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The Ohio Long-Term Care Factbook

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Ohio Long-Term Care Factbook



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During the 20th century, unprecedented increases in longevity 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 are attentive to the issues of planning and paying for care, and managing assistance for themselves and their loved ones. Service providers are working to improve the quality of the services they provide, modifying services to meet the changing preferences of older adults now and anticipating change in the future. Recognizing that growing numbers of Ohioans are seeking information about long-term care, this factbook is designed to provide a basic introduction to long-term care, with an emphasis on Ohio. It provides a look at Ohio's long-term care services, the people who are served, the public and private funding sources that support them, and a look at the future of long-term care both nationally and in Ohio.

A list of sources is included, along with a list of websites that provide additional long-term care information. Terms in **bold** appear in a glossary at the back of the report. Although long-term care is a topic of importance for all ages, this book focuses on long-term care for older adults. This second edition includes updated statistics on long-term care use and expenditures, as well as new information on long-term care quality initiatives, innovations in long-term care, additional Internet resources, and an updated and expanded glossary.

About Long-Term Care in Ohio

6

Fast Facts

- In 2005, Ohio had approximately 1.5 million people age 65 years or older.
- 29% or 441,964 of these individuals had a moderate or severe disability.
- On any given day in 2003, about 76,850 Ohioans lived in nursing homes.
- On any given day in 2005, approximately 25,000 Ohioans age 60+ received PASSPORT home & community-based services.
- Ohio currently has approximately 970 nursing home facilities.
- The typical nursing home in Ohio has about 100 beds.
- 13.8% of Ohio's nursing homes were cited in 2003 for deficiencies that led to actual harm or put their residents in immediate jeopardy .
- Ohio currently has approximately 540 residential care facilities.
- In 2004, Ohio spent \$3.1 billion on long-term care services for Medicaid recipients.
- 40% of Ohio's 2004 Medicaid budget was spent on long-term care.
- The average cost for nursing home care in the state in 2005 was \$5,170 per month.
- The average cost for PASSPORT (Medicaid) home care services in 2004 was \$1,050 per month.
- In 2003, Ohio nursing homes had an occupancy rate of 84.7%.
- More than one-half of nursing home residents stay three months or less.

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

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



Who Uses Long-Term Care?

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

Most of us don't think about our tasks of daily living, such as eating or bathing. For individuals with a chronic **disability** it is assistance with these tasks however, that have a major impact on their lives. Two measures are used extensively in **long-term care** to measure functional ability, the **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 care** services. IADL limitations, such as meal preparation and shopping, are more common, but are less likely to result in formal service use. For example, **nursing home** and **PASSPORT** eligibility require the consumer to have ADL limitations in addition to IADL limitations.

Cognitive functioning is also an important factor in determining the type of services and supports required. Persons with Alzheimer's disease and other forms of **dementia** typically have cognitive limitations that require assistance. Several assessment tools, such as the Mental Status Questionnaire that asks questions such as "Do you know who the President is?" and "Do you know your address?" are widely used.

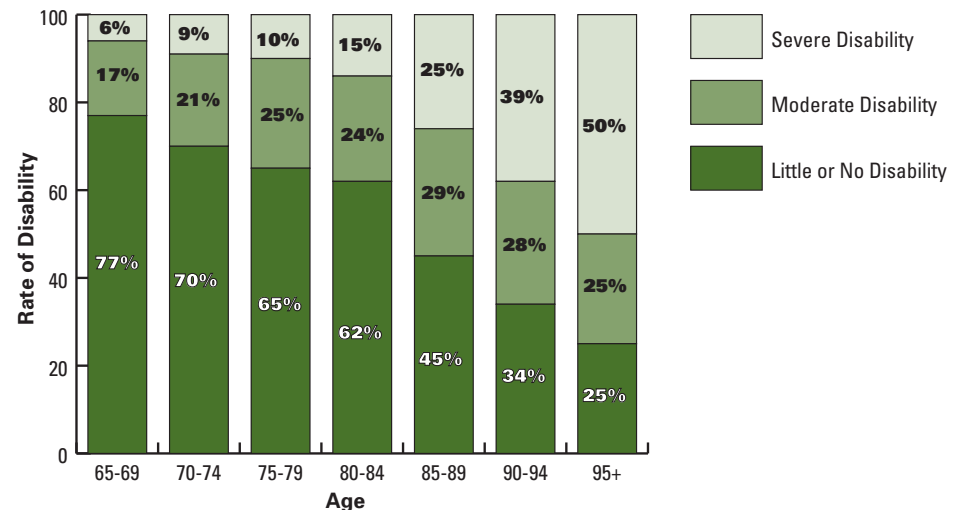
Disability may occur at any age. However, the older people are, the more likely they are to be disabled. Figure 1 shows the gradual, but marked increase in levels of **disability** for people 65 and over in Ohio. In Figure 1, **disability** is classified as severe, moderate, or little/none. People with moderate **disability** are impaired in at least one **ADL** or at least two **IADLs**; persons with severe impairment need help with two or more **ADLs**.

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

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

Figure 1

Estimated Distribution of Disability Status in Ohio
Older Population by Age, 2004



(Mehdizadeh, Ciferri, Roman, Wellin, Ritchey, & Kunkel, 2004).

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 Figures 2 and 3. When compared to their counterparts, 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 African Americans has declined over the past decade and is now similar to the rate of **disability** among Whites (Manton & Gu, 2001). Lack of exercise, chronic disease, and mental impairment also increase the likelihood of **disability**.

Figure 2

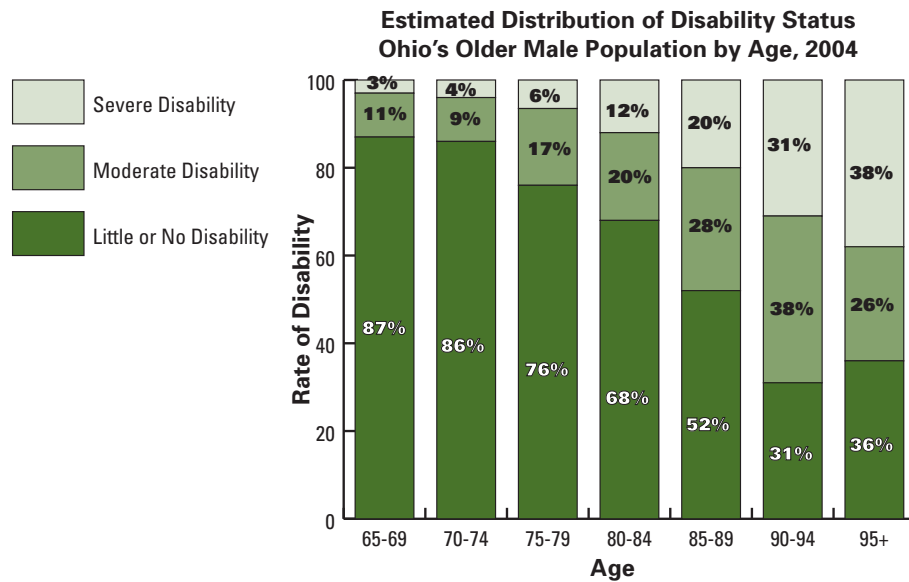
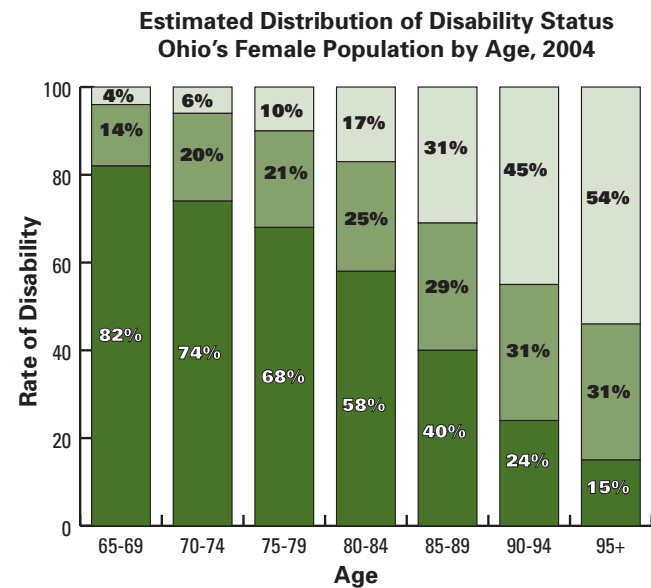


Figure 3



(Mehdzadeh, Ciferri, Roman, Wellin, Ritchey, & Kunkel, 2004)

Across the state, **long-term care** service recipients have varying needs for care. When looked at as a group, **nursing home** residents are more impaired than community-dwelling older people. Figures 4 and 5 show that in 2004, over three-fourths of **nursing home** residents in Ohio had limitations with four or more **ADLs**, compared to around one-quarter of **Medicaid** clients receiving **PASSPORT** services (Mehdizadeh & Applebaum, 2005b). The typical **Medicaid** home care client requires help with an average of **3 ADLs** and **6 IADLs** (Mehdizadeh & Applebaum, 2005b). However, most disabled older adults prefer to remain in the community, and for every severely disabled older person in a **nursing home**, there are two severely disabled older adults living in the community (Mehdizadeh, Kunkel, & Ritchey, 2001).

The typical Ohio resident in **assisted living** is about 83 years old and female (OALA, 2002). Residents typically move to **assisted living** directly from their home. In addition, these **assisted living** residents usually need help with about two **ADLs** such as bathing, dressing, or using the toilet and need or accept help with many **IADLs** (Dollard & Hodlewsky-National Center for **Assisted living**, 2001). Although many **assisted living** residents require help with **ADLs**, 19% need no help with **ADLs** (Dollard & Hodlewsky- National Center for **Assisted living**, 2001).

Percentage of Ohio PASSPORT Clients with ADL Impairments, 2004

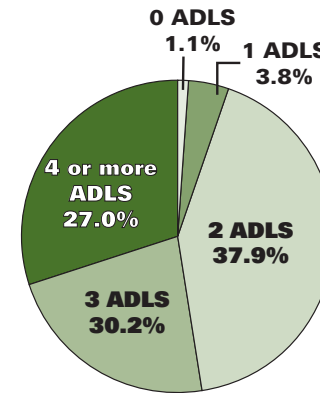


Figure 4

Percentage of Ohio Nursing Home Residents with ADL Impairments, 2004

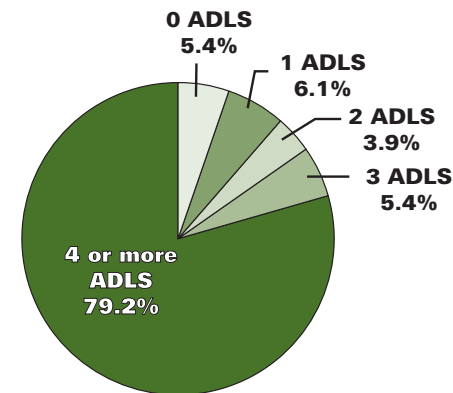


Figure 5

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

(Mehdizadeh & Applebaum, 2005b)

Service Use

Among the nearly 30,000 Ohioans served by the **PASSPORT** program in 2004, the most commonly used services were **personal care, emergency response system, home delivered meals, home medical equipment and supplies, transportation, and homemaker services.** (see Figure 6). Figure 7 reports the percentage of **PASSPORT** dollars spent on each type of service.

Figure 6

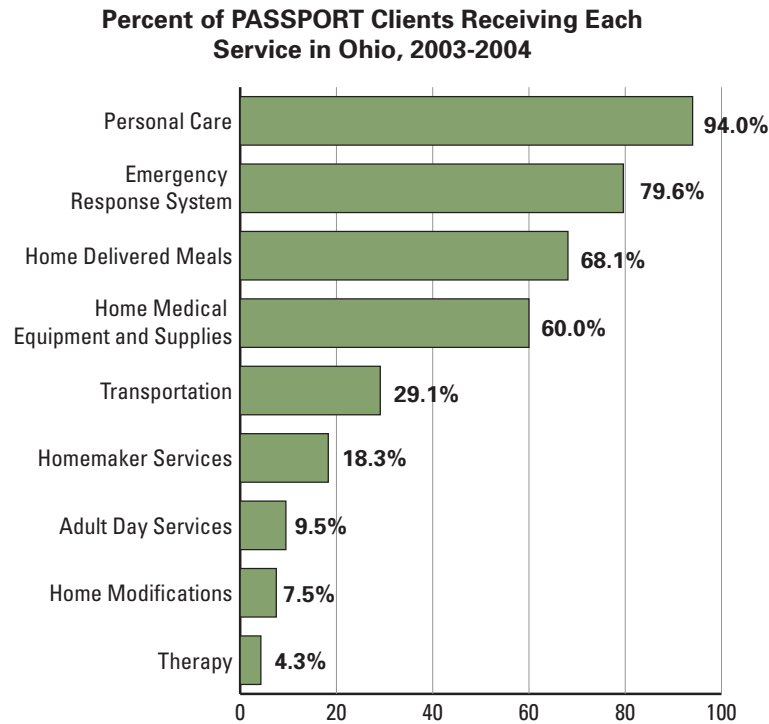
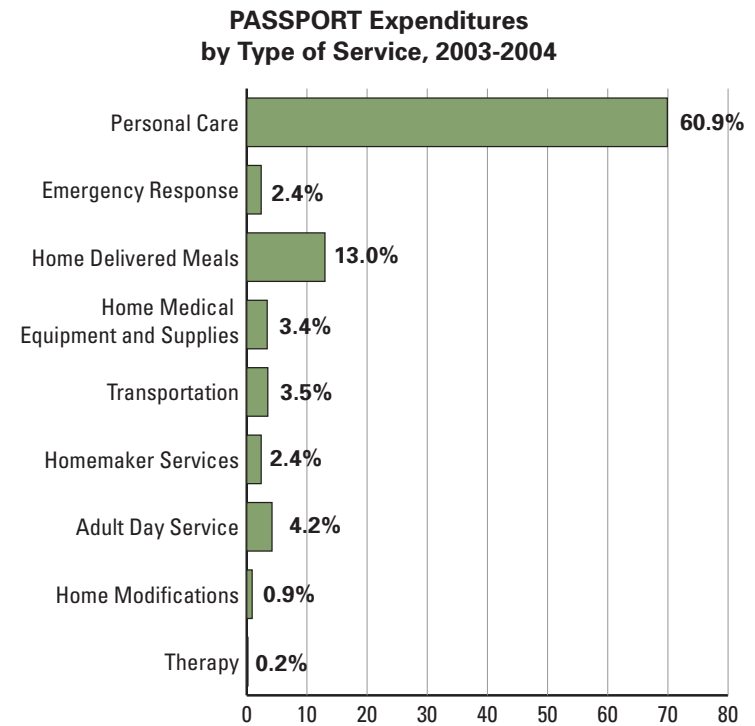


Figure 7



(ODA, 2005)

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

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 1994 to 57% in 2001, the proportion of residents who left within 6 months increased from 59% in 1994 to 68% in 2001, while the proportion who left within 12 months increased from 68% in 1994 to 84% in 2001.



Who Provides Long-Term Care Services?

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

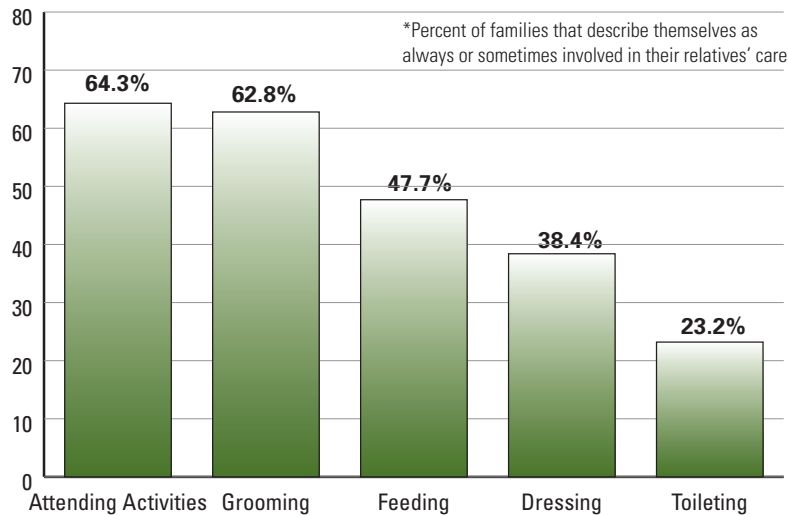
Informal **caregivers** are family members, friends, or neighbors who provide care without receiving pay for these services. These individuals care for community-dwelling older adults and they provide supplemental care to family and friends living in **nursing homes** or **assisted living** facilities. In 2000, Ohio had an estimated 98,000 full-time equivalent unpaid **caregivers** who provided help to the severely disabled population over age 60 residing in the community (calculations are based on Mehdizadeh & Murdoch, 2003). About 80% of care provided to older persons in their homes is provided informally by family and friends.

Informal Caregivers

Many families and friends of **nursing home** residents who responded to the 2002 Ohio **Nursing Home** Family Satisfaction Survey reported remaining very involved in the care of their relatives and friends (see Figure 8). Figure 9 shows that sixty percent of families visit at least several times a week including about one-fifth of families who visit daily (Straker, Ehrichs, Ejaz, & Fox, 2003).

Figure 8

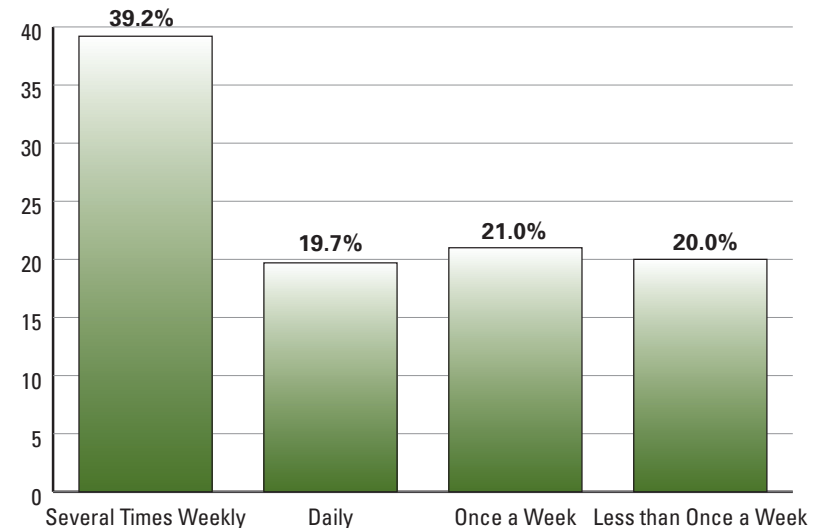
Family Assistance with Nursing Facility Care*, Ohio, 2002



(Straker, Ehrichs, Ejaz, & Fox, 2003)

Figure 9

Visitation Practices by Family of Nursing Home Residents, Ohio 200



Formal Service Providers in the Community

Home & community-based services (HCBS) include:

- Homemaker or chore services
- Home delivered meals & nutrition counseling
- Personal care or home health care
- Transportation
- Home repair
- Escort services
- Emergency response systems
- Social work/counseling
- Durable medical equipment
- Adult day care
- Respite care¹
- Care management

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

Long-term care services are also provided in institutional settings. The two general categories of institutional settings are **residential care facilities (RCFs)** and **nursing homes**. **Residential care facilities**, of which **assisted living** is a subcategory, are most often used by people needing **personal care** services, while **nursing homes** provide care for people with more skilled medical needs. **Adult care homes** are for adults who require less than 24-hour supervision. Adults in these settings receive room and board and other services (such as meals, supervision, and transportation). **Adult care homes** are often in a single family home with 3-16 residents.

There is no single definition of “**assisted living**” because regulations vary from state to state. Ohio law and regulations use the term **residential care facility (RCF)**, rather than **assisted living** (Applebaum & Mehdizadeh, 2001). Currently in Ohio, approximately 540 **RCFs** serve 16,000 to 18,000 individuals. **Assisted living** usually offers individual living units and privacy, community space such as dining and laundry rooms, and a greater emphasis on resident choice and independence. In order to be a certified **Medicaid assisted living** provider, facilities must provide residents with their own units. 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). **RCFs** offer a wide range of services based on resident needs and preferences, but can only provide intermittent skilled nursing care for

Residential care (assisted living) services

- Housekeeping
- Transportation
- Personal care services
- Routine nursing care
- Monitoring of service plans
- Access to specialty care providers
- Behavioral management
- Meals & special diets
- Medication administration

Nursing home services

- Custodial care
- Skilled nursing care
- Routine nursing care
- Physical therapy
- Occupational therapy
- Rehabilitation therapy
- Mental health treatment

¹Not currently covered by PASSPORT

residents for less than 120 days a year.

Ohio has almost 1,000 **nursing homes** containing just over 90,000 beds (Applebaum, Mehdizadeh, & Straker, 2005). The typical **nursing home** in Ohio has between 90 and 100 beds and most are in urban areas. Ohio has a higher ratio of **nursing home** beds to its elderly population than the national average for both people age 65 and older, and 85 and older. In 2003, Ohio **nursing homes** had an average occupancy rate of 84.7%, down from 90.7% in 1993 (see Figure 10). This decrease mirrors the national trend (Applebaum, Mehdizadeh, & Straker, 2005).

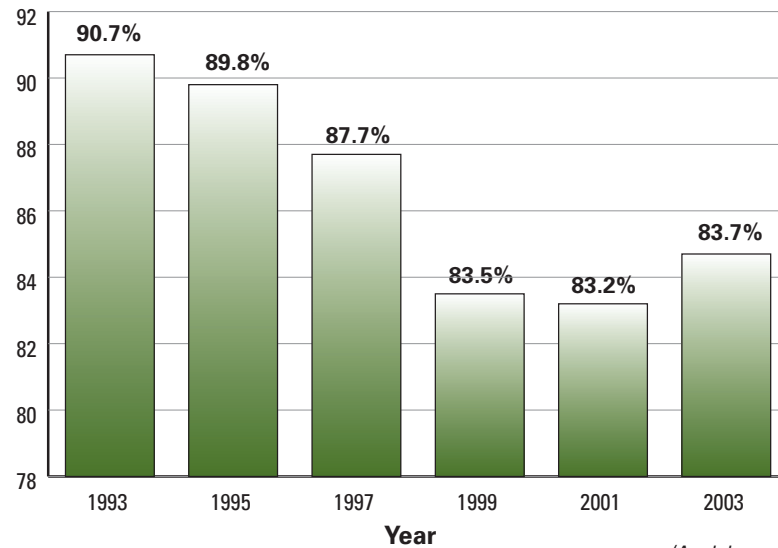
Table 1

Ohio Long-Term Care Facilities - 2005
Nursing homes: 973
Nursing home beds: 90,712
Residential care facilities: 526
Residential care facility beds: 36,894 ¹
Adult care facilities: 670

¹Many of the newly built residential care facilities are part of the assisted living industry and are licensed for dual occupancy, but most units house one person.

Occupancy Rates in Ohio's Nursing Facilities, 1992-2003

Figure 10

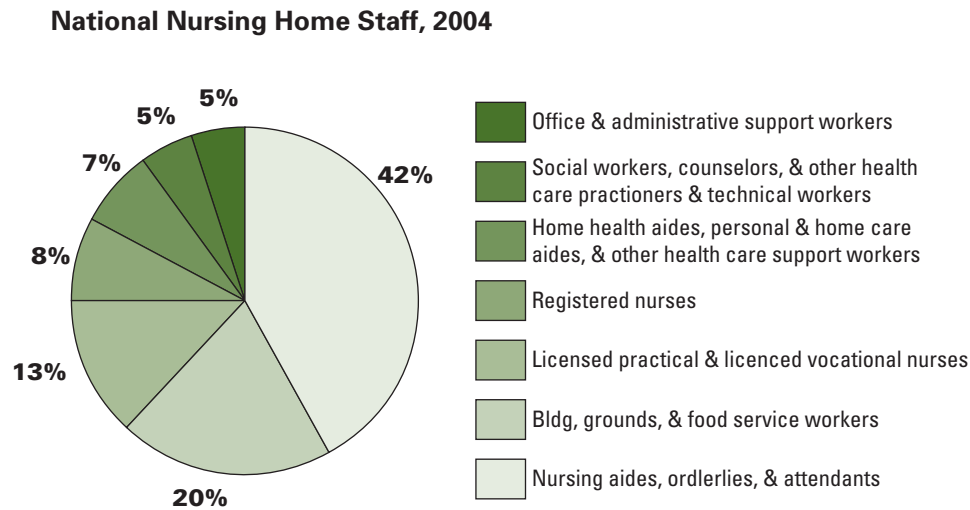


(Applebaum, Mehdizadeh & Straker 2005)

Long-Term Care Staffing

In 2005, there were nearly 160,000 people employed in Ohio **nursing homes** and **residential care facilities** (Ohio Department of Job and Family Services, Bureau of Labor Market Information). Average pay rates for some of these positions can be found in Table 2. The Bureau of Labor Statistics estimates that in 2004, Ohio had 74,510 nurse aides, orderlies, and attendants working in all types of facilities (BLS, 2004). Overall, these are paraprofessional frontline workers who deliver as much as 90% of the care in **nursing homes**. State-tested nurse aides must pass a written examination and skills test after completing 75 hours of training. **Nursing homes** also employ social workers, dieticians, and therapists, as well as housekeeping, clerical, and maintenance staff (see Figure 11). All staff that has contact with residents are subject to a criminal background check.

Figure 11



(Bureau of Labor Statistics, no date)

Table 2

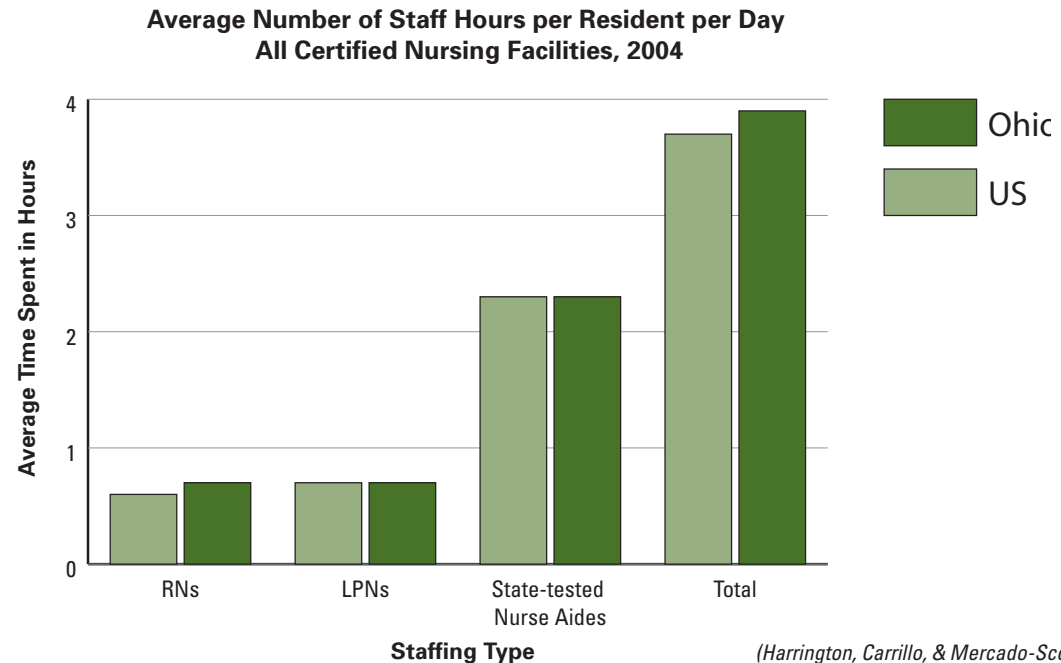
Average Hourly Wages – All Health Care Settings, Ohio, 2004	
Registered nurses	\$24.92
Licensed practical and vocational nurses	\$17.33
Nursing aides, orderlies, and attendants	\$10.55
Home health aides	\$ 9.28
Personal and home care aides	\$ 8.62

(Bureau of Labor Statistics, 2004)

Special care units in **nursing homes** provide additional services in separate wings or areas of their facilities. Some of the services commonly offered include: **hospice**, Alzheimer's care, rehabilitation, head trauma, and respiratory/ ventilator units. In 2004, there were 9,293 beds in **special care units** in Ohio (Harrington, Carrillo, & Mercado-Scott, 2005). The majority (82%) are Alzheimer's beds. These special care units make up a small portion of total beds, but appear to be increasing, especially for beds dedicated to residents with Alzheimer's disease (Harrington et al., 2005). It is important to note that many **nursing homes** without dedicated special care units will admit and care for residents with special needs.

There has been a great deal of interest in maintaining the appropriate ratio of **nursing home** staff to residents. In 2002, a staffing rule went into effect in Ohio that specifies the minimum amount of time that nurse aides and registered nurses should spend with each resident per day (Ohio Administrative Code, 3707-17-08). Staffing data gathered during nursing facility inspections show that Ohio **nursing homes** are staffed at levels very close to the national average (see Figure 12) and, on average, exceed the minimum standards of the staffing rule (Harrington, et al., 2005).

Figure 12





How Is Long-Term Care Paid For?

Long-term care is paid for through many sources including individuals and their families, federal, state, and local dollars, and insurance. The cost for **home care** services varies depending on the **provider** agency and the services received, and also on geographic location. The average hourly rate for a **home health** visit in Ohio is \$20 per hour. Services from **Medicare** certified agencies are slightly more expensive with an hourly average of \$21.15. **Homemaker services** in Ohio are less expensive than **home health**; uncertified **home care** agencies charge an average of \$16.41 per hour with a range from \$12.75 to \$21.50 (Genworth Financial, 2006). The annual average cost of home care in 2005 in Columbus, Ohio was approximately \$27,300 per year and approximately \$22,100 in Cleveland, based on 5 hours per day, 5 days per week (Metlife Mature Market Group, 2005). In 2003, the average daily private pay rate at a **nursing home** in Ohio was \$158, for an average annual private pay cost of \$57,670 (Scripps Gerontology Center, 2003 Annual Survey of Long-Term Care Facilities, 2004).

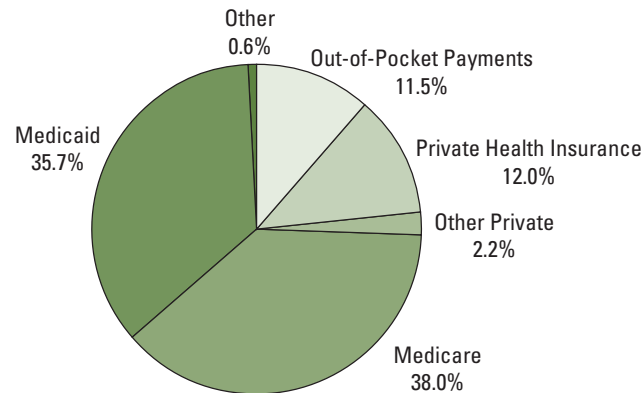
Even for people with **Medicare** or **Medicaid**, not all **long-term care** expenses are covered. Care recipients and their families often pay for services that they need, want, or are not covered by other sources. Some examples are: medications, products that make caregiving easier such as special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

The amount paid by individuals and their families for **long-term care** is staggering. Nearly one-third of all **long-term care** costs in 1998 (for adults of all ages) were paid by private payers (Tilly, Goldenson, & Kasten, 2001). In 2003, nearly one quarter (24%) of Ohio's **nursing home** stays were paid for privately (Ohio Department of Health, Annual Survey of **Long-term care** Facilities, 2000). Figures 13 and 14 show the national breakdown of the various payment sources for both **home health care** and **nursing home** expenditures.

Self Pay

Home Health Care Expenditures by Payment Source, U.S., 2004
Total = \$43.2 million

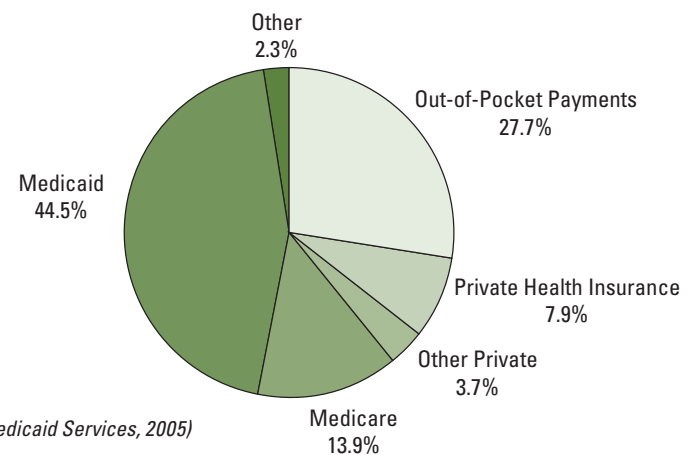
Figure 13



(Centers for Medicare and Medicaid Services, 2005)

Nursing Home Expenditures by Payment Source, U.S., 2004
Total = \$115.2 million

Figure 14



Medicaid and Long-Term Care

Requirements for Medicaid Home-Based Services:

- Age 60 years or older
- Meet Ohio's institutional level of care criteria (i.e., frail enough to require nursing home level of care).
- Able to remain safely at home with consent of physician.
- Have income of less than \$1,737 per month (2005)¹
- Have no more than \$1,500 in assets²

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

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

Medicaid is a joint program funded by both federal and state governments and it provides health benefits for persons with limited income and assets. In 2006, the federal government provided approximately 60% of all **Medicaid** funds for Ohio while the state provided 40% (U.S. Department of Health and Human Services, 2004). The **Medicaid** program pays for both facility-based and **home and community-based services**.

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

In 2004, approximately 30,000 people were enrolled in the **PASSPORT** program (Mehdizadeh & Applebaum, 2005a). Tens of thousands more were screened and assessed for **nursing home** placement as part of the program. In 2004, **personal care** and **home delivered meals** were the most frequently used **PASSPORT** services. **Personal care** accounted for 60.9% of all **PASSPORT** expenditures (Mehdizadeh and Applebaum, 2005a) (see Figure 7, page 12).

In 2003, **Medicaid** provided **nursing home** care for approximately 51,000 older Ohioans (Applebaum, Mehdizadeh, & Straker, 2005) and spent an average of \$57,670 annually for each resident (Scripps Gerontology Center, 2003 Annual Survey of **Long-Term Care** Facilities, 2004).

Medicaid estate recovery is a federally mandated rule that allows for the recovery of the cost of **LTC** services provided by **Medicaid** from the **long-term care** 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). In 2004, almost \$4 million was recovered in Ohio.

Medicare pays for limited **home health care** services when an enrollee requires skilled nursing care at home. To qualify for **Medicare home health care** benefits, a person must be confined to his or her home, need at least one skilled nursing or therapy service, and have a doctor-established plan of care. Skilled services can include IV administration, medication administration, **physical, speech, and occupational therapies**. **Medicare** is primarily an acute care program. In 2005, only 5% of total **Medicare** dollars were paid to skilled nursing facilities and another 4% went toward **home health care** services (Congressional Budget Office, no date).

Medicare will pay for 100% of **home care** expenses that are medically necessary, but will not pay for help with **ADLs** or **IADLs** when those are the only kinds of services a person needs. Approximately 6% of Ohio's **Medicare** beneficiaries received **home health care** in 2002 (Kaiser Family Foundation, statehealthfacts.org, no date [a]). Once required deductibles are met, **Medicare** also pays 80% of the **Medicare**-approved cost of **durable medical equipment**.

Medicare will pay for **nursing home care** only after a hospital stay of 3 or more days. In 2005, after 20 days in a **nursing home**, residents paid a per diem **co-payment** of \$114. After 100 days, the resident is responsible for 100% of the cost.

In 2004, about 70% of Ohioans with **Medicare** coverage also have **Medigap** coverage (Flowers, Gross, Kuo, & Sinclair, 2005). For the most part, **Medigap** policies provide coverage for acute services, although some do pay the required **nursing home** deductible for days 21-100. Policy premiums vary for the array of **Medigap** policies widely available and only some of the benefits of **Medigap** policies are related to **long-term care**. For example, in 2004 premiums for a 65-year-old ranged from \$56 per month for basic supplemental coverage to \$429 a month for comprehensive coverage, depending upon the insurance carrier (OSHIIP, 2004).

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, deductibles, co-payments, and **long-term care** expenses as needed.

Nationally in 2003, 17% of the **Medicare** population and 14% of the **Medicaid** population were **dually eligible** (Kaiser Family Foundation, statehealthfacts.org, no date [b]). In Ohio, 13% of the **Medicare** population and 11% of the **Medicaid** population were dually eligible in 2003 (Kaiser Family Foundation, statehealthfacts.org, no date [b]). Nearly three-quarters (72%) of **dual eligible** spending in Ohio goes to **long-term care**, compared to 66% nationally. The **dual eligible** group accounted for about 46% of **Medicaid** expenditures in Ohio compared to 40% nationally. (Kaiser Family Foundation, statehealthfacts.org, no date [c]).

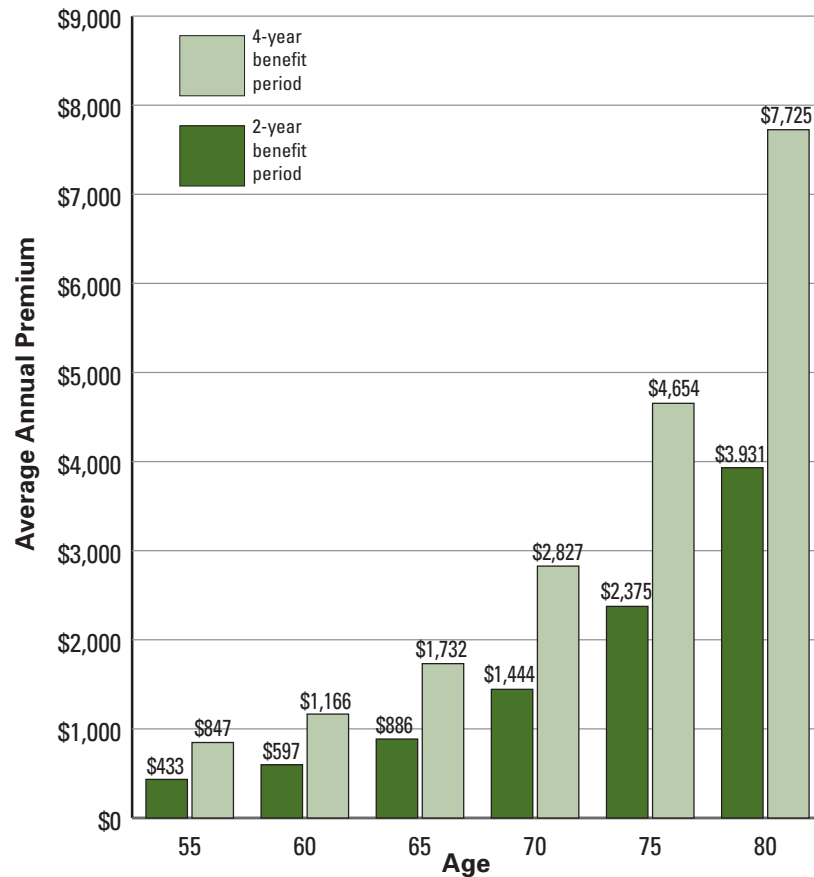
Long-Term Care Insurance

Private **long-term care insurance** covers many **long-term care** services, including both skilled and non-skilled **care**. Nearly all policies now cover both facility and home care (AHIP, 2004). **LTC insurance** is a relatively small part of **long-term care** funding. Nationally, only about 3% of all **nursing home** costs and 8% of home health care costs are paid through private **LTC insurance** (Johnson and Uccello, 2005). Enrollment in **LTC insurance** plans is limited. Only 9% of adults age 55 and older and 7% of near-older adults (those age 55 to 64) had **LTC insurance** in 2002 (Johnson and Uccello, 2005).

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 15 shows that the older a person is when purchasing **LTC insurance**, the higher the yearly premium. According to AHIP (2000) 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 67 years; about two-thirds of **LTC insurance** purchasers have incomes greater than \$35,000. Premium affordability, ability to maintain premium payments, and having health problems are all barriers to obtaining and sustaining **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).

Figure 15

**Average Annual LTC Insurance Premiums
for Women* in Ohio by Age and Type of Policy, 2002**



(ODI, 2003)

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

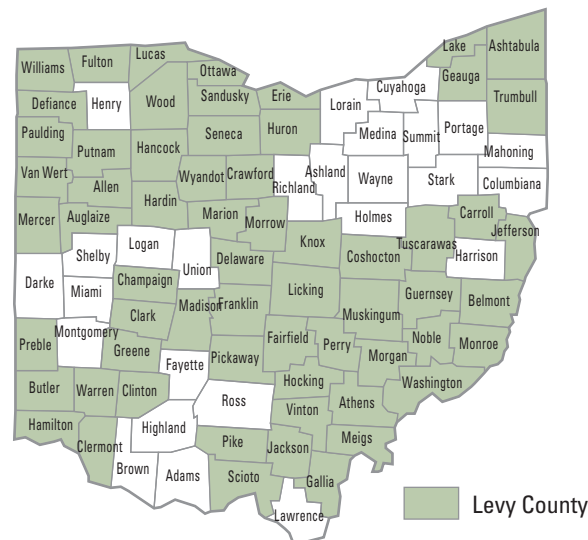
Sales of **LTC insurance** policies have grown in the last decade (AHIP, 2004). From 1987 to 2002, the **LTC insurance** industry experienced an 18% annual growth in policy sales (United States Government Accountability Office, 2006). Just over 9 million **LTC insurance** policies were sold as of the end of 2002, however, only 70% of those policies remain in force (Kassner, 2004). The US GOA (2006) reports that many carriers in recent years have raised premiums, stopped selling **LTC insurance**, or merged with other larger insurance companies, causing a decline in policy sales. These recent changes in the **LTC insurance** industry are in response to: high administrative costs, lower-than-expected lapse rates, low interest rates, and new government controls on telephone direct marketing (US GOA, 2006).

The Long-Term Care Partnership Program combines private **LTC insurance** with public **Medicaid** coverage. Under this program, once a **long-term care** recipient exhausts his or her **LTC insurance** (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 may elect to protect some or all (up to the total amount of benefits paid by the policy) of their assets from **Medicaid spend-down** requirements. Originally started in four states (California, Connecticut, Indiana, and New York) as demonstration projects, other states (including Ohio) have plans to establish such partnership programs. Recent legislation mandates that Ohio establish their qualified state **LTC insurance** partnership program by September 1, 2007 (State of Ohio, 2006).

Local Funding Sources for Long-Term Care

Figure 16

Ohio Counties with a Senior Services Levy 2006



Note: Cuyahoga and Montgomery counties do not have senior services levies, but do have human services levies that benefit older adults.

Many care services are provided through countywide tax **levies**, which are voted on in local elections and must be renewed every 5 years. 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 May 2006, 62 of 88 counties in Ohio have senior citizen **levies** that generate over \$100 million per year (Payne and Applebaum, 2006). Figure 16 shows the counties in Ohio with senior services tax levies.

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

The Residential State Supplement (RSS) program provides elderly, blind, and/or disabled adults who have very low incomes with a cash supplement that helps them to live in a home-like congregate setting such as an **adult care home**. To qualify for **RSS**, a person must be age 18 or older, need help with **personal care** but not require **nursing home care**, have less than \$1,500 in resources, and have a monthly income of \$800 or less (for a **residential care facility** or **group home**), or \$700 or less (for an **adult care home** or **foster home**) (ODA, 2005d). This program served 2,489 Ohioans in 2004 (ODA, 2005f).

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

Facility Costs and Funding

The funding source for **LTC** is often determined by the setting in which services are received. For example, while **Medicaid** will pay for **nursing home** care and for home-based services, it has not paid for **assisted living** in the past. Ohio recently received approval from the **Centers for Medicare and Medicaid Services (CMS)** to begin using **Medicaid** funds to support **assisted living**, and on July 1, 2006 Ohio became the 42nd state to use this funding source.

Table 4 provides information on **long-term care costs** for the **PASSPORT** program, **assisted living**, and **nursing homes**. According to the MetLife Mature Market Group (2005b), the monthly cost in Ohio for a semiprivate room in a **nursing home** is approximately \$5,160, and \$5,697 for a private room. The average monthly cost in Ohio for private **assisted living** was \$3,118 in 2005 (MetLife Mature Market Group, 2005a). **PASSPORT** annual costs per consumer is just over \$12,000 per year. Table 3 illustrates the comparison of annual costs for these three types of **long-term care**.

Nursing homes rely primarily on **Medicaid** as a funding source. **Medicaid** pays for almost two-thirds of all residents (see Figure 17). Just over 20% of **nursing home** stays are paid for out-of-pocket, through insurance, or other sources. Twelve percent of stays are paid for through **Medicare** (Applebaum, Mehdizadeh, & Straker, 2005).

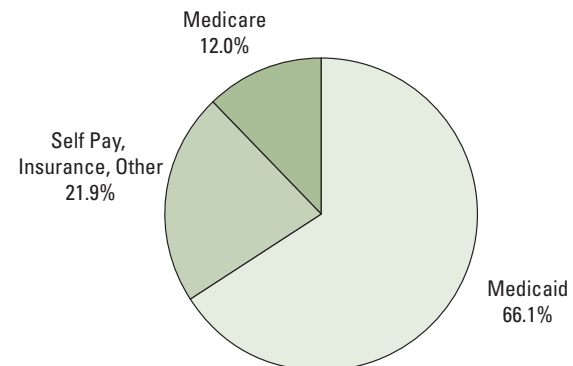
Table 3

Annual Long-Term Care Costs in Ohio – Per Consumer (based on 365 days of service)				
City (2005)	Assisted Living	County (2003)	Nursing Home Care** (semiprivate room)	PASSPORT**
Cincinnati	\$28,548	Hamilton	\$62,050	\$15,470
Cleveland	\$34,980	Cuyahoga	\$59,860	\$15,130
Columbus	\$35,436	Franklin	\$61,885	\$16,716

* Metlife Mature Market Group, 2005a
 ** ODA, 2005

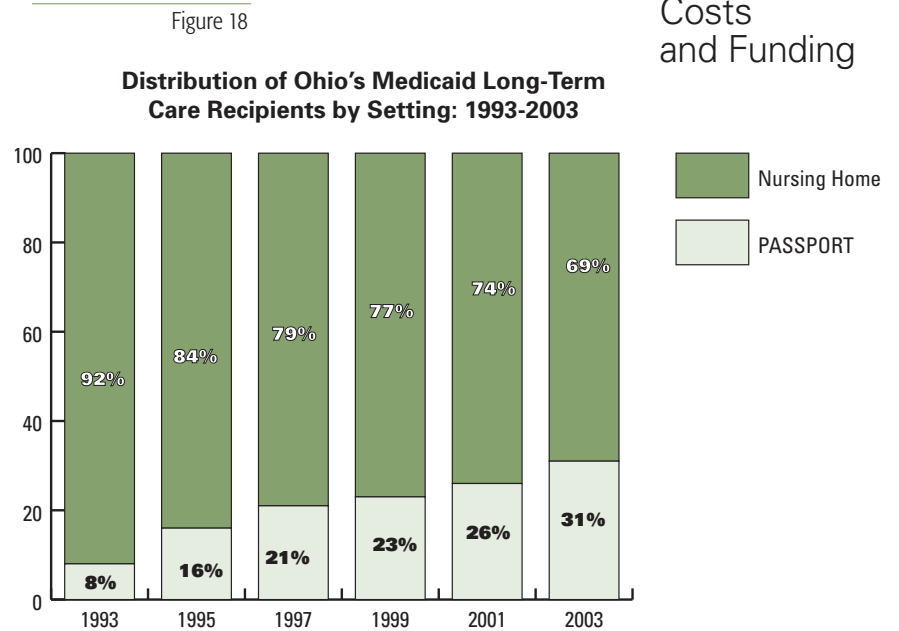
Figure 17

Residents' Payment Source for Nursing Home Stays, 2004
(All Sources)



(Applebaum, Mehdizadeh, & Straker, 2005)

Although the proportion of **Medicaid** funds in Ohio that pay for **home and community-based services** (i.e., **PASSPORT**) has increased over the years, the majority of **Medicaid** funds still go toward **nursing home care**. However, the proportion of Ohio **Medicaid** recipients who receive **long-term care** at home has increased at a faster rate than the expenditures suggest, since it costs less to meet **long-term care** needs in the community versus a **nursing home**. Figure 18 shows that in 1993, only 8% of **Medicaid long-term care** recipients were **PASSPORT** consumers; by 2003 that proportion had risen to 31%.



(Applebaum, Mehdizadeh, & Straker, 2005)

Overall, spending patterns for **LTC** are expected to change. Family resources will pay an increasingly greater proportion of long-term care expenses, as will **Medicaid** (GAO, 2005). Likewise, **Medicare** projects the number of its beneficiaries will double between the years 2000 and 2030 (CMS, 2002b). Between 2000 and 2025, **long-term care** spending for all adults age 65 and over is expected to double, and to quadruple by 2050 (GAO, 2005). By 2011 it is estimated that nationwide out-of-pocket spending on **long-term care** will reach \$51.3 billion, compared to \$36 billion in 2005 (Tritz, 2006, and CMS, 2002a).

How Is Long-Term Care Regulated?

30

Several agencies at both the state and federal level are involved with the regulation and licensing or certification of **long-term care providers**. Licensing includes inspection of a facility or a **LTC** service provider. **Nursing homes** and **home health agencies** that receive funds from **Medicare** and/or **Medicaid** must meet federal standards for staff, physical environment, and the way care is provided. As Ohio implements its new Medicaid Assisted Living Waiver, facilities participating in this program will also have to meet federal and state requirements.

Medicare & Medicaid Certification for Home Health Agencies

Ohio is one of nine states that does not license **home health** or **home care** agencies, but they can be certified for **Medicare** and **Medicaid**. At the state level, the Community Health Care Facilities and Services Board of the **Ohio Department of Health (ODH)** is responsible for assuring that home health agencies are in compliance with **Medicare** certification requirements. In addition to the ODH, there are two organizations that have been authorized by the **Centers for Medicare & Medicaid Services (CMS)** to certify **home health care** agencies: the Community Health Accreditation Program (CHAP) and the **Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**. Because Ohio does not require **home care** agencies to be licensed, accurate reporting of the total number of agencies is difficult. However, there were 569 **Medicare** certified agencies in Ohio in 2005 (www.Medicare.gov, 2005).

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

The **Ohio Department of Aging (ODA)** certifies all **PASSPORT** providers; specifications for each home-delivered service are outlined in Ohio's Administrative Rules. For example, **homemaker service** providers must hire state-tested nurse aides or provide training and testing, demonstrate that they are able to provide services at least 5 days per week, have service back-up plans in case of staff absence, maintain and comply with written policies and procedures, and conduct monitoring visits to consumer's homes at least once every 93 days. Before becoming eligible for **certification**, a provider must have delivered services to at least 2 clients for 90 days or more (Ohio Administrative Code, 173-39-02, & 173-39-03). Most **PASSPORT** providers receive an annual site visit from area agency staff, all are subject to annual audits.

In Ohio, **nursing homes** and **residential care facilities** are licensed by the **ODH**. Additionally, **ODH** has a contract with **CMS** to certify **nursing homes** for the **Medicare** and **Medicaid** programs. In a facility, individual beds can be certified for **Medicare**, **Medicaid**, or both. Facilities that are certified for **Medicaid** and **Medicare** must meet certain requirements in a number of areas (see sidebar). Surveyors inspect facilities to ensure that the regulations and standards are met as specified by the federal government.

Facility Regulation Areas

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

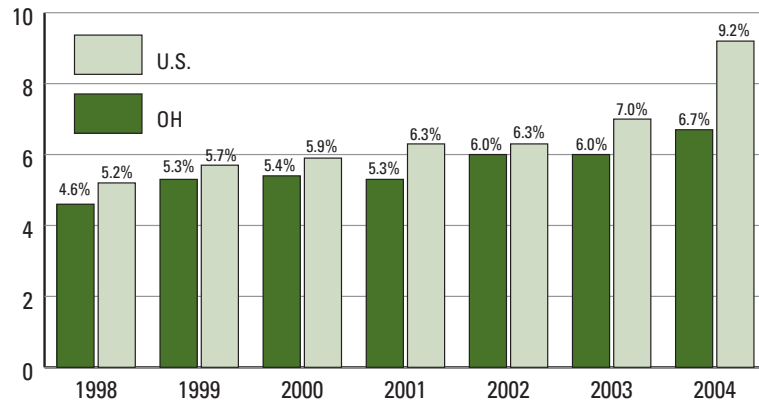
(Code of Federal Regulations, Section 42, Part 483)

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

Facilities that violate state or federal regulations are referred to Ohio's Bureau of Regulatory Compliance for enforcement actions that usually involve the issuing of **deficiencies** and citations, but may also include fines, denial of payment for new **Medicare/Medicaid** admissions, or the revocation of a facility's license when warranted. For the past several years the average number of **deficiencies** in Ohio **nursing homes** has been lower than the national average (see Figure 19). Figure 20 shows a comparison of Ohio to the U.S. for the most often-cited **deficiency** categories.

Regulation Enforcement Procedures

Average Deficiencies per Nursing Facility in Ohio & U.S., 1998-2004

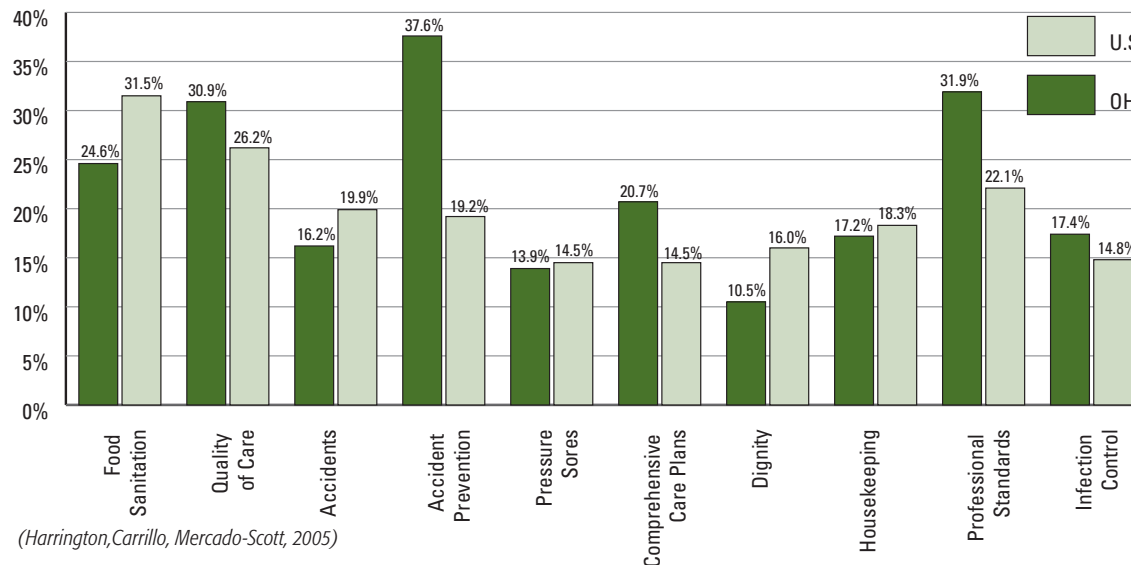


(Harrington, Carrillo, Mercado-Scott, 2005)

Figure 19

A plan of correction for the violation(s) must be submitted and approved. If the plan is approved, penalties may be removed (ODH, 2002). **Deficiency** and plan of correction information for Ohio **nursing homes** is available to the general public on the Ohio Long-Term Care Consumer Guide website (www.LTCohio.org). In addition, the **ODH** compiles a list of licensed and certified **nursing homes, residential care facilities** and other care providers such as hospitals, **hospice, adult care facilities,** and MR/DD facilities. The database can be searched by going to <http://pubapps.odh.ohio.gov/EID/Default.aspx>.

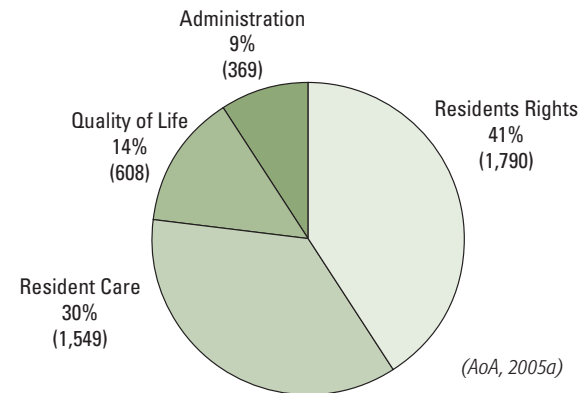
Proportion of Facilities Cited for the Most Prevalent Deficiencies Ohio & U.S., 2004



(Harrington, Carrillo, Mercado-Scott, 2005)

Figure 20

Figure 21

Complaints Against Ohio Nursing Facilities
by Category, 2004

Long-term care ombudsmen serve as advocates for consumers of **long-term care** services in **nursing homes, county homes, residential care facilities, adult care facilities, adult foster homes**, and in private residences. This includes not only consumers, but their families as well. An **ombudsman's** primary duties are to verify and resolve disputes concerning the quality of life and care in these settings. Ohio has 12 regional **ombudsman** offices with 72 paid **LTC ombudsmen** and approximately 350 volunteer **ombudsmen** (ODA Annual Report, 2004). In 2004, Ohio **ombudsmen** handled 8,921 complaints about **home care, residential care, and nursing home care** (ODA Annual Report, 2004). Information for each **ombudsman's** office can be found by contacting the ODA, or the Area Agency on Aging in each region. In the case of **PASSPORT** providers, the **PASSPORT Administrative Agencies (PAAs)** collect and investigate complaints from **PASSPORT** consumers, usually through their case manager. The PAA is responsible for investigating and substantiating the complaint. Complaints may also be made to **ODH**. They may elect to conduct a survey on the basis of a complaint. Figure 21 shows complaints recorded against Ohio **nursing homes** in 2004. Most complaints focus on concerns about resident rights or resident care. If the complaint is substantiated, a deficiency may be cited and other penalties may be assigned depending on the severity of the **deficiency**.

Long-term care, particularly **nursing home care**, is heavily regulated. Given the increasing frailty of both in-home and institutional residents, it is no surprise that a substantial amount of state and federal resources are allocated to regulatory activities. Despite these efforts, concern about the quality of **long-term care** remains a paramount policy issue. **Nursing homes** have received considerable attention in recent years from both the popular press and professional reviews. A common critique is that although **nursing homes** are heavily regulated, they are not well regulated. Inspection surveys have been inconsistent across and within states. Several initiatives have been launched as a response to this latest round of criticism.

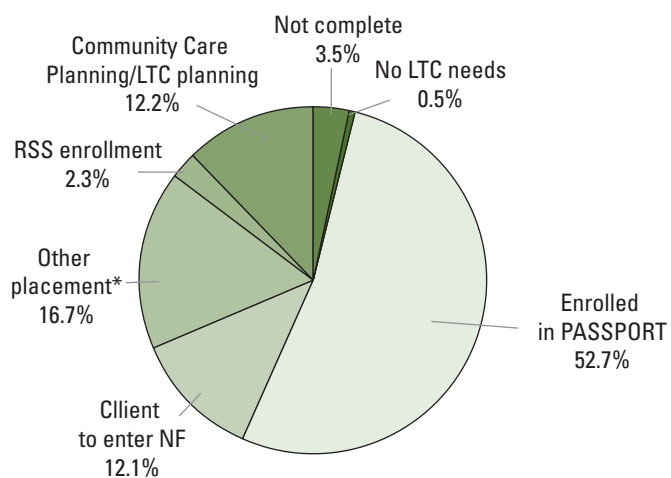
In 2006, the **Centers for Medicare and Medicaid Services (CMS)** launched the Quality Indicator Survey (QIS) Demonstration Project. This revised survey process was designed to achieve greater consistency and accuracy using a more structured process. It provides a comprehensive review of all survey areas,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

Quality initiatives are discussed in the section titled "**Long-Term Care Quality**" (page 35).

Locating Long-Term Care Services

Figure 22

Outcomes of Comprehensive Assessments, FY 2003-2004



(ODA, 2005)

*Other placement includes ODA home care, caregiver support, hospice, community provider, and ICF MR-DD, or psychiatric hospital.

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

Area Agencies on Aging administer the **Care Choice Ohio** program, which helps older Ohioans plan a **long-term care** program to meet their individual needs. **Care Choice** consultants help older people and their families make wise decisions by evaluating their needs against available services, discussing service eligibility requirements, determining the adequacy of their financial resources, and creating an individual plan of care. Because **Area Agencies on Aging** also conduct **pre-admission reviews** for **Medicaid nursing home** placement and administer **PASSPORT**, they are a good first step in locating services. 27,816 assessments were conducted around the state in fiscal year 2003-2004 (ODA, 2005c). The outcomes of these assessments are shown in Figure 22.

The Ohio Long-Term Care Consumer Guide website was developed by **ODA** under legislative mandate to provide consumers with information about **LTC** services (see <http://www.LTCohio.org>). The website includes comprehensive information about **nursing homes**, including results of resident and family satisfaction surveys, state-collected data on **deficiencies** and complaints, contact information, and **nursing home**-submitted descriptions of each facility. Consumers can search for facilities by location, religious or other affiliation, or for 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 **nursing home, home health agency,** and hospital information. Their site, www.Medicare.gov, provides similar but less comprehensive information to that found about **nursing homes** on Ohio's website.

Although issues of quality and regulation have received considerable attention in **long-term care**, quality concerns remain. Health and **long-term care** 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, 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 **long-term care** consumer.

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. 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 improvement 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 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 care** in institutional and community settings. It was expanded to include **nursing homes** in 2002.

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 a 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 will incorporate nine measures of quality in the **nursing home** reimbursement formula beginning in 2007. These measures include resident and family satisfaction, nursing hours, employee retention rates, existence of health **deficiencies**, occupancy rates, **Medicaid** utilization rates, and resident acuity. For each quality measure they meet **nursing homes** will receive one point. Except for the two deficiency categories (where zero **deficiencies** are the requirement) all other categories must score above either the statewide average or above facilities in their geographic care peer group. **Nursing homes** in the top quartile of their peer groups will receive the highest bonus payment, **nursing homes** in the next two quartiles will receive the second and third highest bonuses, while **nursing homes** in the lowest quartile will receive no bonus payment (Ohio Legislative Services Commission, Synopsis of Ohio 2006-07 Budget Bill, H.B. 66, 2006).



Alternative Approaches to Delivery of Long-Term Care Services

In traditional **Medicaid home & community-based services programs**, care recipients receive services from a formal care provider arranged for them by a case manager. In a **consumer directed** program, the consumer is the **employer-of-record**; he or she (or his/her authorized representative) has the responsibility of hiring, training, supervising, and, if necessary, terminating the **home care** worker. The consumer often hires family members, neighbors, or friends to provide for their care. Most programs require a **fiscal intermediary** to handle the financial responsibilities, including payroll.

As interest in **consumer direction** has grown in the United States, a number of demonstration projects have been conducted. The Arkansas Cash and Counseling Demonstration evaluated the experiences of almost 1,800 elderly and non-elderly adults who were randomly assigned after a baseline assessment, to receive either the traditional agency-directed or **consumer-directed** approach to **personal care** services. Researchers followed-up with consumers from both groups nine months after baseline. When compared to consumers receiving agency-directed care, consumers receiving **consumer-directed** care reported quite favorable results (Foster, Brown, Phillips, Schore, & Carlson, 2003). **Consumer-directed** care receivers:

- were more satisfied with their care. In particular, they were more satisfied with the timing of their care. Their paid care providers were also more likely to work all their scheduled hours, complete all their tasks, and perform tasks satisfactorily.
- reported being more satisfied with the relationships they had with their paid care providers. They were less likely to report feeling neglected or rudely treated by them.
- reported fewer unmet needs and greatly enhanced quality of life.
- did not report an increase in health problems or adverse events.

An evaluation of California's In-Home Supportive Services (IHSS) program revealed similar findings. This state program has both a Consumer-Directed Model (CDM) and a traditional Professional Agency Model (PAM). California's CDM program is the largest **consumer-directed** program in the nation. Evaluation efforts have compared the consumers in the CDM program to consumers in the PAM program. Researchers have looked at issues of empowerment, unmet needs, service satisfaction, and quality of life. According to Doty, Benjamin, Matthias, & Franke (1999), from a random sample of 1,095 receiving services either from the CDM or PAM program, CDM consumers reported:

- higher satisfaction than PAM consumers with their paid care provider. This included higher ratings on technical quality of care and service impact.
- having more choice than PAM consumers in choosing a care provider, assigning tasks, directing how the tasks are performed, and scheduling the needed services.
- higher quality of life (i.e. emotional, social, and physical well-being) than PAM consumers. On the dimension of physical well-being, CDM consumers who hired family members as providers reported higher scores on quality of life than those consumers who hired non-family members.

Consumer Direction

In Ohio, the “Independent Choices” initiative evaluated the cost, quality, and effectiveness of **consumer-directed** options within the **PASSPORT** program in Columbus, Ohio (Kunkel & Nelson, 2005). The “Independent Choices” evaluation revealed that the majority of consumers hire family members. **Choices** consumers also experience higher levels of satisfaction with services and the amount of control they have over worker schedules than those in the traditional **PASSPORT** program. In addition, **Choices** consumers receive significantly more hours of care than traditional **PASSPORT** program participants. Currently, **Choices** is available to **PASSPORT** consumers in Central and Southern Ohio, with plans to gradually expand to other parts of the state.

A similar model in southwestern Ohio was tested within the **levy**-supported Elderly Services Program in Hamilton and Butler counties (Kunkel & Nelson, 2004). The results from the pilot program in the Cincinnati area were similar to those from other demonstrations. Most consumers hired family members. In addition, they had higher levels of satisfaction with the ability to hire own workers, receive services when they wanted them, and choose the number of hours needed than when they initially entered the program. Even though the relationship between consumers and case managers in **consumer direction** is different, consumers were just as satisfied with their case managers as those receiving traditional services. Finally, **caregivers** of the consumers were very satisfied with the program, with the majority stating that the services provided were “good to excellent”. Furthermore, *every caregiver* responding said that they would recommend the program to others.

Integration of Acute Care and Long-Term Care Services

The **Program of All-inclusive Care for the Elderly (PACE)**, delivers medical, social, and **long-term care** services to frail older adults. It uses a **managed care** model and a combined **Medicare** and **Medicaid** capitation payment system. **PACE** provides, or funds a range of **long-term care** and acute services including personal care, social services, specific therapies, health care, **nursing home** care, hospital care, **adult day service** care, nutrition counseling, meals, and transportation. Many of these services are provided at a **PACE** center and/or in personal residences. **PACE** helps people, who would otherwise need to live in a facility, to remain in their homes while receiving high-quality services. Ohio is one of 18 states with **PACE** demonstration projects (CMS, 2005b). The current demonstration sites in Ohio are Concordia Care serving Cuyahoga county, and TriHealth SeniorLink serving Hamilton county and areas of Warren, Butler, and Clermont counties (ODJFS, 2002a).

Evercare offers **managed care** coverage to **Medicare** beneficiaries under the **Medicare+Choice** option and uses an **HMO** model (CMS, 2001). The goal of this type of program is to reduce hospital admissions among **Medicare nursing home** residents. Evercare serves over 65,000 older adults in 17 states, with three sites in Ohio: West Chester (Cincinnati area), Cleveland, and Westerville (Columbus area) (Evercareonline, 2005).

Pioneer Network

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 setting into “homes” for elders. Active culture change coalitions have been established in the following nine states: Colorado, Florida, Illinois, Michigan, New Jersey, North Carolina, Pennsylvania, South Carolina, and Washington.

As an organization, the Nursing Home Pioneer Network strives to promote the following values to accomplish cultural change:

- Know each person.
- Each person can and does make a difference.
- Relationship is the fundamental building block of a transformed culture.
- Respond to spirit, as well as mind and body.
- Risk taking is a normal part of life.
- Put person before task.
- All elders are entitled to self-determination wherever they live.
- Community is the antidote to institutionalization.
- Do unto others as you would have them do unto you.
- Promote the growth and development of all.
- Shape and use the potential of the environment in all its aspects: physical, organizational, and psycho-social/spiritual.
- Practice self-examination, searching for new creativity and opportunities for doing better.
- Recognize that culture change and transformation are not destinations but a journey, always a work in progress.

Eden Alternative

The Eden Alternative is a philosophical approach to **long-term care** that has been incorporated in whole or in part by many **nursing homes** and other institutions. The philosophy is centered in the belief that older adults should be treated with dignity and respect, that the choices of older adults matter, and that the environment of **LTC** facilities should be as home and community-like as possible. This philosophy has implications for the design and management of **nursing homes**. Edenized environments include children, plants, and animals. There are currently 16 Eden-registered homes in Ohio. For a list of these facilities, go to <http://www.edenalt.com/region4/region4c.htm>. Ten principles guide the Eden Alternative:

1. The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders.
2. An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.
3. Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
4. An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.
5. An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.
6. Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
7. Medical treatment should be the servant of genuine human caring, never its master.
8. An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.
9. Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.
10. Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.

Wellspring

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).

Green House

Another innovation being explored in **long-term care** is the Green House Project. Designed as an alternative to the traditional **nursing homes** by Dr. William Thomas the developer of the Eden Alternative, the Green House model uses a very different design while meeting all of the state and federal regulations for **nursing homes**. The model is designed to serve as a home-like alternative to the typical **nursing home**. Green Houses are organized into pods and no home includes more than 10 residents. Pods typically include five houses located in geographic proximity to one another. Residents have a private room and bath and all meals are served family style in the house dining room. The model is now being evaluated for both quality of care and cost-effectiveness outcomes, but results have not yet been released. More information can be found on the project web-site (www.thegreenhouseproject.com).



The Future of Long-Term Care

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

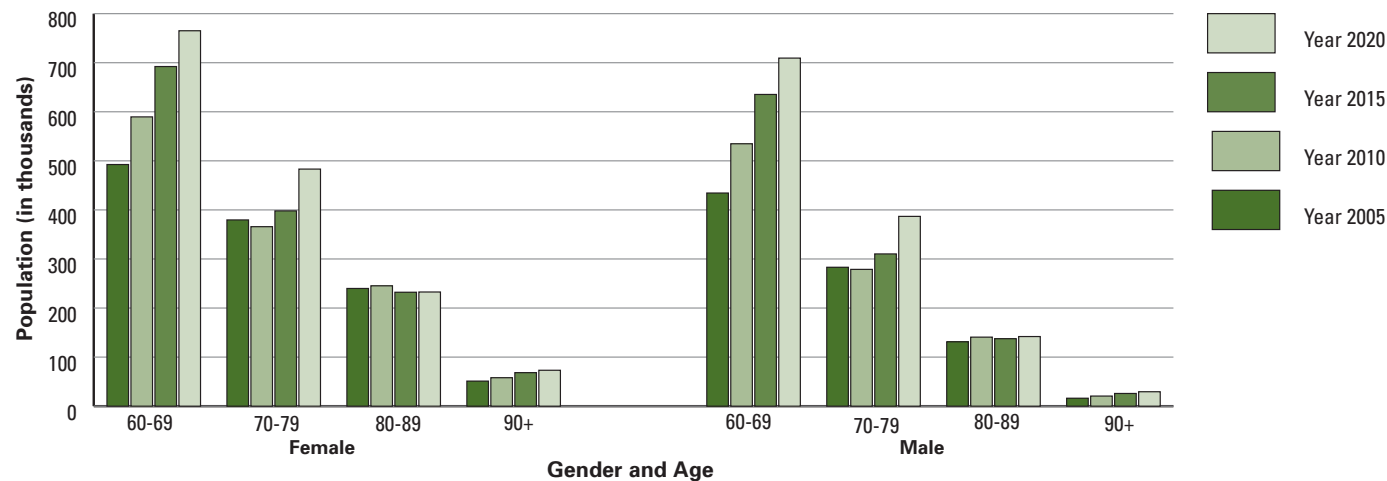
In 2005, Ohio's population consisted of just over 2 million adults age 60 years and older (Mehdizadeh, Roman, Wellin, Ritchey, Ciferri, and Kunkel, 2004). Ohio has one of the largest populations of older adults, just behind California, Florida, New York, Texas, and Pennsylvania. From 2005 to 2010, this older population is projected to increase 10%, but 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 23 shows the growth of Ohio's older population by gender and age group.

Projections of Ohio's Older and Disabled Population

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 **disability** from the years 2005 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 24 shows the growth in **disability** from 2005 to 2020 by type of **disability** and age group.

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

Figure 23



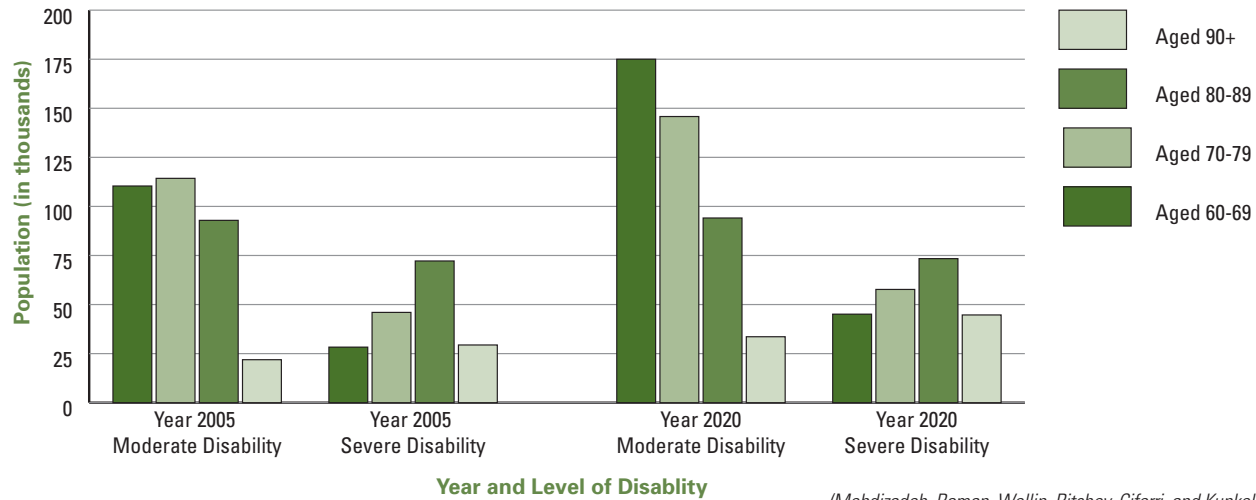
(Mehdizadeh, Roman, Wellin, Ritchey, Ciferri, and Kunkel, 2004)

Projections of Ohio's Older and Disabled Population

Cognitive decline is another source of **disability**. Alzheimer's disease is one of the major causes of **dementia**, and 4.5 million Americans are believed to have the disease (Herbert, Scherr, Bienias, Bennett, & Evans, 2003). It is estimated that at least 11.3 to 16 million people in the United States will have the disease by 2050 unless a cure is found.

Figure 24

Projections of Ohio's Older Population by Level of Disability and Age, 2005 & 2020



(Mehdizadeh, Roman, Wellin, Ritchey, Ciferri, and Kunkel, 2004)

A gubernatorial executive order in June 2000 created a task force known as Ohio Access to undertake a comprehensive review of Ohio's systems of care for people with disabilities, and to make recommendations for improvements by 2006 (Fox-Grage, Folkemer, Straw, & Hansen, 2002). The taskforce (comprised of representatives from a number of state departments, consumers, and consumer representatives) focuses on people with physical and developmental disabilities, with the priority recommendation ensuring that people live with dignity in the setting they prefer. While the original report focused on fiscal and policy issues in the health care arena, Ohio Access' most recent report updates and expands its strategic framework to include the services that are critical for an individual to live with dignity in home and community settings.

Overview of the Ohio Access Strategic Plan	
Vision	<ul style="list-style-type: none"> • Ohio's seniors and people with disabilities live with dignity in settings they prefer. • They are able to maximize their employment, self-care, interpersonal relationships, and community participation. • Government programs honor and support the role of families and friends who provide care.
Goals	<ul style="list-style-type: none"> • Offering individuals meaningful choices. • Aligning systems to improve quality and provide better outcomes for individuals. • Getting the best possible value from taxpayer investments.
Performance Measures	<ul style="list-style-type: none"> • Ratio of people receiving Medicaid home and community-based waiver services to people residing in Medicaid-reimbursed nursing facilities and ICFs/MR. • Ratio of total public expenditures for community-based long-term services and supports to total public expenditures for institutional services. • Per member per month (PMPM) rate of growth of total public expenditures for long-term services and supports. • Ohio's ranking on various measures reported by other organizations, like the American Association for Retired Persons (AARP).
Recommendations	<ul style="list-style-type: none"> • Give consumers meaningful choices. • Focus on behavioral health. • Improve quality and outcomes for individuals. • Get the best possible value from taxpayer investments. • Prevent the causes of disability. • Support employment of people with disabilities.

Staffing Issues Faced by Long-Term Care Providers

Because the level of **disability** will increase among both **home care** clients and **nursing home** residents, and because the absolute numbers of persons needing care will continue to rise, the number of staff needed to care for them is expected to increase. According to the Bureau of Labor Statistics (2005a), home health aides and personal and **home care** aides are expected to be two of the top ten fastest growing occupations from 2004-2014. In fact, the occupation of home health aide is expected to be the number one fastest growing occupation in this ten-year period. Furthermore, the Bureau of Labor Statistics (2005b) has predicted the 10 occupations with the largest job growth from 2004-2014. Registered nurses, home health aides, nursing aides, orderlies, and attendants all appear in this top 10 list. Despite the growth in these occupations, supply may not keep up with demand. For example, the demand for full-time equivalent registered nurses in Ohio is supposed to exceed supply by almost 30% by 2020 (U.S. Department of Health and Human Services, no date).

To address the current and pending workforce shortage in health and **long-term care**, the **Ohio Department of Health** and other agencies convened the Ohio Health Care Workforce Shortage Task Force in 2002. This task force submitted fifteen recommendations to Ohio legislators aimed at addressing the health care workforce shortage. The Ohio Health Care Workforce Advisory Council continued the Task Force's work and submitted its own recommendations to the Governor's Workforce Policy Board (see box) on ways to alleviate the workforce shortage and strengthen workforce policy and planning (Ohio Health Care Workforce Advisory Council, 2004).

Ohio Health Care Workforce Advisory Council Recommendations

Establish and Support a Health Care Workforce Center

1. Establish a health care workforce center to ensure ongoing state leadership and facilitate public-private initiatives to alleviate health care workforce shortages and prevent future crises.
2. Establish and maintain a health care workforce data collection and analysis system.
3. Recruit and prepare diverse populations for health care occupations.
4. Sustain statewide efforts to recruit new workers in health care professions.
5. Retain current health care workers.
6. Fund pilot demonstration projects to promote the infusion of creativity and new technology into health care workforce initiatives.
7. Support local and regional efforts.

Establish Career Paths and Articulation Agreements

8. Implement the Ohio Nursing Articulation Model at all Ohio nursing schools.
9. Develop a statewide credentialing process for direct care workers across work environments and service recipient populations as a foundation on which to build career pathways.
10. Establish and implement statewide articulation agreements for health care occupations to provide accessible career and educational pathways.
11. Increase educational capacity in nursing schools.

Implement System Reforms

12. Advocate for improved wages, benefits, and job quality for direct care workers at state and national levels.
13. Review Medicaid reimbursement rates to ensure appropriateness and consistency.

In addition to the state's efforts to address workforce issues, local initiatives are underway in Northeast Ohio. Researchers at the Margaret Blenkner Research Institute at Benjamin Rose are studying the perceptions of direct care workers and supervisors on the adequacy of the training they receive. The research findings from "Better Jobs Better Care" will help to shape local and state initiatives to improve training and education for direct **long-term care** workers and supervisors. "The Greater Cleveland Long-Term Care Workforce Initiative" is a project of the Center for Applied Gerontology at Cuyahoga Community College. This initiative is designed to ensure that a properly trained, motivated, and adequately compensated workforce is available to meet the **long-term care** labor needs in Northeast Ohio.

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

Efforts to better support **caregivers** are now underway. Both state and federal programs designed to provide a range of services to **caregivers** have been enacted. 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 recent 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** consumers have at least one active **caregiver**.
- By sustaining **caregiver** activities and keeping care at home, the cost difference between keeping the **PASSPORT** consumer enrolled in **PASSPORT**, compared to the average cost of **nursing home** care is significant.
- Any additional investment in Ohio's **respite** strategy will save the state money in the future.

Programs that allow payment to be given directly to **caregivers** are also being tested 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. Although these programs are still under study, preliminary concerns about quality or fraud have not been substantiated. Some states are also exploring tax credits or other tax system incentives to assist with the caregiving role. Although the optimum strategies have yet to be designed, the need for a strong caregiving support system 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 care** 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 allowing a larger proportion of the disabled population to be served. State efforts to encourage personal responsibility, through **long-term care insurance** options, could assist in lowering the number of Ohioans that eventually rely on **Medicaid** support. Finally, changes in federal policy which recognize **long-term care** as a national responsibility, rather than a state and individual one, could drastically change the state's role in **long-term care**. However, given the federal track record in this arena, it seems prudent for the state to develop policy based on limited federal involvement.





Additional Internet Resources

51

Web Sites

American Bar Association (ABA) Commission on Law and Aging is a multidisciplinary group dedicated to examining the law-related concerns of older persons. 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/>

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>

Aging in Ohio at The Ohio State University Extension Office provides resources for seniors and their families, programming information for professionals working with seniors and information about aging education events being offered in Ohio. <http://www.hec.ohio-state.edu/famlife/aging>

Alzheimer's Association, a national network of chapters, is the largest national voluntary health organization dedicated to advancing Alzheimer's research and helping those affected by the disease. <http://www.alz.org/>

Alzheimer's Disease Education & Referral Center provides information about Alzheimer's disease and related disorders. The ADEAR Center is a service of the National Institute on Aging. <http://www.alzheimers.org/>

American Association of Homes & Services for the Aging (AAHSA) is a membership organization of mission-driven, not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. <http://www.aahsa.org/>

American Association of Retired Persons (AARP) is a nonprofit membership organization dedicated to addressing the needs and interests of persons 50 and older. <http://www.aarp.org/>

American Society on Aging (ASA) has many electronic and print resources on long-term care. 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/>

Association of Ohio Philanthropic Homes, Housing, & Services for the Aging (AOPHA) advocates for the quality of life for all Ohioans, represents to the public the interests of its diverse not-for-profit membership, and provides specialized services to enable members to accomplish their individual missions. <http://www.aopha.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 seniors 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.cashandcounseling.org>

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>

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/>

Web Sites

Eden Alternative creates habitats for people who live and work in long-term care facilities. This organization is also responsible for the “Green House” movement in long-term care.
<http://www.edenalt.com/>

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

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/>*

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>*

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 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 Center on Women and Aging focuses national attention on the special concerns of women as they age, develops solutions and strategies for dealing with these concerns, and reaches out to women and organizations across the country. Current center activities include research on income security, health, and caregiving. *<http://www.heller.brandeis.edu/national/>*

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>

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

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

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

Ohio Council for Homecare 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.ohioinsurance.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 information and education resource to Ohio's long-term care providers for the ICF/MR population, their suppliers, consultants and to the public at large. *<http://www.ohca.org/>*

Ohio Long-Term Care Consumer Guide provides information to assist consumers and professionals in identifying long-term care services to meet individual needs. *<http://www.LTCohio.org>*

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

Scripps Gerontology Center at Miami University, Oxford, Ohio has publications addressing many long-term care 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/>

Veterans Affairs website provides information for U.S. veterans and their families on a wide variety of benefits and services, including health benefits. *<http://www.va.gov/>*

Glossary*

**This glossary is an extensively revised version of the previously published "From ADL to V.A.: A Glossary of LTC Terms" by M. Scala (1999) Scripps Gerontology Center, Miami University, Oxford, Ohio.*

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

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 care 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 certain types of 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, visiting nurses or home health aides, adult day care, and homemaker services.

Congregate housing – Individual apartments

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

Conservatorship – A legal arrangement granted by the court in which a person chooses an individual to make personal decisions on his/her behalf. The person 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 care** 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. Provides 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 care expense that consumers must pay before their insurance or the program will cover further expenses.

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 works. **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 – Person/ 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, dietitians, physical and occupational therapists, and others to conduct comprehensive assessments and to develop recommendations for care. Centers usually have a **geriatrician** on staff, and are often affiliated with a hospital or a university medical school. Centers have 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

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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**. **This** 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 care 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 care facility. Includes home health services, volunteer support, grief counseling, and pain management.

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.

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 care (LTC) – 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 care 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**.

Long-term care insurance – Insurance policies which pay for long-term care services (such as nursing home and home care) that **Medicare** and **Medigap** policies do not cover. Policies vary in terms of what they will cover, and premiums vary accordingly. Coverage

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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 **Medicare** 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 care 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.

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 the following

Home-delivered meals (also called **meals-on-wheels**) – hot, nutritious meals delivered to homebound older people on weekdays. Can accommodate special diets.

Congregate meals – hot, nutritious lunches served to older adults in group settings such as churches or synagogues, **senior centers**, schools, etc. Donations are requested, although not required. Subsidized with funds from the **Older Americans Act**.

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**) in 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 care facilities and other types of medical providers in 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 care** 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

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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 care 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 hospital. Care settings include: skilled nursing facilities, the home (through home health agencies), long-term care 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 care options are

presented to all older people who are able to take advantage of them.

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

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

Private fee-for-service – 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 frail elderly people 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 care** services (e.g. doctors, hospital, physical therapists, home health aides, and more).

Provider sponsored organization (PSO)

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

Qualified Disabled and Working Individual (QDWI)

– Category of dual eligibility (See Dual eligibles/ eligibility). Such a dual eligible lost **Medicare Part A** benefits because they returned to work, but is 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; includes physical therapy, occupational therapy, and/or **speech therapy**. May be provided at home or in **long-term care** facilities. May be covered in part by **Medicare**.

Residential Care – 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.

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 either in which 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

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days) to allow caregivers of an older or disabled person some time away from their caregiving role.

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 care** 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 care** facilities and hospitals which may include **rehabilitation services**, specialized care for certain conditions (such as stroke and diabetes) and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of 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 – (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 care** benefits (**nursing home** care and home care) benefits to veterans of the United States Armed Forces, and in some cases, their families. Services are provided by V.A. medical centers around the country.

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

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