Ohio State Plan on Aging
FFY 2012 - 2013

Ohio's blueprint for innovation and responsiveness to its ever-changing population

Prepared by the
Ohio Department of Aging

John R. Kasich, Governor **Bonnie Kantor-Burman, Director**

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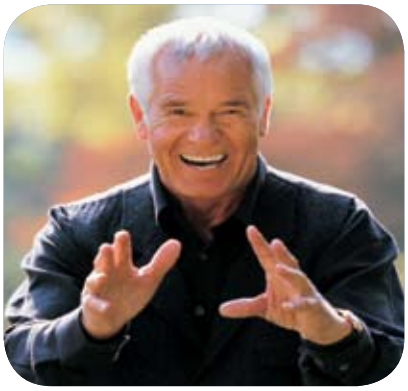






“The Department of Aging’s purpose is to promote choice, independence and quality of life for aging Ohioans wherever they call home**.”** - Executive Summary

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Ohio Department of Aging
Vision

Ohio will be on the leading edge of innovation and responsiveness to Ohio's growing and changing older population.

Goals

- Ohio's elders are respected as vital members of society who continue to grow thrive and contribute;
- Ohio's state agencies and communities integrate aging needs into their plans and services;
- Ohioans maintain quality of life and independence by taking preventive measures to maintaining their health throughout their lifespans;
- Ohio's system of long-term services and supports reflects a balance between home- and community-based and facility-based services;
- Aging Ohioans access a wide array of high quality services and supports that are person-centered in policy and practice and are well-coordinated; and
- Ohioans and their caregivers make informed decisions as they age.

Strategies

- Advocate for the rights and choices of aging Ohioans;
- Promote and provide resources that encourage healthy and engaged aging;
- Prepare and build a responsive statewide infrastructure for Ohio's rapidly growing aging population; and
- Ensure that Ohioans needing long-term services and supports receive well-coordinated, person-centered care.

Executive Summary

The Ohio Department of Aging's 2012-2013 State Plan supports Governor John R. Kasich's vision to position Ohio for economic growth while protecting our most vulnerable citizens. On June 30, 2011, Governor Kasich signed Am. Sub. HB153 which closed the nearly $8 billion budget deficit he inherited upon taking office and enacted sweeping policy changes toward delivering health care and senior services in a person-directed manner.

As the federally designated state unit on aging, the Department of Aging's purpose is to promote choice, independence and quality of life for aging Ohioans wherever they call home. Giving elders a say in how they choose to stay healthy and independent for as long as possible is good not only for families, but also for taxpayers - a win-win-win situation for all involved. The demand for publicly funded services will continue to grow and impact policy decisions well into the future. Between 2007 and 2020, Ohio's total population is projected to increase five percent while the number of Ohioans over age 60 is expected to increase by 34 percent. The 85-plus cohort is projected to increase by 82 percent by 2030.

This plan applies the person-centered principles guiding Ohio's Medicaid transformation to Ohio's Older Americans Act infrastructure, programs and services and outlines the steps to achieve it within the two-year plan period.

During the state plan development process, we identified four strategic issues that we will address in FFY 2012-2013, resulting in greater access to services and more opportunities to stay healthy with proven prevention programs. This also will develop stronger community involvement in providing our elders and their caregivers with greater choice in how their needs are met.

This report also includes the required assurances and information for the State Plan, as well as Ohio's five-year, statewide Aging and Disability Resource Network plan and an executive summary of the scope of Alzheimer's disease in Ohio.

The Department of Aging, working alongside our network partners, is poised to create a new culture of aging in Ohio. This plan provides the map to achieve it.

Verification of Intent

The Ohio State Plan on Aging, 2012-2013, is hereby submitted for the federal fiscal years Oct. 1, 2012 through Sept. 30, 2013. Included are assurances (Appendix A: State Plan Assurances, Required Activities and Information Requirements) and plans to be implemented by the Ohio Department of Aging under provisions of the Older Americans Act of 1965 as amended in 2006. The Ohio Department of Aging has been given authority to develop and administer the plan in accordance with all requirements of the Act, and is primarily responsible for the development of comprehensive and coordinated services for older Ohioans, as well as for serving as their effective and visible advocate.

Assurances have been reviewed and approved by Governor John R. Kasich, constituting authorization to proceed with activities under the plan upon approval by the Assistant Secretary of Aging.

The Ohio State Plan on Aging, 2012–2013, was developed in accordance with all federal statutory and regulatory requirements.

7/26/11
Date

Bonnie Kantor-Burman, Director
Ohio Department of Aging

7/27/11
Date

John R. Kasich, Governor
State of Ohio

Ohio Overview

The ways we provide Ohio's elders with services and programs through our aging network over the next two years will be influenced by economic and policy trends, local service delivery needs, new efficiencies, a unified long-term care system and senior civic engagement.

Economic Conditions

In February 2011, the Governor's Council of Economic Advisors, comprised of leading economists from several Ohio financial industries, forecasted that Ohio will continue modest economic growth and recovery from the recent recession. Ohio's unemployment rate was 8.8 percent in June 2011, down from 10.1 percent in June 2010.

Although the rate of unemployment among older workers is lower than that for their younger counterparts, older persons who do become unemployed spend more time searching for work, according to the U.S. Department of Labor. In February 2010, workers age 55 and older had an average duration of joblessness of 35.5 weeks (not seasonally adjusted), compared with 23.3 weeks for those age 16 to 24 and 30.3 weeks for those age 25 to 54.

Ohio enjoys a diverse occupational base, as manufacturing loosens its grip on the state's economic make-up. The economic well-being of Ohioans can also vary broadly across the state. According to the Ohio Department of Development and the 2005-2009 American Community Survey, the average poverty rate per county in most of Ohio is 13.1 percent while the state's 32-county Appalachian region has an average poverty rate per county of 16 percent. Counties with the highest poverty rates are Adams, Athens, Gallia, Pike and Scioto, ranging from 22.1 to 32.8 percent. Most counties and larger cities in Ohio have seen a significant increase in poverty rates since 1999. Poverty rates also are higher for summary types of areas, such as urban, rural and metropolitan area divisions. Ohio counties with the lowest poverty rates are Delaware, Medina, Putnam, Union and Warren, ranging from 4.5 to 6.9 percent.

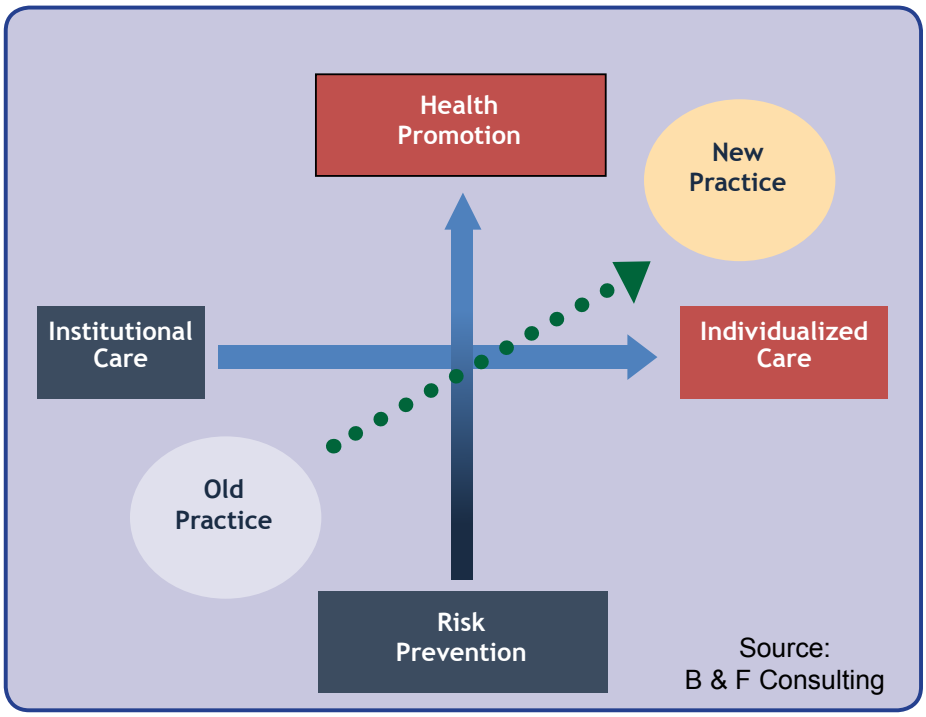
Policy Direction

When John R. Kasich became Governor in January 2011, Ohio faced a $7.7 billion biennium budget deficit that required a creative approach to address. Pledging to produce a balanced budget that protected our most vulnerable citizens, he created the Governor's Office of Health Transformation (OHT) to develop and implement a coordinated plan to improve the financial efficiencies and health outcomes of Ohio's Medicaid program. The strategies place emphasis on person-centered approaches to delivery of services. This approach will carry over to other aging network programs which will further strengthen options that give elders more choices about their care.

Unified Long-term Care System

Ohio is moving toward a health and long-term care system based on primary care and prevention and in which providers will be paid for improving the health of their patients and clients through measurable outcomes. For the past five years, the Ohio Department of Aging (ODA) has worked with other state agencies and stakeholders to create a unified long-term care system. OHT was created in 2011 to modernize Ohio's fragmented health delivery system, improve the quality of health services available to consumers and families, and provide the best value to taxpayers. OHT has improved Ohio's Medicaid system to serve more elders in home- and community-based settings instead of in institutional settings. In this new approach, ODA joins a national movement dedicated to the transformation of services from a clinical-based model to one based on person-centered values and practices. (Fig. 1) ODA will take a lead role in developing a new person-centered, quality oriented reimbursement system for Medicaid-funded nursing home care that will base a significant portion of the reimbursement rate on an individual nursing home's ability to achieve specific measures of quality.

Figure 1



Until the current budget, Ohio budgets traditionally allocated a much larger percentage of the funding for long-term care to nursing homes, compared to other states. Of the total spent for long-term care in the most recent budget biennium, Ohio spent 72 percent on nursing homes, which is the ninth-highest spending on institutional long-term care in the country and well above the national average of 59 percent. The new budget includes long-term care rebalancing reforms that emphasize quality and person-centered care and an increase in the numbers of Ohioans receiving services in home- and community-based settings, while realizing cost savings.

The SFY 2012-2013 biennial budget combines all Medicaid long-term care funds into one line item. The new unified system is budget-neutral. Money follows the needs of the individual and is not tied to the limitations of each system. A new delivery system provides coordination through a single entry point (the “front door”), supports choice and ensures person-centered care through a single state waiver for home- and community-based long-term care programs. In SFY 2013, Ohio’s five Medicaid waivers for those who would otherwise qualify for nursing facility care will be combined into a single, consolidated waiver.

The number of Ohioans age 85 and older is expected to reach 322,497 by 2030, an 82 percent increase from 2000. Left unchanged, this growth would create unsustainable increases in Medicaid long-term care expenditures. For more than five years, ODA has worked with stakeholders, including nursing homes, area agencies on aging, service providers and consumer advocates to create a unified long-term care system. Through OHT, these recommendations have been put into practice by consolidating all funds for long-term care into a single line item to give state officials the flexibility to spend the money where it is needed, according to the needs and desires of consumers. The transformation to a person-centered approach to care will require systemic changes in organizational practices, physical environments and relationships at all levels.

Medicaid-eligible consumers who need long-term care enter Ohio’s long-term system from many different points in the aging, job and family services (i.e., Medicaid) and hospital discharge planning networks. They must choose from as many as five different waiver options and two state Medicaid plan options run by five different agencies. Each option has its own entry point, delivery system and funding. All these factors make the system confusing to consumers, families and providers, and prevent them from accessing the information they need to make informed choices about care. Many Ohioans are admitted to nursing homes in part because they are unaware of or unable to access other, more cost-effective services, such as those provided in their own homes.

Another focus of the department has been on transitioning current nursing home residents to community settings and diverting those at high risk for nursing home placement from having to enter a nursing home. This effort, mandated by the General Assembly in the last biennium, has been successful. Between March 1, 2010 and May 1, 2011, the department transitioned or diverted more than 3,600 individuals. If Ohio continues these aggressive efforts, it will save an additional $300 million per year in costs by 2020, for a total of $1 billion annually when combined with estimated savings from reducing the reliance on Medicaid by Ohio’s elders.

Governor's Office of Health Transformation Guiding Principles

Ohio's fragmented health care system involves long-term care services funded through hospitals, Medicare, Medicaid and home- and community-based service delivery systems. These systems are largely disconnected and can result in higher-cost care provided to our vulnerable elderly population. With forward-thinking, solutions-oriented strategies, the Department of Aging aims to use Older Americans Act programs, services and supports to help transform Ohio into a model of health and economic vitality – and bring the system back in line with the state's heartland values. (Fig. 2)

Figure 2

Principles	OHT Definition	Aging Network Application
Market-based	Reset the basic rules of health care competition so the incentive is to keep people as healthy as possible.	Transform Ohio's LTC system from one that primarily pays for risk prevention through traditional care to one that rewards health promotion through an individualized, person-centered approach.
Personal Responsibility	Reward Ohioans who take responsibility to stay healthy – and expect people who make unhealthy choices to be responsible for the cost of their decisions.	Give consumers the education and resources they need to make healthy choices. Shift some spending away from symptom management to disease prevention and health promotion.
Evidence-based	Rely on evidence and data to complement a lifetime of experience, so doctors can deliver the best quality care at the lowest possible cost.	Focus on care approaches that have been or can be proven effective. Equip consumers and care providers with information about quality care.
Transparent	Make information about price and quality transparent, and get the right information to the right place at the right time to improve care and cut costs.	Regularly evaluate services and help consumers, providers and policy makers make informed decisions about the cost and quality of services.

Principles	OHT Definition	Aging Network Application
Value	Pay only for what works to improve and maintain health – and stop paying for what doesn't work, including medical errors.	Ensure that the care ordered for and received by each consumer is the most efficient and effective means of health promotion. Reduce redundancy in service provision and billing.
Primary Care	Transform primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible.	Give primary care professionals more responsibility for coordinating their patients' care and engage them as health coaches to prevent or delay disease and injury.
Chronic Disease	Prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs.	Reduce the risk of disability from chronic disease by promoting prevention and teaching effective self-management. Develop care plans that manage symptoms, but also improve outcomes and reduce costs.
Long-term Care	Enable seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.	Ohio will align the access points to LTC so that individuals can obtain needed services and supports in a seamless, timely and cost-effective manner in settings they choose.
Innovation	Innovate constantly to improve health and economic vitality – and demonstrate to the nation why Ohio is a great place to live and work.	Develop a more coordinated and fully integrated approach to care and caring as our population continues to age. We will not meet the needs of the burgeoning group of Ohio elders simply by improving on what we've been doing.

New Efficiencies

When it comes to funding adequate programs and services for our elders and ensuring choice, independence and quality of life for all aging Ohioans, our state cannot get to where it needs to be simply by doing the same things better. To provide older Ohioans and their caregivers with the services they need and at a cost Ohio's taxpayers can afford, the department must demand the highest level of efficiency and quality and has required the area agencies on aging to take a candid look at real, measurable efficiencies. We will accomplish this by:

- More effectively monitoring that services being used are necessary;
- Developing care plans that are truly individualized;
- Analyzing and addressing factors that lead to increased costs; and
- Sharing data and best practices across planning and service area boundaries.

These efficiencies are manageable and will provide our elders with greater access to quality services. Ohio's aging network can achieve better control over service plan costs while continuing to meet consumers' needs.

Local Service Delivery

The policy changes in the current budget combined with the increasing population of elders requires the aging network to creatively change the way services are provided, and places the elders we serve in the forefront. Elders requiring assistance to remain in their homes will have greater access to help through PASSPORT, Assisted Living and Choices Medicaid waivers and the PACE program. To ensure unfettered access to these programs for those who qualify, the department is establishing utilization management protocols that will hold monthly average service plan costs at current levels. Provider reimbursement rates for most of the department's Medicaid-funded programs will be reduced by three percent.

Reference Appendix B for more Ohio demographic trends.

Older Americans Act Values & Principles

The Older Americans Act of 1965 was the first federal funding initiative to provide comprehensive services for older adults. The act is more than a funding source; it supports the development of a comprehensive, coordinated and cost effective system that serves, supports and engages adults over age 60. The act requires states to target services to those with the greatest economic or social need, as well as to those at risk of institutionalization. The resulting aging network in Ohio includes the U.S. Administration on Aging, the Ohio Department of Aging (ODA), 12 area agencies on aging and numerous senior centers and local service providers.

> ***"Freedom, independence and the free exercise of individual initiative in planning and managing their own lives, full participation in the planning and operation of community-based services and programs provided for their benefit, and protection against abuse, neglect and exploitation."***
>
> ~ Older Americans Act Preamble

Local control over policy and program decisions provides the best mix of services for the community served. Area agencies utilize public input to produce area plans that outline service provision, service coordination and cooperative partnerships with public and private organizations within their planning and service areas.

ODA has used information from these local plans, including environmental scans as well as analyses of strengths, weaknesses, issues and positions (SWIP) and service needs and gaps to develop this state plan. (Fig. 3) Area agencies collectively reported service needs and gaps in transportation inside and outside the county of residence; affordable housing, including subsidized and universal designed housing; home- and community-based care for elders with low and moderate incomes; health promotion and disease prevention programming; and information access and assistance.

The Older Americans Act makes community-based services available to all Americans age 60 and older, regardless of income with priority given to frail, homebound and isolated elders in greatest need. These elders are served primarily through care coordination programs that are paid for using a combination of Older Americans Act, state and local senior services levy dollars. The remaining act funds provide supports to promote health and wellness and prevent or delay institutionalization of elders.

Figure 3

State units on aging and area agencies are charged with pursuing resources beyond those over which they have statutory authority. Since Older Americans Act Title III allocations are relatively small, state and local authorities must leverage federal, state and local resources and supports to provide a value-based, continuous health delivery system. Local matching funds are required, and client cost share is encouraged. Local match can include cash or in-kind goods or services.

Since the 1980s, Ohio law has enabled counties and municipalities to use voter-approved levies on property or sales taxes to fund services and facilities for older adults. Currently, elders in 72 counties benefit from such levies, including 70 countywide levies and 14 municipal levies. Ohio's levies generate more than $135.6 million statewide each year. These funds support a range of home- and community-based services for older adults, such as congregate and home-delivered meals, transportation, adult day services and in-home support (including homemaker services).

Most of the costs associated with home, community, caregiver support, Alzheimer's respite and Older Americans Act-funded caregiver services are for the direct provision of services to older Ohioans. Costs vary by service, but generally include labor, supplies and transportation. Costs are expected to increase at a rate equal to or more than the consumer price index during the next biennium. Food and fuel costs have the greatest impact on delivery of home, community and caregiver support program services.

Consumer Base

A two-year comparison of Ohio's Older Americans Act funded programs and services for 2009-2010 reveals a change in the profile of the elders we are serving. While the total consumers registered for programs increased, the number of minority consumers and those below poverty declined. Rural consumers, consumers with three or more activities of daily living and the number of consumers served at high nutrition risk increased.

Consumer Base	2009	2010	Difference
Total consumers	181,785	244,864	35%
Total registered consumers	94,162	110,041	17%
Minority consumers	21.83%	17.11%	-22%
Rural consumers	38.39%	37.33%	-3%
Consumers below poverty	30.71%	26.63%	-13%
Consumers with 3+ ADLs	6,197	6,834	10%
Persons at high nutrition risk	27,318	32,141	18%

Source: State Program Report to the U.S. Administration on Aging, Ohio Department of Aging

Consumer Involvement

Elders are encouraged to be their own advocates by participating in public hearings on aging issues, holding seats on advisory councils to the area agencies and organizing grass-roots efforts to improve legislation and policy. More importantly, OAA programs give Ohio's elders many opportunities to take personal responsibility for their health and to contribute financially toward the services they receive, resulting in more resources for the system.

Senior Civic Engagement

Ohio's Senior Civic Engagement Initiative, launched in 2009, seeks to develop a greater understanding of the benefits of healthy and active aging through civic engagement for Ohio's older adults. Focusing on senior employment, volunteering and lifelong learning, the initiative aims to:

- Ensure that Ohio's workforce includes older workers with new or updated skill sets;
- Actively engage older adults with diverse skills in volunteer service throughout Ohio; and
- Provide educational opportunities that enrich the lives of older adults and offer opportunities for career growth.

The department will work with the Ohio Board of Regents to further several of the goals embodied in the recommendations of the Senior Civic Engagement Council.

Senior Corps

During 2010-2011, more than 16,000 older Ohioans contributed their time and talents in one of three Senior Corps volunteer programs. Foster Grandparents served as tutors and mentors to more than 3,700 young people who have special needs. Senior Companions helped more than 1,300 homebound seniors and other adults maintain independence in their own homes. Retired and Senior Volunteer Program (RSVP) volunteers conducted safety patrols for local police departments, protected the environment, tutored and mentored children, responded to natural disasters and provided other services through more than 1,700 groups across Ohio. While foster grandparents and senior companions are paid a small stipend ($2.65 per hour), the total value of RSVP service is valued at $31,403,496.

Older Americans Act Programs, Services and Innovations

Ohio's Older American Act programs and services support a continuum of healthy aging and quality and person-centered care for elders and their caregivers of all incomes and needs. The following section highlights current OAA program and services and innovations and practice change that will enhance services.

Core Services

OAA core services in Ohio mitigate the effects of declining physical health and functioning experienced by frail older adults. In 2010, OAA core services helped more than 240,000 elders. Case management, chore services, congregate and home-delivered meals, personal care and homemaker services provided supports for some of the frailest elders, many of whom are homebound. Still other core services, including transportation, health promotion (preventive health), legal assistance and other community-based services provided added supports for community and social involvement.

Senior Community Services state funds are awarded annually to each area agency on aging to provide a range of community-based services using local systems. Many of these services also are funded by Older Americans Act Title III, helping the local area agencies on aging fulfill non-federal match requirements. These funds pay for home repairs, housing information, transportation, various nutrition services, personal care, homemaker, adult day services, case management and the associated cost of reporting. They also support the entire range of services that are part of the Act.

Care coordination programs funded by federal, state and local dollars enable case managers to arrange in-home services and caregiver support for frail individuals (many of whom are at or near a nursing home level of care) and their families. Several area agencies on aging have implemented consumer-directed models of care coordination. The average participant's cost of care coordination is under $300 per month. These care coordination programs are efficient, are designed to assist those who are ineligible for Medicaid-funded home- and community-based waiver services and are less costly than nursing home placement. Many consumers participating in care coordination support a portion of the cost of care through cost sharing and contributions.

The Congregate Nutrition Program and Home-delivered Nutrition Program offer health-sustaining food and other benefits to older adults who may be frail, have multiple chronic diseases and live on marginal incomes. Staff screen consumers and refer those at high risk for nutrition-related problems to appropriate resources, including physicians, dietitians and dentists. Each program provides links to other community services, such as food stamps and food pantries. Consumers and caregivers also receive nutrition education and counseling to learn about good nutrition practices, the need for physical

activity and the importance of food safety. Recently, Ohio's nutrition programs have focused on providing person-centered services, which have been shown to directly influence quality and consumer satisfaction. New options at meal times include alternate menu items, special diets, ethnic meals, flexible frequency and form of meals (for home-delivered meal programs) and, in some locations, restaurant meal programs. Ohio provides nearly 100,000 older adults with more than 8.7 million nutritious meals annually. Even so, current programs still fall short of meeting the nutritional needs of many older Ohioans.

Most consumers receiving Older Americans Act services get nutrition screening during enrollment. This allows providers and case managers to assess the potential health risks consumers may face and allows them to recommend more aggressive interventions to keep consumers healthy and in the home. According to Dr. Theodore E. Wymyslo, director of the Ohio Department of Health, "Choosing good nutrition and an active lifestyle will allow people to live a life that is not only longer, but also of higher quality. The benefits are not only physical and emotional, but also financial."

To better understand senior nutrition and address the critical issue of hunger, the department and the Ohio Association of Second Harvest Foodbanks sponsored the first-ever Ohio Senior Hunger Summit in June 2011. Other summit partners were the Corporation for National and Community Service, Ohio Association of Area Agencies on Aging, the Ohio Association of Senior Centers, AARP Ohio, the Ohio Department of Job and Family Services, The Ohio State University Extension Office and private partners.

In most communities in Ohio, demand for **transportation services** exceeds the capacity of local providers and exhausts existing public and private resources. The department and the area agencies on aging are focusing more time and resources to coordinated planning and service delivery, including better land use planning (e.g., "complete streets" and "livable communities") and coordinated transportation delivery and mobility management systems. Coordinated transportation services are proven to be discernibly more cost effective.

The department works collaboratively with Ohio's Office of Transit and human service agencies through the Transportation Partnership of Ohio to address regulatory barriers at the state level and promote coordination among payers and providers of human services transportation. We have developed uniform provider requirements (including vehicle inspections, driver training and other standards) across funding sources and collaboratively offer provider training. Our leadership also has led the area agencies on aging to participate in local coordinated transportation plans and to tap federal New Freedom grants and other vital resources and technical assistance.

Alzheimer's disease is a progressive and fatal neurodegenerative disorder marked by cognitive and memory deterioration, progressive impairment of activities of daily living and a variety of symptoms and behavioral disturbances. According to the Ohio Council of the Alzheimer's Association, approximately 230,000 Ohioans have Alzheimer's disease today, and that number is expected to increase to 250,000 by 2025. This equals about 1,700 new cases each year. More than 1.2 million Ohioans provide informal care for a family member with Alzheimer's disease. (*Appendix K: Executive Summary: The Scope of Alzheimer's Disease in Ohio*). According to the council, direct care workers often receive little or no training on providing quality care for people with Alzheimer's disease or related dementia. The quality of care these individuals receive is inconsistent. Also, Ohio has no statewide standardized requirements regarding how dementia care is provided in long-term care facilities. The council wants to help create dementia-capable systems to respond to early diagnosis and referrals for people with dementia and family caregivers to supportive services that delay or prevent institutionalization and reduce long-term care costs in Ohio.

The **National Family Caregiver Support Program (NFCSP)** and **State Alzheimer's Respite** funds provide information and assistance, individual counseling, organization of support groups, caregiver training and respite services to family members and others who care for and assist frail elders in the community. These services help keep the caregivers healthy while Older Americans Act services keep care recipients in their homes and communities. Many informal caregivers work outside their homes and some are still raising their own children. Area agencies on aging provide respite care and supplemental services on a limited basis to eligible caregivers of individuals determined to be frail or to have dementia. Some agencies allow relative caregivers to be paid to provide respite or are otherwise increasing consumer-directed care options. Some are considering adoption of evidence-based caregiver support programs. The department and the area agencies on aging collaboratively developed tools to facilitate caregiver self-identification.

Lifespan respite care programs coordinate systems of accessible, community-based respite care services for family caregivers of children or adults with special needs. In March 2011, state partners held the Ohio Respite Summit to support the lifespan respite grant application that was submitted to and funded by the Administration on Aging.

The department has two additional Alzheimer's Disease Supportive Services Program innovation grants that have allowed it to partner with the Benjamin Rose Institute on Aging, Alzheimer's Association, area agencies on aging and other organizations to test and evaluate innovative approaches to assist people with early-stage dementia and their families. We are working to integrate these interventions into existing state programs.

- **ECHO (Empowering Elders by Enhancing Cognitive Health Outcomes)** improves cognitive functioning of people with early-stage dementia and their families to alleviate depression and enhance well-being.

- **EDDI-II (Early Diagnosis Dyadic Intervention II)** further evaluates a promising practice to provide early intervention and enhance communication skills in families caring for people with dementia.

Ombudsman

The Office of the State Long-term Care Ombudsman works on behalf of consumers to resolve nearly 9,000 annual complaints about providers and services. Ombudsmen are the only connection many consumers have to an individual who is not a care provider. They help consumers select long-term care providers, offer information about benefits and consumer rights, and make regular visits to nursing homes. Ohio's ombudsmen are experts on person-centered care, and they empower consumers, families and facilities to expect excellence. They work to make sure the rights of residents are upheld. The office leads the Ohio Person-Centered Care Coalition, which is comprised of providers, consumers and government agencies working together to influence and support culture change in long-term care settings.

Ohio has almost 1,600 facility-based long-term care providers, and the ombudsman program strives to conduct quarterly visits with each facility, with a goal of reaching 100 percent quarterly visitation by 2014. The state ombudsman is partnering with AARP to recruit additional volunteers, who will help the program increase presence in long-term care facilities. Nine of the 12 regional ombudsman programs are transition coordinators for Ohio's Money Follows the Person demonstration project. They have helped nearly 200 nursing home residents return to the community. The project has also been a significant source of revenue, which is being used to increase ombudsman presence in facilities.

Ending Elder Abuse

The department is dedicated to ending and preventing the abuse, neglect and exploitation of elders, an issue that impacts the lives of millions of older adults. According to research, every five seconds an elder is abused, and most of these cases will go unreported. Through our involvement on the Ohio Attorney General's Elder Abuse Task Force, the department is one of the leading advocates for strengthening the state's elder justice laws to increase the number of mandatory reporters who suspect abuse, authorize development of county or regional interdisciplinary teams and expand the ombudsman's injunctive authority for violation of the rights of adult care facility residents, among many other changes. The department also has a seat

on the Ohio Senior Medicare Patrol Advisory Council, which focuses on reducing Medicare fraud, and the State Ombudsman is a member of the Ohio Coalition of Adult Protective Services. With their one-to-one contact with elders, our regional ombudsman programs are at the forefront of ending and preventing ending elder abuse, neglect and exploitation. Title VII prevention funding supports their work on local collaboration, training and triads. As a recipient of the Administration on Aging's Model Approaches to Statewide Legal Assistance Systems grant, the ombudsman's office is developing a more integrated and coordinated senior legal services delivery system to ensure that Ohio's elders remain independent, healthy and financially secure.

Emergency Preparedness

Per sections 306 and 307 of the Older Americans Act, area agencies on aging are required to develop long-range emergency preparedness plans and coordinate activities with local emergency response agencies, relief agencies and other state and local entities and facilities with roles in disaster planning, response and recovery. The department plays an important role in Ohio Emergency Management Agency (OEMA) emergency planning, response and recovery efforts, and played a similar role with the Ohio Department of Health's development of a pandemic flu response plan. The department participates in seasonal awareness week activities and supported the Ohio Legal Rights Services' development of an Emergency Management Be Prepared Kit, available online. Both of these are intended to help people with disabilities of all ages to accept personal responsibility for emergency and disaster preparedness. When OEMA activates its Emergency Operations Center, the department coordinates activities with other state agencies at the center and with area agencies on aging affected by the current emergency. The department has obtained two Administration on Aging grants to enable area agencies on aging to deliver gap-filling services to consumers in affected and contiguous counties.

Practice Change and Innovation

Evidenced-based Models

The Administration on Aging's **Evidence-based Prevention Demonstration Initiatives** provide resources to successfully translate evidence-based interventions into practical, attractive, low-cost programs that improve the health of older adults and are likely to reduce health care costs. The Administration, through a partnership with the National Council on Aging, offers grants that provide additional funds for these initiatives. These programs help older people improve their health and well-being by better managing their chronic diseases, being more physically active, avoiding falls, managing medications and improving nutrition and diet. They are offered through a network of community-based aging service provider organizations and sometimes in conjunction with other Older Americans Act services.

Evidenced-based Disease Prevention Programs reduce health care utilization (e.g., emergency room visits) and costs of services for all consumers. They are offered at varying degrees through all 12 area agencies on aging. During this state plan period, we will recruit other organizations to pay for or provide these services. The proven outcomes will help private partners save money on health care expenses, and the additional sources of funding will help drive innovation in the programs. These programs are disease prevention and health promotion services that are supported with limited Title III-D funds. In addition, funds are used as seed money to promote a flexible service system that is client-centered and promotes health and wellness. The system can provide flexible grants or service contracts that pay for defined units. This will provide a minimal amount of services that allow elders to stay in their communities.
In collaboration with the Ohio Department of Health, area agencies on aging, local health departments, Alzheimer's Association chapters, Senior Corps, Senior Community Service Employment Program, senior centers and other providers, the department has put in place a statewide training infrastructure to implement the following programs in Ohio:

- **Healthy U –** The Chronic Disease Self-Management and Diabetes Self-Management Programs, titled "Healthy U" and "Healthy U: Diabetes" in Ohio, were developed by researchers at Stanford University. The programs help people gain confidence in their ability to manage symptoms and understand how their health problems affect their lives. The grant targets incentive programs at relatively healthy populations, as well as those with multiple chronic illnesses. Healthy U treats the whole person by providing person-centered care focused on specific ailments that can hinder the ability to remain in the home. Healthy U: Diabetes is identical in structure but is specifically tailored to people with type 2 diabetes. Healthy U is offered in all regions of the state by the area agencies on aging and their local partners through funding from the Administration on Aging, the American Recovery & Reinvestment Act of 2009 and local funding.

- **Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) –** This depression self-management program is conducted by case managers and includes screening and assessment, education for clients and family caregivers, referral and linkages to appropriate health professionals, and behavioral activation. The department, the Older Ohioans Behavioral Health Network and the Ohio Department of Mental Health have trained the area agencies on aging to use this intervention in their case-managed programs, and Ohio has three certified Healthy IDEAS trainers based in selected agencies. During 2011, the department and its partners will expand Healthy IDEAS into other venues, such as senior centers, home health agencies, nutrition programs, Alzheimer's Association chapters and patient-centered medical homes.

- **Reducing Disability in Alzheimer's Disease –** AoA's Alzheimer's Disease Supportive Services Program supports Ohio's implementations of Reducing Disability in Alzheimer's Disease, a program developed by researchers at the University of Washington. In the program, people with Alzheimer's disease who live at home receive exercise training while their family caregivers receive simultaneous training about management of behavioral symptoms. The program initially was piloted in northwestern Ohio but now is offered by all seven Ohio Alzheimer's Association chapters.

The Departments of Aging and Health support additional evidence-based disease prevention programs:

- **A Matter of Balance** is an eight-session program that reduces the participants' fear of falling and increases their physical activity to prevent falls. Because two older Ohioans die every day from fall related injuries, this program is an important part of the evidence-based programming in Ohio and will expand to three new area agencies on aging by December 2011.
- **Active Living Every Day** uses facilitated group-based problem solving methods to integrate physical activity into everyday living.

Consumer-Directed Care

In October 2008, the department and Area Agency on Aging District 7, Inc. received an Administration on Aging grant to investigate the challenges of implementing a consumer-directed long-term care services program to serve non-Medicaid older adults in rural Appalachian Ohio. Through the **Community Living Program**, the area agency on aging created the My Care, My Way program, which targeted 50 individuals at imminent risk of nursing facility placement and spend-down to Medicaid eligibility. The program included a menu of services and resulted in significant cost saving at several levels, including nursing facility diversion, reduced hospital stays and reduced emergency room visits. The project shifted service provision toward consumer-directed care, which changed the way the agency, options counselors and its partners functioned. It also transformed Older Americans Act funding to support consumer direction. These changes were supported by extensive training of staff and services providers, the development of computerized tools used for screening and assessing potential participants, and the development of written directives for both staff and participants that will facilitate project continuation and replication.

Ohio's participation in the Community Living Program helped launch interest and participation in **Veterans Directed – Home- and Community-Based Services**. This program provides a package of services that the Veterans Administration purchases from area agencies on aging on behalf of eligible veterans. The program provides veterans the opportunity to direct their own long-term services and supports that will enable them to avoid institutionalization. This initial participation could support expansion statewide through the Veterans Integrated Services Network.

Medicare Improvements for Patients and Providers Act

The act provides financial assistance for Medicare Parts B and D through the Medicare Savings Program and the Low Income ("Extra Help") Subsidy. Because so many individuals who are eligible for these programs are not enrolled, the act provided grants to state units on aging and state senior health insurance information programs to conduct outreach and education about Medicare program changes and financial benefits, and to submit benefits applications on behalf of low-income individuals. Ohio has been awarded two grants, the second of which runs through September 29, 2012. Between June 2009 and March 2011, the department, the Ohio Senior Health Insurance Information Program and their partners collectively submitted nearly 4,300 applications with an estimated value of nearly $2 million in benefits.

Performance Outcome Measures Project

The department Aging continues to participate in the Administration on Aging's **Performance Outcomes Measures Project** (POMP). Representatives from the department have worked with representatives from five other states to complete the Advanced POMP project. This project involved collecting data from area agencies on aging to determine the impact of Older Americans Act services on reducing nursing home placement. The preliminary results provide new evidence and insights for the effectiveness of home- and community- based services in helping seniors maintain their independence. A cross-validation of nursing home placement prediction models is nearing completion, as well as projects undertaken in the Next Generation POMP project. These include: predictive modeling using existing prior POMP survey data, longitudinal POMP studies and development of a POMP-TO-GO toolkit for use by state units on aging, area agencies on aging and providers to help determine outcomes from services.

Direct Service Workforce

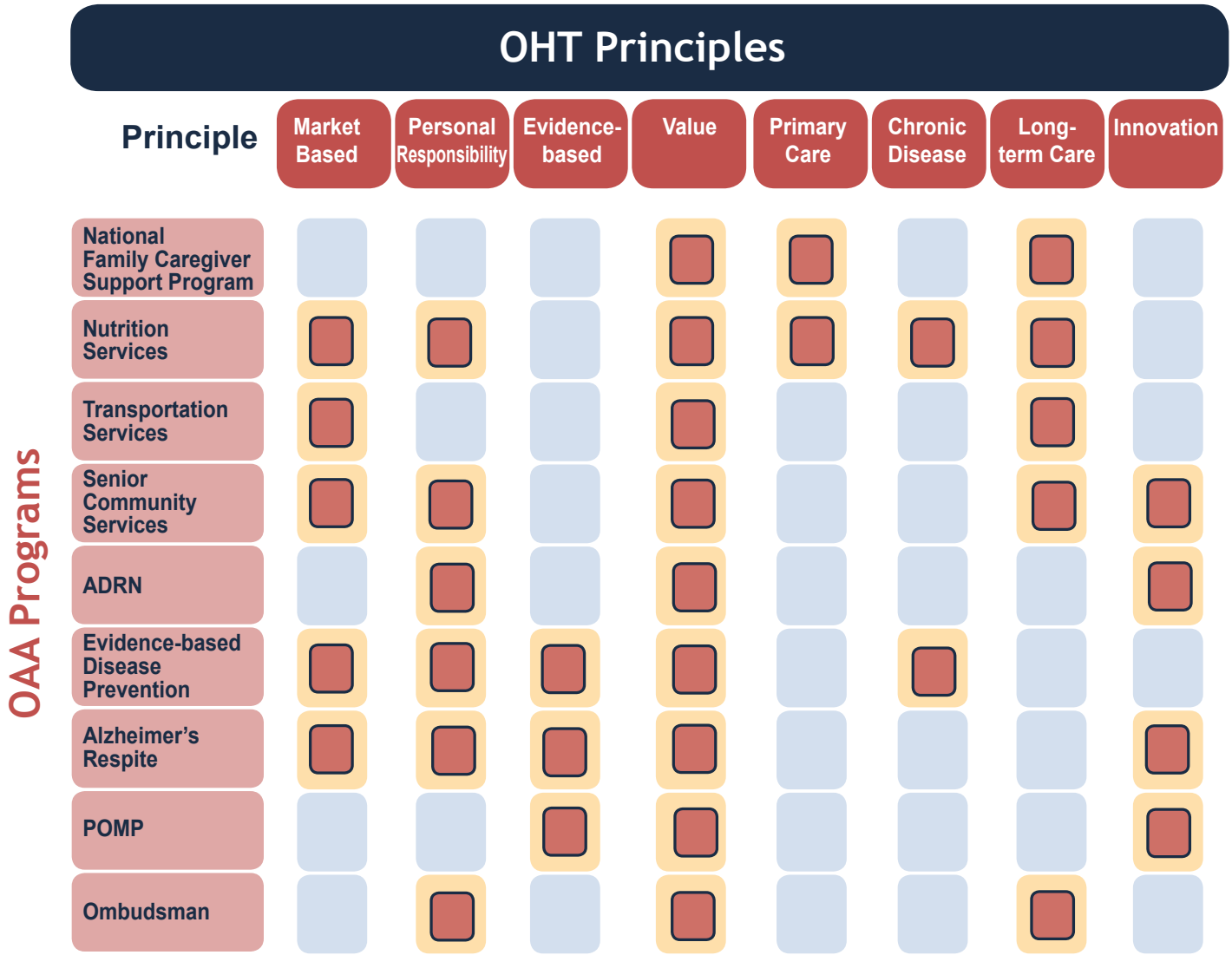
The department is co-leading a multi-agency effort to cultivate a highly trained and flexible direct service workforce that is responsive to the needs of employers and consumers of long-term services and supports in Ohio. Ohio's workforce development and Medicaid agencies, working in conjunction with business, industry and education stakeholders, will help workers and prospective workers achieve higher levels of skill, document the skills they have and help businesses easily identify workers' skills. We

are identifying specific workforce needs across disciplines and service sectors, as well as collaborative solutions to leverage costs and create efficiency. State partners also will develop and adopt a comprehensive, statewide long-term care worker certification program, including a set of core competencies for individuals who wish to pursue entry-level employment providing long-term services and supports. Additional certificates will be developed to demonstrate competencies in long-term services and support skills. The long-term care worker certification program will serve as a stepping-stone for individuals with a high-school degree or equivalent, who wish to pursue a career in health and human services.

Summary

The following chart (Fig. 4) illustrates how Older Americans Act programs, services and supports mesh with the values of the Governor's Office of Health Transformation to transform Ohio into a model of health and economic vitality, bringing the system back in line with our heartland values.

Figure 4



Strategic Goals & Objectives, FFY 2012-2013

In preparing this plan, the ODA utilized the input of Ohio's aging network, public comment and the Governor's Office of Health Transformation principles. During the planning process, four critical issues to address emerged, which ODA and the aging network will focus on addressing to ensure older Ohioans ever changing and growing needs are met.

This plan identifies innovative ways the department can modernize and expand the role of Older Americans Act funds to serve Ohio's elders and their caregivers.

Goals and objectives are subject to change or reprioritization based on changes in policy direction and funding availability.

Issue 1: **Improve access to services through the Aging and Disabilities Resource Network (ADRN).**

Goal: The ADRN will serve as a statewide, fully-functional "front door" point of access for Ohioans needing aging and disabilities resources.

Objectives

1. Create a state-level advisory group to oversee and direct development of the ADRN in Ohio.
2. Develop a consistent brand that supports increased awareness of the ADRN for use by all partners.
3. Establish an assessment instrument that determines functional eligibility and links individuals to available services.
4. Support on-going collaborative efforts of Ohio's 12 area agencies on aging to develop the ADRN and move toward "fully-functioning status."

Measureable Outcomes

1. The ADRN advisory group will be established by Oct. 31. 2011. Regular reports on the progress toward a fully-functional designation will be issued starting in 2012.
2. By July 31, 2012, Ohio will have criteria for "fully functioning" ADRNs against which each area agency and its partners will be measured.
3. The universal assessment instrument will be in use by July 2012.
4. Ohio will have brand standards and guidelines for the ADRN by Jan. 31, 2013.

Ohio's five-year ADRN plan is attached as Appendix L.

Issue 2: **Expand Ohio's aging network's evidence-based prevention programs both inside and outside the network.**

Goal: Embed evidence-based prevention programs (e.g., Healthy U, Matter of Balance, Healthy IDEAS, Reducing Disability in Alzheimer's Disease, Care Transitions) into communities and organizations, creating a culture of healthy aging for Ohioans.

Objectives

1. Expand the availability of evidence-based prevention programs, especially to high-risk and hard-to-serve populations.
2. Expand outreach to elders and their caregivers about the effectiveness of evidence-based prevention programs in improving health and quality of life.
3. Expand access to evidence-based programs through engagement of the health-care community (e.g., public health, federally qualified health centers, primary care physicians, pharmacies, emergency rooms, discharge planners, health plans).
4. Strengthen the culture of wellness and prevention within the aging network (e.g., stakeholders, partners, case managers, program and administrative staff).

Measureable Outcomes

1. Identify and pilot at least one new evidence-based program that is proven to improve health outcomes for homebound individuals by Sept. 30, 2013.
2. Expand the number of organizations implementing evidence-based prevention programs by 15 percent by Sept. 30, 2013, measured against a baseline established for 2011.
3. Develop and provide a toolkit for health care professionals that can be used to refer consumers and patients to evidence-based prevention programs by Dec. 31, 2011.
4. Develop and implement targeted marketing campaigns (e.g., health plans, senior community service employment programs, retirement systems, family physicians) to build awareness of the availability of evidence-based prevention programs that includes, but is not limited to, the use of social media and outreach events by Dec. 31, 2011.
5. Develop at least three new partnerships with sister state agencies and other organizations (e.g., rehabilitation and corrections, veterans services, rehabilitative services, mental health, cooperative extension services, Alzheimer's Association) to expand evidence-based prevention programs to at-risk or hard-to-serve populations (e.g., ex-offenders, veterans, persons with disabilities, rural residents, persons with dementia) by Sept. 30, 2013.
6. Host learning sessions for aging network stakeholders and partners to provide support and techniques for strengthening the culture of wellness and prevention within their respective organizations beginning March 31, 2012.

Issue 3: **Ensure that long-term services and supports are provided in a person-centered manner and available to meet the needs of elders and their caregivers.**

Goal 1: Individuals receiving Older Americans Act core services or other long-term services and supports will have opportunities to exercise choice and self-determination in services in any setting.

Objectives

1. Develop consistent person-centered service quality measures and establish target outcomes.
2. Make quality information available to consumers by adding home- and community-based service providers to the Long-term Care Consumer Guide.
3. Provide training and technical assistance to aging network and other long-term care providers on the principles of person-centered care, including related quality measures.
4. Review and, if necessary, include person-centered language in administrative rules according to Ohio's statutory schedule.
5. Monitor state and federal legislation, including the Federal Elder Justice Act, to ensure the department is ready to implement any changes in laws that aim to protect our elders from abuse, neglect and exploitation.
6. Advocate for passage of state legislation to improve Ohio's response to instances of elder abuse, neglect and exploitation.

Measurable Outcomes

1. Pilot person-centered quality measures and establish target outcomes by June 30, 2013.
2. Conduct a home- and community based- consumer satisfaction survey using a statistically valid sample of consumers by June 30, 2013. Post results on the Long-term Care Consumer Guide by Jan. 15, 2014.
3. All 12 of Ohio's area agencies on aging will complete in an ODA-sponsored learning session on person-centered quality measures by Sept. 30, 2013.
4. One hundred percent of administrative rules that are reviewed during the plan period of Oct. 1, 2011 through Sept. 30, 2013 will include person-centered philosophy and outcomes.

Goal 2: Ohio's system of Medicaid-funded long-term services and supports will employ a balance of facility-based and home- and community-based care.

Objectives

1. Manage Medicaid and other home- and community-based programs to achieve a balanced system of long-term services and supports.
2. Partner with others to improve the quality of life and care in nursing homes by incorporating key principles of person-centered care.
3. Provide support to all caregivers, recognizing that caregiving doesn't stop at the nursing home door.
4. Develop and improve strategies for care coordination.
5. Ensure that Ohio's healthcare and long-term services and supports system have professional and direct service workers in sufficient number and skill to serve all Ohioans.

Measurable Outcomes

1. Achieve a 50/50 balance of individuals receiving Medicaid services in nursing facilities and in the community by Sept. 30, 2013.
2. Collaborate with the Ohio Lifespan Respite Coalition and Ohio Family and Children First to develop components of a lifespan respite system by Sept. 30, 2013.
3. Develop a nursing home Medicaid pay-for-performance system that is focused on two domains: quality of life and quality of care. The department, working with public and private partners, will identify seven to eight performance measures for these domains by June 30, 2012.
4. Collaborate with the Ohio Department of Job and Family Services to facilitate statewide implementation of a health and human service career lattice and long-term service and support system workforce consortium for Ohio by June 30, 2013.

Issue 4: Encourage and develop a network of volunteers, neighborhoods and communities to support the needs of older Ohioans and their caregivers.

Goal 1: Encourage and support the development of member-driven cooperatives (e.g., village movement, co-housing) to meet the home- and community-based service needs of elders living in defined neighborhoods and communities (e.g., naturally occurring retirement communities).

Objectives

1. Promote the benefits of member-driven cooperatives.
2. Identify potential private funding sources (e.g., foundations, insurance companies, membership fees) to support development of cooperatives.
3. Provide technical assistance to communities and organizations interested in forming cooperatives.
4. Engage volunteer, faith-based and academic organizations to support the establishment of member-driven cooperatives.
5. Review and revise, if necessary, department policies and administrative rules to enable area agencies to support the development of member-driven cooperatives, including, but not limited to, providing one-time seed or start-up funds.

Measurable Outcomes

1. The department will host a learning session for communities and individuals interested in establishing member-driven cooperatives by Sept. 30, 2012.
2. Establish member-driven cooperatives in at least one urban, one suburban and one rural community by Sept. 30, 2013.
3. Identify at least one funding source to support the development of cooperatives by Sept. 30, 2013.

Goal 2: ODA, the Ohio Emergency Management Agency (EMA), AAAs and other disaster response organizations and representatives of their local counterparts will develop best practices for responding to older adults and other vulnerable populations in emergencies of all types, regardless of where the vulnerable populations live.

Objectives

1. ODA and the Ohio EMA will facilitate an information exchange between area agencies and county EMAs about how their respective emergency plans address vulnerable populations, regardless of where they live.
2. ODA will revise and adopt the proposed ODA Policy 317.0 to help area agencies and local emergency organizations plan and respond to vulnerable individuals in emergencies of all types.
3. ODA and the area agencies will develop a toolkit of existing resources for planning and responding to vulnerable populations in an emergency, to include policies, best practices developed by local level partnerships and systems that identify and notify authorities of unusual circumstances that may warrant checking on the welfare of particular vulnerable individuals.

Measurable Outcomes

1. ODA Policy 317.0 will be revised and finalized by Dec. 31, 2011.
2. Vulnerable population and emergency notification best practices will be provided to area agencies and county EMAs by Sept. 30, 2012.
3. Fifty percent of county emergency management plans will address the specific needs of vulnerable populations, especially older adults, by Sept. 30, 2013.

Goal 3: Identify and develop new reimbursement streams (e.g., managed care organizations, health homes, veterans administration, private pay, retirement systems, employers) that build on existing aging network infrastructure and services (e.g., care planning, evidence-based prevention, caregiver support, dementia care) to enhance and expand services to older adults and their caregivers.

Objectives

1. Identify and develop a procurement model or models for Older Americans Act funded care coordination programs and private pay programs that are consistent with federal procurement policies and requirements.
2. Establish standards to guide area agency implementation and support of private pay models.
3. Develop specifications for services that are available statewide (e.g., legal services, disease prevention and health promotion, respite services), but that currently do not have consistently applied specifications.
4. Identify potential statewide reimbursement streams.
5. Working with area agencies, the Ohio Department of Veterans Services and regional veterans administration medical centers, expand the Veterans Directed – Home and Community-Based Services Program to additional area agencies.

Measurable Outcomes

1. Enact or revise polices and, if necessary, administrative rules that guide Older Americans Act funded care coordination programs by Oct. 31, 2011, and area agency implementation and support of private pay models by Sept. 30, 2012.
2. Secure at least four new statewide reimbursement streams for evidence-based prevention programs, including but not limited to, PASSPORT and one health plan by Sept. 30, 2013.
3. Implement the Veterans Directed-Home and Community Based Services Program in at least four area agencies by Sept. 30, 2013.
4. At a minimum, develop services specifications for OAA Title III legal services, disease prevention and health promotion and respite services by Sept. 30, 2012.

Ohio State Plan on Aging
FFY 2012 - 2013

Appendices

Ohio's blueprint for innovation and responsiveness to its ever-changing population

Prepared by the
Ohio Department of Aging

John R. Kasich, Governor | Bonnie Kantor-Burman, Director

August 1, 2011

State Plan Assurances, Required Activities and Information Requirements Attachment A Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

Assurances

Sec. 305(a) - (c), Organization

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), Area Plans

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, State Plans

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide
assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State

Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to t he fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income mi nority older individ uals in the State, including the number of low incom e minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, Planning, Coordination, Evaluation and Administration of State Plans

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, Additional State Plan Requirements (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

Required Activities

Sec. 307(a) State Plans

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the St ate agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluat ions of the effectiveness of serv ices provided to individuals with greatest ec onomic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older indi viduals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

Information Requirements

Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))

The term “in-home services” includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

Section 305(a)(2)(E)

provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Section 306(a)(17)

Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Section 307(a)

(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306
(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

Section (307(a)(3)

The plan shall:

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the “statement and demonstration” are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such

services (including the cost of providing access to such services).

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8)) (Include in plan if applicable)

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Section 307(a)(21)

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

Section 307(a)(28)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority

older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Section 307(a)(29)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Section 307(a)(30)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

Bonnie Hardin Burns — 7/26/11

Signature and Title of Authorized Official — Date

FY 2012 State Plan Guidance
Attachment B

Intrastate Funding Formula (IFF) Requirements

Each State IFF submittal must demonstrate that the requirements in Sections 305(a)(2)(C) have been met:

> OAA, Sec. 305(a)(2)
> "*States shall,*
> *(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review and comment a formula for distribution within the State of funds received under this title that takes into account--*
> *(i) the geographical distribution of older individuals in the State; and*
> *(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals*."

- For purposes of the IFF, "best available data" is the most recent census data (year 2000 or later), or more recent data of equivalent quality available in the State.

- As required by Section 305(d) of the OAA, the IFF revision request includes: a descriptive Statement; a numerical Statement; and a list of the data used (by planning and service area).

- The request also includes information on how the proposed formula will affect funding to each planning and service area.

- States may use a base amount in their IFFs to ensure viable funding for each Area Agency but generally, a hold harmless provision is discouraged because it adversely affects those planning and service areas experiencing significant population growth.

Ohio Demographic Characteristics

Two main sources were used for these data. Age data represents the most current available, and came from Census 2010's Demographic Profile -1. All other characteristics are based on the American Community Survey of population estimates for 2005-2009.

Population

Ohio's population is aging. From 2000 to 2030, based on U.S. Census Bureau projections, the percentage of Ohioans age 65 and older will increase from 13 percent to 20 percent; the old-age dependency ratio (age 65-plus/age 20 – 64) will increase from 23 to 38; and Ohio's median age will increase from 36.2 to 40.2. Net growth in the number of Ohioans age 65 older will increase from 14 per day currently to 119 per day in 2012.

Nationally, the 65-plus population grew from 34,991,753 in 2000 to 38,000.870 in 2010. In Ohio, this population increased from 1,507,757 in 2000 to 1,622,015 in 2010.

Age & Gender

Based on Census 2010 data, Ohio's 60-plus and 75-plus populations, factors used in the intrastate funding formula, are growing. Ohio has 1,005,862 men and 1,281,562 women age 60-plus, totaling 2,287,424. This total represents an increase of 323,935 older residents since 2000. The 75-plus population increased slightly over the past decade as well. In 2010, 294,502 men and 477,279 women, totaling 771,781 individuals, are age 75 or older. In 2000, there were 255,749 men and 461,756 women, totaling 717,505 individuals in this cohort.

Based on Census 2010, Ohio has 230,429 older adults age 85-plus. The 85-plus population has grown by 53,633 persons since Census 2000.

Marital Status & Households

According to 2005-2009 ACS population estimates, 57.3 percent of Americans age 60 and older were married during the survey period, but separated; 24.5 were widowed; 11.8 percent divorced; 1.4 percent separated; and 5.1 percent were never married. In Ohio, 56.8 percent of residents age 60-plus were married during this period but were separated during the survey; 25.6 percent were widowed; 12 percent divorced; 0.9 percent separated; and 4.7 percent were never married.

Of household types in Ohio, 54.9 percent were identified as family households for adults age 60-plus; 45.6 percent were married couples; 7.3 percent were female householders with no husband present; 45.1 percent were nonfamily households; and 43 percent were householders living alone.

Educational Attainment
The census looked at the educational attainment of the population age 25 and older in its 2005-2009 ACS population estimates. Nationally, for the 60-plus population, 22.9 percent were not high school graduates; 33.2 percent were high school or equivalent graduates; 22.3 percent had some college or an associate's degree; and 21.7 percent had a bachelor's degree or higher. In Ohio for the same population, 22.2 percent were not high school graduates; 41.2 percent were high school or equivalent graduates; 19.6 percent had some college or associate's degree; and 16.9 percent had a bachelor's degree or higher.

Race and Hispanic or Latino Origin
Based on 2005-2009 ACS population estimates, 99.4 percent of Ohioans age 60 and older identified themselves by one race. Of that percentage, 89.7 percent are White; 8.4 percent are Black or African-American; 0.1 percent are American Indian and Alaska native; 0.9 percent are Asian; 0.3 percent are some other race; and 0.6 percent are two or more races. Additionally, 1 percent identified themselves as Hispanic or Latino origin (of any race) and 89 percent as White alone, not Hispanic or Latino.

Nativity and Language
Four percent of people living in Ohio in 2005-2009 were foreign born, while 96 percent were native to the U.S., including 75 percent born in Ohio. Of the 2,047,433 state residents who were 60-plus, 96 percent were native born Ohioans; 21.4 percent were not a U.S. citizen; and of these individuals, 78.6 percent were naturalized U.S. citizens.

Among people age 60 or older living in Ohio during 2005-2009, 94.9 percent spoke English only at home; 5.1 percent spoke a language other than English at home; and 2.2 percent spoke English less than "very well." Besides English, other language groupings were Spanish or Spanish Creole; other Indo-European languages; Asian and Pacific Island languages; and other languages in general.

Income & Poverty
Based on 2005-2009 ACS population estimates, 42.7 percent (566,890) of Ohioans age 60 and older had earned income; 79.1 percent (1,050,140) had Social Security income; 4.7 percent (62,398) received Supplemental Security Income; 1.7 percent (2,257) received cash public assistance income; 52 percent (690,358) had retirement income; and 6.2 percent (8,231) received food stamp benefits.

Employment
According a recent fact sheet from the Urban Institute, although improved health, educational gains, and declines in physically demanding work have improved employment prospects for older adults, significant challenges still remain. Unemployment rates hit a record high for older workers in 2009. Job loss has serious repercussions at older ages, and age discrimination persists. During 2005-2009, 2.9 million Americans age 55 and older were working or looking for work. The majority were

employed, including 27.1 million ages 55-plus and 6.1 million ages 65-plus. During this period in Ohio, 2,599,186 (90.7 percent) older adults age 55-plus were in the labor force and 341,018 (11.9 percent) were unemployed.

Health Insurance Coverage
During 2005-2009, 99.5 percent of non-institutionalized Ohioans age 65 or older were covered by some type of health insurance. Medicare, which covers mostly acute care services and requires beneficiaries to pay part of the cost, covered 95 percent. In addition to Medicare, 62 percent also were covered by private insurance whether employment based, self-employment, or direct purchase; 6.2 percent by Medicaid; and 7.4 percent by military health care. In contrast, 0.5 percent of Ohioans age 65-plus were not covered at any time during 2009.

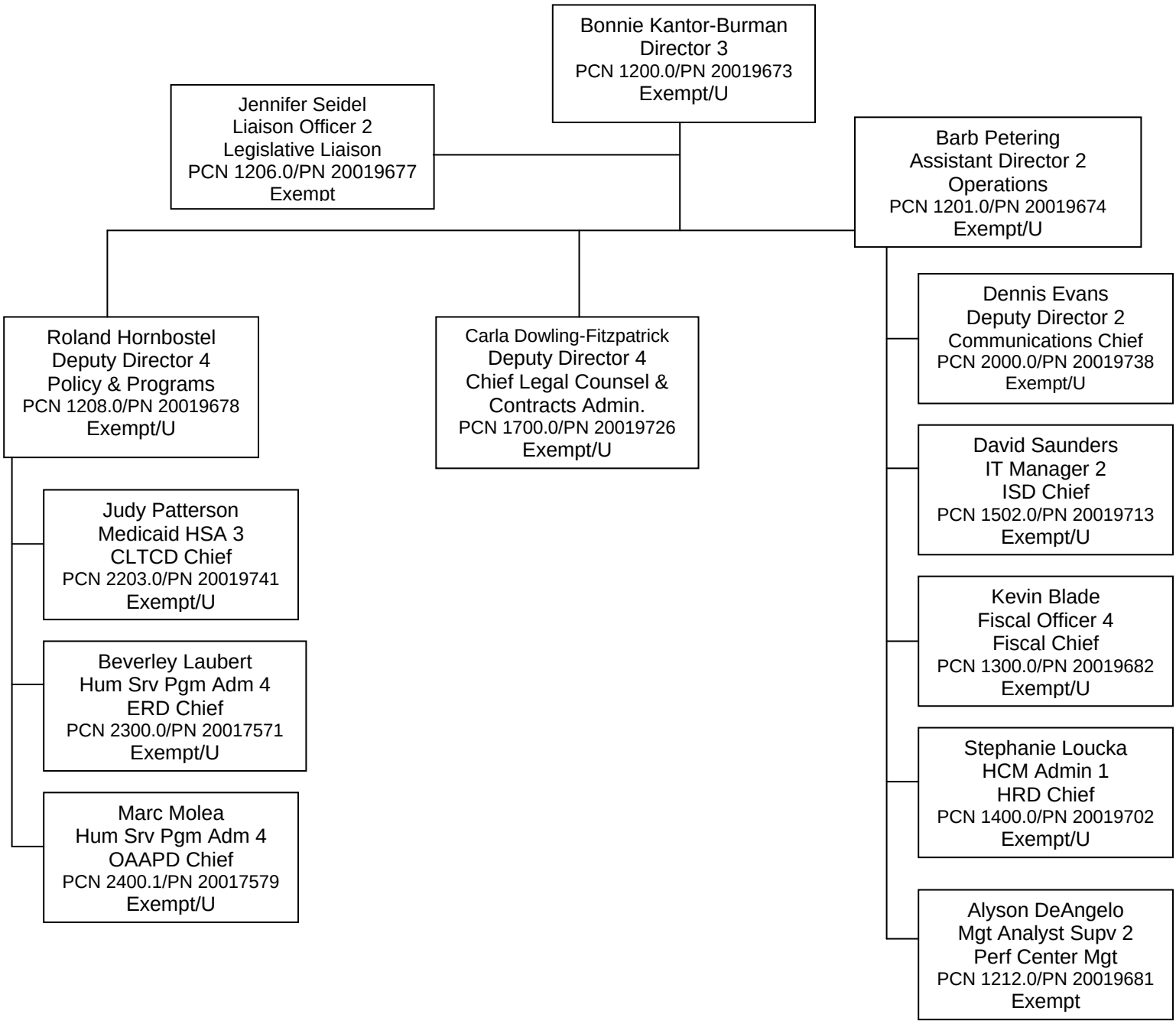
Disabilities
According to 2009 population estimates, there are 37,932,497 older adults age 65 and older in the U.S. Of that total, 14,189,006 (37 percent) have a disability. Of Ohio's 1,519,620 adults age 65-plus, 560,102 (37 percent) also have a disability.

Housing
Based on 2005-2009 ACS population estimates, Ohio has 2,145,085 houses that are occupied by owners. Of that number, 385,182 are occupied by Ohioans age 65 or older; 313,488 of those occupants are living alone. Of those houses that are occupied by renters, 28,394 householders are age 65 or older.

Grandparents
Nationally, with a universe population of 176.5 million adults age 30-plus, 30 percent are age 60-plus. Of the elders, 5.2 percent have grandchildren living with them, and 1.6 percent have primary responsibility for the care of the grandchildren. In Ohio, the universe population shifts to 31 percent age 60-plus. Of the elder population, 3.5 percent have grandchildren living with them, and 1.3 percent have primary responsibility for care of their grandchildren.

Appendix C

Ohio Department of Aging
Executive Staff



03/14/11

Appendix D

ODA Advisory Council on Aging

Members

Belle Likover, Chair
Sandy Calvert, Vice Chair
Donald W. Davis
William R. Demjan
Jack L. Edwards
Marian Harris
Heath Hughes
Joseph H. Mudra
Virginia D. Ragan
Molly Varner

Ex-Officio Members

Semanthie Brooks, Benjamin Rose Institute on Aging
Michele Colliver, Ohio Attorney General's Office
Toni Fortson-Bigby, CareSource
Matthew Hobbs, Ohio Department of Job & Family Services
Selina Larson, Ohio Department of Health
The Honorable Todd McKenney, Ohio House of Representatives
Denise C. Niese, Ohio Association of Senior Centers
Kathryn Remer, Ohio Department of Mental Health
The Honorable Dan Ramos, Ohio House of Representatives
Larke Recchie, Ohio Association of Area Agencies on Aging
Pamela C. Schuellerman, Alzheimer's Association
Jane Taylor, AARP Ohio

Planning and Service Areas

Ohio is divided into 12 geographic regions called planning and service areas (PSAs) for service delivery purposes. Each PSA is overseen by an area agency on aging (AAA). Each AAA develops a comprehensive and coordinated service system and advocates for the needs of all older Ohioans in the PSA.

Area Agencies on Aging

PSA 1
Council on Aging of Southwestern Ohio
175 Tri County Parkway
Cincinnati, Ohio 45246
Phone: 513/721 1025
1-800/252-0155
Fax: 513/721-0090
www.help4seniors.org
Suzanne Burke, CEO

PSA 2
Area Agency on Aging, PSA 2
40 W. Second St., Ste. 400
Dayton, Ohio 45402
Phone: 937/341 3000
1-800/258-7277
Fax: 937/341 3005
www.info4seniors.org
Doug McGarry, Ex. Dir.

PSA 3
Area Agency on Aging 3
200 E. High Street, 2nd Fl.
Lima, Ohio 45801
Phone: 419/222 7723
1-800/653-7723
Fax: 419/222 6212
www.psa3.org
Jacquelyn Bradley, Dir.

PSA 4
Area Office on Aging of Northwestern Ohio, Inc.
2155 Arlington Avenue
Toledo, Ohio 43609
Phone: 419/382 0624
1-800/472-7277
Fax: 419/382 4560
www.areaofficeonaging.com
Billie Johnson, Dir.

PSA 5
Ohio District 5 Area Agency on Aging, Inc.
780 Park Avenue W
Mansfield, Ohio 44906
Phone: 419/524 4144
1-800/860-5799
Fax: 419/522 9482
www.aaa5ohio.org
Duana Patton, CEO

PSA 6
Central Ohio Area Agency on Aging
174 E. Long Street
Columbus, Ohio 43215
Phone: 614/645 7250
1-800/589-7277
Fax: 614/645 3884
www.coaaa.org
Cindy Farson, Dir.

PSA 7
Area Agency on Aging District 7, Inc.
University of Rio Grande/F32
160 Dorsey Drive
PO Box 500
Rio Grande, Ohio 45674
Phone: 740/245 5306
1-800/582-7277
Fax: 740/245 5979
www.aaa7.org
Pamela Matura, Ex. Dir.

PSA 8
Area Agency on Aging 8
1400 Pike Street
Marietta, OH 45750
PO Box 370 (mail only)
Reno, Ohio 45773 (mail only)
Phone: 740/373 6400
1-800/331-2644
Fax: 740/373 1594
www.areaagency8.org
Rick Hindman, Dir.

PSA 9
Area Agency on Aging Region 9, Inc.
60788 Southgate Road
Byesville, Ohio 43723
Phone: 740/439 4478
1-800/945-4250
Fax: 740/432 1060
www.aaa9.org
James Endly,
Ex. Dir.

PSA 10A
Western Reserve Area Agency on Aging
925 Euclid Avenue Ste. 600
Cleveland, Ohio 44115
Phone: 216/621 8010
1-800/626-7277
Fax: 216/621 9262
www.psa10a.org
Ron Hill, Dir.

PSA 10B
Area Agency on Aging 10B, Inc.
1550 Corporate Woods Parkway, Suite 100
Uniontown, Ohio 44685
Phone: 330/896 9172
1-800/421-7277
Fax: 330/896 6647
www.services4aging.org
Joseph Ruby, Pres. and CEO

PSA 11
Area Agency on Aging 11, Inc.
5555 Youngstown-Warren
Suite 2685 Second Floor
Niles, OH 44446
Phone: 330/505-2300
1-800/686-7367
Fax: 330/530-8862
www.aaa11.org
Joe Rossi, Ex. Dir.

Ohio Assoc. of Area Agencies on Aging
88 E. Broad Street, Suite 870
Columbus, OH 43215
Phone: 614-481-3511
Fax: 614-481-3566
www.ohioaging.org/pages/home
Larke Recchie, Ex. Dir.

12/20/2010

Appendix F

Spending & Grants, SFY 2008-2011

Programs and Services	FY 2008	FY 2009	FY 2010	Estimated FY 2011
Community Services and Nutrition	81,455,068	92,360,231	100,639,707	49,936,446
Support for Informal Caregivers	11,819,380	11,621,686	10,032,225	9,635,699
Senior Farmers Market Nutrition Program	1,167,190	1,635,822	1,916,572	1,260,556
Service Coordination in Senior Housing	315,847	22,573	626,127	329,620
Residential State Supplement (RSS)	10,728,965	11,782,683	8,563,750	7,926,069
PASSPORT	381,474,774	426,602,517	471,394,137	524,856,177
PACE	24,597,775	23,871,133	24,235,776	25,257,805
Assisted Living	8,992,692	22,256,133	37,956,275	53,625,294
Long-Term Care Ombudsman	2,915,495	3,217,342	3,649,677	3,347,761
Long-Term Care Consumer Guide	1,008,192	257,684	1,037,707	253,708
Golden Buckeye Card	118,282	273,314	245,202	74,002
Ohio's Best Rx	1,485,147	1,296,901	52,657	-
Senior Community Services Employment Program	4,177,819	4,755,684	5,890,476	7,060,183
National Senior Service Corps	335,296	335,296	268,237	241,413
Senior Olympics	14,856	14,856	-	-
Community Outreach	60,397	40,219	117,942	181,320
Americorps and Other Volunteer Opportunities	6,941,535	6,423,159	7,366,096	6,855,482
Community Infrastructure Development	1,346,505	1,325,507	1,609,836	3,123,717
OCSC Program Management	176,052	556,534	139,230	142,856
Local Leveraged Funds (OAA Related)	57,246,352	59,613,659	56,289,487	56,289,487
Total	**596,377,618**	**668,262,931**	**732,031,118**	**750,397,594**

Appendix G

Intrastate Funding Formula

During the 2008-2011 state plan period, the Department of Aging used Census 2000 data for population factor weights in its formula – except for rural and medically underserved factors, which were based on Census 1990 data. The department has since rebased its funding formula to reflect Census 2000 for the rural factor, and will continue to use the medically underserved factor with 1990 population data. The department still is researching a new medically underserved factor more suitable for an older population.

Allocation of Title III funds to area agencies on aging is based on the economic and social needs of the population of persons age 60 or older in each planning and service area after a base level of funding is assured to each agency.

Title III Factors

Each area agency is allocated a base grant of $375,000. Of that amount, $170,000 is allocated for administrative costs. After base and administrative funds are removed, the balance of Title III funding to each agency is based on the population factor weights:

Individuals at or above age 60: 43 percent
Individuals at or above age 75: 28 percent
Individuals at or above age 60 and below the federal poverty level: 11 percent
Minorities at or above age 60: 8 percent
Individuals at or above age 60 who live alone: 8 percent
Individuals at or above age 60 who live in rural areas: 2 percent

Data Source: U.S. Census 2000

Title III-D Factors

Title III-D funds are allocated based on these population factor weights:

Persons at or above age 60: 20 percent
Minorities at or above age 60: 20 percent
Low-income persons at or above age 60: 20 percent
Medically underserved persons at or above age 60: 40 percent

Data Sources: U.S. Census 2000, U.S. Census 1990 and Ohio Department of Health

State Plan Process

The Ohio State Plan on Aging, FFY 2012-2013 was developed to comply with requirements established in Sections 305, 306, 307, 308, 373 and 705 of the Older Americans Act (OAA) of 1965, as amended in 2006. The plan follows guidance provided by the Administration on Aging in Program Instruction AoA-PI-10-05 and includes all assurances, provisions, information and intrastate funding formula requirements.

Strategic Area Plans

Section 306 of the Older Americans Act and ODA Policy 204.00: Area Plan require area agencies on aging to develop strategic plans for the period, CY 2011-2014. These plans set the stage for area agency direction at strategic and operational levels. In the strategic level, agencies describe their planning and service areas, and develop goals and objective based on this assessment. Agencies update their plans annually, noting changes in circumstances that could not be foreseen when strategic plans were first developed.

State Plan

The Department of Aging developed a two-year strategic plan for the new period FFY 2012-2013. Service needs and gaps, environmental scans and SWIP analyses from area plans were key elements the department employed to conduct its own SWOT (strengths, weaknesses, opportunities and threats) strategic analysis and lay the foundation for its plan.

Best Practices

In addition to analyzing trends in area plans developed by area agencies, the department reviewed state plans from other state units on aging. The department was especially interested in learning about best practices to modernize and re-balance long-term care in other states; state unit leadership roles in developing client-centered Aging and Disability Resource Networks; and how long-term care systems are integrated into existing Older Americans Act programs and services for older adults.

Agency Readiness

The Older Americans Act Programs Division has overall responsibility for planning, developing and submitting the state plan. Once the plan is approved by the administration, the division tracks implementation of goals and objectives affecting the entire department.

Division staff and department leadership agreed to change the strategic plan cycle from four years to two to allow for the biennium budget and change in governor. The current four-year plan expires Sept. 30, 2011. Director Bonnie Kantor-Burman quickly embraced the change in planning cycles as it allowed the department to reflect the vision, leadership and direction of Governor John Kasich, who took office in January 2011. Ohio's next strategic plan will be for three years.

Staff from all levels and divisions were involved during the agency readiness process. An overarching steering committee comprised of program staff was organized as well as a sub-committee made up staff from the Older Americans Act Programs and Communications Divisions.

The department hosted a retreat on April 19, 2011, which engaged 58 aging network stakeholders, including department and area agency staff, advisory council members and regional long-term care ombudsmen. During the retreat, workgroups led by facilitators were formed around five pre-identified strategic issues, and were the basis for discussion and development of goals, objectives, strategies and outcome measurements following SWOT analyses. The fifth issue was dropped as its concept was already embedded into the others.

Communicating the Plan

Department leadership chose a variety of collaborative interactions between various entities to garner input on the state plan:

Advisory Council on Aging: Council members were actively involved in helping to develop goals and objectives for the plan. The council is composed of 12 governor-appointed, voting members. Also appointed are two legislators who are ex-officio members, along with representatives from various state agencies and associations. The council reviews plans, budgets and issues that impact older Ohioans and advocates specific administrative and legislative actions.

Ohio Association of Area Agencies on Aging: The association is composed of the 12 area agency on aging directors and the association's executive director. Agency staff, along with other stakeholders, helped develop and refine strategic goals, objectives, strategies and outcomes and measurements, and will be involved in the implementation of same.

Ohio Association of Senior Centers: The Ohio Association of Senior Centers represents more than one-quarter million older adults and has membership in most of Ohio's 88 counties and all 12 of its planning and services areas. Strategic direction for the plan was discussed at the Association's April 2011 meeting.

Ohio Council of the Alzheimer's Association: The Department of Aging partners with seven Alzheimer's Association chapters, which are represented on the department's advisory council and whose strategic plan parallels this one and is attached as Appendix K: Ohio Council of the Alzheimer's Association Plan. Alzheimer's Association chapters provide information, programs and services, including support groups and educational workshops, to persons with Alzheimer's disease, their family members and caregivers.

Regional Long-term Care Ombudsman Programs: Representatives from six of Ohio's 12 regional ombudsman programs actively participated in the stakeholders' retreat and helped develop strategic goals and objectives.

General Public: General public feedback on the department's goals and objectives was obtained through its website in June 2011 and a blast electronic mailing to 2,200 subscribers to the department's publications, its social media outlets and individuals who recently requested information about ODA programs and services. All comments received are summarized and responded to in Appendix I: Summary of State Plan Public Input Comments.

Implementing the Plan

Ohio's plan was developed through much collaboration and interaction among various entities and stakeholders, including older adult consumers and their families and caregivers. The department now is poised to implement the goals and objectives developed through this interactive process effective October 1, 2011.

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Summary of State Plan Public Input Comments

Comments were received as public feedback from 19 responders on the four strategic issues, seven goals and related objectives and measurable outcomes developed by the Ohio Department of Aging. Commenters reacted to a draft of goals, objectives and measurable outcomes that the department made available through an electronic blast to its staff and 2,220 subscribers, social media outlets and a notice to stakeholders.

A summary of comments and the department's response are presented below. Input was reviewed and, where appropriate, was used to revise or clarify goals, objectives and outcomes. Detailed comments are available at the department and will be provided to staff, committees and workgroups responsible for implementing the plan.

General Comments

Several commenters expressed concerns about the limited time available to review and comment, problems accessing the draft online and the unexplained acronyms contained in the draft document.

> ***Response:*** *The review was not intended to follow the department's rules review process, but was to serve as a sort of online public meeting to seek input on draft goals, objectives and outcomes. Department staff resolved access issues as they arose. A summary listing of acronyms used in the plan is attached as an appendix.*

Several commenters provided support for specific goals and objectives.

> ***Response:*** *Thank you.*

Several commenters expressed concerns about the ambitious timetable for implementing the plan.

> ***Response:*** *Timetables attached to outcomes are tentative; they will be reviewed, and if appropriate, revised by staff, committees and workgroups responsible for implementing the plan.*

Numerous commenters volunteered to assist in implementing components of the plan or to provide information on the needs of elders living in their communities.

> ***Response:*** *The names for interested parties and resources will be passed on to the staff, committees and workgroups responsible for implementing the plan.*

Several commenters expressed concerns that specific needs (e.g., nutrition) or programs (e.g., advanced directives) were not addressed by goals and objectives.

> ***Response:*** *The plan targets implementing innovative strategies that enhance Ohio's Older Americans Act infrastructure, programs and services, and ensures that long-term services and supports are person-centered and available to meet the needs of consumers and their caregivers. It is not a work plan for all department and aging network programs.*

Issue 1: Aging & Disability Resource Network (ADRN)

One commenter warned that ADRN should not supplant or dilute the department's mission.

Several commenters expressed concern about developing a statewide brand for the ADRN when many area agencies already have established identities in their respective communities.

Multiple commenters provided support for the ADRN concept and volunteered to serve on the advisory group.

Several commenters suggested domains that should be included in the assessment tool (e.g., memory loss, nutrition)

> ***Response:*** *The intention of the ADRN is to support persons in the community who need information about and access to services. This aligns with the department's mission by creating partnerships and collaborations among the many entities that support people in the community. The department recognizes that area agencies and their partners have invested time and energy in establishing their presence in their local communities. The branding strategy in particular is intended to wrap around existing strategies and to provide common unifying elements to all of the partners and programs across the state that are a part of the ADRN. It is not intended to replace existing strategies, or create an undue burden for any of the partners to implement. As the department continues to develop and refine the ADRN, it is interested in including current and new partners to develop tools and continue discussions to implement this concept.*

Issue 2: Evidence-based Programs

Several commenters expressed concern about the available of resources (e.g., funding, staff time) needed to implement evidence-based programs.

> ***Response:*** *ODA shares the commenters' concerns. We included a goal in issue 4 that focuses on identifying additional reimbursement streams for evidence-based prevention programs.*

Several commenters suggested particular evidence-based programs (e.g., Dining with Diabetes) that should be added to Ohio's menu of evidence-based prevention programs.

> ***Response:*** *Identified programs and resources will be passed on to the staff, committees and workgroups responsible for implementing the plan.*

Several commenters were confused about the scope of the proposed marketing campaign objective.

> ***Response:*** *This goal was revised to target specific populations and referrers.*

Some commenters wanted information about how their organization could be engaged to implement evidence-based programs, or volunteered to serve as resources during learning sessions.

> ***Response:*** *These names will be provided to the appropriate staff, committees and workgroups responsible for implementing the plan.*

Issue 3: Person Centered Care

Multiple Commenters supported the emphasis on person-centered care.

Several commenters expressed concerns that implementing person-centered care practices during times when budgets, care plans and reimbursement rates are being reduced may impede progress towards this goal.

Several commenters expressed concern that the 50/50 goal between in-home and facility based care was not ambitious enough.

One commenter suggested that more emphasis need to be placed on transitioning inappropriate placements (e.g., mental health) out of nursing facilities.

> ***Response:*** *The department recognizes the ambitiousness of this issue and yet the overwhelming desire for this person-centered approach in home and community-based care settings. The department is aware that this change in philosophy will be made more difficult in light of budgetary cuts and that those changes may require re-evaluation of current policies such as "any willing provider." The department also is sensitive to the*

need for transferring people younger than 60 and those with mental illness out of restrictive institutions.

Issue 4: Community Supports and Needs

Numerous commenters noted current initiatives and resources that should be included in the disaster preparedness toolkit.

Response: *This goal and related objectives were revised to reflect comments received, especially as they pertained to resources and initiatives already available in Ohio.*

Several commenters questioned whether the department and area agencies have the staff resources to support the development of member-driven cooperatives.

Response: *The department will take on the initial responsibility for providing education and technical assistance. Focus will also be given to attracting funding to support implementation of this goal.*

Appendix J

Acronyms

AAA	Area Agencies on Aging
ACS	American Community Survey
ADRC	Aging and Disability Resource Center
ADRN	Aging and Disability Resource Network
ADSSP	Alzheimer's Disease Supportive Services Program
AoA	U.S. Administration on Aging
ARRA	American Recovery & Reinvestment Act of 2009
CDSMP	Chronic Disease Self-Management Program
CMS	Centers for Medicare and Medicaid Services
CLP	Community Living Program
CPI	Consumer Price Index
CY	Calendar Year
DSMP	Diabetes Self-Management Program
EBDP	Evidenced-based Disease Prevention
ECHO	Empowering Elders by Enhancing Cognitive Health Outcomes
EDDI-II	Early Diagnosis Dyadic Intervention II
EOC	Emergency Operations Center
FFY	Federal Fiscal Year
FY	Fiscal Year
IDEAS	Identifying Depression, Empowering Activities for Seniors
LIS	Low-Income Subsidy
MFP	Money Follows the Person
MIPPA	Medicare Improvements for Patients and Providers Act
MSP	Medicare Savings Program
NASUAD	National Association of States United for Aging and Disabilities
NCOA	National Council on Aging
NFCSP	National Family Caregiver Support Program
NORS	National Ombudsman Reporting System
OAAPD	Older Americans Act Programs Division
ODA	Ohio Department of Aging
ODJFS	Ohio Department of Job and Family Services
OEMA	Ohio Emergency Management Agency
OHT	Governor's Office of Health Transformation
O4a	Ohio Association of Area Agencies on Aging
PAA	PASSPORT Administrative Agency
PACE	Program of All-Inclusive Care for the Elderly
PASSPORT	Pre-Admission Screening System Providing Options and Resources Today
POMP	Performance Outcomes Measures Project
PSA	Planning & Service Area
PYs	Program Years
RDAD	Reducing Disability in Alzheimer's Disease

RLTCOP	Regional Long-term Care Ombudsman Program
RSVP	Retired & Senior Volunteer Program
SCS	Senior Community Services
SCSEP	Senior Community Service Employment Program
SFY	State Fiscal Year
SHIP	Senior Health Insurance Program
SWOT	Strengths, Weakness, Opportunities, Threats
TASC	Technical Assistance Support Center
TPO	Transportation Partnership of Ohio
US	United States
VD-HCBS	Veteran Directed Home- and Community Based Services

Appendix K

Ohio's Aging and Disability Resource Network (ADRN) Statewide Plan

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I. Vision and Goals

Ohio ADRN Project Vision Statement:

Ohio will support individuals as they explore and choose among the long-term service and support options available to them through the statewide presence of highly-visible, person-centered, fully-functioning Aging and Disability Resource Networks that provide information about and access to services, support informed decision making, ensure effective transitions across care settings, and facilitate streamlined access to publicly-funded services.

Project Goal # 1:

Ensure statewide presence for a fully-functioning Aging and Disability Resource Network (ADRN) that provides information on the range of long-term services and supports available to Ohioans of all ages.

Description of Approach:

Ohio has taken a "no wrong door" approach to its Aging and Disability Resource Network (ADRN). The network approach recognizes that individuals may access long-term services and supports in many different ways, through many different organizations. The goal is to ensure that no matter where a consumer first makes contact with the service delivery system, it's the right place for them to be. To achieve this, the ADRN brings together the diverse organizations that play a role in long-term services and supports to streamline access to services for the consumer. The intent is to develop and strengthen collaborative efforts at the local/ regional level with an emphasis on building relationships to support the five core services of an ADRN.

Ohio's twelve Area Agencies on Aging have been charged with identifying appropriate partners and building collaborative relationships to ensure the core functions of an ADRN are provided in the community. Through the work of the Unified Long-term Care System Workgroup, the state has identified initial key partners in the development of the ADRN at the regional level. Those partners include Centers for Independent Living, county Medicaid offices, 2-1-1/I&R providers, mental health board, developmental disabilities boards, long-term care ombudsman, the operating entity for the Ohio Home Care waiver (waiver for those under 60), ABD managed care entities, hospitals, physician offices and other partners as determined by the AAAs as lead agencies. The list of additional partners varies from AAA to AAA, but reflects the diverse relationships the AAAs have built to serve their local communities. Many of the relationships are in place, with varying degrees of formality based on the agreement of the partners.

The emphasis in the existing ADRC grant has been on building relationships at the local level among the partners and putting in place formal relationships in the form of Memorandums of Understanding, at a minimum between the AAAs and the Centers for Independent Living (CILs). Grant funding has been available to both the AAAs and the CILs to support this relationship building. As a result, the partners are engaging in discussion about areas of common interest, developing referral protocols and hosting cross training to develop a better understanding of the roles and responsibilities of each organization. The responsibility of the state and Area Agencies on Aging for developing the ADRN has been included in budget language for the state fiscal year 2012. From these relationships, the ADRN will identify the role and support each partner plays in achieving fully-functioning status.

At the state level, the Unified Long-term Care System Workgroup provided significant impetus for the development of the ADRN through discussions of the regional collaboration needed to support the "front door" to long-term services and supports. That work and discussion continues with the Office of Health Transformation, through the state's plans to transform Medicaid and create balance in the long-term care system. It is under this umbrella that a stakeholder group to oversee ongoing development of the ADRN will be developed. That stakeholder group will support the regional efforts to develop the ADRN and will identify expansion opportunities. The state level group will also develop a statewide marketing plan that creates clear messaging about the ADRN and identifies additional partners to participate in its development. A part of this work will be the development of a "brand" that ties together the various partners across the state into a unified system and provides consistency statewide.

Goals are included in this plan that more specifically address the core services of an ADRN that support our efforts to move to a statewide, fully-functional system.

How will you measure progress toward your goal?

Progress towards the goal of collaboration for the ADRN is measured by the relationships developed by the Area Agencies on Aging in their local community. Development of these partnerships is reported to the state on a semi-annual basis. Phase one of our statewide plan is for the AAAs to achieve “designation” status- this status reflects that they have developed the key relationship with their CIL or other disability partners as appropriate and that significant progress has been made in developing relationships with their other key partners as well. The second phase involves each ADRN identifying the role each partner plays in the core services, as steps to achieving the status of fully functioning.

Ohio will start with the fully-functioning criteria established by AoA/ADRC TAE and chart the progress of each ADRN towards achieving this status. In addition, a stakeholder group will identify other functions that are a part of the Front Door and create measures to chart progress. Ohio will create a “map” that shows how the core functions of the ADRN are being performed across agencies and continue to chart progress as populations served by the ADRN are expanded.

What are your anticipated barriers? How will you address these challenges?

The ADRN is still seen in some circles as an “aging” program, rather than as a cross-disability program. The AAAs, as lead agencies in developing the ADRN for their region, has been developing the disability component of the ADRN through partnerships with Centers for Independent Living, county-based developmental disability agencies and others. These partnerships are being developed with limited available funds (ADRN grant funds and use of administrative dollars from other funding sources) and put a heavy burden on the AAAs in on-going management of the partnerships.

The Centers for Independent Living, working through the Money Follows the Person/ re-balancing dollars, are being given opportunities to play a lead role in developing collaboration around specific community needs (cross disability home modification co-ops, personal assistance co-ops, housing co-ops), which will share the responsibility for developing the collaboration needed to support the ADRN in the regional area. The CILs are expected to partner with the AAAs, ADRN and others in development of their collaborative effort.

At the state level, the ADRN concept is “housed” at the Department of Aging, but isn’t integrated into other state agencies and state level organizations. The state will identify a stakeholder group to support and guide the development of the ADRN as it expands beyond the initial partners identified for collaborative activity. The stakeholder group will include appropriate state agency representation, disability provider representation (e.g. Olmstead Task Force, Statewide Independent Living Council, etc.), consumer representatives, AAAs and other aging network partners. Representatives of these

groups have participated in the state's Unified Long-term Care System discussions, and this stakeholder group for the ADRN seems a logical extension of that work as it continues.

What is your overall timeline and key dates?

The initial collaborative partners are expected to be in place by the end of the current ADRC grant period (October 2012). (As of the writing of this plan, 9 of the twelve AAAs, with their partners, have been designated as ADRNs. However, statewide the AAAs have been functioning as the front door to long term care services and have developed many relationships.) Fully-functioning status is expected to be in place in all ADRNs by October 2012. These activities are not linear, but are happening, in some cases in concert. On-going collaboration and partnership is key to the success of the ADRN in Ohio and this effort will be supported by the stakeholder group that guides on-going development.

The stakeholder / advisory group will be established in the fall of 2011. That group will review the plans for achieving fully-functioning status for the ADRN and help to establish reasonable timeframes and milestones for the work.

Project Goal # 2:

Individuals seeking publicly funded services and supports will access that assistance through a single-entry point system that provides comprehensive assessment of need and facilitates enrollment into available services.

Description of Approach:

Ohio has eight waivers serving older adults, individuals with physical disabilities and individuals with developmental disabilities, as well as Medicaid state plan services that support individuals with long-term care needs. Ohio has multiple doors and, in some cases, multiple steps through which individuals' access publicly-funded (Medicaid) services. The doors are distinct based on the services the individual is trying to access. Ohio's Area Agencies on Aging (AAAs) are the access point for the PASSPORT Home Care waiver, the Assisted Living waiver and the Choices (consumer directed) waiver, providing in-person assessment of need and facilitating service delivery. The AAAs also conducts pre-admission review and level of care determinations for individuals seeking nursing facility care. The county Medicaid offices are the access point for the Ohio Home Care waiver (59 and under) for the financial determination, while a contracted case management provider provides the functional eligibility determination after financial eligibility is determined.

The county boards of Developmental Disabilities provide access to the developmental disability waivers, and the state Developmental Disabilities agency determines level of care and eligibility. The Ohio Department of Developmental Disabilities began a futures planning process that is transforming the way services are provided for individuals with Developmental Disabilities. The DD transformation process is not included in this goal.

As part of the state's plan to transform Medicaid in Ohio, the state will move from multiple waivers serving older adults and people with disabilities, to a new waiver that serves these populations. The multiple doors that act as entry points into Medicaid services will be merged to a single entry point system for anyone seeking these services.

There are multiple tools that assess an individual's level of care and eligibility for publicly-funded programs. Ohio will develop a uniform assessment instrument that will support the individual's ability to choose among service options based on a person-centered, objective evaluation of need. The state has started work to modify existing level of care rules to support person-centered assessment and outcome. Development of the Universal Assessment Instrument will go hand-in-hand with the rule work. In addition, web-based and other tools that support eligibility determination will be developed, including a web-based referral system that eliminates duplicate entry of basic information from initial contact to the single entry point.

How will you measure progress toward your goal?

Ultimately, this goal will be achieved when Ohio has a single-entry point system for Medicaid funded services, which is anticipated to mirror the development of the combined waiver for aging and disabled populations with a projected date of July 2012. A comprehensive plan for achieving this goal will be developed with appropriate milestones to chart progress. Steps toward this goal include development of the universal assessment instrument and identification of tools that support streamlined entry into services.

What are your anticipated barriers? How will you address these challenges?

This is a significant change to the long-term service and support system in Ohio, but one that will ultimately result in more logical service delivery system that supports consumer choice and streamlines access to services. The approximate timeframe for this transformation is one year. The activities involve multiple stakeholders (to ensure buy-in) and will be labor intensive to achieve the timeframe. Challenges include creating a universal assessment tool that captures the needed elements to determine functional eligibility and linking those to specific service packages. Ohio has already begun the process of revising level of care rules and as part of that activity has initiated

conversations among stakeholders about a universal assessment instrument that captures relevant functional information and links it to services. Creating the technology to support this activity could be a challenge depending on whether an existing system is utilized or if one is built from scratch. Discussions of a universal assessment instrument are still in the very early stages, but already the need for additional support from a consultant to guide the process has been identified.

What is your overall timeline and key dates?

The single entry point system is set to begin function July 1, 2012, in conjunction with the single waiver serving multiple populations.

Project Goal # 3:

Ohio will expand use of its web-based information and referral portal, www.connectmeohio.org, positioning it as a source of information and decision support tools for those seeking services and supports.

Description of Approach:

Ohio developed www.connectmeohio.org with Systems Change dollars beginning in 2004. In state discussions of the role of a “front door” in a unified long-term care system, stakeholders identified key components for a virtual front door. In 2010, Connect Me Ohio (CMO) was chosen as the tool to meet this goal.

Connect Me Ohio is built on a provider driven model for including services. In this model, providers voluntarily submit information about their organizations, programs and services. That information is reviewed at the state level and included in the database. Without the on-going promotion necessary to keep this tool in front of providers, this method of provider data procurement has resulted in a less than robust data set. Ohio will continue to expand provider listings in Connect Me Ohio through partnerships with state agencies and other entities that collect and maintain provider information. The Ohio Department of Developmental Disabilities is using CMO as the web portal for its public search function. Information about long-term service and support providers is coming from the state Medicaid agency and the Department of Mental Health provider data is also being uploaded to the system. Preliminary discussions about the expansion project also included the state agencies for alcohol and drug addiction services, health and rehabilitation services. In addition, other sources of data about providers that are specific to particular populations (e.g. Veteran’s, brain injury) will be actively recruited for inclusion in the database.

Ohio will expand promotion of Connect Me Ohio as a source of information about programs and services available to Ohioans by linking to the site from partner agencies

that have supplied information about providers. Connect Me Ohio will support new efforts, such as Lifespan Respite, that share a goal of disseminating information about available services to individuals. Connect Me Ohio is one of the tools used by Ohio's Community Living Service (Local Contact Agency) providers for MDS section Q return to community efforts.

Ohio will continue to develop resources that support long-term service and support choice and decision making and will make those available through Connect Me Ohio. In addition, Connect Me Ohio provides a link to other web-based tools that support individuals in Ohio. These include the Long-term Care Consumer Guide (searchable database on nursing and residential care facilities, with a planned expansion to home and community-based services), the Ohio Benefit Bank (an Internet-based, counselor assisted service that connects low and moderate income families to tax credits and work supports), the Ohio Housing Locator (rental property listings focused on subsidized housing opportunities) and other complementary tools available to assist individuals in their decision making about long-term services and supports.

How will you measure progress toward your goal?

Ohio's web-based information and referral portal, www.connectmeohio.org, will experience an increase in providers listings included in the database and traffic to the site. This work has already begun, with the Developmental Disabilities site expected to be live by fall 2011 and the Medicaid and mental health provider data to be included by fall as well. Additional potential sources of data (brain injury, veteran's, etc.) have been identified, and some preliminary discussion about their inclusion in Connect Me Ohio has begun. These additional data sources are expected to be in place by July 2012, but work to expand the provider listings is an on-going process. The number of providers/ services is tracked in the database and Google Analytics provides monthly reports on traffic to the site and the referral source for those visits.

We will also track on a monthly basis usage of the additional supports, tools and resources that are added to Connect Me Ohio, enhancing its ability to support individuals in their decision making process. Home Choice, Ohio's Money the Follows the Person grant project, has developed a Relocation Workbook for individuals transitioning to the community. In addition, a Community Living Guide that supports the Section Q return to community work is in development. Both of these tools will be developed with an eye towards use in conjunction with Connect Me Ohio.

Feedback mechanisms, such as consumer satisfaction tools that are integrated into the system, will help inform the on-going usefulness of these tools and development of additional tools.

What are your anticipated barriers? How will you address these challenges?

There are a number of web-based information and referral portals available in Ohio, each with its champions and advocates. Many of the AAAs has developed local portals, as have the 2-1-1s, the Centers for Independent Living and a number of the state agencies. A couple of the AAAs, through their ADRN partnerships with their 2-1-1 Agencies, are moving towards using the 2-1-1's data management system, Refer. Refer has been selected by the Ohio Alliance of Information and Referral Systems (Ohio AIRS) as their common data platform; work to move all of the providers to this platform is continuing. At this time, rather than replace one system with another, Ohio will work towards coordinating efforts across systems, ensuring that accurate, comprehensive information is available that supports informed decision making, with an eventual goal of streamlining systems into a fewer number.

What is your overall timeline and key dates?

Initial efforts to include state agency information and develop a functional method for sharing data will be in place in 2012. This project is on-going, as additional populations are served by the ADRN and partner agencies, the breadth of information and resources will continue to expand.

Project Goal # 4:

Individuals seeking long-term services and supports will receive appropriate guidance that proactively matches the person's needs, preferences and values with available services, maximizing consumer choice and informed decision making.

Description of Approach:

Ohio meets the ADRC requirement for "options counseling" through its existing long-term care consultation (LTCC) service. The provision of the LTCC is specified in state statute, with the intent of reaching out to individuals who are considering admission to a nursing home to offer community-based alternatives instead. The statute identifies individuals for whom a LTCC is mandatory, but also provides flexibility to the performing agency to identify those who "might benefit" from the service. Neither the statute nor the operational protocols provide further direction about target populations other than that it be made available to "anyone who requests it," or detail about subject areas to cover, other than a "broad range of services." As it is currently performed, the long-term care consultation is usually a unique, most often one-time, interaction with a consumer.

The service is offered by the Area Agencies on Aging through their Medicaid and Non-Medicaid administrative function and is available statewide. The statute gives the

Department of Aging the responsibility for certifying those who may perform the service, but a formal program that establishes statewide expectations for knowledge base or skills has not been developed. All individuals who contact the AAA are offered an in-person visit, either through an assessment for waiver eligibility or a LTCC. Staff performing the LTCC has significant experience (licensed individuals-RN, LSW) in providing information about available options.

The LTCC is often cited as the solution for reaching new populations as we strive to better balance our long-term service and support system. Initiatives proposed in the state through its unified long-term care system goals (e.g. visits with nursing facility residents to identify community-based options, expansion of consumer direction in publicly funded services), as well as in national initiatives (e.g. working with the Veteran's Administration to provide home and community-based options) provide the opportunity to standardize the practice, expectations and subject areas the service covers so we can meet the needs of a changing service delivery system and the people of Ohio who are trying to navigate that system. The work to standardize our LTCC started with a vision developed at the state for the service, with the intent that every face-to-face interaction with a consumer start with the broad perspective of providing options, rather than determining eligibility for specific programs. From that, we are developing standards and practice expectations for the LTCC, through a workgroup of representatives from the AAAs, under the auspices of the existing ADRC grant. We are also developing a modular training program that will support the practice at the local level. Rather than supplanting existing training, we will use existing materials as a base and point of common reference. As the specific topic areas that may be covered in a LTCC are defined, we will seek input and support from subject matter experts to develop the messaging and training. The Centers for Independent Living, the SHIP program and legal service providers all can provide valuable input on the development of the modules, as will other state agencies and partners from the stakeholder group.

In addition to the LTCC, other services that meet the broad definition of options counseling also occur in the state (e.g. Medicare/health insurance counseling through the State Health Insurance Program, facility selection/ decision support through the Ombudsmen, peer support and advocacy through the Centers for Independent Living, etc.). Expanding the definition of Options Counseling to include the broad range of other services that meet the definition is crucial to fully understanding all the methods through which an individual may receive decision support. We will identify how this service is provided across systems and share development of consistent standards for Options Counseling that will support implementation across providers.

How will you measure progress toward your goal?

We track the use of the long-term care consultation in our data management system and review the numbers in preparation for the Semi-Annual Reporting Tool every six months. This practice will continue beyond the life of the grant, with reports to the LTCC providers about trends in the utilization of the service. We will work with other "options counseling" providers to determine their tracking mechanisms and reporting tools so the full picture of Options Counseling becomes apparent. As part of the further development of the LTCC, we are working on a consumer satisfaction measurement tool specific to the service that will be utilized statewide.

A part of this goal is to create a "map" of the ways options counseling is provided in the state, in addition to the long-term care consultation. As we develop this inventory of options counseling, we will initiate discussions about existing standards and create standards for those activities that are included in options counseling in the state.

What are your anticipated barriers? How will you address these challenges?

The state administrative code rule that governs the provision requires a five day turnaround from when the request is received to when the LTCC is performed. This tight time frame creates barriers to use and barriers to accurate reporting of how often the LTCC is performed. While the rule does require the five day time frame, it is flexible to meet the needs of the consumer. Further education will be provided to the LTCC providers on the flexibility in providing the service.

The long-term care consultation, as an existing resource, comes with perceptions about its role and purpose- some believe it is specific to those entering a NF, others believe it is only for a non-Medicaid population. As such, the service is performed and utilized differently among the providers. The service is not fully understood by stakeholders who may not realize its potential for reaching a broad audience. As we build the standards and structure for the service, we will need to conduct a lot of training, explaining its role and purpose, and re-positioning it as a tool available to many populations.

There are many opinions about what "options counseling" includes, depending on the service delivery system. As we research the many services available that play a role in options counseling, we will further refine expectations for options counseling from the state's perspective.

An additional barrier may be funding to provide this provision, which may be true of all service providers who perform some aspect of options counseling. For the AAAs that performs long-term care consultations, the LTCC is funded through a combination of Medicaid and non-Medicaid funds. Because of the state budget challenges and

anticipated budget cuts, the AAAs may need to prioritize LTCCs to those who would most benefit from the interaction, e.g. those for whom a nursing facility admission is imminent without intervention as opposed to those who are doing advance planning without an immediate need in mind. We will watch the numbers carefully as the budget year progresses and make budget adjustments as needed so the service remains available to a wide range of people.

What is your overall timeline and key dates?

Work on creating structure for the long-term care consultation has begun as part of the existing ADRC grant activities. Development of the core elements and training requirements will continue through 2012 and will be implemented in 2013. Initial conversations about options counseling in all its varieties will begin as partners and stakeholders are identified for the steering committee that will oversee on-going development of the ADRN in Ohio (fall 2011).

Project Goal # 5:

Ohio will support individuals as they transition between care settings by offering services that ensure coordination of care and supportive services that facilitate movement between care settings.

Description of Approach:

Ohio is taking a comprehensive approach to care transitions, looking at not only the evidence-based care transition services that support individuals as they move from hospital to community, but also transitions from hospital to nursing facility and nursing facility to home. The state has set an ambitious goal of re-balancing its long-term care system, with the intent of seeing a 50/50 mix of institutional and home and community-based care settings for adults age 60+ with physical/ cognitive disabilities and 40/60 institutional/HCBS distribution for adults age 59 and under with physical/ cognitive disabilities. To achieve this goal, the state will support a multi-faceted approach to diversion and transition activities, ensuring that individuals seeking long-term services and supports have access to the most appropriate decision support.

Recognizing that hospitals are an important source of nursing facility admissions, a number of the Area Agencies on Aging have developed programs to offer options. AAA10B, in Akron, has a long-standing partnership with Summa Health System that, among other things, places nurse assessors at Summa Hospitals. The nurse assessors are available to hospital staff and patients to assist with community-based options and to provide assessment for needed community-based services. AAA7 serving southern Ohio developed the Bridges program with a local hospital. Bridges gives the hospital

expedited access to AAA assessment staff to assist with patients beginning the discharge process, so that community-based options can be explored. The Council on Aging of Southwestern Ohio, AAA1, has developed relationships with their local hospitals that also provides expedited access to AAA services and AAA assistance with planning for discharge to the community and the Care Transitions Intervention.

Ohio has been studying diversion activities for the past two years, under the FY2009-2011 state budget. A working team of staff from the Department of Aging and the Area Agencies on Aging developed intervention strategies which were then implemented by the AAAs. Diversion activities are directed at helping individuals in the community choose among the care options, with a preference for home and community-based services. This is supported by information and assistance in the initial contact and then by long-term care consultations and assessments for more in-depth information and assistance as requested. To build community diversion activities, the AAAs have been partnering with hospitals to increase the awareness of home and community-based options among staff and to support interaction with patients to educate them about options in the community. These partnerships have developed slowly, but are gaining momentum with onset of health care reform activities that require partnerships between facilities and community-based organizations.

The state has also placed an emphasis on retention of waiver consumers as a form of diversion. Activities that support this diversion include reviewing and increasing care plan costs for individuals who have an acute episode that might otherwise result in a nursing facility admission; and, proactively following up with waiver consumers admitted to a hospital or nursing facility to maximize their potential to return to community.

Transition activities conducted as part of the state's 09-11 budget initiatives include developing working relationships with nursing facilities to ensure staff and resident awareness of community-based options; linking closely to transition coordinators working under the auspices of the Home Choice Program (Money Follows the Person grant); strengthening relationships with Ombudsmen to identify and support individuals who may express interest in returning to the community; and, more closely reviewing and following individuals who are known to the AAA through the Pre-Admission Review (PAR) process.

The diversion and transition activities conducted as part of the study include 1974 individuals identified for diversion and 1259 identified for diversion. These numbers only include those for whom particular intervention strategies was implemented and may not reflect all of the diversion and transition activity that is conducted throughout the state. Lessons learned from these pilot projects will inform practice as we move forward with specific outcomes relative to re-balancing through diversion and transition.

The efforts of community-based care transition coordinators for the Home Choice (Money Follows the Person- MFP) have also supported 1167 individuals as they transitioned to community living. AAAs, Centers for Independent Living and other community-based staff are also acting as “Community Living Specialists” (CLS) for Ohio’s MDS Section Q implementation. The CLS responds to referrals from nursing facilities for residents who express an interest in speaking to someone about return to the community. These interactions between CLS and nursing facility residents are funded by re-balancing dollars realized with the MFP project. The use of re-balancing dollars to support the CLS activity has provided an opportunity to more closely integrate the AAA and MFP efforts to transition staff and has created a closer working relationship between the state Medicaid agency and the Department of Aging.

Staff at each of Ohio’s Area Agencies on Aging has been trained in the (Coleman) Care Transitions Intervention, in order to position themselves to take advantage of opportunities afforded by health care reform. With this service in place, Ohio is positioned to reduce the incidence of preventable re-admissions. This will be accomplished by targeting hospitals with high re-admission rates and linking them with community based organizations that provide care transitions services. The combination of trained staff ready to implement the Care Transitions Intervention and the relationships built with hospitals through the ADRN project puts Ohio in an excellent position to address transition from hospital to community. In addition to offering the Care Transition Intervention, there is a practical use for the skills developed as part of the service. The AAAs plan to utilize the Care Transitions Intervention for waiver consumers, ensuring that their return to community after hospitalization is successful, that re-admissions are prevented and supporting the state’s diversion initiatives.

How will you measure progress toward your goal?

Specific outcomes for balancing the long-term service and support system have been developed for the AAAs as the day-to-day waiver administrators. Outcome one: increase the percentage of diversion from admission to nursing facility for both community and waiver participants, as measured by increase in length of stay in the waiver programs, gain in waiver census and decrease in nursing facility utilization. Outcome two: Reduce the percentage of ODA administered waiver participants discharged from the program to a nursing facility, measurement captured in the waiver IT system. Outcome three: Increase number of nursing home transitions to community settings of choice, as measured by “assessment outcome” data from the waiver IT system.

The state had considered including an outcome related to the Care Transitions Intervention and waiver consumers, but at this time data to support practice is not available. (The state Medicaid agency is undergoing a major overhaul to its data management system, with an August “go-live” date.)

What are your anticipated barriers? How will you address these challenges?

Funding will be a barrier as reduced budgets for program operations will change the ability of provider agencies to seek out and assess individuals in nursing facilities. We will identify characteristics for those able to successfully return to the community and will target assessments to individuals with the greatest likelihood of return to community. The MDS Section Q work is supporting the transition activities, providing information about individuals with an interest in return to community. The state will continue to use the Community Living Specialist service as a tool to identify consumers likely for transition.

Funding is also a barrier for wide-spread implementation of the Care Transitions Intervention, as without a dedicated funding source, this service cannot be performed. We will approach health care systems, insurance providers and managed care program operators to find common goals and ensure the service is available and reaching its intended audience. Agreement has been reached with the AAAs for implementation of the Care Transitions Intervention with waiver consumers, so we will have a practical base from which to build a statewide system when funding is available.

What is your overall timeline and key dates?

The outcome driven diversion and transition activities begin with the state’s fiscal year, July 1, 2011 through the agreements with the AAAs as waiver administrators. As this plan is being written, specific benchmarks and budget criteria are being developed. Outcome driven performance measures will require careful data review and adjustment over the course of the first year to ensure practice meets expectations.

II. Who are the key players and responsible parties?

The Area Agencies on Aging have been given responsibility for development of the ADRN within their region (based on the Planning and Service Area for the AAA). Key partners in ADRN development at the regional level are the Centers for Independent Living, county Department of Job and Family Services (Medicaid) offices, 2-1-1/ I&R providers, county-based Mental Health boards, county-based Developmental Disabilities boards, Long-term Care Ombudsman, the Home Care Waiver operator, Care Star, ABD managed care entities, hospitals and physician offices. This list of

partners for regional collaboration was developed as part of the state's efforts towards a Unified Long-term Care System. These entities are seen as essential to the development of a front door to long-term services and supports. The state is encouraging formal partnerships with these entities, as demonstrated by a contract, MOU or other written protocol identifying how the partners will work together. Development and maintenance of these relationships is the responsibility of the Area Agency on Aging.

In addition, the Area Agencies on Aging, with their collaborative partners are identifying additional organizations that make sense to have as part of their regional collaboration activities. These may include senior centers, county offices on aging, housing entities, Community Action agencies, legal aid, disaster preparedness entities and others depending on the needs identified by the partners. The mix of partners involved in development of the ADRN will vary depending on the resources available in the community and in the component of the ADRN which is being developed.

At the state level, the key partners are the Office of Health Transformation, the health and human service cabinet agencies (aging, Medicaid, health, developmental disabilities, mental health and alcohol and drug addiction services), legislators, the Rehabilitation Services Commission, Olmstead Task Force, Statewide Independent Living Council, stakeholder groups and associations, AARP and others that have participated in the Unified Long-term Care Systems workgroups (300+ people) that continue to participate in the state's transformation efforts. As with the work at the local level, the mix of partners involved in development of the ADRN varies depending on the component being developed.

The Department of Aging has been charged with leading development of the ADRN in Ohio, in concert with the Area Agencies on Aging and their partners. This role has been clarified in legislation included in the budget beginning July 1, 2011. Within the Department, the development of the ADRN has been integrated across divisions. Project Manager Deanna Clifford is housed in the Community Long-term Care Division, which primarily oversees the Medicaid Home and Community-based waiver programs. She works closely with the Older Americans Act division staff to ensure implementation and support for ADRN concepts within the non-Medicaid programs. The Department is a part of the Office of Health Transformation, which brings together the health and human service agencies. The Office is leading the state's efforts to transform Medicaid and has established a direction for the state that builds on earlier efforts to unify the long-term care system. Part of that is the recognition of a need for a clear front door, built on the ADRN concept. The Department works closely with the state Medicaid agency on projects that affect the entire long-term care system, including review of the

state's level of care rules, implementation of MDS Section Q and support for the Money Follows the Person grant as a transition tool.

III: Financial Plan- Resources to Sustain Efforts

What existing funds/ programs are currently being used to carry out ADRC activities?

Ohio is building its Aging and Disability Resource Network using, as much as possible, existing services and funding streams. This is a deliberate strategy that will allow for on-going support of the ADRN in the state. Current ADRC grant funds are supporting the AAAs and the Centers for Independent Living in their efforts to build relationships at the local/ regional level. Those funds support staff time, travel and training related to ADRN development.

ADRN Activities:

1. Information and Assistance: At the AAA, I&A is supported by Medicaid dollars through the waivers (screening activities), Older Americans Act dollars and local funding sources (levies). In addition Older Americans Act dollars support I&A provided at the community level through contracts with service providers. The Centers for Independent Living receive funding for information and assistance through Title VII of the Rehabilitation Services Act; 2-1-1/ I&R providers receive United Way and other local funding for information and assistance. Annual fees for Connect Me Ohio are supported by state revenue; the current expansion project is funded with re-balancing dollars through the Money Follows the Person grant.
2. Options Counseling: Currently we are using the Long-term Care Consultation to meet this requirement. The LTCC is funded by state revenue and Medicaid funds. As we further develop our concept of Options Counseling, it will become more clear how much and what sources of funds are directed to this service.
3. Care Transitions: Our care transitions activities directed at waiver consumers are funded by waiver and state revenue funds. The AAAs are seeking funding through health care reform initiatives to pilot programs in local communities with hospital partners and 3rd party payers. A few AAAs are active in their community in the development/planning of ACOs in their region, which promotes partnership and participation of ACOs and Health Homes in the future.
4. Streamlined Eligibility/ Single Entry Point: Functional eligibility determinations for Medicaid programs are funded by Medicaid dollars through the waiver services. Eligibility determinations for non-Medicaid services are funded with state revenue

and Older Americans Act dollars through care coordination and caregiver support services.

Many of the state's initiatives to transform and streamline access to services are being supported by re-balancing dollars through the Money Follows the Person grant, with its emphasis on system transformation goals. Activities for which re-balancing dollars will be used include the local housing service cooperatives (led by the Centers for Independent Living) and the Level of Care review/ Universal Assessment Instrument development (led by the Medicaid agency).

What additional programs and service offerings are necessary to operate fully functional ADRCs across the state?

Much of the function work of an Aging and Disability Resource Network is already in place through existing contracts and agreements with community-based providers. Our challenge is in creating consistency across delivery systems. At this point additional programs and service offerings have not been discussed; though embedding the ADRN in upcoming opportunities will continue to be a priority. A review of the core functions of the ADRN and the match of those services to state needs will be a task for the state level advisory group. As the group identifies new opportunities, it will also be challenged with implementation and funding strategies.

What is your estimated cost to expand statewide (e.g. new MIS purchase)?

Additional needs have not been identified at this point, so a budget for expansion beyond existing resources is not in place.

How will you access the resources and create the revenue opportunities necessary for sustainable ADRC implementation on a statewide basis?

Since we are building the ADRN on existing services, our greatest challenge is maintaining those funding streams to ensure services continue to grow to meet demand. In the current restrictive budget times, it has become even more crucial to reach out and explore new partnerships that expand use of existing services to new populations, with new sources of funding. Certainly as streamlining/ transformation efforts continue to unfold, the goal will be to realize savings and re-purpose dollars to support activities that assist the state in meeting its re-balancing goals. As new opportunities to expand the ADRN to additional populations are identified, careful consideration for financial support will be considered.

In order to diversify the funding streams that support the state's long-term care system, new partnerships are being developed with, among others, health insurance providers and the state's three retirement systems. We are including goals in the state plan to create marketing and positioning tools for the ADRN so the services available become known and used by additional agencies/ entities. We are in discussion with the state's retirement systems about using the ADRN to support, for example, care transition services for retirement system members, whose health care costs are funded by the retirement system. This partnership will create a new source of revenue for the ADRN partners delivering the service, while saving the retirement system money on re-admissions.

These new partnerships have the potential to bring new sources of funding that will support key programs, but to also expand the population of people that may interact with the ADRN.

What are the estimated project cost savings/ offsets of having fully functional ADRCs statewide?

Development of a statewide, fully functional ADRN in Ohio is crucial to the state's Medicaid transformation goals. The delivery system for long term services and supports in Ohio is complicated and fragmented. Today a Medicaid-eligible consumer who needs long term services must navigate through a system that includes as many as five different waivers and four Medicaid state plan delivery models with different enrollment requirements and processes and different service packages for each.

The complexity inherent in the current delivery system magnifies the institutional bias created by a federal preference for nursing facilities. Individuals seeking long-term services are often making decisions under significant time pressures and emotional stress. Our system transformation efforts take a number of approaches: Combining Medicaid funding for long-term services and supports into one line item for people with disabilities and older adults; merging five waivers into one; and simplified access to services. A clear "front door" into the delivery system for long-term services and supports is essential for individuals to understand their options, access services in the most appropriate setting for their needs and achieve balance among various settings. The Office of Health Transformation and the state agencies will work to align access points so individuals can obtain needed services and supports in a seamless, timely and cost-effective manner in settings they choose. This effort will build on work already

underway through the Money Follows the Person program and the Unified Long-Term Care Systems Stakeholder Workgroup.

By implementing a unified delivery system for long-term services, the barriers to a balanced delivery system are removed. These policy changes are important steps toward providing consistent opportunities for choice to individuals needing long-term services and supports to live in and receive services in the settings they prefer and provide opportunities for improved care coordination. In addition, Ohio will also achieve greater transparency in price and quality by combining funds and programs for individuals needing long term services. The Unified Long-Term Service System‖ also is an important element in the implementation of the Integrated Care Delivery System (ICDS), Ohio's proposed demonstration to integrate services for dually eligible individuals and other individuals with long term care needs.

Based on the projections for cost savings estimated by the Lewin provided Cost Offsets Calculator, the impact of the ADRN in Ohio on Medicaid costs ranges from nearly $1.7 million per year (1% of those screened remain in the community) to just over $3.3 million (2% of those screened remain in the community) in 2011 (with ADRNs not yet available statewide). With 100% coverage of the ADRN, cost savings range from $7.3 million (1% remain in community) to $14.6 million (2% remain in the community). These numbers will provide a barometer against which to measure the impact of our efforts to re-balance the long-term care system.

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Appendix L

The Scope of Alzheimer's Disease in Ohio
May 2011

Executive Summary

Ohio Council represents the seven Alzheimer's Association chapters that serve Ohioans dealing with Alzheimer's disease (AD) and other dementias. The mission of the Ohio Council of the Alzheimer's Association is to provide a statewide advocacy voice to ensure that executive, legislative and judicial decisions meet the needs and represent the interests of Ohioans with Alzheimer's disease and related disorders, their families and caregivers.

The ***Scope of Alzheimer's Disease in Ohio*** document is comprised of a detailed outline of the prevalence and care needs of Ohioans with Alzheimer's disease or a related dementia in Ohio. It also includes several recommendations and strategies submitted by the Ohio Council of the Alzheimer's Association for consideration for the state's future public policy response to this growing epidemic.

The included recommendations were created by Alzheimer's Association staff and volunteers, caregivers, Ohioans living with memory loss, professional caregivers and community stakeholders.

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Alzheimer's Disease

Alzheimer's disease is a progressive and fatal neurodegenerative disorder manifested by cognitive and memory deterioration, progressive impairment of activities of daily living and a variety of neuropsychiatric symptoms and behavioral disturbances. Studies indicate that people 65 and older survive an average of 4-8 years after a diagnosis of Alzheimer's disease, yet some live as long as 20 years. This indicates the slow, insidious nature of the progression of Alzheimer's, with the loss of memory and thinking abilities, as well as the loss of independence over the duration of the illness.

Today, as many as 5.4 million Americans are living with Alzheimer's disease, the sixth leading cause of death in the country and the fifth leading cause of death for those 65 years of age and older. Since 2000, while deaths from other major causes (stroke, HIV Aids, heart disease, prostate and breast cancer) have actually decreased, deaths from Alzheimer's disease have increased by 66%. Projections estimate that the disease will strike 10 million baby boomers, or one in every eight. Without advances in therapy and treatment, the number of cases in the United States is predicted to rise to 13.2 million by 2050.

Alzheimer's is a family disease. Alzheimer's captures and changes the lives of the whole family -- physically, spiritually, emotionally and financially. The whole family needs assistance and support. There are millions of unpaid caregivers which are very often family members, as well as neighbors and friends. In 2010, nearly 15 million Americans provided unpaid care for a person with Alzheimer's or other dementia. This care totaled 17 billion hours, a contribution to the nation valued at over $202 billion. Eighty percent of care provided at home is delivered by family caregivers; fewer than 10 percent of older adults received all of their care from paid caregivers. Caregiving for a person with Alzheimer's or another dementia is very difficult, and many family and other unpaid caregivers experience high levels of emotional stress and depression as a result. Caregiving impacts the emotional well being, health, income, employment and financial security of the caregiver.

Paid caregivers also play a significant role in the lives of those living with Alzheimer's or a related dementia. It is projected that the United States will need an additional 3.5 million healthcare providers by 2030 just to maintain the current ration of paid caregivers to the population. Education and training are an essential element of professional caregiving programs needed for people with dementia. Nothing can replace the person-to-person sensitivity of a dedicated, trained paid caregiver. Too often direct care workers receive little or no training on providing quality care for persons with Alzheimer's disease or a related dementia. The quality of care that these individuals receive varies and is inconsistent. At the present time, there are no statewide standardized requirements for long term care facilities in how dementia care is provided.

As the number of people with Alzheimer's grows in the future, aggregate payments for their care will increase dramatically. The projected cost of their care by 2050 is $1.1 trillion.

Source: *2011 Alzheimer's Disease Facts and Figures.* Alzheimer's Association

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Alzheimer's Facts and Figures in the State of Ohio

Today, approximately 230,000 Ohioans have Alzheimer's disease and 250,000 Ohioans will have Alzheimer's disease by 2025. That's about 1,700 new cases each year. There are over 1.2 million caregivers in Ohio caring for a family member with Alzheimer's disease.

In existence since 1987 (Hobson-Quilter Bill), the Alzheimer's Respite Line Item 490-414 (Department of Aging) provides funding for respite and respite-related services for caregivers and those with AD. The Alzheimer's Associations in Ohio have received portions of this funding since the line item's inception and has been able to provide vital "Core Services" to Ohioans in need of a break from caregiving. Core services include over 500 support groups in Ohio, thousands of caregiver education programs across the state, as well as needed care consultations so necessary for families planning on-going care for this long-term, incurable disease. The chapters across Ohio are also a crucial link for families as they seek information about Alzheimer's and direction for available community services and resources.

State Supported Respite Programs Save Ohio Money

- Respite can often delay the need for nursing home placement. Regular use of respite reduces stress for caregivers and extends their ability to care for their loved one at home.
- Half of Medicaid beneficiaries in nursing facilities have AD.
- By 2015 Medicaid expenditures for residential dementia care will increase 80 percent.
- A one-month delay in nursing home placement could save Ohio $1.12 billion annually.

Alzheimer's Impact on Business:

- Ohio businesses lose $3.2 billion annually in lost productivity and health care costs due to Alzheimer's and related dementias.
- Nationally, costs to businesses due to Alzheimer's exceed $63 billion a year - $25.6 billion covers Alzheimer's health care and $37.5 billion covers costs related to caregivers of individuals with Alzheimer's disease, including lost productivity, absenteeism and worker replacement.

Projected Number of Ohioans Aged 65 and Older with Alzheimer's Disease

Year	Projected Number of Ohioans with Alzheimer's	Percent Change in comparison to year 2000
2000	200,000	
2010	230,000	15%
2025	250,000	25%

Number of Alzheimer and Dementia Caregivers, Hours of Unpaid Care and Economic Value of the Care in Ohio (2010 data)

Number of Alzheimer/Dementia Caregivers	Hours of Unpaid Care per 100,000	Value of Unpaid Care
585,317	666,558,493	$7,952,042,822

Number of Deaths Due to Alzheimer's and Age-Adjusted Rates in Ohio (based upon 2007 population)

Number of Deaths	Age-Adjusted Rate per 100,000
3,671	32.0

Cognitive Impairment in Ohio Nursing Home Residents (2008 data)

Total Nursing Home Residents	Percentage of Very Mild/Mild Cognitive Impairment	Moderate/Severe Cognitive Impairment
191,179	27% (51,618)	43% (82,207)

Source: *2011 Alzheimer's Disease Facts and Figures*. Alzheimer's Association

Non-Ohio Specific Facts

- An estimated 500,000 individuals in the United States have early-onset or younger on-set dementia. Of these 500,000, 40% (200,000) have early on-set Alzheimer's disease.

- Women are more likely than men to develop Alzheimer's disease.

- 61% of caregivers of people who have dementia report high or very high emotional stress levels due to caregiving

- Average payments for hospital care for Medicare beneficiaries aged 65 and older is higher for individuals with dementia than Medicare beneficiaries in the same age group.

Average Per-Person Payments for Healthcare Services, Medicare Beneficiaries Aged 65 and Older with or without Alzheimer's Disease and Other Dementias, 2009 Medicare Beneficiary Survey

Healthcare Service	Average per Person Payment for Those with No Alzheimer's or Other Dementia	Average per Person Payment for Those with Alzheimer's or Other Dementia
Hospital	$3,503	$9,768
Medical Provider	$3,948	$5,551
Skilled Nursing Facility	$424	$3,862
Home Health Care	$359	$1,601
Prescription medications	$2,203	$3,198

Source: *2011 Alzheimer's Disease Facts and Figures*. Alzheimer's Association

- According to the July 2010 AAA Caregiving Survey Results by Jane K. Straker, Abbe E. Lackmeyer, Suzanne R. Kunkel, and Emily J. Robbins, Scripps Gerontology Center, Miami University, of the Area Agencies on Aging that were surveyed, 66.4% reported they have a formalized relationship with the Alzheimer's Association.

Identified Needs, Recommendations and Objectives

Each Ohio Alzheimer's Association chapter was asked to survey constituent groups from their local areas and pose several questions related to their experiences with memory loss, whether that be personal, professional or in the community. Three significant themes were consistent from this exercise: the need for Alzheimer education and resources, the level of the quality of care in the health-care setting and the need for continued and increased respite services. Below is a summary of those themes and additional needs identified as result of this survey and reflections of the needs of individuals who are impacted by this disease.

Access to Services

Identified Need: Lack of dementia-specific knowledge and access to resources and services for individuals with dementia, family caregivers and professional caregivers.

Recommendation: Offer Alzheimer's disease and related dementias specific information and education, including Alzheimer's Association awareness, in a coordinated, efficient manner to the healthcare community and individuals upon initial diagnosis.

Objective: To educate physicians and other healthcare professionals to improve accurate diagnosis, appropriate treatment and referrals as early in the disease process as possible.

Evidence-Based Programming

Identified Need: Education and respite programs were identified as vital programs for family caregivers and people with dementia; therefore an identified need is to increase in evidenced-based programs for individuals who are impacted by Alzheimer's disease and related dementias.

Recommendation: Examine and expand evidenced-based programs for families who are impacted by Alzheimer's disease and related dementias which can help maintain independence and reduce premature institutionalization.

Objective: To expand Reducing Disability in Alzheimer's Disease (RDAD) program and explore additional evidenced-based programs related to caregiver education, care consultation, early stage memory loss, respite care and other models for further implementation.

Person-Centered Care

Identified Need: There is a lack of quality care available across the health care spectrum. Specific areas of needs include hospitals, physicians, nursing homes, assisted living and home health-care agencies.

Recommendation: Provide person-centered, dementia-specific training and resources to the health care system to improve quality care in the most cost-efficient manner possible.

Objective: To offer dementia specific training to professional caregivers long-term care (nursing homes, assisted living and home care agencies) through mandated dementia-specific training and through collaborations with hospitals.

Community Supports and Service Infrastructure

Identified Need: Lack of awareness about Alzheimer's disease and related dementias as well as services available to support families, including the Alzheimer's Association

Recommendation: To continue to develop a supportive scope of dementia-specific services through an increased number of partnerships with private and public entities, including but not limited to the Ohio Department of Aging, Area Agencies on Aging, Ohio Alzheimer's Association Chapters, and other related organizations, to support families in the setting they prefer and maintain the highest quality of life possible.

Objective: To maintain and explore ways to offer additional respite services to families.

Objective: To continue to offer "Core Services" – support groups, caregiver education programs, information and referral, and Medic Alert Safe Return through collaborations with the Ohio Department on Aging, Area Agencies on Aging and the Alzheimer's Association.

Marketing Innovations

Identified Need: Lack of Alzheimer's (dementia)-specific awareness, information, support and services in a wide array of areas.

Recommendation: Increase awareness about the numbers of individuals affected by Alzheimer's disease and related dementias in Ohio, the impact of this epidemic, and current services available in the community.

Objective: To explore and establish a pilot program with a health plan or retiree system that supports Alzheimer-specific services.

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Cleveland Area Chapter
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Greater Cincinnati Chapter
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