Ohio Long-Term Services and Supports Factbook




SCRIPPS GERONTOLOGY CENTER
AN OHIO CENTER OF EXCELLENCE

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During the 20th century, unprecedented increases in life expectancy have 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 services and assistance for increasing numbers of older adults has also grown. These noteworthy changes have brought increased public expenditures, greater obligations for families and friends of older adults, and a complex array 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 need to be more attentive to the issues of planning and paying for care, and managing assistance for themselves and their loved ones. Providers are working to improve the quality of the services they offer, 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 services and supports, this factbook is designed to provide a basic introduction, with an emphasis on Ohio. It provides a look at Ohio's long-term services, the people who are served, and the public and private funding sources that support them. While previous versions of this publication have focused only on Ohio's older population, this new edition of the factbook has expanded the scope to include individuals of all ages with physical or cognitive limitations.

This third edition includes updated statistics on long-term service use and expenditures, as well as new information on long-term service quality initiatives, innovations in long-term services, additional Internet resources, and an updated and expanded glossary.

Fast Facts

- In 2009, Ohio had approximately 1.6 million people 65 years or older.
- 29%, or 441,964, of these individuals had a moderate or severe disability.
- On any given day in 2009, about 78,000 Ohioans lived in nursing homes.
- On any given day in 2009, 34,000 Ohioans 60+ received PASSPORT home & community-based services.
- In 2009, Ohio had approximately 970 nursing home facilities.
- The typical nursing home in Ohio has 96 beds.
- In 2009, Ohio had approximately 580 residential care facilities.
- In 2009, the state of Ohio spent $4.5 billion on long-term services and supports for Medicaid recipients.
- 36% of Ohio's 2009 Medicaid budget was spent on long-term services and supports.
- The average cost for nursing home care in the state in 2009 was $5,300 per month.
- The average cost for PASSPORT (Medicaid) home care services in 2009 was $1,100 per month.
- In 2009, Ohio nursing homes had an occupancy rate of 86%.
- More than one-half of nursing home residents stay three months or less.

Long-term services and supports (LTSS) are provided to people who have limitations that impact their ability to perform daily activities, such as getting in and out of a chair, bathing, dressing, shopping, preparing meals, or housekeeping. Each person's use of and experience with long-term services and supports is unique, depending on their individual needs and situation. Because people need differing types and amounts of assistance, long-term services and supports are really a continuum of care ranging from infrequent assistance with one or two activities to constant assistance with all activities. Services can range from occasional transportation to daily help with bathing and dressing in someone's home. Services may also be delivered in institutions, such as intermediate care facilities for persons with intellectual or developmental disabilities, residential care, assisted living or nursing home facilities. Family members and friends provide much of the care, particularly for those living in the community, and they also use services to supplement the care they provide and to receive respite from caregiving. Formal service providers and workers supply care services in the home and in facilities. Long-term services and supports are paid for through many sources, including individuals and their families, federal, state, and local dollars, and private insurance.

Measuring Functional Eligibility

Activities of Daily Living (ADLs)
- Eating
- Getting in or out of bed or a chair
- Getting to the toilet
- Dressing
- Bathing
- Walking/Getting around
- Continence

Instrumental Activities of Daily Living (IADLs)
- Shopping
- Preparing meals
- Housekeeping
- Using transportation
- Handling finances
- Taking medication
- Using the telephone

People who have physical or cognitive limitations that impact their ability to perform daily activities need long-term services and supports. There are standardized ways to measure and quantify the extent of disability which, in turn, qualify individuals to receive long-term services. The amount of assistance required by individuals is called level of care (LOC) or functional eligibility. The various levels are described in the glossary and include: protective, intermediate, intermediate care for individuals with intellectual or developmental disabilities (ICF ID/DD), and skilled. In order to qualify for Medicaid institutional or home & community-based services, an individual must meet a nursing home level of care (either intermediate or skilled level of care) or level of care required for intermediate care facilities for persons with intellectual or developmental disabilities.

Currently, there are multiple ways to measure functional ability, depending upon the setting or program. For example, all nursing home residents are assessed with the Minimum Data Set (MDS), used to evaluate physical, psychological, and psycho-social functioning.

Two common measures used in long-term services and supports to measure functional ability are activities of daily living (ADL) and the instrumental activities of daily living (IADL) scales (see box). ADL items, such as bathing, transferring from bed to a chair and dressing, are important determinants of the level of support an individual needs, and limitations in these areas often result in the need for formal long-term services. IADL limitations, such as meal preparation and shopping, are more common, but are less likely to result in formal service use. Cognitive functioning is also an important factor in determining the type of services and supports required. For example, persons with Alzheimer's disease and other forms of dementia typically have cognitive limitations that require assistance.

Providers serving the ID/DD population require a diagnosis of intellectual disability, which includes an IQ score of 70 to 75. In addition to an IQ score lower than 75, individuals must also be limited in two or more adaptive skill areas (see box) and experience onset of the condition beginning at age 18 or younger.

An intermediate level of care is required for certain Medicaid home & community-based services serving the ID/DD population. The requirements differ for different age groups. For example, children age 6 to 15 must have deficits in at least three of the six areas of deficiencies (see box). At age 16, a seventh area of deficiency is added (economic self-sufficiency), and those who are 16 years of age or older must meet at least three of the seven areas.

Intellectual disability diagnosis

Adaptive behavior covers three types of skills. Individuals must be deficient in at least two of the three.

- Conceptual skills—language and literacy; money, time, and number concepts; and self-direction
- Social skills—interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., wariness), social problem solving, and the ability to follow rules, obey laws, and avoid being victimized
- Practical skills—activities of daily living (personal care), occupational skills, healthcare, travel/ transportation, schedules/routines, safety, use of money, use of the telephone

Intermediate Level of Care

The major life areas are used to measure level of care. Children age 6 to 15 must be deficient in at least three of the first six areas and those older than 15 must be deficient in three of seven areas.

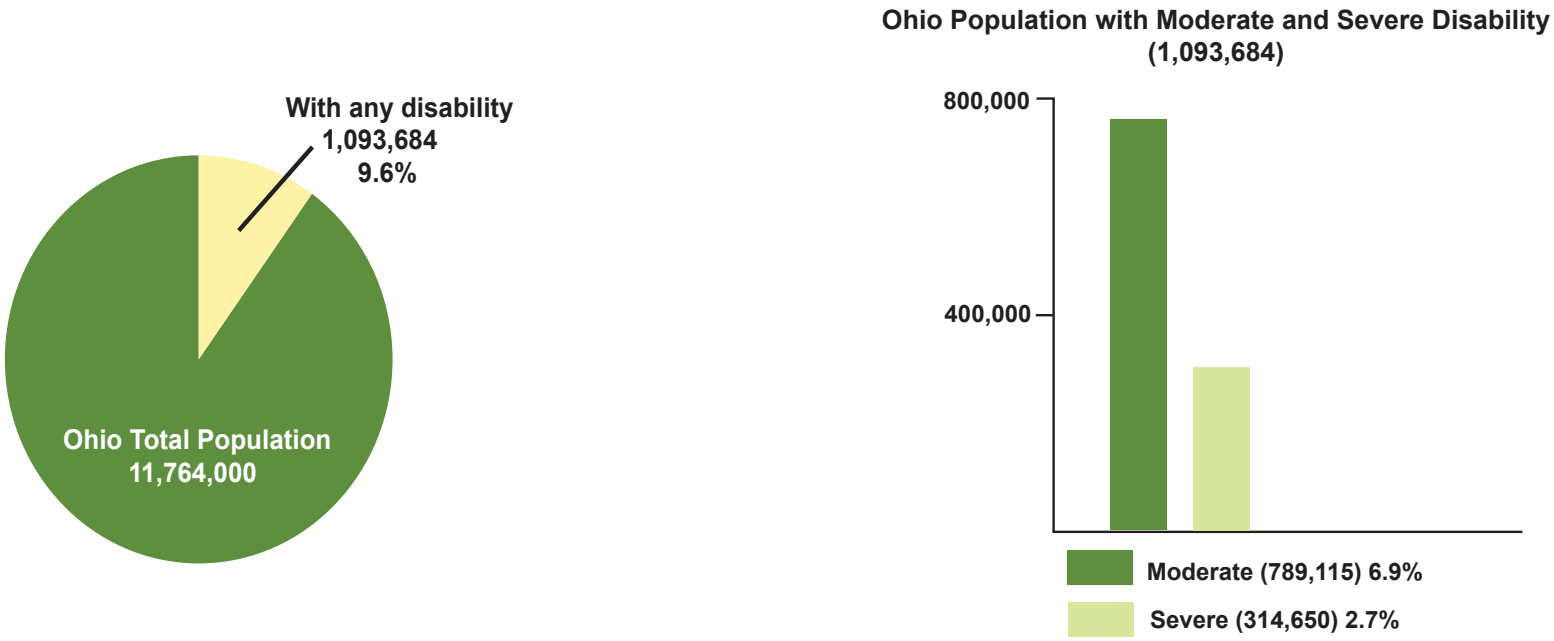
- Independent living
- Communication
- Learning
- Mobility
- Personal care
- Self direction
- Economic self sufficiency

In 2005, approximately nine and one-half percent of Ohio's total population lived with a disability (Mehdizadeh, 2008). Those who use long-term services and supports services include individuals of all ages with physical and/or cognitive disabilities, intellectual/ developmental disabilities (ID/DD), chronic (severe) mental illness, and their caregivers. Figure 1 shows the distribution of disability by type and severity for all Ohioans. People with moderate disability are impaired in at least one ADL or at least two IADLs; persons with severe impairment need help with two or more ADLs. Disability levels are relatively low across the total population. Fewer than 7% of Ohioans have a moderate disability; only 2.7% are severely disabled.

Disability may occur at any age; however, with the exception of individuals with ID/DD (who are diagnosed early in life and have lower life expectancies), people are more likely to become disabled with age. Figure 2 shows the gradual, but marked, increase in levels of severe disability in later life for people in Ohio in 2007, due primarily to the growth in physical and/or cognitive disability.

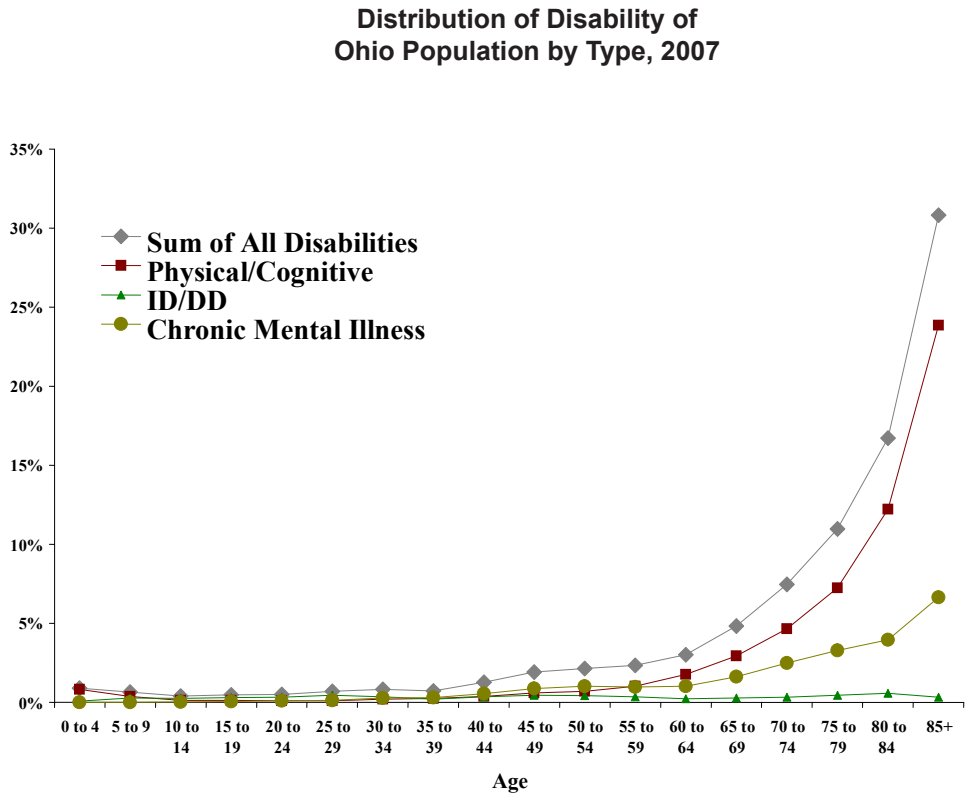
Figure 1

Percentage of Ohio's Population with a Disability by Type, 2010



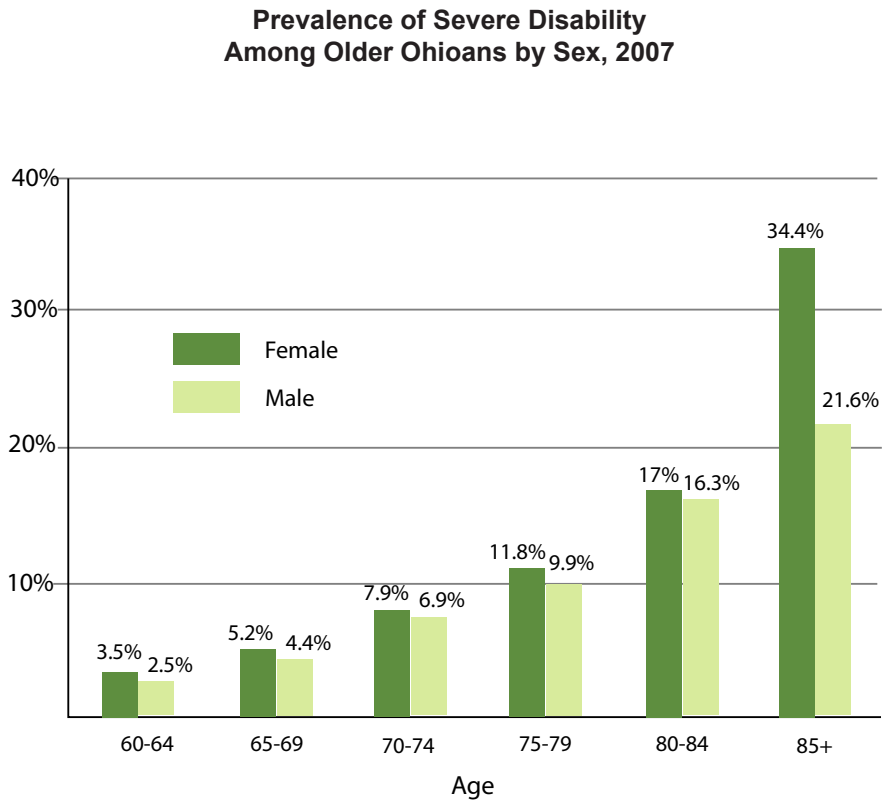
(Mehdizadeh, 2008)

Figure 2



(Mehdizadeh, 2008)

Figure 3



(Mehdizadeh, 2008)

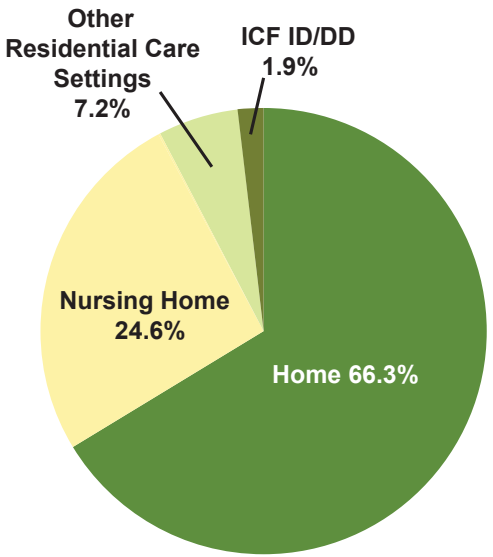
Age, gender, ethnicity, marital status, living arrangements, and poverty are all associated with disability. As a group, older women are more likely to be disabled than older men, as illustrated in Figure 3. Often, minority persons and those with lower educational levels and/or lower than average incomes are in poorer health and have higher levels of disability as they age (Cantor & Brennan, 2000). However, the fast-growing Hispanic sub-population does not follow this trend and warrants special attention in future research (Palloni & Arias, 2004). Until recently, the older African-American population had higher rates of disability than Whites. Chronic disability among this group has declined 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.

Where do Individuals with Disabilities Receive Long-Term Services and Supports?

Individuals with disability reside in various settings, including private residences (homes), nursing homes and ICF ID/DD, and other residential settings such as assisted living, residential care facilities (RCFs) and adult care facilities. Figure 4 shows that two-thirds of Ohioans with severe disabilities reside in private residences. For every individual with a severe disability who is in a facility, there are approximately two living with severe disability in their own homes or the homes of family or friends (Mehdizadeh, 2008).

Figure 4

Proportion of Ohio's Population with a Severe Disability by Setting, 2007



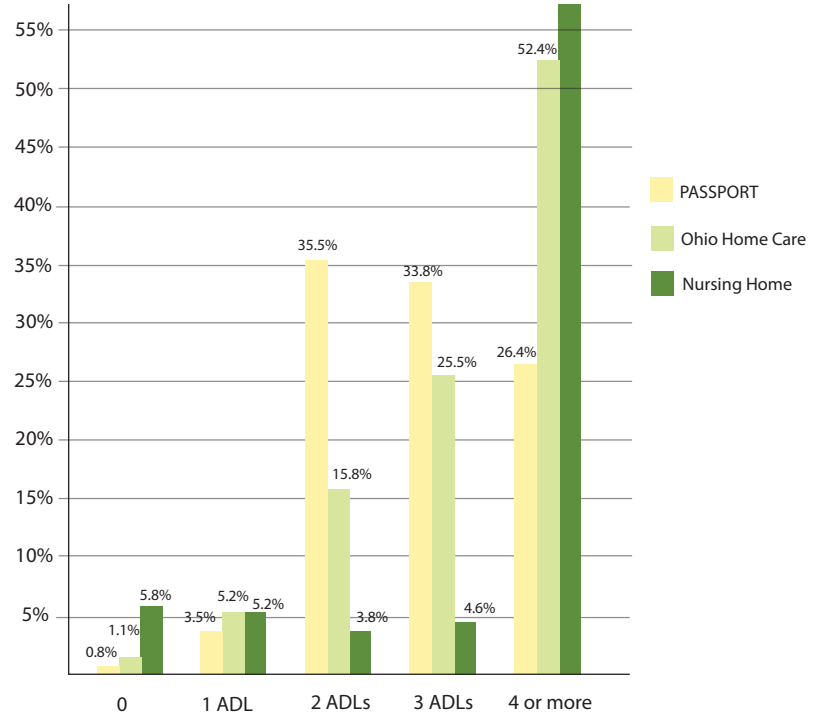
(Mehdizadeh, 2008)

Service Recipients

Across the state, long-term services recipients have varying needs for care. For example, when viewed as a group, nursing home and ICF ID/DD residents are more impaired than community-dwelling service recipients. Figure 5 shows the impairment level of nursing home residents compared to participants in PASSPORT, (a Medicaid home-and community-based services program for adults over age 60). Figure 6 compares the impairment level of ICFs ID/DD residents and Medicaid home-and community-based services participants with ID/DD (Brothers-McPhail & Mehdizadeh, 2009). The typical PASSPORT Medicaid home care participant requires help with an average of 3.0 ADLs while nursing home residents, on average, need help with 4.5 ADLs (Brothers-McPhail & Mehdizadeh, 2009).

Figure 5

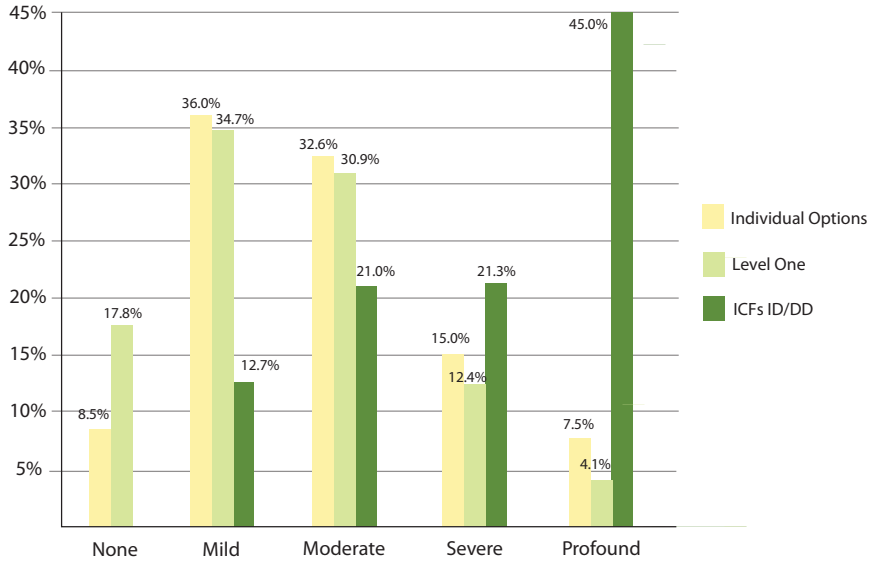
Comparison of Impairment Level: HCBS and Nursing Home, 2008



(Mehdizadeh et. al., 2009)

Figure 6

Comparison of Impairment Level: HCBS and ICF ID/DD, 2007



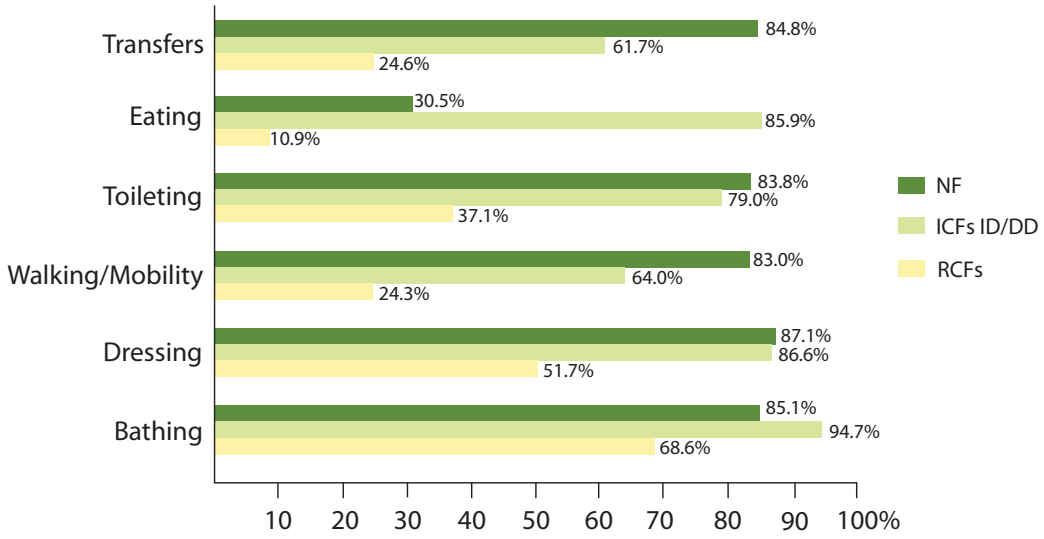
(Mehdizadeh et. al., 2009)

In addition to ICF ID/DD and nursing home facilities, there are other residential settings that serve individuals with disabilities. For example, residential care facilities or assisted living are options for individuals who require assistance with personal care services, but do not require skilled nursing services for more than 120 days a year. The average age of an Ohio resident in assisted living is about 85 years old. Most are female (Vital Research, 2008). Over one-half of residents move to assisted living directly from their homes (Vital Research, 2008). In addition, many of the assisted living residents need help with ADLs (such as bathing, dressing, and mobility) and need help with many IADLs (Applebaum, et. al., 2007).

Another way to measure service use is reported as the number of days a person has lived in a facility, commonly called “length of stay.” According to a survey of 529 assisted living (residential care) facilities in Ohio, the average length of stay in 2007 was 2.2 years (Vital Research, 2008). The most common reason for leaving an assisted living facility is moving to a nursing home. The next common reason is death. Other reasons include relocating to another facility or moving back to the community (2007 Biennial Survey of Long-Term Care Facilities: Residential Care).

Figure 7

Comparison of Proportion of Residents of NFs, ICFs ID/DD, and RCFs by Type of ADL Impairment, 2007- 2008



(Brothers-McPhail & Mehdizadeh, 2009; Mehdizadeh, Applebaum, Deacon, & Straker, 2009)

Dramatic changes have occurred in the last 10 years in regard to nursing home length of stay patterns in Ohio. One of these changes is an increasing use of nursing homes for short-term care. A comparison of an earlier study (1994-1996) with a more current study (2001-2004), both by Scripps Gerontology Center, shows a continued increase in the use of nursing homes for short-term rehabilitative care (Mehdizadeh, Nelson, & Applebaum, 2006). For example, the proportion of residents who left a facility within 3 months increased from 43% in 1996 to 57% in 2004, the proportion of residents who left within 6 months increased from 59% in 1996 to 68% in 2004, and the proportion who left within 12 months increased from 68% in 1996 to 84% in 2004.

Home- & Community-Based Services

Home and community-based services includes an array of assistance needed by individuals with severe disability to remain in their own homes. Table 1 provides a listing of services, followed by detailed service definitions.

Table 1

Home- & Community-Based Services

Adult day service/health	Medical equipment and supplies
Chore	Nursing
Emergency response system	Nutritional consultation
Home modifications	Respite
Home-delivered meals	Social Work & Counseling
Homemaker/personal care	Transportation
Independent living assistance	

Adult day services (ADS) are nonresidential community-based facilities designed for daytime supervision of adults with physical and/or cognitive impairments. They provide a setting with structured, comprehensive and continually supervised programs and activities, typically during regular office working hours (e.g., 8 a.m. to 5 p.m.). Since Ohio does not require licensure of adult day service providers, an exact number is not available. However, according to the Ohio Association of Adult Day Services, 142 centers were listed in April 2009 (www.oads.com).

Chore services are services designed to assist individuals with home improvement, maintenance, restoration, sanitation, and safety. Providers may supply services that include, but are not limited to, heavy household cleaning (e.g., shampooing carpets or washing walls), basic repair tasks (e.g., unclogging drains or lighting pilot lights), insect control, and garbage removal (Ohio Administrative Code (OAC) 173-39-02.5).

Emergency response system (ERS) is an emergency intervention service that is intended to provide consumers with a method of contacting emergency response personnel in the event of an urgent situation. With this service, consumers receive a portable device that, when activated, sends a signal to an emergency response center. Emergency response personnel are then able to intervene (OAC 173-39-02.6).

Home modification services allow consumers to receive environmental accessibility adaptations around their places of residence. These services are designed to allow consumers to become more independent and remain in their households. Tasks in this category include, but are not limited to, minor home modifications (e.g., installation of safety or accessibility equipment), minor home maintenance (e.g., inspection of furnaces or electrical repairs), and minor household repairs (e.g., repair of screens or replacement of electric fuses) (OAC 173-39-02.9).

Home-delivered meal services are intended to provide consumers with one to two safe and healthy meals daily. These meals are prepared and delivered to the consumer's place of residence. All meals are required to conform to one-third of the existing dietary guidelines for Americans. Exceptions may be made for meals prepared in agreement with a diet prescription ordered by a licensed dietitian or physician (OAC 173-39-02.14).

Homemaker services assist consumers in establishing a clean, safe, and healthy living atmosphere. These services may include, but are not limited to, meal planning assistance, meal preparation, laundry services, and basic housecleaning tasks (e.g., dusting, vacuuming, washing windows, or taking out trash) (OAC 173-39-02.8).

Medical equipment and supplies (HME) services provide health-related equipment and supplies as a means of attempting to increase the functional independence of consumers in their places of residence. Examples of items that can be obtained through this service include, but are not limited to, beds, gloves, lifts, medication dispensers, syringes, and walker baskets (OAC 173-39-02.7).

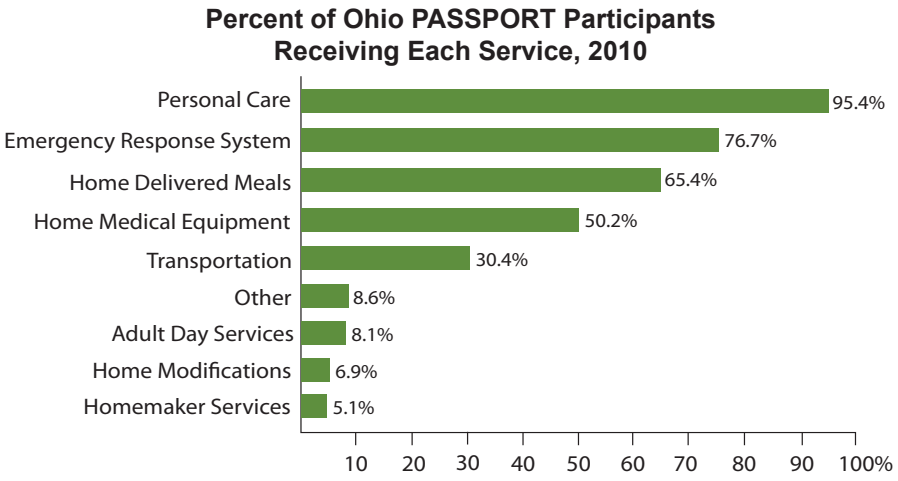
Nursing services provide support to consumers who require nursing facility or hospital levels of care. Services are provided by registered nurses and licensed practical nurses and include, but are not limited to, tasks such as medication administration and management, tube feeding, infection control, shots, and overall assessment (Brothers-McPhail & Mehdizadeh, 2009).
Nutritional consultation (medical nutrition therapy) services provide personalized nutrition information to consumers with special needs. This consultation process most often occurs at the residence of the consumer and takes into account the consumer's health status, desires, cultural background, socio economic background, and available resources. From the information gathered, a nutrition plan is developed, implemented, and monitored (OAC 173-39-02.10).

Personal care assistance services assist consumers with day-to-day tasks of daily living, such as driving, bathing, and transferring from bed to chair.

Respite care services provide supervision and assistance to consumers for short periods of time (a few hours to a few weeks) in order to allow caregivers to take a break from their caregiving responsibilities (Brothers-McPhail & Mehdizadeh, 2009).

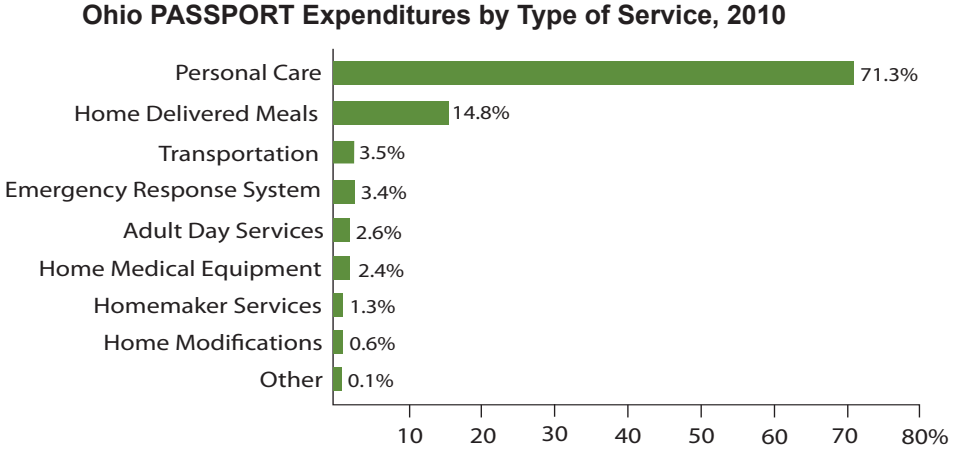
Social Work and Counseling services are intended to assist in adjustment when consumers face emotional, social, or physical well-being challenges. Services are provided by trained professionals such as clinical counselors (LPCC), licensed psychologists (MA or PhD), and licensed independent social workers (LISW). Services may also be available to family members and caregivers, along with the consumer, if the service allows these individuals to better function with the consumer or the purpose is associated with the consumer's care (OAC 173-39-02.12).

Figure 8



Transportation services provide a vehicle and driver to transport consumers for non-emergency medical trips. Examples of transportation destinations include senior centers, government offices, grocery stores, pharmacies, and doctor's offices. As part of the transportation services, drivers assist consumers in getting to and from the vehicle at their pick-up locations and destinations (Brothers-McPhail & Mehdizadeh, 2009).

Figure 9



(Mehdizadeh, et. al., 2011)

Among the nearly 43,000 Ohioans served by various Medicaid waiver programs in 2009, by far the most commonly used service was personal care. Other common services include home delivered meals

Table 2

Long-Term Services Residential Facilities, 2008

Institutional setting	Ages served	Level of care	Total Number of Facilities	Total Number of Beds
Nursing homes	All	Nursing home	972	93,000
Residential care/ Assisted living facilities	All	All	585	38,125
ICFs/MR	All	ICF/MR	440	7639
Adult care facilities or Adult group home	18+	Protective	652	5156
Adult foster homes	18+	Protective	78	156

(Brothers-McPhail and Mehdizadeh, 2009)

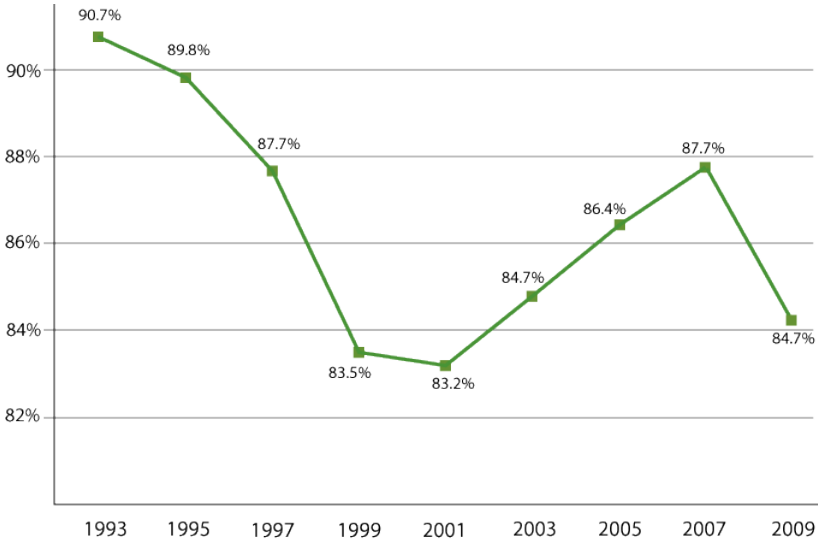
and emergency response systems. To illustrate the utilization and the cost of waiver services, Figure 8 shows the percent of participants who used each type of service in 2010 and Figure 9 reports the percentage of PASSPORT waiver dollars spent on each type of service. These figures show how the most common service (personal care) also accounts for nearly three-quarters of total PASSPORT expenditures. The emergency response system, the next commonly used service, accounts for only 3% of PASSPORT spending.

While two-thirds of individuals with disability receive services in their own homes or in the homes of family and friends, the balance receive their care in facilities. These facility settings vary by size; from as small as an adult foster home with as few as two residents to a nursing home which could have over 350 residents. In addition, these settings vary by the level of care they can provide to the residents. For example, an adult group home accommodates individuals who require a protective level of care, while nursing homes require individuals to have an intermediate or skilled level of care. Table 2 also shows the ages of the individuals served by the different providers and the number of facilities and beds for each setting.

By far, the setting with the largest capacity in Ohio is nursing homes, with 970 facilities containing approximately 93,000 beds (Mehdizadeh et. al, 2011). The typical nursing home in Ohio has about 100 beds, and most are in urban areas. About 74% are for

Figure 10

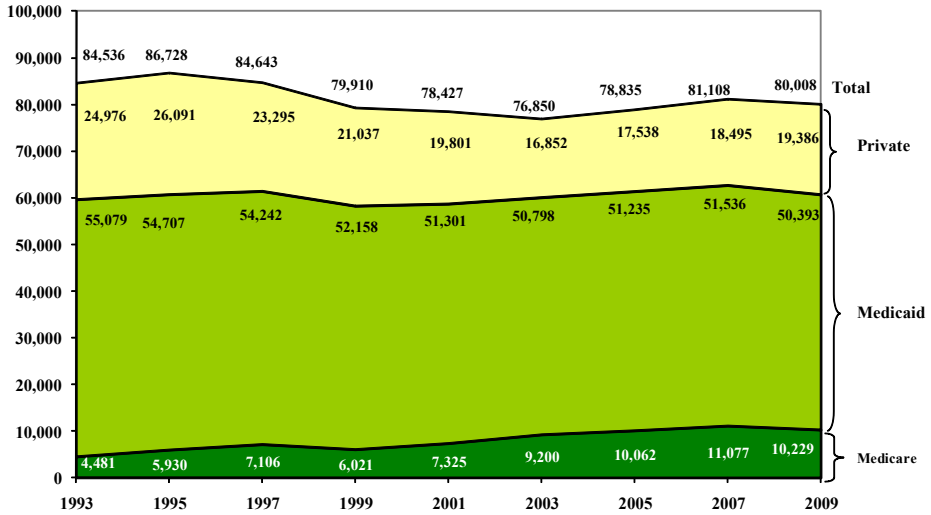
Occupancy Rates in Ohio Nursing Homes, 1993 - 2009



(Mehdizadeh, Applebaum, Nelson, & Straker, 2011)

Figure 11

Average Daily Nursing Home Census, 1993 - 2009



profit, 23% are not-for-profit, and 2.5% are government owned. One quarter (26.7%) are located in rural counties. Ohio has a higher ratio of nursing home residents to its elderly population than the national average and ranks 8th for people age 65 and older, and 6th for those 75 and older (AARP Public Policy Institute, 2009). In 2009, Ohio nursing homes had an average occupancy rate of 84.7%, down from 90.7% in 1993 (see Figure 9). As a result of an expansion of nursing home options, Ohio is serving fewer people in nursing homes today than it did in 1993 despite an increase of more than 75,000 people age 85 and above.

The residential setting with the second largest capacity is residential care facilities, of which assisted living is a subcategory. While nursing homes provide care for people with more skilled medical needs, RCFs are most often used by people needing personal care services. Individuals in RCFs can receive skilled nursing care, but the amount cannot exceed more than 120 days a year. There is no single definition of “assisted living” because regulations vary from state to state. Ohio law and licensing regulations use the term residential care facility (RCF), rather than assisted living (Applebaum & Mehdizadeh, 2001). An assisted living facility is a type of RCF that offers individual living units and privacy, community space such as dining and laundry rooms, and a greater emphasis on resident choice and independence. To participate in the Medicaid waiver, the units must be single occupancy, have doors that lock, include a full bathroom, and include a space for socialization (OAC, 173-39-02.16). About 400 (68.4%) of Ohio’s RCFs meet the criteria for the Medicaid assisted living waiver (Mehdizadeh et. al., 2011).

Intermediate care facilities for persons with intellectual or developmental disabilities are either residential units within larger organizations or agencies that provide residential services. About two-thirds of the individuals in these settings have severe levels of disability (Brothers-McPhail & Mehdizadeh, 2009).

Who Provides Long-Term Services and Supports?

Services are provided in a variety of LTC settings, including private homes, the community and facilities by non-paid family and informal caregivers and/or paid service providers. Approximately 40% of those with severe disability who receive services in the community are cared for by family and informal caregivers and/or pay out-of-pocket for services received from formal service providers (Mehdizadeh, et. al., 2011).

Family and Informal Caregivers

Informal caregivers are family members, friends, or neighbors who provide care without receiving pay for these services. These individuals care for community-dwelling individuals, young and old. In 2009, at any given time Ohio had an estimated 1.66 million unpaid caregivers who provided assistance to individuals of all ages with disabilities residing in the community (AARP Public Policy Institute, 2011).

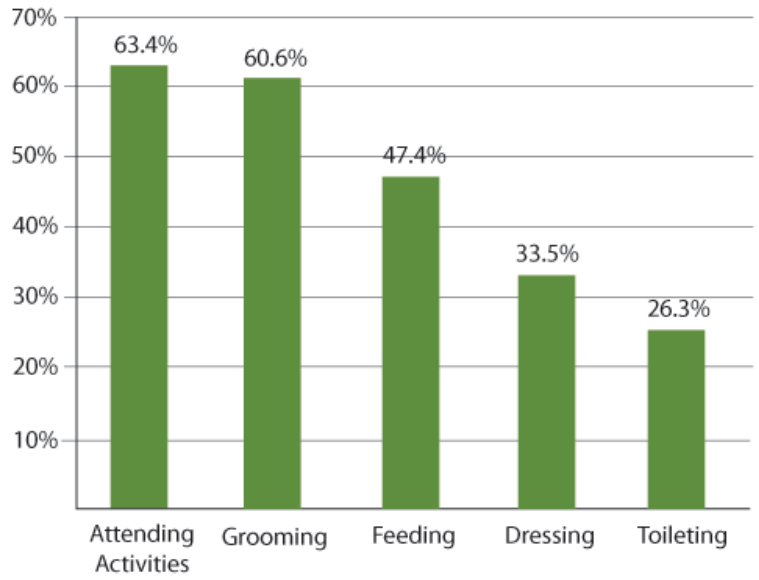
It is estimated that 60% of caregivers are women and the majority of them are between the ages of 35 and 64 (National Alliance for Caregiving & AARP, 2004). According to the Family Caregiver Alliance (2005), an older adult care recipient is most likely to be cared for by an adult child. However, with advanced age, spouses are more likely than adult children to perform the caregiving role. Although women are more likely to be caregivers than men, the percentage of men who are providing care is on the rise. While White elders are more likely to receive care from a spouse, Hispanic and African American elders are more likely to receive care from an adult child and a nonfamily member, respectively (National Academy on an Aging Society, 2000).

Although the work provided by these caregivers is unpaid, the economic value of their contribution to the long-term services system is immense. Based on an average rate paid for such work ($11.03/hour) and the average number of hours caregivers perform care work (1,080/week), it is estimated that the economic value of the 1.66 million unpaid caregivers in the state of Ohio in 2009 was 17.5 billion dollars (AARP Public Policy Institute, 2011). Other costs of caregiving include out-of-pocket costs (for such things as groceries and medicines), lost wages and retirement income as well as worker productivity (since many caregivers are employed) and threats to the mental and physical health of caregivers (AARP Public Policy Institute, 2011).

Informal caregivers also provide supplemental care to family and friends living in residential facilities. For example, many families and friends of nursing home residents who responded to the 2010 Ohio Nursing Home Family Satisfaction Survey reported remaining very involved in the care of their relatives and friends (see Figure 12). Figure 13 shows that 77% of families visit at least once a week, and about one-fifth of families visit daily (Straker, Chow, Mwangi & Reddecliff, 2011).

Figure 12

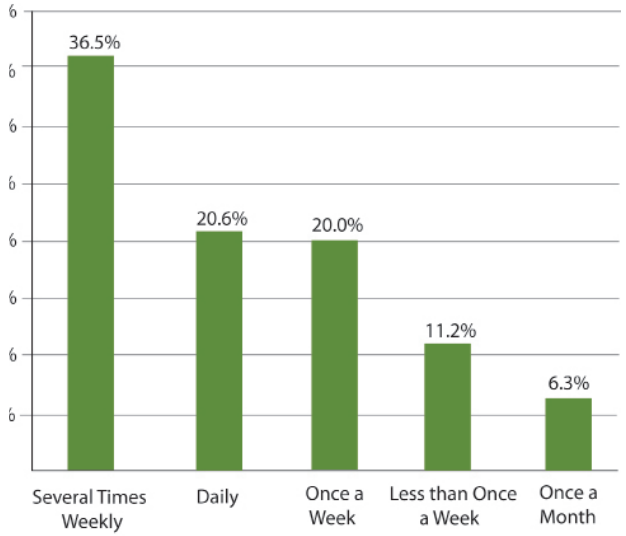
Proportion of Families Providing Assistance with Nursing Facility Care, Ohio 2010



(Straker, et. al., 2011)

Figure 13

Visitation Practices by Families of Nursing Home Residents, Ohio 2010



(Straker, et. al., 2011)

Formal Service Workers, Agencies, and Institutional Settings

Workers

Direct service staff workers (e.g., home health aides, personal care workers, and nursing aides) provide daily living assistance to individuals with disabilities who reside in the community as well as in institutions, such as nursing homes. According to Miller & Mor (2008), when compared to the workforce in general, these workers are more likely to be: nonwhite women with a high school education or less; unmarried; and have children at home. Further, about one-half are between the ages of 25 and 44 years, and the same percentage earn incomes lower than 200% of the federal poverty level. Comparing aides who work in home care to aides working in nursing homes, Miller & Mor show that home care aides tend to be older, and are more apt to be Hispanic and/or foreign-born or non-citizens of the United States. Table 3 shows the average 2007 hourly rates in Ohio for home health aides, personal and home care aides, as well as nursing aides, LPNs and RNs. The table also illustrates the proportion of the direct-service staff workers who work in home care and those who care for people in institutions, such as nursing homes, residential care facilities, and ICFs ID/DD. The table also includes workforce employment projections from 2006 to 2016. Home health aides and personal care aides are two of the fastest growing occupations. This projected increase reflects the growing older population, a growing demand for in-home care, and increasing national, state, and local funds available for in-home services.

Table 3

Direct Service Staff Employment Statistics for Ohio

Average Hourly Wages – Ohio, 2007		Long-Term Services and Supports Workforce Proportion by Setting[2]		Workforce Employment Projections[2]		
Long-Term Services and Supports Direct Care Service Occupations	**Hourly Wage[1]**	**In-Home Care**	**Institutional Care**	**2006**	**2016**	**Increase**
Homemaker (Personal & home care aides)	$9.44	41.9%	58.1%	19,170	26,990	41%
Personal care aides (Home health aides)	$9.64	74.0%	26.0%	42,200	62,500	48%
Nursing aides, orderlies, and attendants	$11.20	4.7%	95.3%	77,140	88,250	14%
Licensed practical and vocational nurses	$18.57	14.5%	85.5%	38,690	44,070	14%
Registered nurses	$27.56	36.7%	63.3%	113,050	138,640	23%

([1]Bureau of Labor Statistics, 2007; [2]Ohio Department of Job and Family Services, Office of Workforce Development, Bureau of Labor Market Information, no date)

Workers

Workers who are employed through a home care or home health agency are paid through the use of private and public dollars (see next chapter for more information on paying for long-term services). Public programs, such as home and community-based Medicaid waivers and county levies for seniors or individuals with developmental disabilities, cover some of the costs of agency workers. 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. The Medicaid and Medicare programs also provide home health services for individuals recovering from acute care illnesses.

Although the bulk of HCBS are provided by agency workers, the use of non-agency workers is on the rise. For example, self-directed workers fall into this category. The terms “self-directed care,” “participant-directed care,” or “consumer-directed care” are applied to services for people with disabilities who assess their own needs and make choices about what services would best meet those needs and when, how, and by whom those services should be provided. Oftentimes, the workers hired are people in the consumer’s life who are already performing caregiving work informally.

Home care and home health agencies furnish trained workers who provide care in individual homes. Determining the exact number of agencies is difficult because Ohio does not require agency licensure. However, Medicare and Medicaid do require agency certification in order for agencies to receive funding from these programs; as of August 2011 there were approximately 600 certified agencies (Ohio Department of Health, 2011). These agencies can be freestanding or part of a larger provider entity, such as a hospital. Over three-quarters of the agencies operate on a for-profit basis (Medicare.gov). A 2006 survey of a subset of home care and home health agencies certified as providers of PASSPORT (a Medicaid-waiver program serving individuals age 60 and older with disability) showed that, on average, the 350 agencies had been in business for 19 years, served 77 clients per week, and had 48 employees (56% of whom are part-time) (Straker, Carr & Chow, 2007).


500

What are the Funding Sources for Long-Term Services and Supports in Ohio?

Figure 14

Utilization of Long-Term Services and Supports, 2009

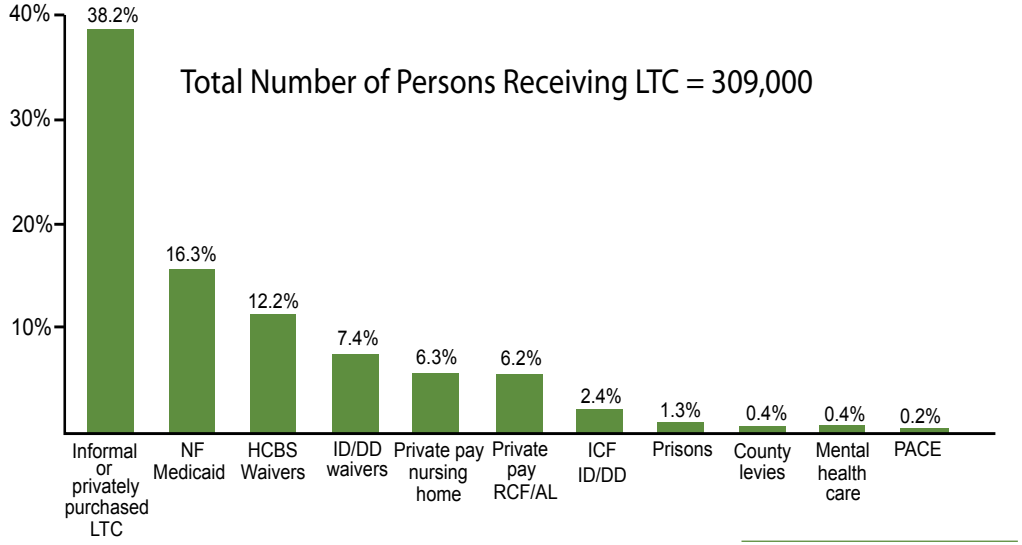
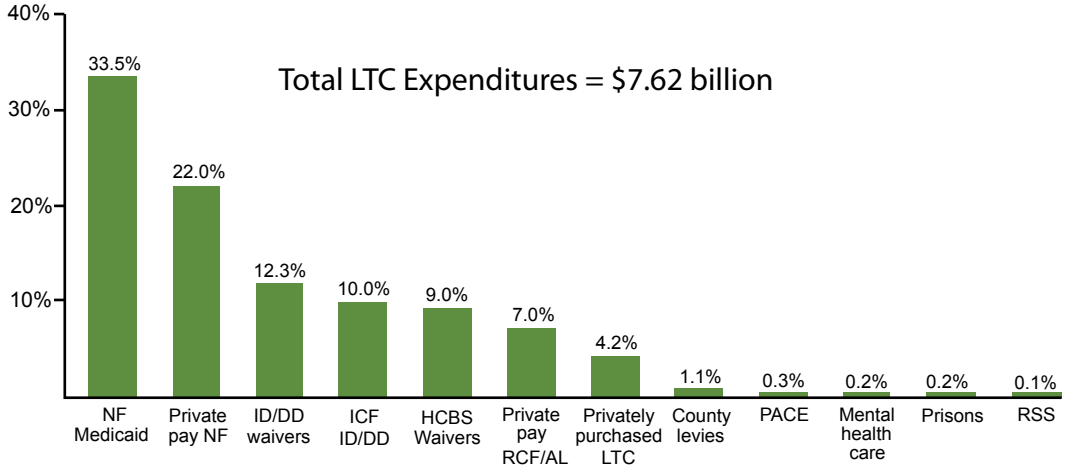


Figure 15

Long-Term Services and Supports Expenditures, 2009



Both in-home and institutional long-term services are paid for through private and public sources, including individuals and their families who pay out-of-pocket (or self pay); private insurance, such as long-term care insurance; and public federal, state, and local dollars from programs such as Medicare, Medicaid and county-wide property tax levies. Of the $7.6 billion dollars spent on long-term services and supports in Ohio in 2009, two-thirds, or $5 billion, came from public sources, while private payments accounted for the remaining one-third, or $2.4 billion.

Medicaid

Medicaid is the major source of funding for long-term services and supports. Medicaid is a joint program funded by both the federal and the state governments, and it provides benefits for persons with limited income and assets. The federal government provides approximately 60% of all Medicaid funds for Ohio, while the state provides 40%.

The Medicaid program pays for both institutional care and care received at home and in the community. Nursing homes and ICFs are a major recipient of Medicaid dollars, receiving 72% of the total LTC expenditures. Approximately 30% of Medicaid funds are expended on in-home services, the vast majority on Medicaid waiver programs. Medicaid waivers are programs that waive traditional government funding regulations to help pay for home- and community-based services for individuals with disabilities who would otherwise live in a nursing home or an ICF ID/DD facility due to their level of care needs. Medicaid estate recovery is a federally mandated rule that allows for the recovery of the cost of LTC services provided by Medicaid from the recipients' 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. Ohio has a conservative estate recovery program in comparison to other states. In Ohio, the ratio of recovered expenditures to total Medicaid expenditures is 0.31%; the national median is 0.57% (Karp, Sabatino, & Wood, 2005). Ohio has seven home- and community-based waivers. The services provided under each are shown in Table 4.

Table 4

Services Provided in Medicaid Waiver Programs

Service Type	Choices	PASSPORT	Ohio Home Care	Transitions ICF ID/DD	Transitions Carve-Out	Individual Options	Level One
Adult day service/health	X	X	X	X	X	X	
Chore		X					
Day habilitation						X	X
Home modifications	X	X	X	X	X	X	X
Home-delivered meals	X	X	X	X	X	X	
Homemaker/personal care	X	X	X	X	X	X	X
Independent living assistance		X					
Interpreter						X	
Nursing			X	X	X		
Nutritional consultation		X				X	
Emergency response system	X	X	X	X	X		X
Respite			X	X	X	X	X
Social work and counseling		X				X	
Medical equipment and supplies	X	X	X	X	X	X	X
Supported employment						X	X
Transportation		X	X	X	X	X	X

To be eligible to receive home- and community- based services through the

Medicaid waiver, an individual must have certain level of care needs. Typically these needs are determinded by measuring the participant's need for assistance with daily activities such as bathing, dressing and getting to the bathroom. Additionally, individuals must meet certain financial criteria, including having limited assets ($1,500), and low income ($1,911 per month for 2008). Table 5 lists details about each of the waiver programs, including the age and functional eligibility. In addition, the size of the waiver programs (by the number of persons served as well as the annual per member cost) is also included.

Requirements for Medicaid Home-Based Services

- Meet Ohio's institutional level of care criteria
- Have income of less than $2,022 per month (2011)[1]
- Have no more than $1,500 in assets[2]

[1] If monthly income exceeds the limit, it is possible to "spend-down" to an eligible level

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

PASSPORT Waiver

The PASSPORT (Pre-Admission Screening Services Providing Options and Resources Today) Waiver program is jointly administered by the Ohio Department of Aging (ODA) and the Ohio Department of Job and Family Services (ODJFS) and provides home- and community-based services to individuals age 60 and older with nursing home level of care needs. The program provides in-home services allowing older adults to remain in their communities. Services offered include adult day services, chore, emergency response systems, home-delivered meals, homemaker services, home medical equipment and supplies, independent living assistance, minor home modifications, nutritional consultation, personal care services, social work and counseling services, and medical transportation.

Choices Waiver

The Choices Waiver program is jointly administered by the Ohio Department of Aging (ODA) and the Ohio Department of Job and Family Services (ODJFS) and provides home- and community-based services for individuals age 60 and older with nursing home level of care needs. Services offered by this waiver include adult day care, personal care and home care assistance, minor home modifications, home-delivered meals and alternate meals, medical equipment and supplies, emergency response systems, and pest control. This program provides services in home and community settings to delay or prevent nursing home placement and is currently available in four of the 12 geographic regions served by Area Agencies on Aging, with plans to expand the program to other geographic locations in Ohio. This waiver embraces the philosophy of self-directed care: people receiving long-term services have the ability and the right to state their needs, decide how those needs should be met and by whom, and determine the quality of the services they are

Table 5

Ohio Medicaid Waiver Programs, 2009

Program	Ages Served	Functional Eligibility	Number Served	Requires Medicaid Eligibility	Average Monthly per Person Cost*[a]
Assisted Living Waiver	21+	NH LOC	1696	Yes	$1,518
Choices Waiver	60+	NH LOC	525	Yes	$1,500
Individual Options Waiver	All	ICF ID/DD LOC	15,037	Yes	$4,698
Level One Waiver	All	ICF ID/DD LOC	6068	Yes	$854
Ohio Home Care Waiver	<60	NH LOC	8535	Yes	$2,133
PASSPORT Waiver	60+	NH LOC	34,264	Yes	$1,067
Transitions Aging Carve-Out Waiver	60+	NH LOC	1745	Yes	$2,339
Program for All-Inclusive Care for the Elderly (PACE)	55+	NH LOC	815	Yes	$2,645
Transitions MR/DD Waiver	All	ICF ID/DD LOC	3004	Yes	$1,968

[a]This amount does not include individuals' contributions toward the cost of their care.

(Mehdizadeh & Applebaum, 2011)

receiving. Self-directed programs require the involvement of the consumer or an authorized representative. Those who meet eligibility requirements and elect this option become employers and hire workers (including friends, neighbors, and certain relatives) to provide services. Participants or their authorized representative receive extensive training on the responsibilities of being an "employer of record."

Ohio Home Care Waiver

The Ohio Home Care Waiver program is administered by the Ohio Department of Job and Family Services (ODJFS) and provides home- and community-based services for individuals up to age 60 who have serious disabilities and/or unstable medical conditions. This waiver allows individuals with a nursing home level of care to receive services in the community. Services offered include personal care, nursing, home-delivered meals, emergency response systems, supplemental adaptive/assistive devices, home modifications, adult day services, out-of-home respite care, social work, nutrition counseling, and supplemental transportation. Once Ohio Home Care Waiver consumers reach age 60, they transfer to the Transitions Aging Carve-Out Waiver.

Transitions Aging Carve-Out Waiver

The Transitions Aging Carve-Out Waiver program is administered by the Ohio Department of Job and Family Services (ODJFS) and provides home- and community-based services to individuals 60 years of age and older who have serious disabilities and/or unstable medical conditions. This waiver serves Ohio Home Care Waiver recipients who have reached the age of 60 and continue to have nursing home level of care needs. Services offered are the same as those offered by the Ohio Home Care Waiver (i.e., personal care, nursing, home-delivered meals, emergency response systems, supplemental adaptive/assistive devices, home modifications, adult day services, out-of-home respite care, social work, nutrition counseling, and supplemental transportation).

Individual Option Waiver

The Individual Option (I/O) Waiver program is jointly administered by the Ohio Department of Developmental Disabilities (DODD) and the Ohio Department of Job and Family Services (ODJFS) and provides home- and community-based services for individuals with intellectual or developmental disabilities who would otherwise be institutionalized. Services offered include day habilitation, homemaker/personal care, transportation, respite care, environmental accessibility and adaptations (home modification), specialized medical equipment and supplies, social work, home-delivered meals, nutritional counseling, interpreter services, adult day services, and supported employment.

Level One Waiver

The Level One Waiver program is jointly administered by the Ohio Department of Developmental Disabilities (DODD) and the Ohio Department of Job and Family Services (ODJFS) and provides home- and community-based services for individuals with intellectual or developmental disabilities (i.e., ICF ID/DD level of care) who would otherwise be institutionalized. Services offered include day habilitation, homemaker/personal care, transportation, respite care, environmental accessibility and adaptations (home modification), specialized medical equipment and supplies, emergency response systems, emergency assistance, and supported employment.

Unlike the Individual Options Waiver (I/O), this waiver places annual limits on four of the services provided by the program. These services and annual limits are listed below. However, with prior authorization the limits may be exceeded up to a combined benefit of $5,000 in each year the individual is enrolled. Homemaker/Personal Care - $1,000; Institutional Respite - $1,000; Informal Respite - $2,500; Transportation - $500.

Assisted Living Medicaid Waiver

The Assisted Living Medicaid Waiver is jointly administered by the Ohio Department of Aging (ODA) and the Ohio Department of Job and Family Services (ODJFS) and offers services to individuals with nursing home level of care needs within residential care facilities licensed by the Ohio Department of Health (ODH) and certified as assisted living facilities by the Ohio Department of Aging (ODA). The program is an alternative to nursing home placement; it promotes an individual's independence, choice, and privacy. Services offered as part of this waiver include twenty-four hour on-site response, personal care, supportive services (housekeeping, laundry, and maintenance), nursing, transportation, medication administration and supervision, three meals a day, social/recreational programming, and community transition.

Program of All-Inclusive Care for the Elderly

The Program of All-inclusive Care for the Elderly (PACE) is jointly administered by the Ohio Department of Aging (ODA) and the Ohio Department of Job and Family Services (ODJFS) and provides a managed-care model for older adults with nursing home level of care needs. The comprehensive service package provides medical, social, and rehabilitative services, allowing older adults to continue living in the community. Each PACE site has a team of doctors, nurses, and other health professionals who assess participant needs, develop an integrated health care plan, and deliver services. Services provided by Ohio PACE centers include: primary medical care,

specialty medical care (e.g., audiology and dentistry), mental health services, physical therapy, occupational therapy, recreational therapy, medical transportation, adult day health and activity services, meals, nutrition counseling, social services, home health and personal care, prescription and over-the-counter medications, medication administration assistance, inpatient services for hospital and nursing home care, and respite care. In 2010, 724 Ohioans were served by this program (Mehdizadeh & Applebaum, forthcoming).

Residential State Supplement

The Residential State Supplement (RSS) is administered by the Ohio Department of Mental Health (ODMH) and provides a monetary supplement to low-income adults with disabilities who require supervision but do not qualify for nursing home care. 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 care home. To qualify for RSS, a person must be age 18 or older, require a protective level of care, and have less than $1,500 in resources and have a monthly income of $824 in most cases (but lower or higher for certain residential settings). This program served 1891 Ohioans in 2007.

Developmental centers for individuals with ID/DD are also funded by Medicaid dollars, representing almost 3% of LTC expenditures. Developmental centers are residential programs serving people with developmental disabilities who have severe medical and/or behavioral needs.

Senior Service Tax Levy Programs

Senior service tax levies support enhanced and expanded services for older adults. These levies are typically implemented by a ballot issue vote at the county level and most often are in effect for five years. Ohio is one of only fourteen states in the U.S. to have levy programs that pay for senior services.

County Tax Levies

Figure 16

Ohio Counties with a Senior Services Levy, 2011

In some counties, levy funds are administered through local government. In other counties, the Area Agency on Aging or a social service agency administers these funds. As of June 2011, older adults in 72 of 88 counties in Ohio benefit from levies that generate over $136 million per year. Levies are used for elderly service programs that provide home care, home delivered and congregate meals, transportation, and can be used to support senior center operations.

(http://aging.ohio.gov/information/seniorserviceslevies/default.aspx)

Medicare and Long-Term Services and Supports

One common misconception many individuals have concerning the financing of long-term services and supports is the role of Medicare, the federal health insurance program for persons age 65 and over (and certain persons with disability under age 65). Medicare is primarily an acute care program that pays for skilled nursing services (in-home and in a nursing home), but does not pay for assistance with ADLs or IADLs when those are the only kinds of services a person needs. Nationwide, 12% of Medicare dollars are spent on long term care in skilled nursing facilities and home health agencies. Medicare will pay for 100% of home care expenses that are medically necessary and for the first 20 days of nursing home care after a hospital stay of 3 days or more and payment of a $1,068 deductible. After 20 days in a nursing home, residents pay a co-payment of $141.50 per day (in 2011). After 100 days, the resident is responsible for 100% of the cost.

Medical Insurance/ Medicap Coverage

In 2006, 68.4% of Ohioans with Medicare coverage also had Medigap coverage also known as Medicare Supplemental Insurance (Purvis and Flowers, 2008). For the most part, Medigap policies provide coverage for acute services, although some do pay the required nursing home deductible for days 21-100. Only some of the benefits of Medigap policies are related to long-term services and supports, and the policy premiums vary. For example, in 2008, premiums for a 65-year-old ranged from $68 per month for basic supplemental coverage to $692 a month for comprehensive coverage, depending upon the insurance carrier (OSHIIP, 2008).

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, the Medicaid program pays for Medicare premiums and deductibles, and co-payments.

Nationally, in 2007, 21% of the Medicare population and 15% of the Medicaid population were dually eligible. In Ohio, 16% of the Medicare population and 14% of the Medicaid population were dually eligible in 2007. Nearly 80% of dual eligible spending in Ohio goes to long-term services, compared to 70% nationally. The dual eligible group accounted for about 40% of Medicaid expenditures in Ohio, compared to 39% nationally (Kaiser Family Foundation, no date).

Other Public Funding Mechanisms

In addition to the two major public funding sources for long-term services and supports, Medicaid and Medicare, there are several smaller public contributors (accounting for less than 5% of the total long-term services and supports bill) to note.

The Veterans Administration provides an array of long-term services to veterans from homemaker/home health aide services to fully skilled nursing home care. Long-term services for veterans whose disability is determined to be a result of their military service are provided at no cost. Veterans whose disability is determined to be non-service related must make co-payments for long-term services. There are three levels of co-pays for veterans. In-patient care, which includes nursing home care, respite care and geriatric evaluations, require co-payments ranging from $0-$97 per day, depending on the veteran's individual financial status. Out-patient care services, which include adult day care, respite care and geriatric evaluations range in cost from $0-15 per day. Finally, domiciliary care, designed for veterans that require care falling between acute care and fully skilled nursing home care, consists of respite services, geriatric evaluation and management by an interdisciplinary team of professionals, community residential care, home health care, adult day care and homemaker/home health aide services, ranges in cost from $0-5 per day. For all types of care, days 0-21 are free of financial obligations and are fully covered by the Veterans Administration. Days 22-180 require co-pay based on the veteran's income. Financial responsibility for care required over 181 days is determined by the individual's income and assets, less $89,280 in liquid assets for spousal resource protection (VA, 2011). Long-term services and supports through the Veterans Administration can be provided in a number of locations: a VA nursing home, a community nursing home, a State Veterans Home or domiciliary or the individual's home. Care provided outside of the VA network is not covered by VA funds. The VA also provides a monetary benefit termed Aid and Attendance and Housebound benefits as a supplement to those receiving a VA monthly pension. The benefit is available to those who require assistance from another person to perform personal functions such as bathing of dressing, or to those that are housebound.

The Older Americans Act (OAA), passed in 1965, allocates a substantial portion of its $2.3 billion allocation to home and community-based services. Major home and community-based services funded by the OAA include aging and disability resource centers (ADRCs) that provide information and referral assistance and long-term options counseling, home delivered meals, care coordination and case management, homemaker, personal care and transportation services, and a series of services in support of caregivers. Although about two-thirds of OAA funds are allocated to home and community-based services, the entire legislative allocation of $1.7 billion has remained flat funded for the last three decades, with the 1980 allocation at $1.1 billion (AOA, 2010). Nevertheless, the OAA provides infrastructure support for the aging network and although underfunded, it remains a core foundation for the service delivery system for older people.

On the right is a financial breakdown of the programs and services described. Because Area Agencies on Aging generate funds from a number of sources, the amount they spend is much larger than their OAA allocation.

Table 6

Selected Older Americans Act Service Expenditures (2009)

Services and Programs	Ohio	National
Personal Care	$3,739,903	$312,625,660
Homemaker	$3,245,090	$261,205,435
Chore	$860,451	$19,594,304
Home Delivered Meals	$35,273,240	$753,326,664
Adult Day Services	$3,718,636	$96,297,055
Case Management	$3,843,261	$257,126,284
Assisted Transportation	$645,625	$18,234,676
Congregate Meals	$15,628,439	$434,269,000
Transportation	$15,378,650	$201,961,170
Information and Assistance	$1,595,619	$146,814,549
Outreach	$115,058	$25,219,779
Caregiver Counseling/ Support Groups/ Training	$570,178	$17,590,109
Caregiver Respite	$2,534,550	$56,063,244
Caregiver Supplemental	$576,146	$14,729,960
Caregiver Access Assistance	$1,358,942	$32,032,198
Ombudsman Program	$5,913,289	$84,414,046
Total Services	$16,156,646	NA

(AoA, 2011)

Self Pay

Even for people with Medicare and/or Medicaid, not all long-term services and supports expenses are covered. Care recipients and their families often pay for services that they need or want, which are not covered by public funding sources. In addition, given that Medicaid is a program for persons with limited income and assets, many people are not eligible and must pay out-of-pocket for LTC services and supports. Thirty-three percent of LTC expenditures are paid for privately.

Payments that individuals make out-of-pocket for HCBS are difficult to estimate, and are not fully captured in the total dollars spent on long-term services and supports. Another cost that is not included in the total expenditures is the value of the work of informal caregivers, estimated at $17.5 billion in Ohio (AARP Public Policy Institute, 2011). (See page 28 for more information on informal caregiving).

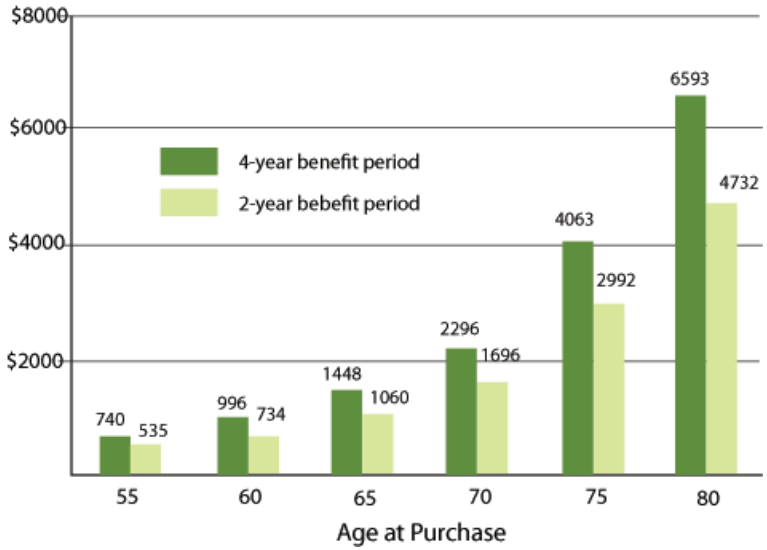
Long-Term Care Insurance

The balance of privately purchased LTC services and supports, or 4.5%, is paid through private long-term care insurance. These types of policies cover many long-term services, including both skilled and non-skilled care at both facilities and at home (AHIP, 2007).

The cost of LTC insurance premiums depends on a person's age and health status at the time of purchase and the extent of the coverage. Figure 17 shows that the older a person is when purchasing LTC insurance, the higher the yearly premium. According to AHIP (2007), purchasers of LTC insurance are wealthier than non-buyers, have more education, and are more likely to be married. Nationally, the average age of LTC insurance buyers is 58 years, down from 68 in 1990. Over four-fifths of LTC insurance

Figure 17

Average Annual LTC Insurance Premiums for Women in Ohio by Age at Purchase and Type of Policy, 2008



(ODI, 2008) Note: Premiums are calculated based on plans that are tax qualified, have a zero elimination period, no pre-existing conditions, and no inflation protection. Men may pay lower premiums.

purchasers have incomes greater than $35,000. Non-buyers cite premium affordability as a barrier to purchase of LTC insurance (Johnson and Uccello, 2005). LTC insurance premiums have been tax deductible in Ohio since 1999 (Davis, 2002). Unsubsidized premiums can be deducted in Ohio if they are not already claimed as deductions on federal returns for the purpose of calculating federal adjusted gross income (Baer, 2006).

From 1987 to 2002, the LTC insurance industry experienced an annual growth in policy sales. Just over 9 million LTC insurance policies were sold as of the end of 2002 (Kassner, 2004). However, many carriers in recent years have stopped selling LTC insurance, or merged with other larger insurance companies, causing a decline in policy sales. In 2010 there were seven million policies in force, less than 5% penetration of the total possible market (Miller, 2010).

The Partnership for Long-Term Care Program combines private LTC insurance with public Medicaid coverage. Under this program, once a recipient exhausts the benefits of his or her LTC insurance policy (designated by the state as a partnership policy), Medicaid coverage is available without having to spend down all his or her assets. The aim of the program is to create an incentive to purchase a more limited and therefore more affordable LTC insurance policy “with the assurance that they could receive additional LTC services through the Medicaid program as needed after their insurance coverage is exhausted” (Ahlstrom, Clements, Tumlinson, & Lambrew, 2004, p. 2). Individuals still must meet certain income and asset requirements. The income requirements remain the same as for other Medicaid recipients, but they can protect (up to the total amount of benefits paid by the policy) of their assets from Medicaid spend-down requirements. Ohio established its qualified state LTC insurance partnership program in September 2007.

The cost for home care services varies depending on the provider agency, the services received, and geographic location. In 2008, the average hourly rate for a home health visit in Ohio was $20 per hour for services (Metlife Mature Market Institute, 2010). Homemaker services in Ohio are slightly less expensive than home health; homemaker agencies charge an average of $19 per hour with a range from $18 to $20 (MetLife Mature Market Institute, 2010). Table 7 shows the median hourly rates and annual costs for homemaker services and home health aide services for different geographic locations across the state of Ohio.

Table 7

Homemaker and Home Health Services
Private Pay Hourly Average Rates and Annual Average Rates* in Select Ohio Cities, 2010

Region	Homemaker Services (hourly)	Homemaker Services (annually)	Home Health Aide (hourly)	Home Health Aide (annually)
Cincinnati-Hamilton	$18	$23,400	$19	$24,700
Cleveland-Akron	$18	$23,400	$21	$27,300
Columbus	$20	$26,000	$22	$28,600

*Calculated using an average of five hours per day, five days per week or 1300 hours per year.
(Metlife Mature Market Institute, 2010)

In addition to homemaker and home health services, Adult Day Care centers are also a growing home- and community-based service for which individuals and their families pay out-of-pocket. According to MetLife Mature Market Institute (2010), the average daily rate was $56 in 2010, ranging from $35 to $179 per day. Daily rates also vary depending upon the geographical location of the center. Table 8 shows the median daily rates for select Ohio locations.

Table 8

Adult Day Care Costs (average daily rates for select Ohio locations)

Region	Daily Median Rate	Annual Median Rates
Cincinnati	$64	$16,640
Cleveland	$55	$14,300
Columbus	$53	$13,780

*Calculated using an average of five days per week or 260 days per year. (Metlife, 2010)

Table 9 provides information on costs for the PASSPORT program, assisted living, and nursing homes. According to the MetLife Mature Market Group (2010), the monthly cost in Ohio for a semiprivate room in a nursing home is approximately $5,900, and $6,630 for a private room. The average monthly cost in Ohio for private assisted living was $3,199 in 2010 (MetLife Mature Market Group, 2010). PASSPORT annual costs per consumer in 2009 (including case management) are just over $14,000 per year. Table 9 illustrates the comparison of annual costs for these three types of Long-Term Services and Supports in selected areas.

Table 9

Individual Average Annual Long-Term Services and Supports Costs in Ohio, 2010

Metro Area	Assisted Living*	County (2003)	Nursing Home Care (semiprivate room)	PASSPORT**
Cincinnati	$37,596	Hamilton	$69,715	$12,744
Cleveland	$38,532	Cuyahoga	$75,190	$17,028
Columbus	$45,828	Franklin	$71,540	$16,644

* Metlife Mature Market Institute, 2010
** ODA, 2009, costs in PSA1, 10A, and 6

How do People Locate Long-Term Services and Supports?

The way in which individuals locate long-term services and supports in Ohio depends on the individual's age, type of disability, and income level.

Applying for Public Programs

Public programs, such as Medicaid waivers (e.g., PASSPORT, Individual Options, or Ohio Home Care), have financial and level-of-care criteria that individuals must meet in order to qualify. Adults 60 years of age or older meet with one of twelve Area Agencies on Aging to determine level-of-care needs, and for initial screening for Medicaid financial eligibility.

Area Agencies on Aging provide long-term care assessments to help older Ohioans plan to meet their individual needs. Assessors help older people and their families make 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 for older people. The Administration on Aging partners with states to conduct the Own Your Future awareness campaign to encourage long-term care planning, and also provides a National Clearinghouse for Long-Term Care Information (www.longtermcare.gov).

In addition to Area Agencies on Aging, The National Council on Aging also provides a free, online service to older adults called BenefitsCheckUp (www.benefitscheckup.org). This web-based screening tool furnishes a personalized report for consumers listing state and federal benefits for which they may qualify.

Locating Long-Term Services and Supports

Individuals who draw on public dollars to pay for services and supports, as well as individuals who pay out-of-pocket, can locate services in several ways. One place to start is Connect Me Ohio (www.connectmeohio.org), Ohio's first stop for information about home- and community-based services, supports, and opportunities for individuals of all ages with disability.

Eldercare Locator (www.eldercare.gov) is a public service of the U.S. Administration on Aging (AoA). AoA works closely with the National Association of Area Agencies on Aging and the National Association of State Units on Aging to compile and maintain a database in order to help link older adults and caregivers to home- and community-based services in their communities.

The State of Ohio and the Ohio Housing Finance Agency maintain a website (Ohio Housing Locator) of program services and rental housing in Ohio (www.ohiohousinglocator.org). Individuals can search by location, program (e.g., housing vouchers, public housing) and by accessibility and type of housing, such as for senior citizens. In addition to Ohio Housing Locator, the Ohio Department of Health maintains a database of health care providers (http://publicapps.odh.ohio.gov/eid/Default.aspx). Individuals can search by location and type of provider, such as adult care facilities or residential care facilities.

Locating nursing homes and residential care facilities in Ohio is made easier with The Ohio Long-Term Care Consumer Guide (www.ltcohio.org). This website was developed by ODA under legislative mandate to provide consumers with information about LTC services. The website includes comprehensive information about nursing homes and residential care facilities, including results of resident and family satisfaction surveys, state-collected data on deficiencies and complaints, contact information and 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 on a regular basis.

The Centers for Medicare and Medicaid Services host a website with nationwide comparative information for nursing homes, home health agencies, and hospitals (www.medicare.gov). Their site provides similar but less comprehensive information to that found about nursing homes on the Ohio Long-Term Care Consumer Guide.

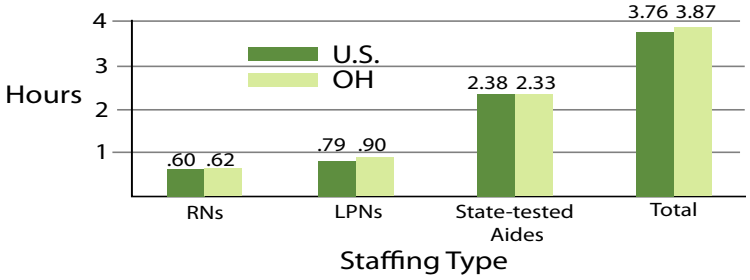
Long-term services and supports, particularly nursing home care, are heavily regulated. Given the increasing frailty of both in-home and institutional residents, it is no surprise that a substantial amount of state and federal resources are allocated to regulatory activities. Despite these efforts, concern about the quality of long-term services and supports remains a paramount policy issue. A common critique is that although nursing homes are heavily regulated, they are not well regulated.

Health and long-term services and supports quality efforts (classified into structural, process, and outcome approaches) have been consistently criticized for placing primary emphasis on structural measures (e.g., hours of work force training, facility structural reviews, and paper work compliance) and process measures (e.g., use of resident councils) rather than on outcomes of the services. In particular, long-standing concerns have focused on the fact that quality and regulatory systems rarely involved the consumer. Nursing homes also have received considerable attention in recent years from both the popular press and professional reviews. Several initiatives have been launched as a response to this latest round of criticism.

Several new initiatives to address quality issues have begun in Ohio. One involves improving the quality of nursing homes through more stringent requirements, such as increased staffing ratios and better training. Staffing data gathered during nursing facility inspections show that Ohio nursing homes are staffed at levels very close to the national average (see Figure 18) and, on average, exceed the minimum standards of the staffing rule (Harrington, et. al., 2010).

Figure 18

Average Number of Staff Hours per Resident per Day
All Certified Nursing Facilitites, 2009



(Harrington, Carrillo, Blank, & O'Brian, 2010)

A second approach 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. In addition to inspection survey data, 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, in 2000 the Centers for Medicare and Medicaid Services launched a program of quality improvement for our nation's health care, the Nursing Home Quality Initiative. This initiative covers both acute and long-term services in institutional and community settings.

Quality measures for hospitals, home health agencies, nursing homes and other providers are available to consumers in order to assist them in making an informed choice of service provider (see www.medicare.gov). Quality Improvement Organizations (QIOs) in every state provide assistance to service providers to help them improve the quality of the care they deliver. They also protect the rights of Medicare beneficiaries regarding the quality and amount of care they receive. Ohio KePro (www.ohiokepro.com) is the QIO for Ohio.

As an incentive for nursing homes to provide or to continue to provide quality care, Ohio's Medicaid system incorporates measures of quality in the nursing home reimbursement formula. The newly developed quality incentive payment system was a result of a legislation passed in HB 153 in June 2011. A subcommittee of the Unified Long-Term Care System Advisory Workgroup identified 20 quality indicators. Because there were no new funds added to the nursing home reimbursement under the initial plan nursing homes will only have to achieve success on five of the twenty indicators to receive the full quality reimbursement. In subsequent years there is an expectation that additional quality funds will be available and to receive new funds nursing homes will need to reach a higher quality threshold. Ohio's 2012 budget proposes additional modifications to this approach.

In 2006, the Centers for Medicare and Medicaid Services (CMS) launched a program of quality improvement, the Quality Indicator Survey (QIS) Demonstration Project. This revised survey process was designed to achieve greater consistency and accuracy using a more structured process, provide a comprehensive review of all survey areas, enhance documentation by automating survey findings, and focus survey resources on facilities with the greatest quality concerns. Ohio was chosen as one of the demonstration states.

The QIS aims to provide a comprehensive reveiw of all survey areas, focus survey resources on facilities with the greatest quality concerns, achieve greater consistency and accuracy through a more structured and objective process, and enhance documentation by automating survey findings. It utilizes a two-staged process wherein surveyors first perform a preliminary investigation by conducting structured resident, family, and staff interviews, record reviews, resident observations, and analyses of Minimum Data Set (MDS) data. In a second stage, surveyors conduct in-depth quality investigations to determine any deficiencies that may exist, as well as their severity and scope. This method is expected to be implemented in every state by the end of 2014 (GAO, 2009).

Monitoring Technology

Technology can be used to assist older adults to "age in place," i.e., remain in one's own home, be it the home they have always lived in or a new living situation. Given that most older adults prefer to remain at home as long as possible (Barrett, 2008), devices that can help them do so are increasingly valuable. Technology in the form of assistive devices and tools can play a role, as can new monitoring technologies. Monitoring technology is generally part of the living environment and can range from a system similar to a home security system with monitors on doors, windows, stoves, and faucets to a whole-house system that records gait, movement and other patterns of the individuals living in the home. A number of commercial providers are developing these applications for both insitutional and individual use.

Another type of monitoring technology is often referred to as "telehealth." These systems allow patients to monitor their vital signs or other health indicators, such as blood pressure, temperature, oxygen levels or blood sugar and electronically transmit the results to physicians or other health care providers in remote locations. This type of monitoring has important use for ongoing patient monitoring that can be far more frequent than if office visits were required, while being far more cost effective for care providers and convenient for patients.

This field is rapidly changing and holds great potential for changing the way older adults function in their own homes and increasing connections with others.

Innovative Models for Nursing Homes

In recent years there have been a series of efforts to change the culture of nursing homes in the U.S.. A description of some of these efforts is included below.

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 the institutional settings into "homes" for elders.

The Eden Alternative is a philosophical approach to long-term services and supports 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 such things as children, plants, and animals. There are currently 13 Eden-registered homes in Ohio. For a list of these facilities, go to http://www.edenalt.org/component/option,com_mtree/task,listcats/cat_id,77/Itemid,39/.

Wellspring is an association of 11 non-profit nursing homes 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).

Small-scale living facilities are associated with better quality of life for elders with and without dementia. This environment also facilitates the development of direct care personal realtionships between elders and staff members. Studies have

found that small-scale living is associated with reduced anxiety, less depression, increased mobility and self care skills, increased communication and friendship formation, and improved eating behavior in elders with dementia (Rabig et. al., 2006).

A concept known as the Green House Model creates a small community for a group of elders and staff. These small living environments for 8-10 residents differ from traditional skilled nursing homes and assisted lving facilities by reducing the size, creating more homelike interiors, and changing staffing patterns and methods of delivering skilled care. They structure their daily operations so that support with acitivites of daily living and clinical care does not become the focus of the day. Develped by Dr. William Thomas, the Green House concept is a model for changes within nursing facilities.

An 18-month study that compared 40 Green House residents with the same number of residents at two conventional nursing homes showed that the Green House residents reported better quality of life, better emotional health, and higher satisfaction with their places of residence (Kane et. al., 2007). Green House residents also had a lower incidence of decline and fewer experiences of depression.

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

Projections of Ohio's Older and Disabled Population

In 2010, Ohio's population consisted of just over 2 million adults 60 years and older (Mehdizadeh, 2010). Ohio has one of the largest populations of older adults, behind California, Florida, New York, Texas, Illinois, and Pennsylvania. From 2005 to 2010, this older population increased by 10%, and from 2010 to 2020 it will grow another 26%. Between the years 2005 to 2020, the greatest population increase is expected in the 60-69 and the 90+ age groups, with projected increases of 60% and 52%, respectively. Figure 19 shows the growth of Ohio's older population by gender and age group.

Growth in the older, disabled population will mirror that of the older population in general. The 60-69 and 90+ age groups will experience the largest increase in persons with disability from the years 2010 to 2020. Between 2005 and 2020, the severely disabled older population will increase by approximately 25%, and the moderately disabled group will increase by over 30%. As a person grows older, the probability of becoming moderately to severely disabled jumps dramatically. Figure 20 shows the growth in disability from 2005 to 2020 by type of disability and age group.

Cognitive decline is another source of disability. Alzheimer's disease is one of the major causes of dementia, and 5.4 million Americans are believed to have the disease (Alzheimer's Association, 2011). It is estimated that 16 million people in the United States will have the disease by 2050 unless a cure is found.

Figure 19

Projections of Ohio's Older Population by Gender and Age

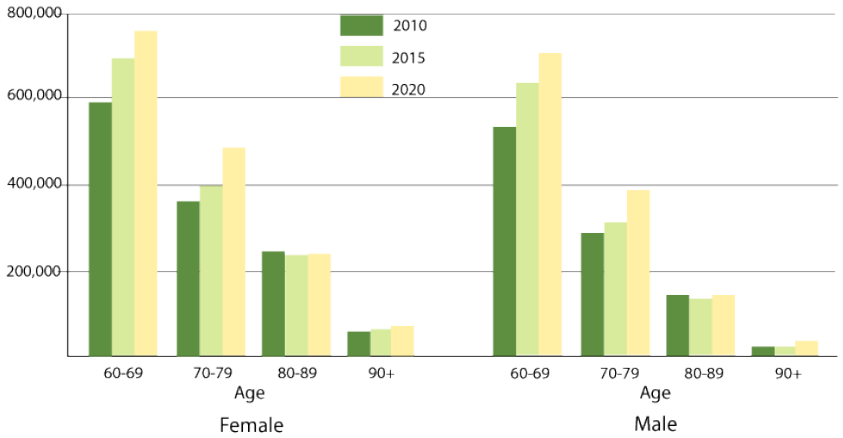
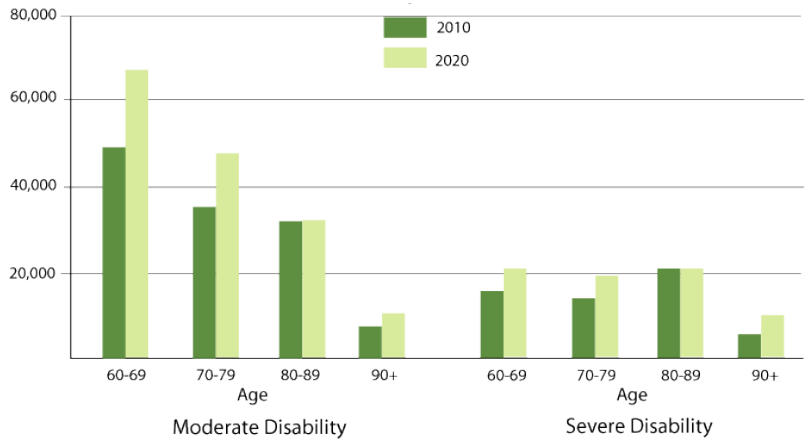


Figure 20

Projections of Ohio's Older Population by Disability and Age, 2010 & 2020



Family, friends and neighbors remain the backbone of the long-term services system. Estimates consistently report that the informal system, particularly adult children and spouses, provides more than 80% of all long-term services and supports 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 services and supports 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. One small demonstration project in southern Ohio shows promise for an in-home training program for informal caregivers, the Council on Aging Learning Advantages Program for Informal Caregivers, or COALA (Straker, Nelson, & Carr, 2005). In this study,

caregivers' pre-training assessments were compared to assessments after training was administered. Results show that self-esteem, competence, and knowledge of caregiving issues increased, burden and the hours of weekly care provided decreased, and the economic strain increased slightly after the intervention.

Caregiver respite will also grow in importance as more people become informal caregivers for their friends and family members. PASSPORT does not currently provide respite services per se, since PASSPORT services are provided to the care recipient, not the caregiver. However, some services may indirectly provide some respite to caregivers (e.g., adult day services, home-delivered meals). A feasibility study by Ciferri, McGrew, and Mehdizadeh (2005) looked at restructuring PASSPORT to include caregiver respite services. Their study revealed the following:

- The majority of PASSPORT participants have at least one active caregiver.
- By sustaining caregiver activities and keeping care at home, the cost difference between keeping the PASSPORT participant enrolled in PASSPORT compared to the average cost of nursing home facility care is significant.
- Any additional investment in Ohio's respite strategy will save the state money in the future.

Programs that allow payment directly to caregivers are also being expanded nationally and in Ohio. Such consumer-directed programs allow consumers to pay family members, friends or neighbors to provide services that would normally be delivered by formal agencies. 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 support system to be strong will be critical as the baby boom generation reaches old age.

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 services, there will be substantial increases in state expenditures. 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, could assist in lowering the number of Ohioans that eventually rely on Medicaid support. Finally, changes in federal policy that recognize long-term services and supports as a national responsibility, rather than a state and individual one, could drastically change the state's role. However, the federal role remains uncertain at this point and thus far long-term services and supports continue to be the responsibility of the state.

Additional Internet Resources

Web Sites

AARP is a nonprofit membership organization dedicated to addressing the needs and interests of persons 50 and older. http://www.aarp.org/

AARP Ohio provides access to AARP news and blogs relevant to individuals living in the state of Ohio. http://www.aarp.org/states/oh/

American Bar Association (ABA) Commission on Law & 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.gov/

Aging Parents and Elder Care (formerly **Age Solutions**) provides information and supportive resources for caregivers. Resources include articles, checklists, and links to other resources including a support group. http://www.aging-parents-and-elder-care.com

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.nia.nih.gov/alzheimers

American Society on Aging (ASA) has many electronic and printed resources on Long-Term Services and Supports. The largest organization of professionals in the field of aging, their website offers information about conferences, current news, publications and many other events and resources. http://www.asaging.org/

Assisted Living Federation of America (ALFA) is the largest national association dedicated to for profit and not-for-profit providers of assisted living, continuing care retirement communities, independent living and other forms of housing and services. Their aim is to promote business and operational excellence through conferences, research, publications and executive networks. http://www.alfa.org/

Bureau of Labor and Statistics (BLS) is a principle employment fact finding agency for the Federal Government. http://www.bls.gov

Cash and Counseling promotes consumer direction by helping frail elders and adults with disabilities maintain autonomy and responsibility through innovative programs, counseling and fiscal assistance. This website offers information about current political decisions and events concerning consumer direction programs in the United States. http://www.bc.edu/schools/gssw/nrcpds/cash-and-counseling.html

Centers for Medicare and Medicaid Services (CMS) 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

The Commonweath Fund is a private foundation that seeks to promote access, quality, and efficiency in United States and international healthcare systems through means of research. http://www.commonwealthfund.org/

Community Health Accreditation Program (CHAP) develops and promotes standards applicable to all types of home- and community-based health service providers. http://www.chapinc.org/

Connect Me Ohio http://www.connectmeohio.org

Elderweb: Ohio is an online directory for older adult computer users. http://www.elderweb.com

Employee Benefits Security 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.doc.gov/ebsa/

Families USA (Medicaid) provides access to information and resources on Medicaid laws and regulations. http://familiesusa.org/issues/medicaid/

Family Caregiver Alliance (FCA) 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. http://www.healthinaging.org/

Front Door Aging & Disabilities Network website Network of Care for Seniors & People with Disabilities, provided by the Western Reserve Area Agency on Aging. The Network of Care serves the counties of **Cuyahoga**, **Geauga**, **Lake**, **Lorain** and **Medina**. The project is part of a broad effort by our community partners to improve and better coordinate long-term supports and services locally. This comprehensive, Internet-based resource is for seniors and people with disabilities, as well as their caregivers and service providers. http://cleveland.oh.networkofcare.org

HCBS, The Clearinghouse for the Community Living Exchange Collaborative, has a searchable rich database of resources related to the infrastructure development for people with disabilities and older adults. http://www.hcbs.org

The Henry J. Kaiser Family Foundation serves as a major independent research organization for United States health

policy and provides in-depth information on health policy issues. http://www/kff.org/

Home Health Compare provides information on all Medicare certified home health agencies across the country and supplies a tool to assist in comparision. http://www.medicare.gov/HHCompare/

Leading Age is a membership organization of mission-driven, not-for-profit organizations including adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes. http://www.leadingage.org/

Leading Age Ohio is a resource for advocacy, education and promotion of public awareness on behalf of not-for-profit providers pursuing excellence in serving older adults. This organization is a statewide nonprofit trade association representing nearly 300 not-for-profit providers of senior housing, adult day care, home- and community-based services, assisted living and skilled nursing. http://www.leadingageohio.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 and hospitals, personal plan finders, prescription coverage 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 receive good, affordable health care. The MRC website offers helpful and reliable Medicare information for consumers and professionals. http://www.Medicarerights.org/

National Association for Home Care & Hospice is a trade association that represents the interests of home care and hospice providers. Has an online locator of home care and hospice providers. http://www.nahc.org/

National Council on Aging is a membership advocacy organization for older adults and the organizations that serve them. They provide a number of resources, their Benefits Checkup© helps older adults determine what programs and benefits they are qualified to receive.

National Caucus and Center on Black Aged seeks to improve the quality of life for elderly African Americans and low income minorities by offering programs on housing, employment, and health promotion. http://www.ncba-aged.org/

National Institute on Aging, an institute within the National Instititutes of Health, offers access to information on varous aging topics. The institute also supports and conducts aging research. http://www.nia.nih.gov/

National Program 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. Current center activities include research on income

security, health and caregiving. http://www.heller.brandeis.edu/womenandaging/

National Committee to Preserve Social Security and Medicare advocates for beneficiaries of Social Security and Medicare. This site includes 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.thefamilycaregiver.org

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

National Institutes of Health is the nation's medical research agency. A part of the Department of Health & Human Services, they devote a large part of their website to senior health and research topics. 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. http://www.nih.gov

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.med.und.nodak.edu/depts/rural/nrcnaa

New York Online Access to Health (NOAH) consists of links to other health sources and websites, listed by categories. For example: physiological changes, hearing, vision, incontinence, sexuality and nutrition. http://www.noah-health.org/en/healthy/aging/

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

Ohio Assisted Living Association 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 Services and Supports 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 for Homecare and Hospice is a statewide association serving the interests of home care and hospice providers and their suppliers through advocacy, education and research. http://www.homecareohio.org

Ohio Department of Aging has information on aging, caregiving, and state service programs. http://www.goldenbuckeye.org

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.Insurance.Ohio.gov

Ohio Department of Job & Family Services (ODJFS) develops and oversees public programs that provide health care, employment and economic assistance, child support, and services to families and children. http://www.jfs.ohio.gov

Ohio Health Care Association (OHCA) serves as an advocacy information and education resource to Ohio's long-term care professionals, 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 Services and Supports services to meet individual needs. http://www.ltcohio.org

Ohioline - Family (formerly **Aging in Ohio) at The Ohio State University Extension Office** provides information, news, and educational resources for individuals, families, and professionals about families, including aging, parenting and family life. http://ohioline.osu.edu/lines/fami.html#AGING

Pioneer Network is a grassroots organization that advocates and facilitates deep system change and transformation in our culture of aging. http://www.pioneernetwork.net

Scripps Gerontology Center at Miami University, Oxford, Ohio, has publications addressing many long-term services and supports issues for LTC professionals, planners and policy makers, and general audiences. Many are available for free download. http://www.scrippsaging.org

Social Security Online is the official website of the Social Security Administration and contains information on Social Security retirement and disability benefits, SSI, SS card replacement, taxes, hearings and appeals, and regional office locations. There is also an online form for applying for SS benefits. 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/

Activities of Daily Living (ADL)- Basic personal activities which include bathing, eating, dressing, mobility (ambulation), transferring from bed to chair, and toileting.

Administration on Aging (AoA)- Federal agency that oversees Older Americans Act programs. An agency of the U.S. Department of Health and Human Services AOA works closely with its nationwide network of state and Area Agencies on Aging (AAA).

Adult care facility- Residential care homes classified as either an adult family home (3-5 residents) or an adult group home (6-16 residents). Skilled nursing services, such as medication administration, cannot be provided in adult care facilities. Many of Ohio's adult care facilities serve residents with mental or behavioral problems.

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- An adult care facility that provides accommodations and support services for three to five unrelated adults and personal care services to at least three of those adults. Adult family homes obtain their license through the Ohio Department of Health.

Adult foster care/home- A live-in arrangement where one or two adults live with and are provided care and/or services by an unrelated individual or family. In addition to room and board, the services include housekeeping, laundry, some personal care, and supervision with finances and medications when deemed necessary. These individuals must not need 24-hour supervision. Adult foster homes are certified by the Area Agency on Aging.

Adult group home- An adult care facility that provides accommodations and support services for 6 to 16 unrelated adults and personal care services to at least three individuals. Licensed by the Ohio Department of Health.

Adult Protective Services (APS)- Service which seeks to protect the rights of frail older adults by investigating cases of abuse, neglect, and exploitation as mandated by law.

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.

Aging and Disability Resource Centers (ADRC)- "One-stop shopping" through community-level centers that help people make informed decisions about their service and support options, and serve as the entry point to the long term care service and support system.

Area Agency on Aging (AAA)- A local or regional agency (Ohio's 12 AAAs are composed of multiple county areas), funded under the federal Older Americans Act, that plans and coordinates various social and health service programs for persons 60 years of age or older. The national network of AAA offices consists of more than 600 approved agencies.

Assisted living / assisted living facility- 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.)

Assistive devices/technology- Any item, piece of equipment, or set of products that helps a person with a disability to increase or improve his/her functional capabilities (examples: grab bars, shower benches, bathtub lifts, wheelchair lifts, and computer and robotic monitoring or reminding technology).

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/case management (CM)- 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 Choice Ohio- Free Long-Term Services and Supports consultation service provided by Ohio PASSPORT Administrative Agencies. Includes professional assessments of present or future Long-Term Services and Supports needs, as well as information about establishing eligibility for government-funded programs.

Caregiver- An informal caregiver is a 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. Formal caregivers are volunteers or paid care providers who are usually associated with an agency or social service system.

Care plan- (also called service plan or treatment plan) Written document which outlines the types and frequency of the Long-Term Services and Supports services that a consumer receives. It may include treatment goals for the consumer for a specified time period.

Centers for Medicare & Medicaid Services (CMS)- This federal organization oversees the Medicare and Medicaid programs. It also provides information to assist consumers in choosing a variety of types of service providers through its website at www.medicare.gov.

Certification- In Medicare and Medicaid, certification refers to approval for providers to participate in those programs. Licensed facilities or agencies might elect not to be Medicare- or Medicaid-certified if they planned to provide services only to private-paying residents. Requirements for certification are specified by the federal government for each type of Medicare and Medicaid provider.

Choices- A consumer-directed Medicaid waiver program that provides home- and community-based services and supports to older Ohioans. Providers can be agency or non-agency professional caregivers or individual providers such as friends,

neighbors or some relatives (spouses, parents, step-parents and legal guardians are ineligible).

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.

Co-insurance (See Co-payment)

Companionship services- (Also called: Companion, Companions, Friendly Visitors) People who provide companionship to elderly and shut-in people, providing conversation, reading, and possibly light errands.

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.

Community-based services- Services designed to help older and disabled people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meals site, visiting nurses or home health aides, adult day care, and homemaker services.

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).

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. Subsidized with funds from the Older Americans Act.

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 for whom the conservatorship is arranged must be mentally competent, but physically unable to manage his or her own affairs.

Consumer direction / consumer-directed care - Consumer direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. The term “consumer-directed care” is used in reference to Long-Term Services and Supports and support services, and emphasizes the ability of people with disabilities to assess their own needs and make choices about what services would best meet those needs and to determine when, how, and by whom services should be provided.

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, giving 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. Requires payment of a monthly fee and possibly a large lump-sum entrance fee.

Continuum of care- The entire spectrum of specialized health, rehabilitative, and residential services available to the frail and chronically ill. The services focus on the social, residential, rehabilitative and supportive needs of individuals as well as needs that are essentially medical in nature.

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- Type of nursing facility that is licensed by the county to offer residents personal care as well as skilled nursing care on a 24 hour a day basis. County homes provide nursing care, personal care, room and board, supervision, medication, therapies, and rehabilitation. Rooms are often shared, and communal dining is common.

Custodial care- Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, transferring, ambulation, and toileting. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible- The initial share of a medical or Long-Term Services and Supports expense that consumers must pay before their insurance or the program will cover the expense.

Deficiency- A finding from a governmentally-administered inspection that a nursing home failed to meet one or more federal or state requirements.

Dementia- Term describing a group of diseases (including Alzheimer's Disease) characterized by memory loss and other declines in mental functioning.

Disability- Limitation in physical, mental, or social activity. There are varying types (functional, occupational, learning), degrees (partial, total), and durations (temporary, permanent) of disability.

Dual eligible/eligibility- Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid. Medicaid pays for premiums, deductibles, and co-payments required by Medicare. There are seven categories of dual eligibles (see Medicaid Only, QMB, QMB Plus, SLMB, SLMB Plus, QI, & QDWI).

Durable medical equipment- (also called home medical equipment) - Equipment such as hospital beds, wheelchairs, and prosthetics used at home. May be covered by Medicaid, 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.

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.

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 on-line (www.eldercare.gov).

Emergency response system (ERS)- (also called 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.

Employer of record- An employer-of-record is a person or agency that handles some employer-related duties for a care receiver who is enrolled in a consumer-directed care program. Though an employer-of-record technically employs the provider(s), the consumer still locates, hires, trains, and supervises his/her support people. This same person or agency may act as fiscal intermediary.

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.

Fiscal intermediary- Agency/organization that takes care of the detailed fiscal responsibilities of being an employer for a care receiver who is enrolled in a consumer-directed care program (pays workers, files paperwork). The hiring/firing of employees remains the responsibility of the consumer.

For profit- Organization or company in which profits are distributed to shareholders or private owners.

Friendly visitor- Programs in which volunteers regularly visit homebound or institutionalized elders to provide socialization, run errands, and generally "check in" with them.

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 has 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.

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.

Geriatrician- Physician who is certified by the American Board of Internal Medicine of Family Practice in the care of older people.

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 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 & community-based services (HCBS)- see **Home care**

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 usually only for a short time (e.g., for a medical appointment) and requires much effort. Individuals may attend adult day programs, religious services, or occasional special social outings and still be considered homebound.

Home care / home care services- Non-medical Long-Term Services and Supports services received in a home. For example: homemaker, personal care, home-delivered meals, chore services, or emergency response systems.

Home-delivered meals- Sometimes referred to as "meals on wheels," home delivered meals are delivered to homebound persons who are unable to prepare their own meals.

Home health care- Medical care delivered at home that includes a wide range of health-related services such as assistance with medications, wound care, and intravenous (IV) therapy.

Home health agency- An organization that provides medically skilled home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

Homemaker services- Help with meal preparation, shopping, light housekeeping, and laundry.

Home medical equipment (See durable medical equipment)

Home sharing/shared housing programs- (Also known as Homeshare, Home Share) Usually involves 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 non-profit organization.

Hospice- Services for the terminally ill provided in the home, a hospital, or a Long-Term Services and Supports facility. Includes home health services, volunteer support, grief counseling, and pain management.

ICF/MRs

Impairment- Any loss or abnormality of psychological, physiological, or anatomical function.

Independent Choices- Demonstration Project through which beneficiaries can receive their Medicaid cash allowance to hire helpers directly, instead of using traditional services provided by agency workers. Beneficiaries can hire family members, friends, and neighbors to assist with intimate personal care tasks.

Independent living- A living arrangement that maximizes independence and self-determination, especially of disabled persons living in a community instead of in a medical facility.

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.

Informal caregiver- An informal caregiver is often a spouse, adult child or other relative who provides care for the care receiver, typically without pay.

Instrumental Activities of Daily Living (IADL)- 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.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)- An independent, non-profit organization that evaluates and accredits nearly 15,000 health care organizations and programs in the United States.

Length of stay (LOS)- Length of stay is usually reported as the number of days a person lived in a facility or received services through a community-based program.

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. In order to qualify for Medicaid nursing home or home & community-based services an individual must meet a nursing home level of care (intermediate or skilled) or ICF/MR level of care.

Level of care (LOC), Intermediate- An individual requires one or more of the following: 1. Hands-on assistance to complete at least two ADLs; or 2. Hands-on assistance to complete at least one ADL and hands-on assistance with medication administration; or 3. One or more skilled nursing services or skilled rehabilitation services at less than a skilled care level; or 4. Due to cognitive impairment, requires the presence of another person, on a twenty-hour a day basis for the purpose of supervision to prevent harm.

Level of care (LOC), Skilled- At least one of the following applies: 1. The individual's condition necessitates, and the individual's physician has ordered that at least one skilled nursing service be provided at the skilled care level; or 2.The individual's condition necessitates, and the individual's physician has ordered, that at least one skilled rehabilitation service be provided at a skilled care level.

Level of care (LOC), Protective- An individual requires one of the following: 1) Supervision of one ADL and assistance with three IADLs; or 2. Supervision of self-administration of medication and assistance with three IADLs; or 3. Due to a cognitive impairment, requires the presence of another person on less than a twenty-four hour basis for the purpose of supervision to prevent harm.

Levy-funded programs- Home care service programs for older adults that are funded by county property tax levies. Services and fees vary by program.

Life care community- A type of **Continuing Care Retirement Community** (**CCRC**) - which offers an insurance type contract and provides all levels of care. It often includes payment for acute care and physician's visits. Little or no change is made in the monthly fee, regardless of the level of medical care required by the resident, except for cost of living increases.

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 Services and Supports (LTCSS)- The broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or condition, and who are expected to need such services over a prolonged period of time. Long-Term Services and Supports can consist of care in the home by family members who are assisted with voluntary or employed help, adult day health care, or care in assisted living or skilled nursing facilities. LTCSS is often referred to as long-term care.

Long-Term Care insurance- Insurance policies which pay for Long-Term Services and Supports 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 premiums vary accordingly. 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 capitation), no matter how much care a member needs during that month.

Meals-on-Wheels- (See Home-delivered meals)

Medicaid (Title XIX)- Federal and state-funded program of medical assistance to low-income individuals of all ages. There are income eligibility requirements for Medicaid.

Medicaid Only- Category of dual eligibility (See Dual eligibles/ eligibility). Such persons are eligible for Medicaid benefits, categorically, or through optional coverage groups such as medically needy or special income levels for institutionalized or home and community-based waivers, but do not meet the income or resource criteria for QMB or SLMB.

Medicaid Waiver Programs- **Medicaid** programs that provide alternatives to nursing home care. These programs have the potential to reduce overall Medicaid costs by providing services in innovative ways, or to groups of people not covered under the traditional Medicaid program. These programs are approved on a demonstration basis, and generally have limited slots available.

Medically needy- An optional Medicaid program which covers the cost of medical care for persons who would qualify for Medicaid on the basis of the services they require, but who have too much income to qualify for the program and too little to pay for the medical services they need. Not all states have medically needy programs. Ohio does not have a medically needy program.

Medicare Advantage- 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. If you have one of these plans, you don't need a Medigap policy. Medicare Advantage is also known as Medicare Part C. Previously this plan was referred to as Medicare+Choice.

Medicare (Title XVIII)- Federal health insurance program for persons age 65 and over (and certain disabled persons under age 65). Consists of 4 parts: Part A (hospital insurance), Part B (optional medical insurance which covers physicians' services and outpatient care in part and which requires beneficiaries to pay a monthly premium), Part C (also known as Medicare Advantage), and Part D (prescription drug coverage).

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- Private health insurance used to pay costs that are not covered by Medicare, such as deductibles and co-payments. Depending on the benefits package purchased, this supplemental insurance may pay for some limited Long-Term Services and Supports expenses. This works only with the original Medicare plan.

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.

Minimum Data Set (MDS)- The Minimum Data Set (MDS) 3.0 is an assessment instrument (RAI) completed for every resident in a Medicare or Medicaid certified nursing facility. Data from the MDS are used for reimbursement purposes, publicly reported quality measures, and quality indicators that guide the nursing home survey (inspection) process. The MDS is completed by facility staff with input from resident interviews.

Needs assessment- An evaluation of physical and/or mental status by a health professional, usually a nurse. This assessment, together with the attending physician notes, determines the level of functional and cognitive incapacity of the patient, and is used to create a care plan and make decisions about the need for home health care, an assisted living facility, or a skilled nursing facility.

Non-profit/not-for-profit- An organization that reinvests all financial surpluses 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 basis. Nursing homes provide nursing care, personal care, room and board, supervision, medication, therapies, and rehabilitation. Rooms are often shared, and communal dining is common.

Nutrition services- Include home-delivered and congregate meals.

Occupancy rate- A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's or nursing home's beds occupied and may be institution-wide or specific for one department or service.

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 (See State units on aging). ODA receives some funds from the U.S. Administration on Aging.

Ohio Department of Health (ODH)- State agency whose responsibilities include inspecting and licensing all Long-Term Services and Supports facilities and other types of medical providers within the state of Ohio.

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

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 Services and Supports and other health insurance.

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 centers, employment programs). Creates the structure of the federal Administration on Aging, State Units on Aging, and local agencies that oversee aging programs.

Ombudsman- Trained professional or volunteer who advocates for the rights of older people receiving Long-Term Services and Supports services (both facility-based care and home care) and who investigates and mediates their problems with or concerns about their care.

PASSPORT- Ohio's home and community-based Medicaid waiver program for low-income persons age 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- Assistance with activities of daily living as well as with self-administration of medications and preparation of 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.

Post-acute care- Post-acute care improves the transition from hospital to the community by providing services to patients needing additional support to assist them to recuperate following discharge from an acute care hospital. Care settings include: skilled nursing facilities, the home (through home health agencies), Long-

Term Services and Supports hospitals, and inpatient rehabilitation facilities. Services include home nursing, personal care, childcare, allied health services, and home health care.

Pre-admission review- Assessment required of all people living independently in the community who wish to enter a nursing home. This ensures that home and community-based Long-Term Services and Supports 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- Health plan which covers care from any hospital, physician, or covered provider.

Program of All Inclusive Care for the Elderly (PACE)- The PACE program is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. It uses a multidisciplinary team approach in an adult day health center supplemented by in-home and referral service in accordance with participants' needs.

Provider- Individual or organization that provides health care or Long-Term Services and Supports 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 Disabled and Working Individual (QDWI)- Category of dual eligibility (See Dual eligibles/ eligibility). Such dual eligibles lost Medicare Part A benefits because they returned to work, but are eligible to enroll in and purchase Medicare Part A.

Qualified Medicare Beneficiary (QMB)- Category of dual eligibility (See Dual eligibles/ eligibility). 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.

Qualified Medicare Beneficiary Plus (QMB Plus)- Category of **dual eligibility** (See Dual eligibles/ eligibility). QMB Plus eligibles have full Medicaid benefits. The

QMB Plus category was created when Congress changed eligibility criteria for QMBs to eliminate the requirement that QMBs could not otherwise qualify for Medicaid.

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.

Quality Improvement Organizations (QIOs)- QIOs are largely non-profit, community-based organizations whose mission is to collaborate with both Medicare providers and beneficiaries to achieve significant and continuing improvement in the quality and effectiveness of health care at the community level. Under the direction of CMS is a national network of 53 QIOs, responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure Medicare patients get the right care at the right time, particularly patients from underserved populations.

Quality of Care- A measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer.

Rehabilitation services- Services designed to improve/restore a person's functioning; include physical therapy, occupational therapy, and/or speech therapy. May be provided at home or in Long-Term Services and Supports facilities. May be covered in part by Medicare.

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 adult care homes and residential care facilities. There is an income eligibility requirement for receiving RSS.

Respite care- Service in which either trained professionals or volunteers come into the home, or where care is provided in an institutional setting for a short-term (from a few hours to a few days) to allow caregivers of an older or disabled person some time away from their caregiving role.

Self-directed care- See Consumer-Directed Care

Senior center- A community organization that provides a variety of on-site programs for older adults, including recreation, entertainment, congregate meals, and some health services. Usually a good source of information about area programs and services for persons age 60 and over.

Service Plan-See Care plan

Skilled care- "Highest level" of care requiring skilled medical services (such as injections, catheterizations, and dressing changes) provided by medical professionals, including nurses, doctors, and physical therapists.

Skilled nursing facility (SNF)- Facility that is certified by Medicare to provide 24-hour residential nursing care and rehabilitation services in addition to other medical services.

Social Security- A federal program established in 1935 that includes a retirement income program, disability and survivors benefits, and health insurance through the Medicare program.

Social Services Block Grant services- (See Title XX services)

Special care units- Long-Term Services and Supports facility units with services specifically for persons with Alzheimer's disease, dementia, head injuries, or other disorders.

Specified Low Income Medicare Beneficiary (SLMB)- Category of dual eligibility (See Dual eligibles/ eligibility). 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.

Specified Low Income Medicare Beneficiary Plus (SLMB Plus)- Category of dual eligibility (See Dual eligibles/ eligibility). SLMB Plus eligibles have full Medicaid benefits. The SLMB Plus category was created when Congress changed eligibility criteria for SLMBs to eliminate the requirement that SLMBs could not otherwise qualify for Medicaid.

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 by using assets or income until they reach the eligibility level.

Spousal Impoverishment Protection- Federal regulations preserve some income and assets for the spouse of a nursing home resident whose stay is covered by Medicaid.

Sub-acute care- Type of short-term care provided by many Long-Term Services and Supports 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 sub-acute care is to discharge residents to their homes or to a lower level of care.

Supplemental Security Income (SSI)- Supplemental Security Income (SSI) is a federal supplemental income program for low-income elderly or disabled persons established in 1972. Many states supplement it with additional state SSI. In most states, SSI recipients are also automatically eligible for Medicaid.

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). (Also see Older Americans Act).

Title XIX services (Medicaid)- Federal and state-funded program of medical assistance to low-income individuals of all ages. There are income and asset eligibility requirements for Medicaid.

Title XX services (Social Services Block Grant 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).

Title XVIII services (Medicare)- Federal health insurance program for persons age 65 and over (and certain disabled persons under age 65). Consists of 4 parts: Part A (hospital insurance), Part B (optional medical insurance which covers physicians' services and outpatient care in part and which requires beneficiaries to pay a monthly premium), Part C which includes Medicare Advantage programs, and Part D which covers prescription drugs.

Transportation services- (also called Escort services) - Provides transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers, or van or ambulance services that can accommodate wheelchairs and persons with other special needs.

Treatment plan (See care plan)

U.S. Department of Veterans Affairs (V.A.)- Offers acute and Long-Term Services and Supports 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.

Veterans Affairs (See U.S. Department of Veterans Affairs [V.A.])

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