided to older persons in their homes is provided informally by family and friends. The typical working **caregiver** spends an average of 22 hours a week on caregiving duties (MetLife Mature Market Group, 1997).

Families and friends of **nursing home** residents who responded to the Ohio Nursing Home Family Satisfaction Survey report remaining very involved in the care of their relatives and friends (see Figure 8). Over half of families visit at least several times a week including about one-fifth of families who visit daily (Straker, Ehrichs, Ejaz, & Fox, 2002).

Figure 8

Family Assistance with Nursing Facility Care*
Ohio, 2001



(Straker, Ehrichs, Ejaz, & Fox, 2002)

Formal Service Providers in the Community

HCB services include:

- Homemaker or Chore Services
- Home Delivered Meals & Nutrition Counseling
- Personal Care or Home Health Care
- Transportation
- Home Repair
- Escort Services
- Emergency Response Systems
- Social Work/Counseling
- Durable Medical Equipment
- Adult Day Care
- Respite Care
- Case Management

Home Care and **Home Health** agencies furnish trained workers who provide care in individual homes. These workers provide many types of care and are paid through many different sources. There are two major, publicly funded programs in Ohio that provide formal **home & community based services (HCBS)** to the older population: **PASSPORT**, which is the **Medicaid** waiver program, and **levy-funded programs** in many Ohio counties. In addition to these sources, community organizations meet limited service needs such as companionship or escort services through the use of volunteers. People can also hire workers privately or contract with **home care** agencies and pay them directly. Agencies can be freestanding or part of a larger provider entity such as a hospital or **nursing home** (see Table 1).

Table 1

Ohio's Medicare/Medicaid Certified Home Health Agencies	
% of Agencies	
Proprietary Home Care	47.1%
Hospital Based	27.0%
Nursing Home Based	3.6%
Private Non-profit	10.5%
Public/County	7.2%
Visiting Nurse Associations	4.6%
Total (n=333)	100.0%

(Straker & Applebaum, 1999)

Long-term care services are also provided in institutional settings. The two general categories are **residential care facilities (RCF)** and **nursing homes**. **Residential care facilities**, which include the newly developing **assisted living** industry, are most often used by people needing less **skilled care** or fewer services, while **nursing homes** provide care for people with more intensive medical needs.

Table 2

Ohio LTC Facilities
92,000 residents
1,034 nursing homes
495 residential care facilities
900 adult care facilities

(ODA, 2001)

There is no single definition of “**assisted living**” because regulations vary from state to state. Ohio law and regulations use the term **residential care facility (RCF)**, rather than **assisted living** (Applebaum & Mehdizadeh, 2001). In Ohio, approximately 495 facilities serve 16,000 to 18,000 individuals. This licensing category includes facilities that can be classified into two main groups: **rest homes** and **assisted living** facilities. **Rest homes** are modeled on the traditional **nursing home** method of care, with residents having fewer **skilled care** needs. **Assisted living** usually offers individual living units and privacy, community space such as dining and laundry rooms, resident choice, and independence. **RCFs** offer a wide range of services based on resident needs and preferences but can only provide intermittent skilled nursing care for residents for less than 120 days in a year.

Residential Facility Classifications in Ohio	
Residential Care	17+ residents
Adult Group Homes	6-16 residents
Adult Family Homes	3-5 residents
Adult Foster Homes	1-2 residents

Table 3

(Ohio Administrative Code, 2001)

In Ohio, there are approximately 1,034 **nursing homes** with 95,701 beds (Applebaum & Mehdizadeh, 2001). The typical **nursing home** in Ohio has between 90 and 100 beds and most are in urban areas.

Residential care (assisted living) services	Nursing home services
• Housekeeping	• Custodial care
• Transportation	• Skilled nursing care
• Personal care services	• Routine nursing care
• Routine nursing care	• Physical therapy
• Monitoring of service plans	• Occupational therapy
• Access to specialty care providers	• Rehabilitation therapy
• Behavioral management	• Mental health treatment
• Meals & special diets	
• Medication administration	

Ohio has a higher ratio of **nursing home** beds to its elderly population than the national average for both people sixty-five and older, and eighty-five and older. In 1999, Ohio **nursing homes** had an average occupancy rate of 83.5%, down from 92% in 1992 (Applebaum & Mehdizadeh, 2001), mirroring the national trend.

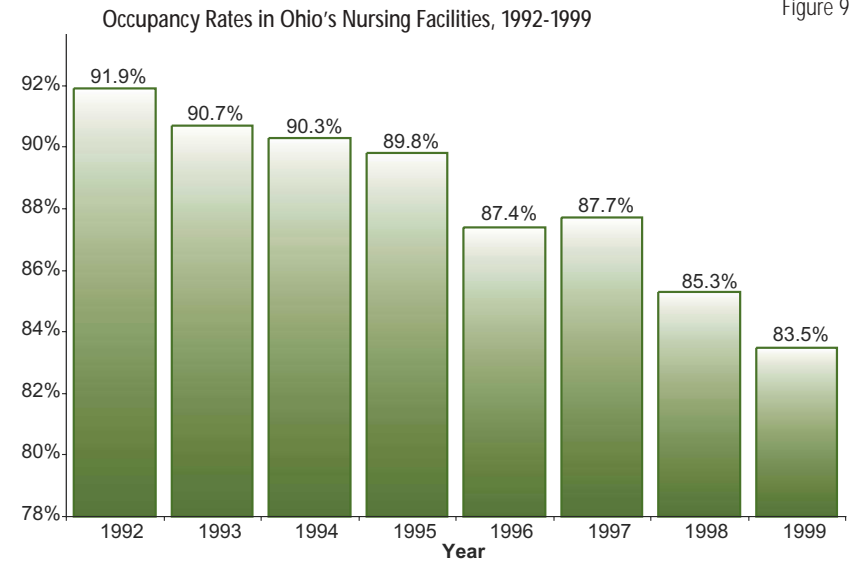


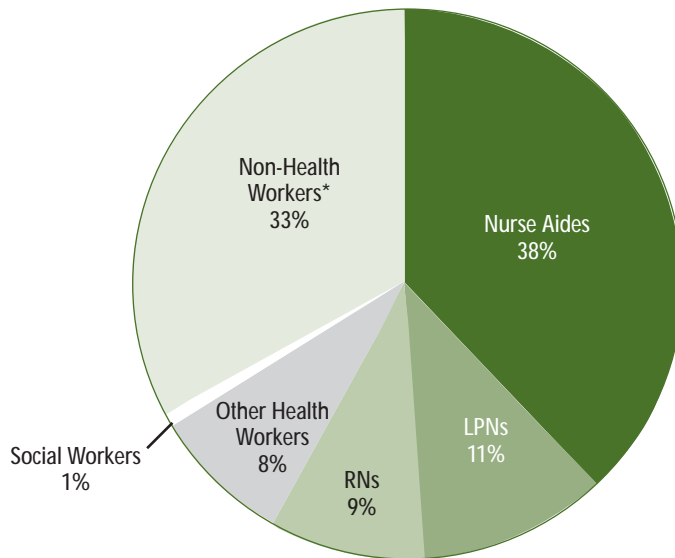
Figure 9

(Applebaum & Mehdizadeh, 2001)

Formal Service Providers in Facilities

Figure 10

National Nursing Home Staff



* housekeepers, dietary aides, maintenance personnel, clerical, & accounting staff

(BHF-NCHWFA, 2000)

In 1998 there were nearly 106,000 people employed in Ohio **nursing homes**. The **Ohio Department of Job and Family Services** estimates that in 2001, Ohio had 66,190 nurse aides, orderlies and attendants working in all types of **LTC** facilities (ODJFS, 2002b). Overall, these are paraprofessional frontline workers who deliver as much as 90% of the care in **nursing homes**. State-tested nurse aides must pass a written examination and skills test after completing 80 hours of training. **Nursing homes** also employ social workers, dietitians, and therapists, as well as housekeeping, clerical, and maintenance staff (see Figure 10). All staff that has contact with residents must pass a criminal background check.

Average Hourly Wages—Ohio, 2001

Nurse Aide	\$9.13
LPN	\$15.49
RN	\$20.93

(ODJFS, 2002b)

Special care units in **nursing homes** provide special services in separate wings or areas of their facilities. Some of the services commonly offered include: **hospice**, Alzheimer's care, rehabilitation, head trauma, and respiratory/ ventilator units. In 2000, there were 8,398 beds in **special care units** in Ohio. The majority are Alzheimer's beds. The number of beds in **special care units** has risen significantly in the past few years (AHCA, 2001b).

There has been a great deal of interest in maintaining the appropriate ratio of **nursing home** staff to residents. In 2002, a staffing rule went into effect in Ohio that specifies the minimum amount of time that nurse aides and registered nurses should spend with each resident per day (Ohio Administrative Code, 2002). Staffing data gathered during nursing facility inspections shows that Ohio **nursing homes** are staffed at levels very close to the national average (see Figure 11) and, on average, exceed the minimum standards of the staffing rule (Medicare, 2002a).

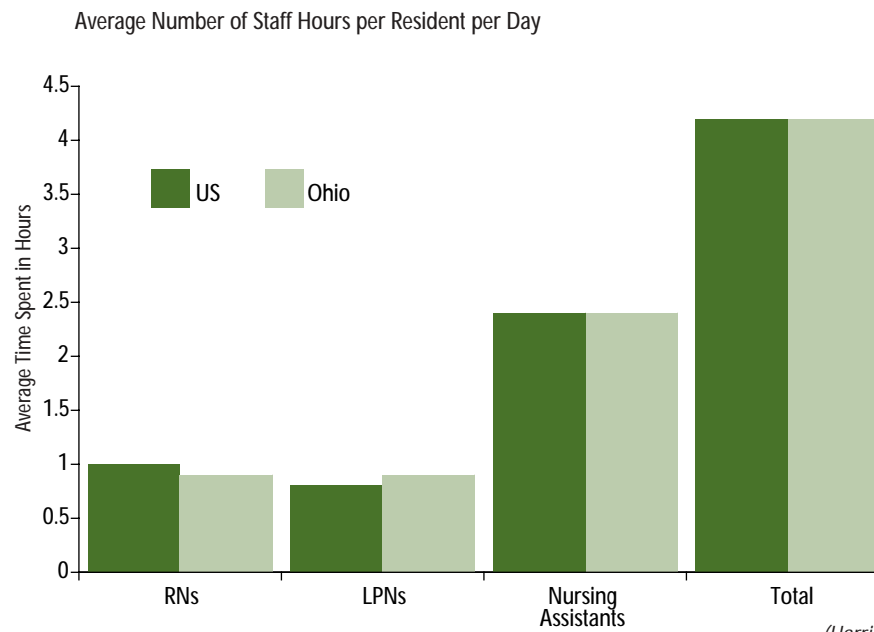


Figure 11

(Harrington, Carrillo, & Wellin, 2001)



How Is Long-Term Care Paid For?

Private Pay

21

Long-term care is paid for through many sources including individuals and their families, federal, state, and local dollars, and insurance.

“Private pay” refers to payments made by a person receiving **long-term care** services or their families. Even for people with **Medicare** or **Medicaid**, not all **long-term care** expenses are covered. Care recipients and their families often pay for services that they need, want or are not covered by other sources. Some examples are: medications, products that make caregiving easier such as special clothing, and special foods.

The amount paid by individuals and their families for **long-term care** is staggering. The cost for **home care services** varies depending on the **provider** agency and the services received, and also on geographic location. For example, the average cost of **home care** in Columbus, Ohio is approximately \$19,799 per year and approximately \$23,075 in Akron (based on 5 hours per day, 5 days per week) (Federal Long Term Care Insurance Program, 2002b). In 2000, the average daily private pay rate for **nursing home care** in Ohio was \$145, for an average annual private pay cost of \$52,859 (Federal Long-Term Care Insurance Program, 2002b).

Nearly one-third of all **long-term care** costs (not only care for older adults) was paid by private payers (Tilly, Goldenson, & Kasten, 2001). Nearly one quarter (24%) of Ohio's **nursing home** stays are paid for privately (Annual Survey of Long-Term Care Facilities, 2000).

Medicare Long-Term Care

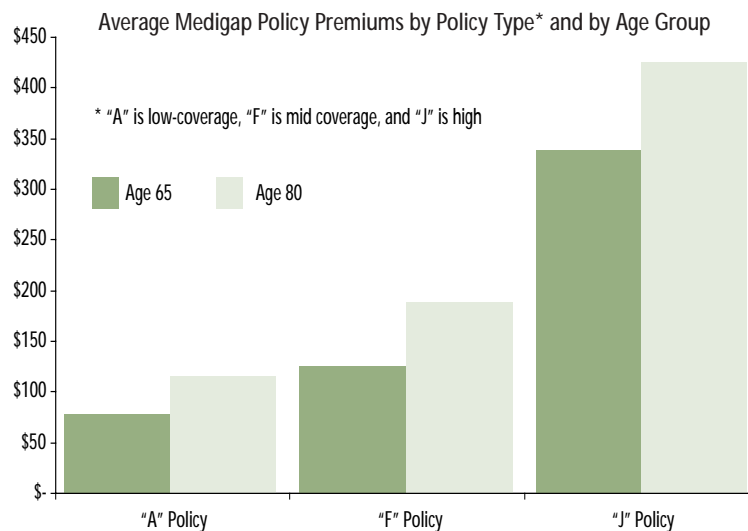
Medicare pays for limited **home health care** service when an enrollee requires skilled nursing care at home. To qualify for **Medicare home health care** benefits, a person must be confined to his or her home, need at least one skilled nursing or therapy service, and have a doctor-established plan of care. Skilled services can include IV administration, medication administration, **physical, speech, and occupational therapy**.

Medicare will pay for 100% of **home care** expenses that are medically necessary but will not pay for help with **ADLs** or **IADLs** when those are the only kinds of services a person needs. **Medicare** also pays 80% of the **Medicare**-approved cost of **durable medical equipment**. Thirty-three percent of Ohio's **Medicare** beneficiaries received **home health care** in 2001 (U.S. General Accounting Office, May 2002).

Medicare will only pay for **nursing home care** after a hospital stay of 3 days or more. After 20 days in a **nursing home**, residents must pay a **co-payment** of about \$100 per day. After 100 days, the resident is responsible for 100% of the cost.

Medical Insurance/ Medigap Coverage

Figure 12



(OSHIIP, 2002)

In 1998, 69% of Ohioans with **Medicare** coverage also had **Medigap** coverage (HIAA, 2002). Only some of the benefits of **Medigap** policies are related to long-term care. As demonstrated in Figure 12, premiums for a 65-year-old ranged from \$53 per month for basic supplemental coverage to \$569 a month for comprehensive coverage depending upon the insurance carrier (OSHIIP, 2002).

There are a variety of federally approved **Medigap** plans. Each includes the basic benefits package and different sets of additional benefits. Figure 12 demonstrates the cost of low, mid-level, and high coverage policy types. Low coverage policies include only basic benefits, mid-level policies also include some coverage of skilled nursing co-payments, and high coverage policies also include limited **home care** benefits.

Medicaid is a state-administered health benefit for persons with limited incomes and assets. This program uses both state and federal funding. In Ohio, the federal government provides approximately 58% of all **Medicaid** funds for Ohio while the state provides 42% (ODA, 2002f). The **Medicaid** program provides both home and community based services and facility-based services.

Medicaid's **home and community based** services for people age 60 and over are called **PASSPORT**. The goals of the program are to direct people who need **LTC** to the appropriate setting for that care and to prevent the institutionalization of those people who can remain in the community by providing necessary **home care**.

In 2001, approximately 25,000 people were enrolled in the **PASSPORT** program (ODA, 2002f). Tens of thousands more were screened and assessed for **nursing home** placement as part of the program. **Personal care/respice** service and **emergency response system** services are the most frequently used **PASSPORT** service. **Personal care/respice** accounts for over 89% of all **PASSPORT** expenditures (ODA, 2002c) (see Figure 6, page 12).

In 1999, **Medicaid** provided **nursing home** care for approximately 44,270 older Ohioans (Applebaum & Mehdizadeh, 2001) and spent an average of \$52,000 (ODA, 2002f) for each resident.

Requirements for Medicaid Home-Based Services

- Meet Ohio's institutional level of care criteria
- Have income of less than \$1,635 per year (2002)¹
- Have no more than \$1,500 in assets²

¹ If monthly income exceeds the limit, it is possible to "spend-down" to an eligible level (Kassner & Shirey, 2000)

² Excludes home, low-valued auto, life insurance, and pre-paid funeral plans

Estate Recovery

Estate recovery is a federally mandated program to recover the cost of **LTC** services received by **Medicaid** recipients from their estate after their death. All property and assets in the deceased's estate can be subject to recovery. For example, the deceased's home can be sold by the state and the money used to repay a portion of the cost of care. **Estate recovery** occurs only when the care recipient and the surviving spouse have both died and when there is no surviving child under 21 years of age or a blind or disabled child of any age. According to the Office of Ohio Health Plans, Ohio has a conservative **estate recovery** program in comparison to other states. In Ohio, the ratio of recovered expenditures to total **Medicaid** expenditures is 0.06%; the national average is 0.26% (ODHS, 1999).

Dual Eligibility

Dual eligibility means a person is eligible for both **Medicare** and **Medicaid** benefits. This person is typically a **Medicare** beneficiary (**Medicare** eligible either because of age or disability) who is low-income and, therefore, **Medicaid** eligible. There are different levels of dual eligibility based on the person's income and assets. In the lowest income category (up to 100% of poverty level), the **Medicaid** program pays for **Medicare** premiums and **deductibles, co-payments, prescription medications** and **long-term care** expenses as needed.

In 1997, 17% of the **Medicare** population and 19% of the **Medicaid** population were dually eligible (Mehdzadeh, 2000). Nationally, this group accounted for about 28% of all **Medicare** expenditures and 35% of **Medicaid** expenditures (Murray & Shatto, 1998).

Long-Term Care Insurance

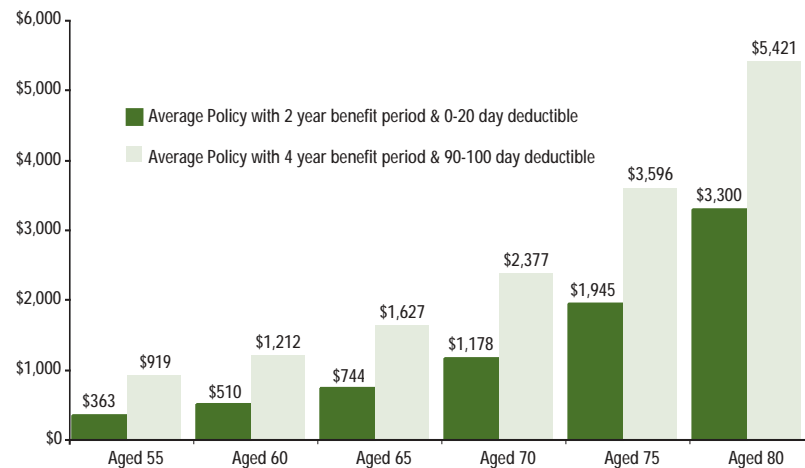
Private **long-term care insurance** covers many types of **long-term care**, including both skilled and non-**skilled care**. Three-quarters of all policies now cover both facility and **home care** (HIAA, 2000). Nationally, about 5% of all **nursing home** costs are paid through private **LTC insurance** (Federal Long Term Care Insurance Program, 2002a).

The cost of **LTC insurance** depends on a person's age and health status at the time of purchase and the extent of the coverage. **LTC insurance** premiums have been tax deductible in Ohio since 1999 (Davis, 2002). Enrollment in **long-term care insurance** plans is low. "Less than 10% of older adults and even fewer near-older adults (those aged 55 to 64) have purchased **long term care insurance**" (Long Term Care: Baby Boom Generation, 2001). As of 1998, there were slightly more than 87,000 **LTC** policyholders in Ohio (ODI, 1999).

In the United States, the average age of **LTC insurance** buyers is 67 years; about two-thirds of **LTC insurance** purchasers have incomes greater than \$35,000. In general, purchasers of **LTC insurance** are wealthier than non-buyers, have more education, and are more likely to be married (HIAA, 2000). Figure 13 shows that the older a person is when purchasing **LTC insurance**, the higher the yearly premium.

Average LTC Insurance Premiums in Ohio by Age and Type of Policy

Figure 13

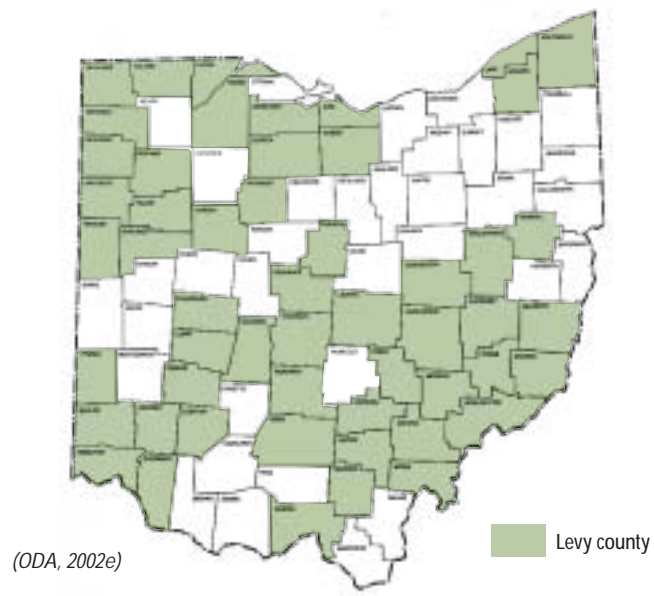


(ODI, 2002)

Local Funding Sources for Long-Term Care

Figure 14

Ohio Counties with a Senior Services Levy



Many **home & community based services** are provided through local tax levies, which are voted on in local elections and must be renewed every 3-5 years. In some counties, levy funds are administered through a local governmental agency or department. In other counties, the **Area Agency on Aging** or a social service agency controls these funds. As of December 2001, 56 counties in Ohio had senior citizen levies that generated over \$68 million per year (see Figure 14) (ODA, 2002e).

Local levies fund a wide variety of elder services, not all of which are classified as **long-term care**. The way in which the funds are used is up to each community and the purpose(s) can change each time the levy comes up for vote. Levies can be used for building and running local **senior centers** as well as elderly service programs that provide **home care**, home delivered and congregate meals, transportation, and other services.

The **Residential State Supplement (RSS)** program provides elderly, blind and/or disabled adults who have very low incomes with a cash supplement that helps them to live in a home-like, congregate setting such as an **adult family** or **group home**. To qualify for **RSS**, a person must be age 18 or older, need help with **ADLs** but not require **nursing home care**, have less than \$1500 in resources and have a monthly income of \$800 or less (for a **residential care facility** or **group home**), or \$700 or less (for an **adult family home** or foster home) (ODA, 2002d). This program served 3,046 Ohioans in 2001 (ODA, 2002f).

Many agencies also receive funds from charitable organizations, particularly agencies that provide services for little or no cost to the recipient. The actual amount of these funds is very difficult to determine because of the large number of charities. The United Way is the single charity statewide from which reasonable estimates are available. During 1999, United Way agencies spent more than \$6 million in Ohio to provide **home and community based long-term care** services (Mehdizadeh & Murdoch, 2003).

Facility Costs and Funding

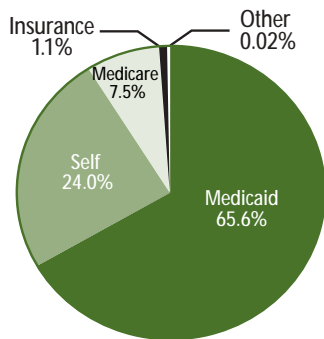
Table 4

Long-Term Care Costs in Ohio			
	Home Health Care	Assisted Living	Nursing Home Care
Akron	\$23,075	\$30,679	\$50,589
Cleveland	\$20,540	\$29,268	\$55,206
Columbus	\$19,799	\$33,990	\$52,779

(Federal Long Term Care Insurance Program, 2002)

Figure 15

Proportion of All Nursing Home Stays, 2000 (All Payment Sources)



(Annual Survey of Long-Term Care Facilities, 2000)

The funding source for LTC is often determined by the setting in which services are received. For example, while **Medicaid** will pay for **nursing home** care and for home-based services, it does not pay for **assisted living**.

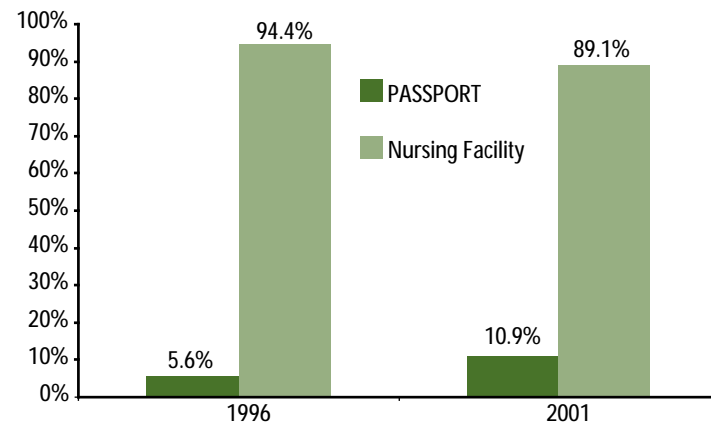
As shown in Table 4, **home and community based services** are less expensive than facility based services. Skilled services, such as **nursing home** care, are more costly than other types of facility-based care. According to the MetLife Mature Market Group (2002b), the monthly cost in Ohio for a semiprivate room in a **nursing home** is approximately \$4,335, and \$5,820 for a private room. The national average monthly cost for a private **assisted living** room was \$2,210 in 2000 (ALFA, 2000). In Ohio, the cost ranges from \$1,800 to \$3,600 per month (OALA, 2002). Approximately 9 out of every 10 **assisted living** residents pay for their care out of their own pockets (Cutler, 1999). More than 30 states use **Medicaid** funds to pay for **assisted living/residential care**. However, Ohio does not. **Medicare** does not pay for **assisted living**.

Nursing homes rely primarily on **Medicaid** as a funding source. **Nursing home** expenditures in Ohio in 2000 were \$2.1 billion. Figure 15 illustrates **Medicaid** as the major payer, accounting for almost two-thirds of all expenditures. Nearly one-quarter of **nursing home** stays are paid for out-of-pocket, 7.5% are paid by **Medicare**, and private **LTC insurance** pays for approximately 1% of all stays.

As illustrated in Figure 16, although the proportion of **Medicaid** funds in Ohio used to pay for **home and community based services** has doubled since 1996, the majority of **Medicaid** funds still goes for **nursing home** care (Burwell, 2001).

Figure 16

Percent of Total Medicaid Long-Term Care Expenditures for PASSPORT and Nursing Facility Care in Ohio, 1996 & 2001



Note: Nursing facility costs do not include spending in intermediate care facilities for the mentally retarded (ICF/MR)

(Burwell, 2001)

How Is Long-Term Care Regulated?

Several agencies at both the state and federal level are involved with the regulation and licensing or certification of **LTC providers**. Licensing includes inspection of the facility and its operations. In order to be certified, **nursing homes** and **home health agencies** must meet federal standards for staff, physical environment, and the way care is provided.

In Ohio, home health agencies are not licensed but they can be certified for **Medicare** and **Medicaid**. At the state level, the Community Health Care Facilities and Services Board of the **Ohio Department of Health** is responsible for assuring compliance with **Medicare** certification requirements of home health agencies. In addition to the Ohio Department of Health, there are two organizations that have been authorized by the **Centers for Medicare & Medicaid Services** (formerly **HCFA**) to certify **home health care** agencies: the Community Health Accreditation Program (CHAP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). There were 333 **Medicare** certified agencies in Ohio in 1999 (Applebaum & Mehdizadeh, 2001).

Under **Medicare**, certification is based on agency policies, practices, the care provision process, and staff qualifications, licensure, and training. "Each agency is required to evaluate their policies and administrative practices, annually, as well as review a sample of ongoing and closed client cases for adherence to clinical practice standards (42 CFR 484)" (Straker & Applebaum, 1999, p. 2). Certification activities consist of on-site visits and auditing of compliance with regulations such as criminal background checks and training of employees.

The **Ohio Department of Aging** approves all **PASSPORT providers**. "Home health agencies with Medicare or JCAHO certification are deemed eligible to provide services under **PASSPORT**" (Straker & Applebaum, 1999, pps. 2-3). Non-certified agencies must attend training sessions, institute policies for back-up staffing, provide written care plans, respect patient confidentiality, give 30 days notice of service termination, adhere to **Medicare** standards for patient rights, and conduct background checks on all personnel who have direct client contact (OAC 5101:3-12-05).

Because **home care** agencies are not licensed in Ohio, accurate reporting of the total number of agencies is difficult. In 1997, an estimated 190 non-licensed Ohio agencies were identified; there are probably fewer now. A change in **Medicare** reimbursement following the Balanced Budget Act of 1997 affected the industry with 142 agencies closing between 1997 and 1999 (Straker & Applebaum, 1999).

Medicare &
Medicaid
Certification
for Home
Health
Agencies

Medicare & Medicaid Certification for Facilities

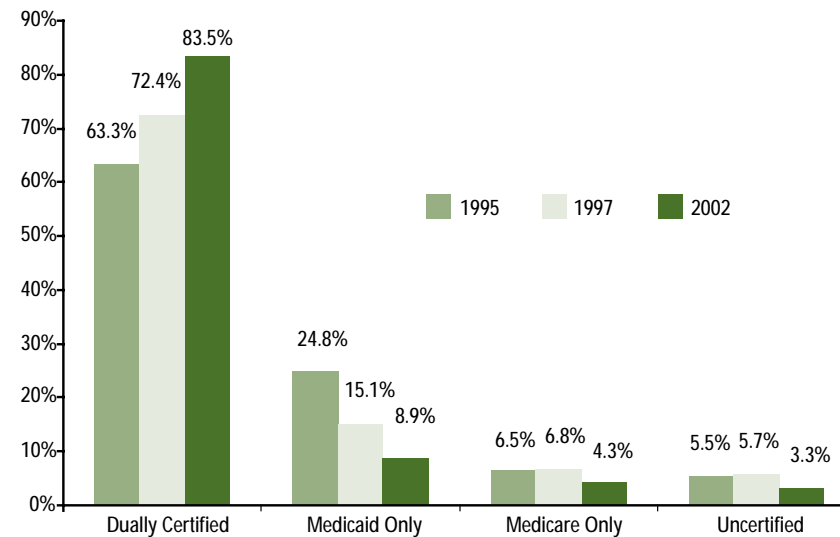
Facility Regulation Areas

- Resident rights
- Resident behavior and facility practices
- Quality of life
- Resident assessment
- Quality of care
- Nursing services
- Dietary services
- Physician services
- Specialized rehabilitative services
- Dental services
- Pharmacy services
- Infection control
- Physical environment
- Administration

(Code of Federal Regulations, Section 42, Part 483)

In Ohio, **nursing homes** and **residential care facilities** are licensed by the **Department of Health (ODH)**. Additionally, **ODH** has a contract with the federal **Centers for Medicare and Medicaid Services** to certify **nursing homes** for the **Medicare** and **Medicaid** programs. In a facility, individual beds can be certified for **Medicare**, **Medicaid**, or both. This is demonstrated in Figure 17. Facilities that are certified for **Medicaid** and **Medicare** must meet certain requirements. These are outlined in the “Facility Regulation Areas” (see sidebar). Surveyors inspect facilities in all of these areas to ensure that facilities are following the regulations as specified by the federal government. Facilities must meet regulations in several areas: staff-to-resident ratios, staff credentials & training, physical work and living environment, record keeping, services and activities, medical treatment and care, and nutrition. Staff working directly with residents must be at least 21 yrs. of age and without a felony conviction.

Figure 17 Percent of Nursing Facility Beds in Ohio by Certification Type, 1995, 1997 & 2002



The **Ohio Department of Health's** Bureau of Healthcare Standards and Quality conducts an unannounced inspection (survey) of facilities at least once every 15 months. Inspection teams consist of RNs, dietitians, sanitarians, social workers, and life safety code specialists. There are 256 different standards or "deficiency" categories that surveyors examine during the 2-3 day inspection (ODH, 2002). The inspectors assess ways in which the residents are cared for, interactions between residents and the staff, and the physical environment. In addition, surveyors review resident records, and interview a sample of residents and family members about life in the **nursing home** (Nursing homes: About nursing home inspections, n.d.).

Facilities that violate state or federal regulations are referred to Ohio's Bureau of Regulatory Compliance for enforcement actions that usually involve the issuing of deficiencies and citations, but may also include fines, denial of payment for new **Medicare/Medicaid** admissions, or the revocation of a facility's license when warranted. The average number of deficiencies in Ohio **nursing homes** has been less than for the U.S. (Figure 18). Ohio and the U.S. are also compared for the most often-cited deficiency categories (Figure 19).

Figure 18

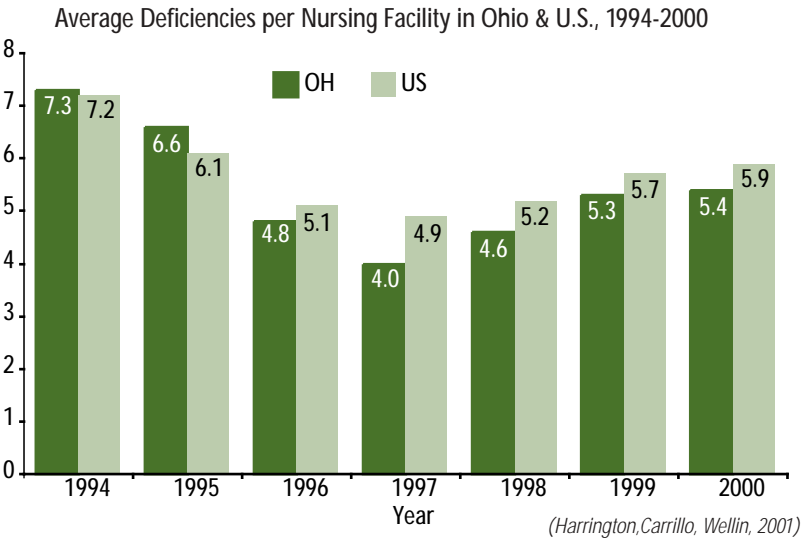
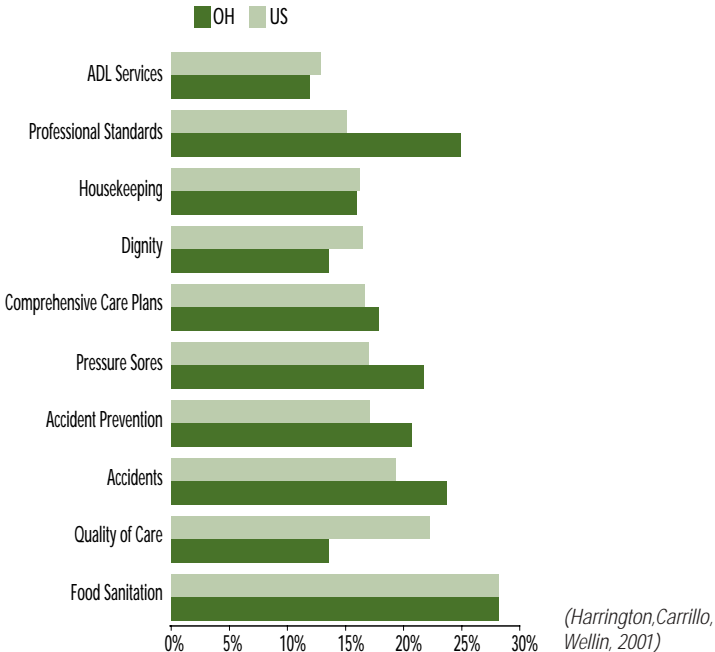


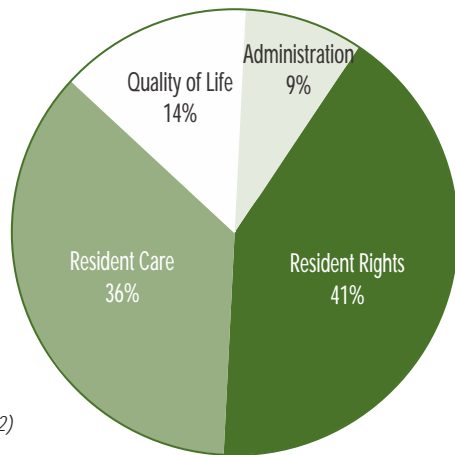
Figure 19

Proportion of Facilities Cited for the Most Prevalent Deficiencies Ohio & U.S., 2000



Resolving Consumer Complaints

Figure 20 Complaints Against Ohio Nursing Facilities by Category, 1998



(ODA, 2002)

A plan of correction for the violation(s) must be submitted and approved. If the plan is approved, penalties may be removed (ODH, 2002). Deficiency and plan of correction information for Ohio **nursing homes** is available to the general public on the **Ohio Nursing Home Consumer Guide** website (www.ltcoho.org). In addition, the Ohio Bureau of Information and Operation Support compiles a list of licensed and certified **nursing homes** and **residential care facilities** by county, and inspection reports for specific homes.

Long-term care ombudsmen serve as advocates for consumers of **long-term care** services in **nursing homes, county homes, residential care facilities, adult care facilities, adult foster homes** and in private residences. This includes not only consumers, but their families as well. An **ombudsman's** primary duties are to verify and resolve disputes concerning the quality of life and care in these settings. Ohio has 12 regional **ombudsman** offices with 75 paid **LTC Ombudsmen** and approximately 310 volunteer **ombudsmen** (ODA, 2001). In 2001, Ohio **ombudsmen** handled approximately 7,300 complaints about home-care, **residential care**, and **nursing home care** (ODA, 2002f). Information for each office can be found by contacting the **Ohio Department of Aging**, or the **Area Agency on Aging** in each region. In the case of **PASSPORT** providers, the **PASSPORT Administrative Agencies (PAAs)** collect and investigate complaints from **PASSPORT** consumers, usually through their case manager. The **PAA** is responsible for investigating and substantiating the complaint.

Complaints may also be made to the **Ohio Department of Health**. They may elect to conduct a survey on the basis of a complaint. If the complaint is substantiated, a deficiency may be cited and other penalties may be assigned depending on the severity of the deficiency.

Locating Long-Term Care Services

Consumers can locate services in several ways including personal research, word-of-mouth referrals, **Area Agencies on Aging**, other local agencies, the **Ohio Long-Term Care Consumer Guide** and the **Care Choice Ohio** program. The National Council on Aging and the **Ohio Department of Aging (ODA)** also provide a free, online service called "**BenefitsCheckUp**" that furnishes a personalized report for consumers that lists state and federal benefits for which they may qualify (ODA, 2002a).

Area Agencies on Aging administer the **Care Choice Ohio** program, which helps older Ohioans plan a long-term care program to meet their individual needs. **Care Choice** consultants help older people and their families make wise decisions by evaluating their needs against available services, discussing service eligibility requirements, determining the adequacy of their financial resources, and creating an individual plan of care. Because Area Agencies also conduct pre-admission reviews for **Medicaid nursing home** placement and administer **PASSPORT** they are a good first step in locating services. In fiscal year 1999, 29,691 assessments were conducted around the state (ODA, 2002c). The outcomes of these assessments are described in Figure 21.

The **Ohio Long-Term Care Consumer Guide** website was developed by **ODA** under legislative mandate to provide consumers with information about **LTC** services (see <http://www.ltcoho.org>). The website includes comprehensive information about **nursing homes**, including results of resident and family satisfaction surveys, state-collected data on deficiencies and other information, contact information and **nursing home**-submitted descriptions of each facility. Consumers can search for facilities by location, religious or other affiliations, or specific services such as Alzheimer's care. Information is updated continuously.

The **Centers for Medicare and Medicaid Services** host a website with nationwide comparative **nursing home** information. Their site, www.medicare.gov, provides similar but less comprehensive information to that found about **nursing homes** on Ohio's website.

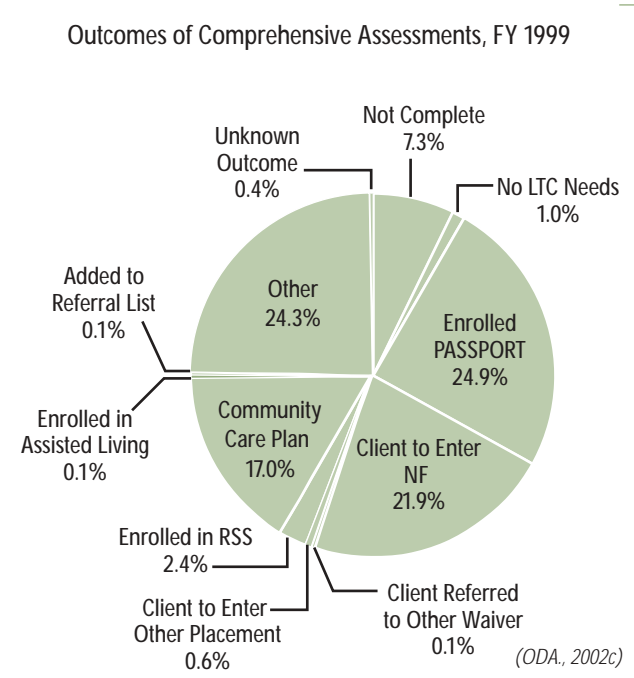


Figure 21



Alternative Approaches to Delivery of Long-Term Care Services

35

Consumer Direction

Consumer direction is an innovative service delivery model that is actually a continuum of approaches ranging from professionally managed services to client-managed and purchased services (Stone, 2000). “Typically, consumer-directed care programs allow the consumer to hire, train, supervise, and fire the **home care** worker. In some programs, beneficiaries receive cash payments enabling them to purchase the services they want” (Tilly, Wiener, & Cuellar, 2000). Consumer direction is being tested in Ohio and several other states. The “Independent Choices” initiative is evaluating the cost, quality, and effectiveness of consumer directed options within the **PASSPORT** program in Columbus, Ohio (Ciferri, Applebaum, & Kunkel, 2002). A similar model is being tested within the levy supported Elderly Services Program in Hamilton and Butler counties (Cincinnati area).

Integration Of Acute Care And Long-Term Care Services

PACE, the Program of All-inclusive Care for the Elderly, delivers medical, social, and **long-term care** services to frail older adults. It uses a **managed care** model and a combined **Medicare** and **Medicaid** capitation payment system. Participants may also be required to pay a monthly premium depending on their eligibility for Medicare and Medicaid. PACE provides a range of **long-term care** services including **personal care**, social services, specific therapies, health care, nutrition counseling, meals, and transportation. These services are provided at a PACE center and/or in the home. PACE helps people, who would otherwise need to live in a facility, to remain in their homes while receiving high-quality services. Ohio is one of 14 states with PACE demonstration projects (Medicare, 2002b). The current demonstration sites in Ohio are Concordia Care serving Cuyahoga county, and TriHealth SeniorLink serving Hamilton county, and areas of Warren, Butler, and Clermont counties (ODJFS, 2002a).

SHMO is a Social **HMO** that provides the same **Medicare** benefits as a standard **HMO** and additional services such as care coordination, prescription drug benefits, short-term **nursing home** stays, and a full range of community and home based services. Some SHMOs also provide vision, hearing, and dental benefits. This program began in the 1980s to test the feasibility of integrating acute care and **long-term care** services (CDHS, 2001). The four **SHMO** sites operate in Portland, OR; Long Beach, CA; Brooklyn, NY; and Las Vegas, NV. Each site has slightly different eligibility criteria.

Evercare offers **managed care** coverage to **Medicare** beneficiaries under the **Medicare+Choice** option and uses an **HMO** model (CMS, 2001). The goal of this type of program is to reduce hospital admissions among **Medicare nursing home** residents. Evercare serves over 500,000 older adults in 15 states. There are three sites in Ohio: West Chester (Cincinnati area), Cleveland, and Westerville (Columbus area) (Evercareonline, 2002).

Innovative Models for Nursing Homes

Eden Alternative	<p>The "Eden Alternative" is a philosophical approach to long-term care that has been incorporated in whole or in part by many nursing homes and other institutions. The philosophy is centered in the belief that older adults should be treated with dignity and respect, that the choices of older adults matter, and that the environment of LTC facilities should be as home and community-like as possible. This philosophy has implications for the design and management of nursing homes. Edenized environments include children, plants and animals. There are currently 13 Eden-registered homes in Ohio (Edenmidwest, 2002).</p>
Pioneer Network	<p>The Nursing Home Pioneer Network (Pioneer Network, 2002) is a resource group of nursing home providers, researchers, staff, family members and others who are promoting cultural change in institutional settings. As a resource center, they identify and promote innovations in practice, which help to turn institutional settings into "homes" for elders. As an organization, they strive to promote the following values to accomplish culture change:</p> <ul style="list-style-type: none">• Know each person• Each person can and does make a difference• Relationship is the fundamental building block of a transformed culture• Respond to spirit, as well as mind and body• Risk taking is a normal part of life• Put person before task• All elders are entitled to self-determination wherever they live• Community is the antidote to institutionalization• Do unto others as you would have them do unto you• Promote the growth and development of all• Shape and use the potential of the environment in all its aspects: physical, organizational, and psychosocial/spiritual• Practice self-examination, searching for new creativity and opportunities for doing better• Recognize that culture change and transformation are not destinations but a journey, always a work in progress

There are Pioneer Network coalitions in the following states: New York, Ohio, Florida, New Hampshire and Illinois.

Wellspring is an association of 11 facilities in Wisconsin. The Wellspring Model “operates under the assumption that providing excellent care is cost-effective” (Reinhard & Stone, 2001). This model has six core elements:

- An alliance of **nursing homes** with top management committed to making quality of resident care a top priority
- Shared services of a geriatric nurse practitioner (GNP), who develops training materials and teaches staff at each **nursing home** how to apply nationally recognized clinical guidelines
- Interdisciplinary “care resource teams” that receive training in a specific area of care and are responsible for teaching other staff at their respective facilities
- Involvement of all departments within the facility and networking among staff across facilities to share what works and what does not work on a practical level
- Empowerment of all **nursing home** staff to make decisions that affect the quality of resident care and the work environment
- Continuous reviews by CEOs and all staff of performance data on resident outcomes and environmental factors relative to other **nursing homes** in the Wellspring alliance

Each Wellspring facility implements the program’s fundamental components, but each facility remains independent and each has unique features, “such as innovative architectural designs, creative use of recreational programming to include community-dwelling residents, and integration of plants and pets into the **nursing home** environment and resident life” (Reinhard & Stone, 2001).



The unprecedented growth in both the older and the older, disabled populations will have a significant impact on health and **long-term care** services in Ohio. The increasing numbers of older, disabled adults will require additional service **providers** and a larger health care workforce for both facility, and **home and community based services**.

Projections Of Ohio's Older Population

Ohio's older population is expected to remain fairly constant through the year 2010 at just under 1.5 million people (Mehdizadeh, Kunkel, & Applebaum, 1996). However, this population will grow dramatically between 2015 and 2050, increasing by 70%. Those Ohioans age 85 and older will increase from a quarter of a million in 2020 to over one million in 2050. Ohio's older population will continue to be predominately female (Mehdizadeh, Kunkel, & Ritchey, 2001).

Projections Of Ohio's Older, Disabled Population

Growth in the older, disabled population will mirror that of the older population in general. The severely disabled older population will more than double between 2015 and 2050 and the moderately disabled group will almost double in size during that time period. The number of older people in Ohio with a long-term disability will reach one million by 2050 (Mehdizadeh, Kunkel, & Ritchey, 2001). As a person grows older, the probability of becoming moderately to severely disabled jumps dramatically. The numbers of severely and moderately disabled people over the age of 85 will more than triple by 2050 (Mehdizadeh, Kunkel, & Ritchey, 2001). Cognitive decline is another source of disability. The Alzheimer's Association estimates that at least 14 million people in the United States will have the disease by 2050 unless a cure is found (Alzheimer's Association, 2000).

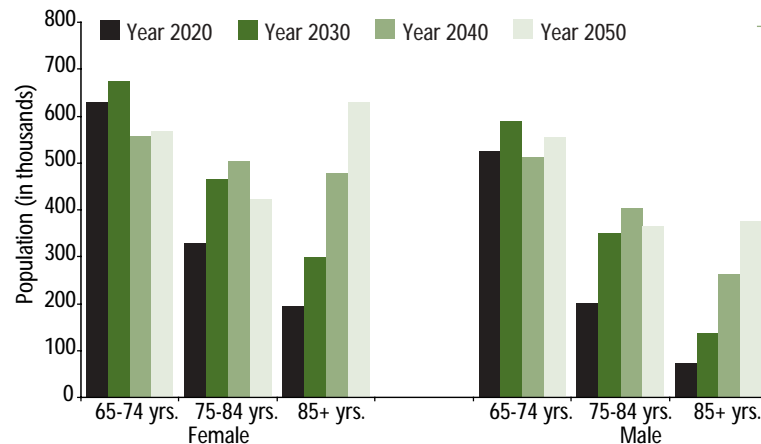


Figure 22
Projections of Ohio's Older Population by Gender and Age

(Mehdizadeh, Kunkel, & Ritchey, 2001)

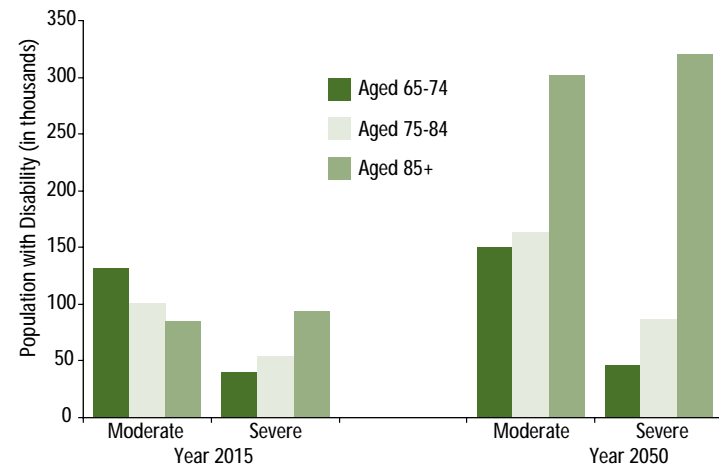


Figure 23
Projections of Ohio's Older Population by Disability and Age

(Mehdizadeh, Kunkel, & Ritchey, 2001)

Because the level of disability will increase among both home-care clients and **nursing home** residents, and because the absolute numbers of persons needing care will continue to increase, the number of staff needed to care for them is expected to increase. In Ohio, an estimated 24,000 additional full-time equivalent (FTE) direct care staff will be needed in **long-term care** between 2000 and 2010. This is expected to occur even though the general older population is expected to remain steady between 2000 and 2010 (Even, Ghosal, & Kunkel, 1998). If occupancy rates in **nursing homes** continue to decline, there may be an accompanying shift in where workers are needed. However, the growth of the labor force is projected to slow down until about 2040 due to fewer people ages 25 to 34 (Mitka, 2000). The American Medical Association predicts that there will be 20% fewer registered nurses than needed by 2020 (Buerhaus, Staiger, & Auerbach, 2000). The Bureau of Labor Statistics predicts that personal and **home care** assistance will be the fourth fastest-growing occupation by 2006 (Stone & Wiener, 2001).

To deal with the current and pending work force shortage in health and **long-term care**, the **Ohio Department of Health** and other agencies convened a task force on the health industry workforce shortage. This task force has investigated the magnitude of the shortage and developed recommendations to address this growing concern (see the final report at <http://www.odh.state.oh.us/ODHPrograms/HCFORCE/finalreport.pdf>). The recommendations focus on licensing standards, practices, recruitment and retention of workers, and education.

The **Ohio Department of Aging** has also convened a Governor's Workforce Policy Board to focus on home, community and institutional **caregiver** issues. The board concentrates on nurses, **personal care** workers, **home health aides**, and nursing assistants working in hospitals, **long-term care** facilities, **residential care** facilities, **home health** agencies, and state agencies (ODA, 2002b). A special Governor's summit was also held on this issue (Report to Governor Taft on the Governor's Summit: Health Care Workforce Shortage, 2000).

Family, friends and neighbors remain the backbone of the **long-term care** system. Estimates consistently report that the informal system, particularly adult children and spouses, provides more than 80% of all **long-term care** delivered in the home. However, because of demographic changes that include an increase in the oldest-old and a decrease in the birth rate, pressure on future **caregivers** will continue to grow. Currently there are 11 **caregivers** for each person needing care. That ratio is expected to drop to 4:1 by 2040 (Reuters Health, 2000). Other social and economic factors such as an increase in dual income households and increased geographic mobility suggest further challenges for long-term caregiving.

Efforts to better support **caregivers** are now underway. Both state and federal programs designed to provide a range of services to **caregivers** have been enacted. Programs that allow payment directly to **caregivers** are also being tested nationally and in Ohio. Such programs allow consumers to pay family members, friends or neighbors to provide services that would normally be delivered by formal agencies. Although these programs are still under study, preliminary concerns about quality or fraud have not been substantiated. Some states are also exploring tax credits or other tax system incentives to assist with the caregiving role. Although the optimum strategies have yet to be designed, the need for the caregiving system to be strong as the baby boom generation reaches old age will be critical.

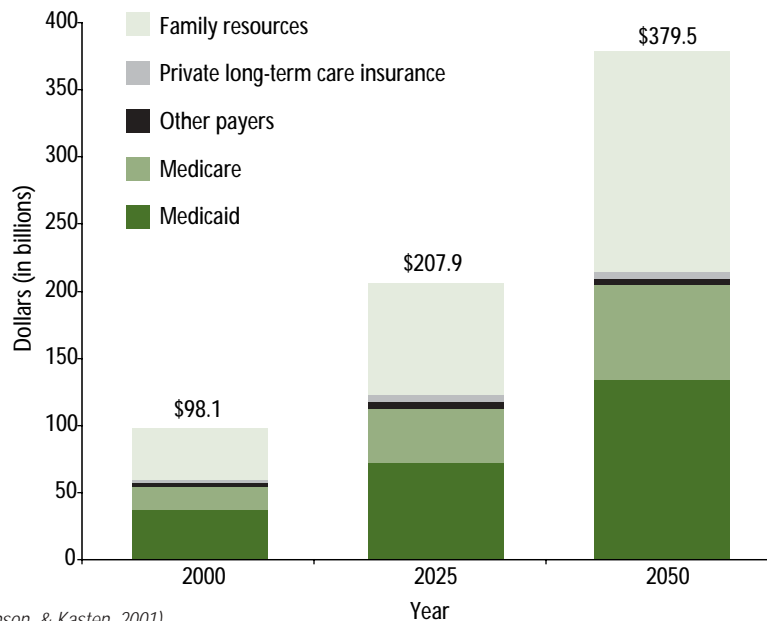
Long-term care, particularly **nursing home** care, is heavily regulated. Given the increasing frailty of both in-home and institutional residents, it is no surprise that a substantial amount of state and federal resources are allocated to regulatory activities. Despite these efforts, concern about the quality of **long-term care** remains a paramount policy issue. **Nursing homes** have received considerable attention in recent years from both the popular press and professional reviews. A common critique is that although **nursing homes** are heavily regulated, they are not well regulated. Several initiatives have been launched as a response to this latest round of criticism. One approach involves improving the quality of **nursing homes** through more stringent requirements, such as increased staffing ratios and better training. A second involves improved data collection efforts for facilities and inspectors to examine individual home performance. Finally, there has been an attempt to provide solid information to consumers and their families to allow consumer choice to become a factor in facility quality improvements efforts. **Ohio's Long-Term Care Consumer Guide** was the first in the nation to include satisfaction data from both residents and their families, in addition to inspection survey data.

Despite these and other efforts, experts in the field have called for a revamping of regulatory approaches in **long-term care**. Critics suggest that consumer outcomes have been secondary to structural factors, such as training requirements, facility structural reviews, and paper work compliance. There is considerable agreement that the regulatory system can be improved.

Overall, spending patterns for **LTC** are expected to change. Family resources will pay an increasingly greater proportion, as will **Medicaid** (Tilly, Goldenson, & Kasten, 2001). Likewise, **Medicare** projects the number of its beneficiaries will double between the years 2000 and 2030 (CMS, 2002b). Between 2000 and 2025, **long-term care** spending for all adults 65 and over is expected to double, and to quadruple by 2050 (Tilly, Goldenson, & Kasten, 2001). By 2011 it is estimated that nationwide out-of-pocket spending on **long-term care** will reach \$51.3 billion, compared to \$42.8 billion that will be spent by the **Medicare** program on **long-term care** (CMS, 2002a).

Figure 24

Projected Costs for Institutional and Home Care for Adults 65+, 1999 Dollars



(Tilly, Goldenson, & Kasten, 2001)

The doubling of the number of older Ohioans expected to experience a disability will place substantial budgetary pressures on the state. If the **Medicaid** program remains the major mechanism for financing in-home and institutional **long-term care** services, there will be substantial increases in state expenditures regardless of state policy choices made about the nature of the system. Several policy initiatives could, however, mitigate the demographic challenges facing the state. First, efforts to create a more balanced system will allow expenditures to be lowered per-capita, thus serving a larger proportion of the disabled population. State efforts to encourage personal responsibility, through **long-term care insurance** options, could assist in lowering the number of Ohioans that eventually rely on Medicaid support. Finally, changes in federal policy which recognize **long-term care** as a national responsibility, rather than a state and individual one, could drastically change the state's role in **long-term care**. However, given the federal track record in this arena, it seems prudent for the state to develop policy based on limited federal involvement.

A gubernatorial executive order in June 2000 created a task force known as Ohio ACCESS to undertake a comprehensive review of Ohio's systems of care for people with disabilities, and to make recommendations for improvements by 2006 (Fox-Grage, Folkemer, Straw, & Hansen, 2002). The taskforce, comprised of representatives from a number of state departments, consumers, and consumer representatives, focused on people with physical and developmental disabilities, with the priority recommendation ensuring that people live with dignity in the setting they prefer.

The ACCESS task force made the following recommendations to improve long-term care services for Ohioans with disabilities.

- Match capacity with the demand for community-based services.
- Generate and sustain the necessary resources to expand community services.
- Overcome federal policy constraints such as the federal Medicaid waiver.
- Address the health care workforce shortage by creating a public-private workgroup; conducting a labor market analysis; studying wage and rate issues; creating demonstration projects to examine career ladders, scholarship opportunities, and payments to family members and other informal caregivers on a controlled basis; examining alternatives to the traditional provision of long-term care by looking at scope of practice issues, assistive technology and the increased use of independent service providers.
- Overcome policy constraints on self-sufficiency and personal and family responsibility by providing better information and assistance for consumers and their caregivers.

As Ohio ACCESS recommendations are implemented, it is clear that the type of services, the locations of services, and the management of long-term care services will change in the near future. (For the text of the full report see www.state.oh.us/age/ohioaccessrpt.pdf).



Additional Information Available on the World Wide Web

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Web Sites

ABA Commission on Law and Aging is a multidisciplinary group dedicated to examining the law-related concerns of older persons and resources on this website include publications, research findings, conferences, and descriptions of demonstration projects.

<http://www.abanet.org/aging/>

Administration on Aging (AoA) provides numerous sources of information for family caregivers, providers, professionals in LTC, and researchers on issues related to aging. AoA is a division of the U.S. Department of Health & Human Services.

<http://www.aoa.dhhs.gov/>

Advisory Panel on Alzheimer's Disease - Alzheimer's Disease and Related Dementias: Acute and Long-term care Services, 1996. This is a report to Congress of the Department of Health & Human Services Advisory Panel on Alzheimer's Disease. This URL takes you to the table of contents.

<http://www.alzheimers.org/pubs/acute96.html>

Aging in Ohio at The Ohio State University Extension Office provides resources for seniors and their families, programming information for professionals working with seniors and information about aging education events being offered in Ohio.

<http://www.ag.ohio-state.edu/~seniors/>

Alzheimer's Association, a national network of chapters, is the largest national voluntary health organization dedicated to advancing Alzheimer's research and helping those affected by the disease.

<http://www.alz.org/>

Alzheimer's Disease Education & Referral Center provides information about Alzheimer's disease and related disorders. The ADEAR Center is a service of the National Institute on Aging.

<http://www.alzheimers.org/>

American Association of Homes & Services for the Aging represents 5,600 mission-driven, not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations.

<http://www.aahsa.org/>

American Association of Retired Persons (AARP) is a nonprofit membership organization dedicated to addressing the needs and interests of persons 50 and older.

<http://www.aarp.org/>

American Society on Aging has many electronic and printed resources on long-term care. Because the list of resources is constantly changing, use the search function on the home page to locate what is currently available.

http://www.asaging.org/ASA_Home_New5.cfm

Assisted Living Federation of America (ALFA) represents over 7,000 for-profit and not-for-profit providers of assisted living, continuing care retirement communities, independent living and other forms of housing and services.

<http://www.alfa.org/>

Association of Ohio Philanthropic Homes, Housing, & Services for the Aging (AOPHA) advocates for the quality of life for all Ohioans, represents the public the interests of its diverse membership, and provides specialized services to enable members to accomplish their individual missions.

<http://www.aopha.org/index.htm>

Centers for Medicare and Medicaid Services (formerly HCFA) offer consumers information about Medicare and Medicaid services, regional office locations and phone numbers, frequently asked questions and explanations of programs and benefits.

<http://www.cms.gov/>

CHAP is the Community Health Accreditation Program that develops and promotes standards applicable to all types of home and community-based health service providers.

<http://www.chapinc.org/index.htm>

Eden Alternative creates habitats for people who live and work in long-term care facilities. This organization is also responsible for the "Green House" movement in long-term care.

<http://www.edenalt.com/>

Elderweb: Ohio is an online community of older adult computer users.

<http://www.elderweb.com/default.php?PageID=1568>

Family Caregiver Alliance - The FCA website has many resources for informal caregivers. While some of the information, such as the lists of caregiver support groups and respite care services, is for California residents, there is a great deal of information which can be used by caregivers regardless of location.

<http://www.caregiver.org>

Foundation for Health in Aging is part of the American Geriatric Society. This website contains information concerning public education, clinical research, and public policy of interest to older adults. Includes the online publication, Eldercare@home.

<http://www.healthinaging.org/>

Healthfinder: Long-term care - This webpage is part of the Healthfinder website and lists over 30 documents or web pages related to long-term care. The topics range from hospice to Medicaid to LTC planning.

<http://www.healthfinder.gov/>

JCAHO is the Joint Commission on Accreditation of Healthcare Organizations, a certification agency for home care providers.

<http://www.jcaho.org/>

Medicare.gov is "The Official U.S. Government Site for People with Medicare." This site has many tools for locating participating providers, comparing nursing homes, personal plan finders, prescription assistance information and other helpful information.

<http://www.Medicare.gov/>

Medicare Rights Center (MRC) is a not-for-profit organization dedicated to ensuring that older adults and people with disabilities get good, affordable health care. The MRC website offers helpful and reliable Medicare information for consumers and professionals.

<http://www.Medicarerights.org/Index.html>

National Association for Home Care has a consumer page with an online guide to choosing a home care provider. There is also a provider locator service.

<http://www.nahc.org/Consumer/coninfo.html>

National Caucus and Center on Black Aged seeks to improve the quality of life for elderly African Americans and low income minorities.

<http://www.ncba-aged.org/>

National Center on Women and Aging focuses national attention on the special concerns of women as they age, develops solutions and strategies for dealing with these concerns, and reaches out to women and organizations across the country.

<http://www.heller.brandeis.edu/national/ind.html>

National Committee to Preserve Social Security and Medicare advocates for beneficiaries of Social Security and Medicare. Included at this site are late-breaking news about Social Security and Medicare, legislative information, an interactive question and answer tool and prescription information.

<http://www.ncpssm.org/>

National Family Caregivers Association is a community-based, non-profit organization that serves as an information resource for family caregivers.
<http://www.caregiver.org/index.html>

National Indian Council on Aging strives to better the lives of the nation's indigenous seniors through advocacy, employment training, dissemination of information, and data support.
<http://www.nicoa.org/index1.html>

National Institute on Aging - An NIA Age Page, this webpage discusses how to plan for long-term care needs, lists tips on evaluating residential programs, and includes links to helpful websites.
<http://www.nih.gov/nia/health/agepages/longterm.htm>

National Institutes of Health - The Resource Directory for Older People contains the names, addresses, telephone and fax numbers, website addresses and email addresses of many organizations such as Federal agencies, AoA-supported resource centers, professional societies, private groups, and volunteer programs. These organizations include many that deal with long-term care issues.
<http://www.nih.gov/nia/health/resource/rd2001.htm>

National Senior Citizens Law Center advocates nationwide to promote the independence and well-being of low-income elderly individuals, as well as persons with disabilities, with particular emphasis on women and racial and ethnic minorities.
<http://www.nslc.org/>

National Resource Center on Native American Aging serves the elderly Native American population of the U.S. and is committed to increasing awareness of issues affecting American Indian, Alaskan Native, and Native Hawaiian elders.
<http://www.und.nodak.edu/dept/nrcnaa/index.htm>

NOAH: Aging and Alzheimer's Disease is an information guide to various topics on aging. This site consists of links to other sources and websites, listed by categories. For example: physiological changes, hearing, vision, incontinence, sexuality and nutrition.
<http://www.noah-health.org/english/aging/aging.html>

Nursing Home Compare is a tool supplied by the U.S. government to provide detailed information about the performance of every Medicare and Medicaid certified nursing home in the country.
<http://www.medicare.gov/Nhcompare/home.asp>

Nursing Home Pioneer Network advocates and facilitates deep system change and transformation in our culture of aging.
<http://www.pioneernetwork.org/index.cfm/fuseaction/showResources.cfm>

Ohio Assisted Living Federation seeks to maintain and promote the growth of quality assisted living in Ohio.
<http://www.ohioassistedliving.org/>

Ohio Association of Area Agencies on Aging provides information on long-term care programs and services, current and pending legislation, and has links to the 12 Area Agencies on Aging in Ohio.
<http://www.ohioaging.org>

Ohio Council of the Alzheimer's Association advocates for people with Alzheimer's and related dementias and their families. The website has pages about legislation, resources, events, and research.
<http://www.ag.ohio-state.edu/-seniors/>

Ohio Department of Aging has information on aging, caregiving, and state service programs.
<http://www.state.oh.us/age/index.htm>

Ohio Department of Insurance website has links for filing complaints, comparing premiums and company performance, ordering consumer publications, and downloadable tax and insurance forms.

<http://www.ins.state.oh.us/>

Ohio Department of Job & Family Services (ODJFS) develops and oversees programs that provide health care, employment and economic assistance, child support, and services to families and children.

<http://www.state.oh.us/odjfs/index.stm>

Ohio Health Care Association serves an information and education resource to Ohio's long-term care providers, their suppliers, consultants and to the public at large.

<http://www.ohca.org/>

Ohio Long-Term Care Consumer Guide provides information to assist consumers and professionals in identifying long-term care services to meet individual needs.

<http://www.ltcoho.org>

Pension and Welfare Benefits Administration is an office of the U.S. Department of Labor that protects the integrity of pensions, health plans, and other employee benefits. This website provides information on various types of pension plans, assistance for dislocated workers, health care plan benefits and other related topics.

<http://www.dol.gov/dol/pwba/>

Scripps Gerontology Center at Miami University, Oxford, OH has publications dealing with many long-term care issues for LTC professionals, planners and policymakers, and general audiences. Many are available for free download.

<http://www.scripps.muohio.edu>

Social Security Online is the official website of the Social Security Administration and contains information on Social Security retirement and disability benefits, SSI and other benefits, SS card replacement, taxes, hearings and appeals, and regional office locations. There is also an online form for applying for SS benefits. This site has a Spanish language version.

<http://www.ssa.gov/>

Veteran's Affairs website provides information for U.S. veterans and their families on a wide variety of benefits and services, including health benefits.

<http://www.va.gov/>

*Glossary previously published separately as "From ADL to V.A.: A Glossary of LTC Terms" by M. Scala (1999) Scripps Gerontology Center, Miami University, Oxford, Ohio.

activities of daily living (ADLs)

basic personal activities which include bathing, eating, dressing, mobility, transferring from bed to chair, and using the toilet.

Administration on Aging (AoA)

federal agency that oversees Older Americans Act programs. Part of the U.S. Department of Health and Human Services.

adult care home

see board and care home

adult day care

see adult day services

adult day services

programs offering social and recreational activities, supervision, health services, and meals in a single setting to older adults with physical or cognitive disabilities. Typically open weekdays during standard business hours.

adult family home

(also called adult care homes, group home or board & care home) residence which offers housing and personal care services for 3 to 16 residents. Services (such

as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home. (Also licensed as an adult group home.)

adult protective services

service which seeks to protect the rights of frail older adults by investigating cases of abuse, neglect, and exploitation as mandated by law. Contact your local PASSPORT Administrative Agency, Area Agency on Aging, or county department of human services for more information.

advance directive

legal document in which people give others instructions about their preferences with regard to health care decisions in case they become incapacitated in some way. Types of advance directives are: living will and durable power-of-attorney for health care.

Area Agency on Aging (AAA)

regional organizations which oversee programs serving elders in Ohio (12 total in the state of Ohio).

Provide information and referral services and also typically serve as PASSPORT Administrative Agencies (PAAs) -with the exception of Champaign, Darke, Logan, Preble, Miami, and Shelby counties for whom Catholic Social Services is the PAA.

assisted living

residences which provide a "home with services" and which emphasize residents' privacy and choice. Residents typically have private locking rooms (only shared by choice) and bathrooms. Personal care services are available on a 24-hour a day basis. (Licensed in Ohio as residential care facilities or as rest homes)

BenefitsCheckUp

free screening service sponsored by the Ohio Department of Aging that provides consumers with information about their eligibility for public programs such as Medicare and Medicaid. Available on-line (www.benefitscheckup.org) or through Area Agencies on Aging.

Care Choice Ohio

free long-term care consultation service provided by Ohio PASSPORT Administrative Agencies. Includes professional assessments of present or future long-term care needs, as well as information about establishing eligibility for government-funded programs.

care/case management

offers a single point of entry to the aging services network. Care/case managers assess clients' needs, create service plans, and coordinate and monitor services; they may operate privately or may be employed by social service agencies or public programs. Typically case managers are nurses or social workers.

care plan

(also called service plan or treatment plan) written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for the consumer for a specified time period.

caregiver

person who provides support and assistance with various activities to a family member, friend, or neighbor. May provide emotional or financial support, as well as hands-on help with different tasks. Caregiving may also be done from a long distance.

Centers for Medicare and Medicaid Services (formerly known as **HCFA**). This federal organization oversees the Medicare and Medicaid programs.

chore services

help with chores such as home repairs, yard work, and heavy housecleaning.

chronic illness

long-term or permanent illness (e.g. diabetes, arthritis) which often results in some type of disability and which may require a person to seek help with various activities.

comprehensive assessment

an organized process for gathering information to determine diagnosis and the types of services and/or medical care needed and to develop recommendations for services.

Depending on the reason for assessment, it may include: a medical and neurological examination and questions about physical, emotional and mental health, family support system, living situation, and the types of assistance that someone may need. May be conducted at home, in the hospital, in an assessment center or clinic, or in a long-term care facility.

congregate housing

individual apartments in which residents may receive some services, such as a daily meal with other tenants. (Other services may be included as well.) Buildings usually have some common areas such as a dining room and lounge as well as additional safety measures such as emergency call buttons. May be rent-subsidized (known as Section 8 housing).

conservatorship

a legal arrangement granted by the court in which a person chooses an individual to make personal decisions on his/her behalf. The person must be mentally competent, but physically unable to manage his or her own affairs. Consult an attorney for more details.

co-insurance

see co-payment

continuing care retirement

community (CCRC) (also called **life care community**) Communities which offer multiple levels of care (independent living, assisted living, skilled nursing care) housed in different areas of the same community or campus and which give residents the opportunity to remain in the same community if their needs change. Provide residential services (meals, housekeeping, laundry), social and recreational services, health care services, personal care, and nursing care. Require payment of a monthly fee and possibly a large lump-sum entrance fee. (Licensed as nursing homes/residential care facilities or as homes for the aging)

co-payment

(also called co-insurance) the specified portion (dollar amount or percentage) that Medicare, health insurance, or a service program may require a person to pay toward his or her medical bills or services.

county home – see nursing home

custodial care

care that does not require specialized training or services.

deductible

the initial share of a medical or long-term care expense that consumers must pay before their insurance or the program will cover the expense.

dementia

term which describes a group of diseases (including Alzheimer's Disease) which are characterized by memory loss and other declines in mental functioning.

durable medical equipment

(also called **home medical equipment**) equipment such as hospital beds, wheelchairs, and prosthetics used at home. May be covered by Medicaid and in part by Medicare or private insurance.

durable medical power of attorney
see **durable power of attorney for health care**

durable power of attorney

a document which names a person (called an “attorney-in-fact”) who will act as someone’s agent and who will make decisions on their behalf, if they are incapacitated. The power of the attorney-in-fact can be restricted to specific areas (such as health care) or can cover broad decision-making responsibilities. Consult an attorney for more details.

durable power of attorney for health care (also called **durable medical power of attorney** or **health care proxy**) document in which someone names another person who will make medical decisions for them in the event that they are not able to make them for themselves. Consult an attorney for more details.

Eldercare Locator

information and referral service sponsored by the Administration on Aging. Call (toll-free) 1-800-677-1116 Monday through Friday from 9 a.m. to 8 p.m. E.S.T. to obtain information about services in your community. Also available online (www.eldercare.gov).

emergency response systems (ERS) (also called **lifelines** or **personal emergency response systems**) a call button—usually worn by the older individual—which can be pushed to get help from family, friends, or emergency assistance in case of emergency. Can be purchased or rented.

energy assistance programs include: **Ohio Energy Credit Program** which offers older consumers a 30 percent credit toward winter utility bills or a one-time payment of winter utility bills. Check with the Ohio Department of Taxation for more details. **home energy assistance program (HEAP)** federal program that offers consumers credit or vouchers to help pay for winter utility bills. Check with your local Area Agency on Aging for more details.

escort services
see **transportation services**

estate recovery
states are required by law to “recover” funds from certain deceased Medicaid recipients’ estates up to the amount spent by the state for all Medicaid

services (e.g. nursing facility, home and community-based services, hospital, and prescription costs).

fee-for-service

the way traditional Medicare and health insurance work. Medical providers bill for whatever service they provide. Medicare and/or traditional insurance pay their share, and the patient pays the balance through co-payments and deductibles.

for profit

organization or company in which profits are distributed to shareholders or private owners.

Friendly Visitor/Senior

Companions programs in which volunteers regularly visit homebound or institutionalized elders to provide socialization, run errands, and generally “check in” with them. Senior Companions receive a modest stipend for their time from the sponsoring agency.

geriatric care manager

health care professionals (usually social workers or nurses) who have aging-

related expertise and are familiar with the services available to assist with care. Fees for these services range from \$30 to \$150 per hour to conduct assessments, arrange for services, and monitor the provision of those services. Their services can meet a one-time need, or provide ongoing assistance.

geriatric assessment center

organization that uses a variety of health care professionals such as physicians, nurses, social workers, dieticians, physical and occupational therapists, and others to conduct comprehensive assessments and to develop recommendations for care. Usually have a geriatrician on staff, and is often affiliated with a hospital or a university medical school. Has access to a wide variety of health and social services.

geriatrician

physician who is certified in the care of older people.

group home

see **board and care home**

guardianship

legal arrangement in which the court appoints a surrogate decision-maker to act on someone's behalf because they are declared incompetent. May include guardianship of the person, estate (finances), or both. The guardian may or may not know this person, depending on the situation at the time of the appointment.

Health Care Financing**Administration (HCFA)**

former name of the federal organization that oversees the Medicare and Medicaid programs. Now known as the **Centers for Medicare and Medicaid Services**.

health care proxy

see **durable power of attorney for health care**

health maintenance organization (HMO)

managed care organization that offers a range of health services to its members for a set rate, but which requires its members to use health care professionals who are part of its network of providers. (See also Medicare HMOs)

home care or home care services

long-term care services received in a home. For example: homemaker, personal care, home-delivered meals, chore services, or ERS.

home & community based services (HCBS) see home care**home health care**

includes a wide range of health-related services such as assistance with medications, wound care, intravenous (IV) therapy, and help with basic needs such as bathing, dressing, mobility, etc., which are delivered in a person's home.

home medical equipment see durable medical equipment**home sharing/shared housing programs**

usually involve unrelated individuals sharing a home and the chores and expenses included in home ownership. Those sharing the home typically have their own rooms, but share common areas (such as the kitchen). The home may be owned by the people living there or by a nonprofit organization.

homebound

one of the requirements to qualify for Medicare home health care. Means that someone is generally unable to leave the house, and if they do leave home, it is only for a short time (e.g. for a medical appointment) and requires much effort.

homemaker services

help with meal preparation, shopping, light housekeeping, and laundry.

hospice

services for the terminally ill provided in the home, a hospital, or a long-term care facility. Includes home health services, volunteer support, grief counseling, and pain management.

independent living facility

rental units in which services are not included as part of the rent, although services may be available on site and may be purchased by residents for an additional fee.

instrumental activities of daily living (IADLs)

household/independent living tasks which include using the

telephone, taking medications, money management, housework, meal preparation, laundry, and grocery shopping.

irrevocable burial account

when determining eligibility for Medicaid, the state allows consumers to set aside money in a trust or with a funeral director for burial expenses as part of a pre-paid burial plan. Consult your county department of human services or an attorney for more information.

level of care (LOC)

amount of assistance required by consumers which may determine their eligibility for programs and services. Levels include: protective, intermediate, and skilled.

levy-funded programs

home care service programs for older adults that are funded by special property tax levies. Services and fees vary by program. Contact your local Area Agency on Aging to find out if such a program exists in your county.

life care community see continuing care retirement community

lifelines see **emergency response systems**

limited guardianship

A legal arrangement whereby the court appoints a surrogate decision-maker, but limits his or her authority to specific decisions or limits the length of time the guardianship is to be in place.

living trust

a trust that is set up while someone (called the grantor or trustor) is still alive. Assets are transferred to the trust, and the grantor names a “trustee” who controls the assets in the trust and “beneficiaries” who will inherit the trust after the grantor has died. May be revocable (meaning that the grantor may change the terms of the trust or take back assets) or irrevocable (meaning that the trust may not be touched by the grantor). May also be considered when determining the grantor’s eligibility for Medicaid.

living will

a document which states a person’s preferences for future medical decisions including the withholding or withdrawing

of life-sustaining treatments such as artificial nutrition and hydration or the use of equipment such as ventilators and respirators. (See also **advance directive**.)

long-term care (LTC)

range of medical and/or social services designed to help people who have disabilities or chronic care needs. Services may be short or long-term and may be provided in a person’s home, in the community, or in residential facilities (e.g. nursing homes or assisted living facilities).

long-term care insurance

insurance policies which pay for long-term care services (such as nursing home and home care) that Medicare and Medigap policies do not cover. Policies vary in terms of what they will cover, and may be expensive. Coverage may be denied based on health status or age.

long-term care ombudsman – see ombudsman

managed care

method of organizing and financing health care services

which emphasizes cost-effectiveness and coordination of care. Managed care organizations (including HMOs, PPOs, and PSOs) receive a fixed amount of money per client/member per month (called a capitation), no matter how much care a member needs during that month.

Meals-on-Wheels see **nutrition services/home-delivered meals**

Medicaid

federal and state-funded program of medical assistance to low-income individuals of all ages. There are income eligibility requirements for Medicaid. Check with your local PASSPORT Administrative Agency or county department of human services for more information.

Medicare

federal health insurance program for persons age 65 and over (and certain disabled persons under age 65). Consists of 2 parts: Part A (hospital insurance) and Part B (optional medical insurance which covers physicians’ services and outpatient care

in part and which requires beneficiaries to pay a monthly premium).

Medicare+Choice

option under Medicare which gives consumers a choice of plans including managed care and fee-for-service plans. Options consist of: traditional fee-for service, HMOs, HMOs with POS, PPOs, PSOs, private fee-for-service, religious/ fraternal benefit society plans, and medical savings accounts. Current Medicare beneficiaries are not required to change plans unless they so desire.

Medicare HMOs

Under Medicare HMOs (health maintenance organizations), members pay their regular monthly premiums to Medicare, and Medicare pays the HMO a fixed sum of money each month to provide Medicare benefits (e.g. hospitalization, doctor’s visits, and more). Medicare HMOs may provide extra benefits over and above regular Medicare benefits (such as prescription drug coverage, eyeglasses, and more). Members do not pay

Medicare deductibles and co-payments; however, the HMO may require them to pay an additional monthly premium and co-payments for some services. If members use providers outside the HMO's network, they pay the entire bill themselves unless the plan has a point of service option.

Medicare HMOs with Point of Service (POS)

Operates similarly to a regular Medicare HMO except that the plan covers part of the expense if members use providers from outside the network.

Medicare Select (also called MedSelect)

a type of supplemental insurance plan (Medigap/Medisup) that combines managed care with a standard Medigap plan. Plans may require members to use the doctors and hospitals within its network, but premiums are likely to be lower than regular Medigap/Medisup plans.

Medigap

insurance supplement to Medicare that is designed to fill in the "gaps" left

by Medicare (such as co-payments). May pay for some limited long-term care expenses, depending on the benefits package purchased.

MedSelect see **Medicare Select**

mental health services

variety of services provided to people of all ages, including counseling, psychotherapy, psychiatric services, crisis intervention, and support groups. Issues addressed include depression, grief, anxiety, stress, as well as severe mental illnesses.

nonprofit/not-for-profit

an organization that reinvests all profits back into that organization.

nursing home

facilities licensed by the state to offer residents personal care as well as skilled nursing care on a 24 hour a day basis. Provide nursing care, personal care, room and board, supervision, medication, therapies and rehabilitation. Rooms are often shared, and communal dining is common. (Licensed as nursing homes, county homes, or nursing homes/residential care facilities)

nutrition services

include the following:

home-delivered meals (also called **Meals-on-Wheels**)-hot, nutritious meals delivered to homebound older people on weekdays. Can accommodate special diets. **congregate meals**-hot, nutritious lunches served to older adults in group settings such as churches or synagogues, senior centers, schools, etc. Donations are requested, although not required.

occupational therapy

designed to help patients improve their independence with activities of daily living through rehabilitation, exercises, and the use of assistive devices. May be covered in part by Medicare.

Ohio Department of Aging (ODA)

state agency that oversees aging services programs (including PASSPORT and RSS) within the state of Ohio.

Ohio Department of Health (ODH)

state agency whose responsibilities include inspecting and licensing all long-term care facilities within the state of Ohio.

Ohio Department of Human Services (ODHS)

replaced by the Ohio Department of Job & Family Services.

Ohio Senior Health Insurance Information Program (OSHIIP)

program sponsored by the Ohio Department of Insurance which provides free information and advice about health insurance, including Medicare, Medicaid, Medigap, long-term care and other health insurance. Check the phone book for the OSHIIP center in your area, or call (toll-free):1-800-686-1578 Monday – Friday, 7:30am to 5pm.

Ohio Department of Job & Family Services (ODJFS)

state agency that oversees programs that provide health care, employment and economic assistance, child support, and services to families and children.

Older Americans Act

federal legislation that specifically addresses the needs of older adults in the United States. Provides some funding for aging services (such as home-delivered meals, congregate meals, senior

center, employment programs). Creates the structure of federal, state, and local agencies that oversee aging services programs. (See also Title III services)

ombudsman

trained professional or volunteer who advocates for the rights of older people receiving long-term care services (both facility-based care and home care) and who investigates their problems with or concerns about their care.

PASSPORT

Ohio's home and community-based long-term care service program for low-income persons 60 and over. (PASSPORT stands for Pre-Admission Screening and Services Providing Options and Resources Today.)

PASSPORT Administrative Agencies (PAAs)

organizations that handle the eligibility determination, assessment, and case management for the PASSPORT program. Generally housed at area

agencies on aging in Ohio. The exception to this is Catholic Social Services in Sidney that serves as the PAA for Champaign, Darke, Logan, Preble, Miami, and Shelby counties.

personal care (also called **custodial care**)

assistance with activities of daily living as well as with self-administration of medications and preparing special diets.

personal emergency response system see **emergency response system**

physical therapy

designed to restore/improve movement and strength in people whose mobility has been impaired by injury or disease. May include exercise, massage, water therapy, and assistive devices. May be covered in part by Medicare.

Planning and Service Areas (PSAs)

multi-county regions of the state whose aging services are coordinated by Area Agencies on Aging.

point of service (POS)

a health maintenance organization (HMO) with this option will cover part of the expense if a member decides to use a provider outside the plan's network.

pre-admission review

required of all people living independently in the community who wish to enter a nursing home. Ensures that community and home-based long-term care options are presented to all older people who are able to take advantage of them.

pre-admission screen

older Ohioans requesting admission to a Medicaid-certified nursing facility must receive approval from their PASSPORT Administrative Agency before they may be admitted. This approval (the Pre-admission screen) is a federal requirement to ensure that nursing home residents who need mental health services or specialized services for the mentally retarded or developmentally disabled are identified at admission.

preferred provider organization (PPO)

managed care organization that operates in a similar manner to an HMO or Medicare HMO except that this type of plan has a larger provider network and does not require members to receive approval from their primary care physician before seeing a specialist. It is also possible to use doctors outside the network, although there may be a higher co-payment.

private fee-for-service see **Medicare + Choice**

provider

individual or organization that provides health care or long-term care services (e.g. doctors, hospital, physical therapists, home health aides, and more).

provider sponsored organization (PSO)

managed care organization that is similar to an HMO or Medicare HMO except that the organization is owned by the providers in that plan and these providers share the financial risk assumed by the organization.

Qualified Medicare Beneficiary (QMB)

individual enrolled in a Medicaid program which pays for Medicare consumer cost-share expenses (deductibles, co-payments, and part B premiums) for low-income elders and persons with disabilities who qualify for Medicare Part A. There are income eligibility requirements for this program. Contact your local PASSPORT Administrative Agency or county department of human services for more information.

Qualifying individual (QI)

individual enrolled in a Medicaid program which pays for all or part of Medicare Part B monthly premiums for low-income elders and persons with disabilities who qualify for Medicare Part A. There are income eligibility requirements for this program. Contact your local PASSPORT Administrative Agency or county department of human services for more information.

rehabilitation services

services designed to improve/restore a person's functioning; includes physical therapy,

occupational therapy, and/or speech therapy. May be provided at home or in long-term care facilities. May be covered in part by Medicare.

residential care – see assisted living**Residential State Supplement (RSS)**

state-funded program which gives cash assistance to older persons and to blind and disabled persons of all ages who are Supplemental Security Income (S.S.I.) recipients and who do not medically qualify for nursing home placement, but who live in other approved group living settings such as board and care homes and adult foster homes. There is an income eligibility requirement for receiving RSS. Contact your local PASSPORT Administrative Agency for more information.

respite care

service in which trained professionals or volunteers come into the home to provide short-term care (from a few hours to a few days) for an older person to allow caregivers some time away from their caregiving role.

rest home see assisted living**senior center**

provides a variety of on-site programs for older adults including recreation, socialization, congregate meals, and some health services. Usually a good source of information about area programs and services.

service plan see care plan**skilled care**

“higher level” of care (such as injections, catheterizations, and dressing changes) provided by trained medical professionals, including nurses, doctors, and physical therapists.

skilled nursing facility (SNF)

facility that is certified by Medicare to provide 24-hour nursing care and rehabilitation services in addition to other medical services. (See also **nursing home**)

Social Services Block Grant services see Title XX services**special care units**

long-term care facility units

with services specifically for persons with Alzheimer's Disease, dementia, head injuries, or other disorders.

Specified Low Income Medicare Beneficiary (SLMB) individual enrolled in a Medicaid program which pays for Medicare Part B monthly premiums for low-income elders and persons with disabilities who qualify for Medicare Part A. There are income eligibility requirements for this program. Contact your local PASSPORT Administrative Agency or county department of human services for more information.

speech therapy

designed to help restore speech through exercises. May be covered by Medicare.

spend-down

Medicaid financial eligibility requirements are strict, and may require beneficiaries to spend down / use up assets or income until they reach the eligibility level. Contact your local PASSPORT Administrative Agency or county department of human services for more information.

spousal impoverishment

federal regulations preserve some income and assets for the spouse of a nursing home resident whose stay is covered by Medicaid. Contact your local PASSPORT Administrative Agency or county department of human services for more information.

subacute care (also called transitional care)

type of short-term care provided by many long-term care facilities and hospitals which may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.

support groups

groups of people who share a common bond (e.g. caregivers) who come together on a regular basis to share problems

and experiences. May be sponsored by social service agencies, senior centers, religious organizations, as well as organizations such as the Alzheimer's Association.

telephone reassurance

program in which volunteers or paid staff call homebound elders on a regular basis to provide contact, support, and companionship.

Title III services

services provided to individuals age 60 and older which are funded under Title III of the Older Americans Act. Include: congregate and home-delivered meals, supportive services (e.g. transportation, information and referral, legal assistance, and more), in-home services (e.g. homemaker services, personal care, chore services, and more), and health promotion/disease prevention services (e.g. health screenings, exercise programs, and more). Contact your local area agency on aging to see what services may be available in your area. (See also Older Americans Act)

Title XX services (also called Social Services Block Grant services)

grants given to states under the Social Security Act which fund limited amounts of social services for people of all ages (including some in-home services, abuse prevention services, and more). Contact your local Area Agency on Aging or county department of human services to find out what services may be available in your area.

transitional care see **subacute care**

transportation services (also called escort services)

provides transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers, or van services that can accommodate wheelchairs and persons with other special needs.

treatment plan see **care plan**

Veterans Affairs (V.A.)

offers acute and long-term care benefits (nursing home care and home care) benefits to veterans of the United States Armed Forces, and in some cases, their families. Services are provided by V.A. medical centers around the country. Contact your local or state V.A. for more information.



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