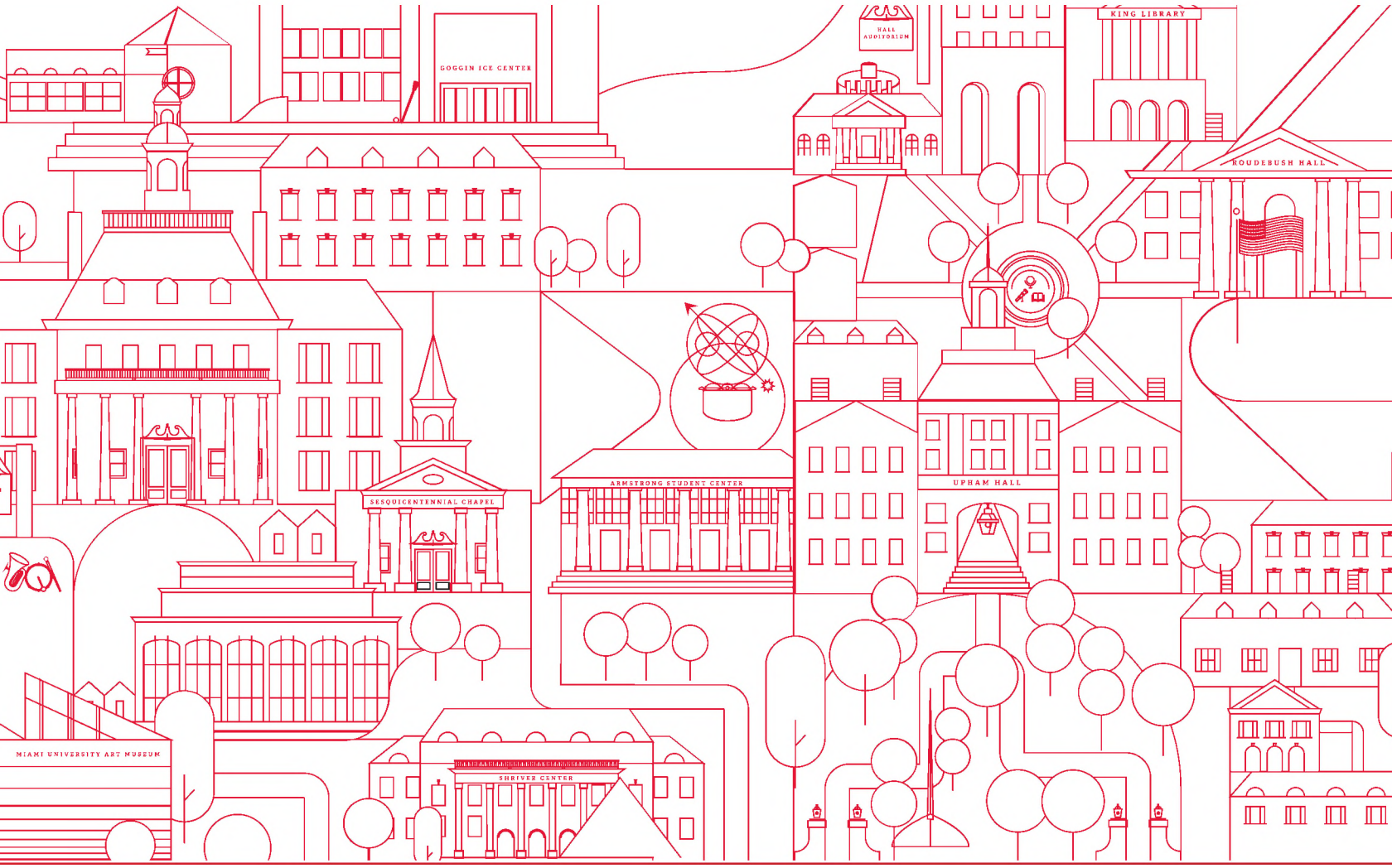
HOME-AND COMMUNITY-BASED SERVICES IN OHIO:

1993-2023

Ohio Department of Aging and
Scripps Gerontology Center

WINTER 2025-2026

MIAMI UNIVERSITY | Ohio Department of Aging



Scripps Gerontology Center

100 Bishop Circle
Upham Hall 396
Oxford, OH 45056

ScrippsAging.org
513-529-2914
Scripps@MiamiOH.edu

MIAMI UNIVERSITY

LETTER FROM THE DIRECTOR

Dear Ohioans,

On behalf of the Ohio Department of Aging (AGE), I am pleased to present this report on Ohio's home-and-community-based services (HCBS). It offers a snapshot of the long-term services and supports environment in Ohio based on a comprehensive analysis and survey responses. We thank the Miami University Scripps Gerontology Center (Scripps) for their ongoing support, and more specifically for coordinating this report.

Everyone's care journey is different and HCBS puts choice at the forefront. The services help people live and age where they feel most comfortable, while receiving the care they need. HCBS is a vital component of the broader long-term care continuum.

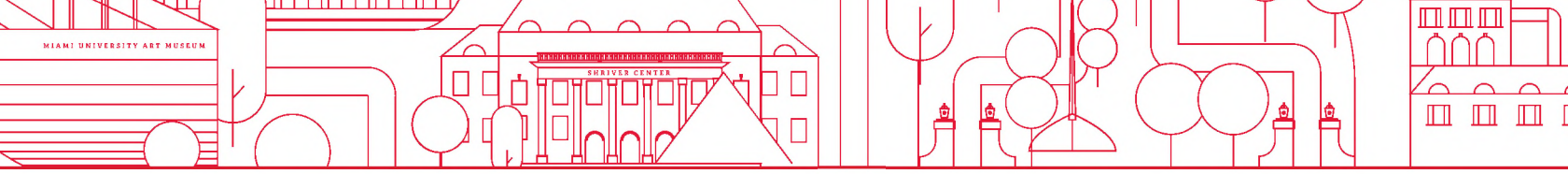
Considerable state resources have been secured to meet the needs of older Ohioans, especially those requiring more complex care. Despite these innovations, as our population continues to grow, we recognize more work must be done. But thanks to the support of Governor DeWine and the Ohio General Assembly, our network is more firmly positioned to meet the needs of current and future generations of aging Ohioans.

The information and insights in this report serve as a roadmap: guiding our efforts, offering encouragement to the aging network, and providing assurances to all Ohioans that we are working to make Ohio the best place to age in the nation.

In service,

Ursel J. McElroy
Director, Ohio Department of Aging

Ohio Department of Aging



ACKNOWLEDGEMENTS

Since 1993, Scripps has worked with the Ohio Department of Aging (AGE) to track long-term services use in Ohio. We would like to thank the many people who supported our three-decade longitudinal study. At AGE, Director Ursel McElroy has continued the incredible support we have received over the past 32 years from the department. Jamie Carmichael has seamlessly stepped in to support our efforts like she has been with us since the start. Our industry partners including Victoria Gresh, Melissa Shanmugam, Larke Recchie, Beth Kowalczyk, Pete Van Runkle, Susan Wallace, and Chris Murray continue to support our many requests for assistance. At the Scripps Gerontology Center Kennedy Berner and Patrick Mese have been invaluable in every step of the study, and Shana Bollmer and Shawn Vanness ably produced our report. We recognize the dedication from the home care and RCF providers who work each day support to older Ohioans facing challenges with daily activities, and we hope the data in this report contributes to an ever-improving system of care.

Robert Applebaum, PhD, MSW
Matt Nelson, MGS
Oksana Dikhtyar, PhD, MBA
John Bowblis, PhD

Winter 2025-2026

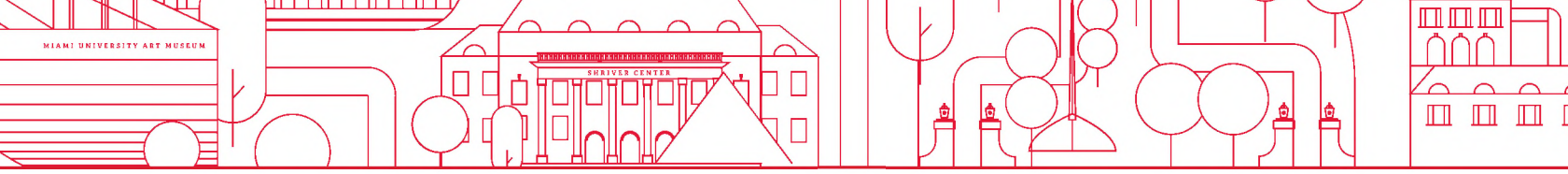
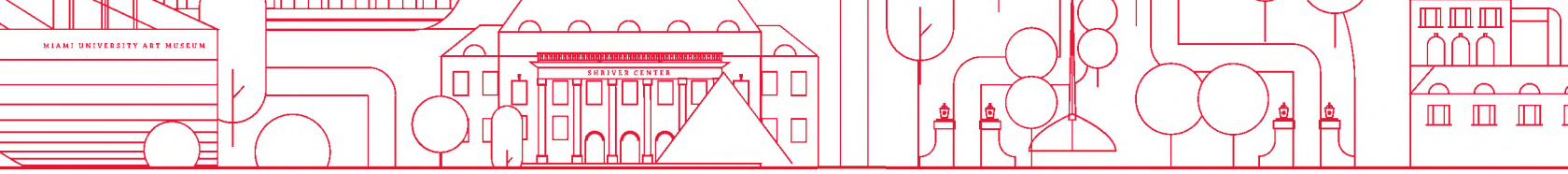
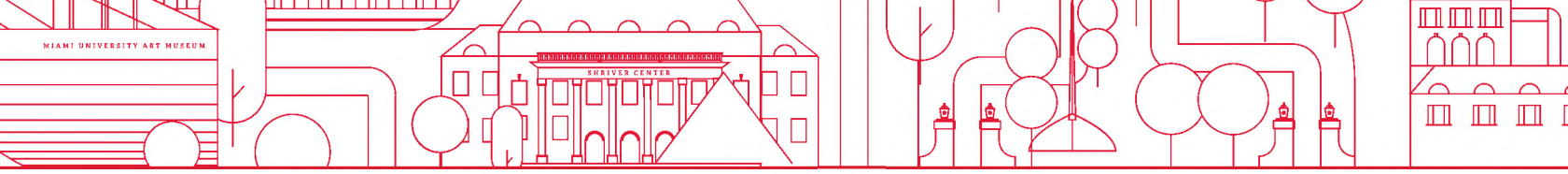
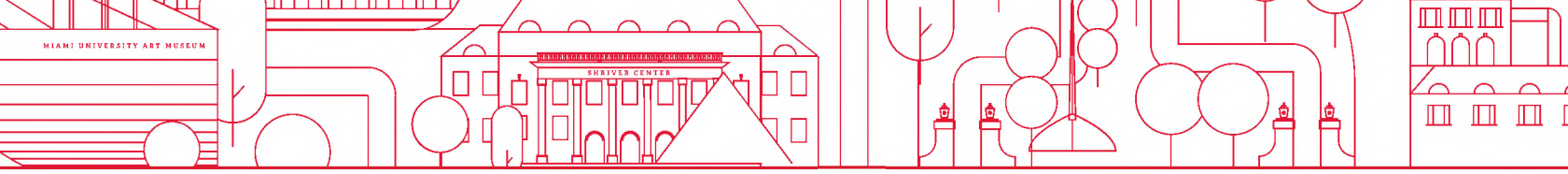


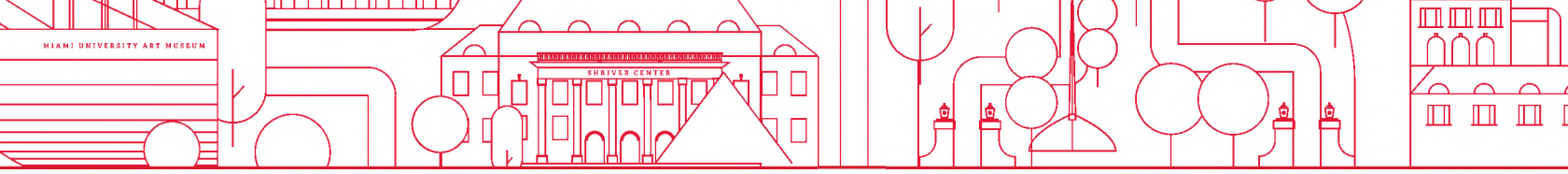
TABLE OF CONTENTS





LIST OF TABLES





LIST OF FIGURES

EXECUTIVE SUMMARY

As a state with one of the largest populations of older people in the nation, Ohio celebrates the progress in extending life expectancy. Having more than 2 million Ohioans age 65 and older and the more than 230,000 individuals age 85 and older also means that individuals, families, and state policymakers must contend with an increase in older Ohioans who experience a disability that limits their ability to do the tasks of daily living such as bathing, dressing or preparing a meal. Ohio policymakers have responded to these challenges with programs and policies that have altered the landscape of the state's approach to delivering long-term services. The shift in how Ohio delivers long-term services has been dramatic, going from one of the states in the nation with high nursing home use as the state has gone from 47 in 1997 in nursing home use compared to home care use, but Ohio is ranked 14 in that category in 2023. However, the projected increase in the number of those age 85 and older will continue to place pressure on the system. Based on our three-decade longitudinal study of long-term services and supports (LTSS), this report documents Ohio's progress in responding to the needs of this growing population and highlights the challenges faced in ensuring that Ohio is a great place to grow old.

DEMOGRAPHICS

- With almost 2.86 million individuals age 60 and older (24% of Ohioans) and more than 2 million people age 65 and older (17% of Ohioans) in 2020, Ohio ranks sixth highest nationally in the number of older adults.
- The size of Ohio's population age 60 and 65 and older will peak in 2030, reaching 2.94 million (25%) and 2.3 million (19.5%) respectively.
- As the baby-boom generation enters the final phase of their lives, the population ages 60+ and 65+ actually drops in 2040 and 2050, estimated to be 2.62 million (age 60) and 2 million (age 65) in 2050. This represents an 11% drop in the 60+ population between 2030 and 2050.
- Reflecting the aging of the baby boom generation, and despite a smaller number of Ohioans age 65 and older, the population age 85 and over, which today has grown to more than 233,000, is projected to increase by 24% by 2050.

- Estimates in 2020 showed that 13% of Ohioans aged 65 and older had high levels of disability, which would qualify them to meet the state's nursing home level of care criteria.
- This translates into 266,000 Ohioans who could need long-term care at home, an assisted living residence, or a nursing home.
- About 7% of the population age 65-69 have a high need for LTSS, but that proportion grows to 44% for those age 85 and older.
- Just over 9% of older Ohioans (191,500) have a moderate need for LTSS, and while not eligible for Medicaid LTSS support today, they are likely to be future Medicaid beneficiaries.

LONG-TERM SERVICES AND SUPPORT SYSTEM CHANGES

- Ohio has dramatically changed how it delivers long-term services funded by the Medicaid program.
- In 1993, nine in 10 individuals needing long-term services age 60 and older supported by Medicaid received care in a nursing home, and today six in 10 receive long-term services in a home- and community-based care (HCBS) setting.
- In 1997, Ohio ranked 47 out of 50 in balancing community-based and nursing home use. By 2023, the state had improved, advancing to a balancing ranking of 14.
- On a typical day, Ohio serves 36,000 older people in nursing homes who are supported by the Medicaid program, while Medicaid supports 56,450 older people at home or in an assisted living residence.
- Ohio actually has fewer licensed nursing home beds and lower occupancy rates than in 1993, even with an increase of more than 100,000 individuals age 85 and older over the last two decades
- Despite concerns that an expansion of HCBS would be an add-on to the system, Ohio's rate of serving individuals with long-term services needs has remained constant over the past 25 years.
- Ohio has made tremendous progress in enhancing the long-term services system, but challenges remain, including pressure on families and caregivers,

workforce supply and quality, financing and in particular the reliance on Medicaid, which does not support preventive services.

RESIDENTIAL CARE FACILITIES (RCF) IN OHIO

- Over the last three decades, the state has seen licensed RCFs emerge as a new assisted living industry. To be considered assisted living under the Medicaid waiver guidelines, a facility needs to have a private room and bathroom, locking doors, temperature controls, and a place to prepare food, if the resident is able.
- In 1992, Ohio had 250 licensed RCFs with fewer than 10,000 beds and 7,400 units. As of 2023, Ohio had 796 licensed RCFs (314% increase) with 68,000 beds and 50,400 units (an increase of 581%).
- Nine in 10 (92%) of Ohio's RCFs meet the criteria for participation in the Medicaid Assisted Living Waiver Program.
- More than half of Ohio's RCFs (52%) report participation in the Assisted Living Medicaid Waiver Program, an increase from 43% in 2021.
- One in five RCFs is part of a continuing care retirement community and almost half (46%) report having a distinct memory care unit or are a memory care facility.
- The average monthly private pay rate in Ohio's RCFs in 2023 was $5,428, an increase of 13.6% from 2021.
- In 2023, the occupancy rate in Ohio's RCF industry was 77.9%, representing an increase from the 2021 rate of 72.1%. Even before the pandemic, occupancy rates in RCFs had been declining, dropping from 89% in 2015 to 81% in 2019.
- More than half of RCF residents are age 85 and older, two-thirds are reported to need assistance with bathing, and half need assistance with dressing.
- Three in 10 RCF residents are reported to have cognitive limitations.
- Full-time staffing levels in RCFs show a 15:1 resident to direct-care worker ratio on the day shift, a 17:1 ratio on the evening shift, and a 23:1 ratio on the night shift. The retention rate for direct-care workers was 68.5%, a slight increase from 2021.

- Full-time staffing levels of RNs/LPNs were 27:1 on the day shift, 35:1 on the evening shift, and 46:1 on the night shift. Nurses had a retention rate of 75.2%, comparable to 2021.
- Starting wages for direct-care workers were reported to be $15.04 in 2023, an increase from $13.20 in 2021. The highest wages reported were $18.38 in 2023, an increase from $16.20 in 2021.
- For LPNs, starting wages were reported at $26.35 in 2023, an increase from $23.30 in 2021. For RNs, starting wages in 2023 were reported to be $31.34, an increase from $28.60 in 2021.
- Staffing ratios on the memory care units were considerably better than the overall RCF rates, with the resident to direct-care worker ratios of 8:1 on the day shift and 12:1 on the overnight shift. The resident to staff ratios for nurses were 18:1 on the day shift and 20:1 ratio on the overnight shift.
- Non-emergency transportation was identified as a problem for those supported by Medicaid with one in five facilities identifying quality and reimbursement as a severe or very severe problem. One in 10 facilities cited severe or very severe access and quality problems for private paying residents.
- Four in 10 RCFs rated the Department of Health Complaint survey process positively, and four in 10 were neutral. Less than 10% of RCFs gave the survey process a poor rating.
- RCFs cited fire safety, medication administration, and infection control as the highest areas of need for technical assistance. Seven in 10 facilities did not have technical assistance needs in any of the areas asked about in the survey.

FUTURE OPPORTUNITIES AND CHALLENGES FOR OHIO

Despite Ohio's improvement, the path forward includes a number of challenges. The size of Ohio's older population today is unprecedented in our history, but a 24% increase in those age 85 and older over the next decades will continue to have an impact. These demographic shifts alone would present challenges to the state, but with additional system complications such as workforce shortages, individual and public funding concerns, quality of care critiques, and family caregiving pressures, efforts to make Ohio the best place to age in the nation will require continued policy attention. To meet the future needs of Ohio's older population policy makers, consumers, family members, advocates, and providers will need to work together to address current issues and future needs.

Ohio's long-term services system, as has been true for almost all of the states, has been very much shaped by the federal/state Medicaid program. Medicaid is typically the largest single expenditure in almost every state in the nation. It is critical to recognize that nine in 10 older people in Ohio are not eligible for the Medicaid program. However, very few older Ohioans have private long-term care insurance, with many individuals unable to afford the premiums. This results in older people ending up on Medicaid when severe health and disability occur, and after these individuals have depleted their savings because of high expenditures. About one-third of all older people in Ohio with high levels of disability currently use Medicaid to support their long-term services either in HCBS or in nursing homes. The question is whether Ohio can do anything to lower the current utilization rate of Medicaid long-term services and supports (LTSS) moving forward as the population in need continues to increase. We continue to explore the major ideas that have been brought forward to address this question including: (1) preventive actions, (2) expanded support services, (3) better support for caregivers, both informal and formal, (4) harnessing technological innovation, and (5) encouraging both community and individual responsibility for LTSS.

Preventive Actions

As a nation, we spend a substantial amount of resources through both the Medicare and Medicaid programs to assist individuals with medical care and long-term services. Policymakers recognize the importance of helping older people in need but providing assistance to individuals prior to a crisis could pay dividends. Evidence-based practices, now supported by the Ohio Department of Aging through the federal Older Americans Act, have been shown to have an impact on disability rates of older people. If Ohio were able to reduce the number of severely disabled older people by just 10%, that could mean 26,000 fewer older people with severe disability and 10,000 fewer individuals needing Medicaid LTSS. Older Americans Act resources used to support these types of programs for the entire nation totaled $44 million, compared to the more than $1.6 billion on Medicare and Medicaid. While states heavily rely on the federal Older Americans Act to support such activities, the overall investment has not kept pace with the dramatic population increases that have occurred.

Expanded Support Services

Medicaid is the major state funding source for LTSS; however, individuals need to have high levels of disability and meet strict income and asset criteria to receive assistance. There are a sizable number of older people (estimated at more than 95,000) in Ohio who experience moderate levels of disability and are likely to be Medicaid eligible as their health trajectory continues to decline. Recent studies have shown that states with fewer supportive services, such as home-delivered meals and personal care, had a higher proportion of low-care residents in nursing homes. Another study found that individuals receiving congregate meals were less likely to be admitted to nursing homes or to be admitted to hospitals compared to a similar group of older people not receiving meals. Finally, some recent work has highlighted the success of combining supportive services in partnership with health care services. Area agencies on aging that had partnerships with health care organizations had significantly lower hospital readmission rates and significantly fewer low-care residents in nursing homes in the regions served.

Ohio's Healthy Aging Initiative, supported in the last biennial budget, is an example of a strategy designed to serve older Ohioans in an effort to prevent or delay the need for support from Medicaid. One-third of the funds were allocated to food assistance and an additional one-quarter of the funds were used for housing assistance, such as home repairs or home adaptation for individuals experiencing disability. About 12% of funds were allocated to internet access or digital literacy for older individuals in the community. The Healthy Aging initiative provided an array of other support services such as transportation, caregiver assistance, emergency response systems, and efforts to combat social isolation. Communities reported a number of examples where these funds led to individuals being able to remain independent in their local communities. This is an example of how Ohio can help individuals avoid spending down to Medicaid eligibility.

Better Support of Caregivers, Both Informal and Formal

While we celebrate increased longevity and the unprecedented number of older people in Ohio, we also recognize that families and friends have never been called upon to provide more long-term services assistance than they are now. Studies consistently indicate that for individuals with high levels of disability, family and friend caregivers provide about 80% of all the assistance received.

The major support for caregivers in the United States comes through the National Family Caregiver Support Program under the Older Americans Act. As was the case for prevention and supportive services, this component of the Act has limited funding, with $145 million allocated annually nationwide for this Older Americans Act program. Family and friend caregiver support is critical in efforts to support older people living independently in the community. In particular, when families, who are providing the bulk of care in this country, can no longer hold up to the pressures of caregiving, nursing home or assisted living care is required. The critical question is, what can local communities and state policy makers do to support but not supplant the work of caregivers?

A continued question across the array of long-term settings in Ohio and the nation overall involves the LTSS formal workforce. While workforce quality and

shortages have improved in the post pandemic era, serious challenges remain. States and providers are exploring options to address the workforce challenges, but there is not one answer that will solve this problem. There is certainly a clear recognition by state policymakers and the industry that this problem must be addressed. Ohio's legislation allocating additional funds to address this challenge in home care and RCFs has been an important response, and both sectors have reported recruiting and retention improvements. However, the rise in the need for long-term services means this challenge will continue. A plan to form a short-term and long-term response to the workforce issues is an important step.

Harnessing Technological Innovation

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

Technological development cuts across the public and private sectors, but how can state policymakers support these activities? As Ohio's manufacturing profile has decreased, could the state leverage such resources as its universities, Wright Patterson Air Force Base, and other locations to design at, develop, test, and market such technologies? With a large aging population and

a strong research and development community, Ohio could become a leader in technology for an aging society.

CONCLUSION

Ohio's progress in LTSS system reform has been significant. The changes that have occurred were almost unimaginable three decades ago. However, the demographic and service hurdles of tomorrow will continue. Our experiences have taught us that we can respond to these new challenges associated with population aging, but it will take creativity, commitment, and cooperation to succeed. While designing an efficient and effective system of long-term services is no small task, Ohioans are counting on Ohio being a good place to grow old.

PREFACE

For the last three decades, the Ohio Department of Aging (AGE) has supported this longitudinal study to track how long-term services are provided in Ohio. Very few states have had the foresight to collect data on their long-term services system and to use these data to improve their systems. During the last 30 years, Ohio has made major strides in improving how older people with a disability and their caregivers receive long-term services. An independent assessment scorecard of state long-term care systems completed by the AARP Public Policy Institute that ranks states based on a series of criteria focusing on access and affordability, choice, quality, support for family caregivers, and effective transitions across health and long-term services provided evidence about Ohio's progress. In 2014, Ohio was ranked 44 out of 50 (50 being the lowest) on overall system performance. In the 2023 rankings, Ohio had improved its overall standing to 32 out of 51.[1] The state still faces challenges as the size of the population in need of long-term services increases over the next two decades, but Ohio has made considerable progress.

The hallmark of the changes that Ohio has made over the last three decades has been the expansion of home- and community-based care options. As was the case for many states, because of the rules surrounding the use of Medicaid funds, Ohio's initial approach emphasized nursing home care for older people needing Medicaid. However, as a result of a series of public and private changes, the balance in the long-term services system has been altered. Factors contributing to this change include a major expansion of home- and community-based services funded through Medicaid, the growth in the private-sector home-care market, the development of the assisted living industry, and the implementation of the Assisted Living Medicaid Waiver. This report examines Ohio's efforts to expand the home- and community-based services available to older Ohioans with a need for long-term services.

STUDY BACKGROUND

OHIO'S DEMOGRAPHIC CHANGES

As a state with the sixth-largest older population in the nation, Ohio has 2.86 million individuals age 60 and older and 2.1 million Ohioans (17.4%) age 65 and older (See Table 1). More than 232,000 Ohioans are age 85 and above. Over the next 20 years, the state's overall population is projected to decline slightly (3.1%, 2020-2040). Estimates find that the population age 60 and older will see a moderate increase in 2030 to 2.94 million, but the 2030-2040 estimates show a decline in the state's population age 60 and over by 7.5%. The population age 65 and older show similar trends, increasing from 2.1 million in 2020 to 2.3 million in 2030, before dropping back to 2.1 million in 2040. The population age 85 and older (232,800 in 2020) is projected to decrease between 2020 and 2030 by 8% before increasing to 261,400 in 2040 and 288,630 in 2050. The 2020-2050 change represents an increase of 24%. While substantial, these estimates are considerably lower as a result of the COVID-19 pandemic projections. Our pre-pandemic projections estimated a 50% increase in Ohioans age 85 and older by 2050.

TABLE 1. OHIO'S OLDER POPULATION, 2020-2050

Age Group	2020	2030	2040	2050
Total Population of Ohio	11.8 million	11.7 million	11.4 million	11.1 million
60 and older	2.86 million (24.2%)	2.94 million (25.1%)	2.72 million (23.8 %)	2.62 million (23.5%)
65 and older	2.1 million (17.4%)	2.3 million (19.5%)	2.1 million (18.6%)	2.0 million (17.6%)
85 and older	232,830 (2.0%)	213,800 (1.8%)	261,400 (2.3%)	288,630 (2.6%)

Source: Scripps Gerontology Center, Ohio Department of Development. (n.d.). Projections of Ohio's Older Adult Population. https://miamioh.edu/cas/centers-institutes/scripps-gerontology-center/research/ohio-population-research.html

Led by AGE, in partnerships with 12 regional area agencies on aging, Ohio's aging network provides the foundation for home- and community-based

services in the state. Data on Ohio's older population in 2023 is organized by the state's 12 regions (See Table 2). One in four Ohioans are age 60 and older, but those proportions vary across the state. The Youngstown region, with three in 10 individuals age 60 and older, has the highest proportion, while the central Ohio region surrounding Columbus is the lowest with one in five individuals age 60 and older. The actual numbers vary dramatically based on the region, with the Cleveland region recording just under 570,000 individuals age 60 and older, while the Marietta region has just under 69,000. Looking at a detailed breakdown of Ohioans age 85 and older in 2023, we see 46,000 individuals residing in the Cleveland region and just over 4,800 individuals in the Marietta region. As noted in our discussion of Table 1, while there is an increase in the population age 60 (2.8%) and older between 2020 and 2030, there is a drop in the population age 85 and older largely as a result of the COVID-19 pandemic, declining from 232,830 to 213,800 for 2030 (-8.1%).

More than 266,000 Ohioans age 65 and older experience levels of long-term disability that would meet the nursing home level of care criteria established by the state (See Table 3). About half of these individuals (46%) have incomes at 300% of poverty or below and one-quarter (27%) have incomes of 200% of poverty or below. Those with high levels of disability and low income are most likely to need support provided through Ohio's Medicaid program. Prior to experiencing high levels of disability, nine in 10 Ohioans do not use Medicaid services. However, only about 10% of individuals age 65 and older have private long-term care insurance, and many Ohioans cannot afford the premiums. While the regional differences are heavily driven by overall population, income levels also vary across the state, impacting the number of individuals with high levels of disability who are below 200% or 300% of poverty. For example, in the Rio Grande region, 58% of those with high levels of disability fall below 300% of poverty and 37% are below 200% of poverty. In the Columbus region, 41% of those with high levels of disability fall below 300% of poverty and 24% are at 200% of poverty. These variations have an impact on waiver program participation rates across the state.

TABLE 2. OHIO'S OLDER POPULATION BY REGION 2023, AGES, 60, 65, 80, 85

PASSPORT Administrative Agency (PAA) Site	Total Population	Total 60+	Percent 60+	Total 65+	Percent 65+	Total 80+	Percent 80+	Total 85+	Percent 85+
Cincinnati	1,726,159	405,342	23.5	294,898	17.1	63,484	3.7	30,195	1.7
Dayton	838,097	216,395	25.8	161,173	19.2	36,896	4.4	17,660	2.1
Lima	357,302	93,243	26.1	68,850	19.3	15,355	4.3	7,414	2.1
Toledo	893,820	235,158	26.3	174,248	19.5	37,514	4.2	17,570	2
Mansfield	516,732	139,145	26.9	103,970	20.1	23,004	4.5	10,883	2.1
Columbus	2,110,402	428,454	20.3	308,286	14.6	62,646	3.0	28,335	1.3
Rio Grande	420,567	110,010	26.2	80,988	19.3	17,066	4.1	7,582	1.8
Marietta	247,251	68,742	27.8	50,843	20.6	10,730	4.3	4,842	2
Cambridge	467,384	129,430	27.7	96,297	20.6	20,916	4.5	9,989	2.1
Cleveland	2,062,087	569,919	27.6	423,943	20.6	96,273	4.7	46,027	2.2
Youngstown	622,996	185,825	29.8	140,220	22.5	31,315	5	14,839	2.4
Akron	1,187,624	321,024	27.0	238,354	20.1	51,958	4.4	24,539	2.1
CSS	335,514	90,588	27.0	66,880	19.9	14,714	4.4	6,673	2
Ohio	11,785,935	2,993,275	25.4	2,208,950	18.7	481,871	4.1	226,548	1.9

Source: U.S. Census Bureau, Population Division, Vintage File 2023 Release Date June 2024

TABLE 3. OHIO'S OLDER POPULATION WITH HIGH LEVELS OF DISABILITY BY REGION, AT 200% AND 300% OF THE POVERTY LEVEL

PAA Site	Total 65+	Estimated Population 65+ with High LTSS Needs	Estimated Population 65+ with High LTSS Needs with Income at or Below 300% of Poverty	Estimated Population 65+ with High LTSS Needs with Income at or Below 200% of Poverty
Cincinnati	294,898	34,393	14,053	8,436
Dayton	161,173	20,262	8,993	5,337
Lima	68,850	8,583	4,250	2,360
Toledo	174,248	20,994	9,728	5,628
Mansfield	103,970	12,787	6,679	3,842
Columbus	308,286	34,411	14,101	8,128
Rio Grande	80,988	9,719	5,640	3,604
Marietta	50,843	5,859	3,188	1,951
Cambridge	96,297	12,029	6,605	3,883
Cleveland	423,943	52,533	23,970	14,743
Youngstown	140,220	17,710	9,336	5,481
Akron	238,354	29,014	13,013	7,542
CSS	66,880	7,943	3,790	2,086
Ohio	2,208,950	266,237	123,345	73,020

Source: U.S. Census Bureau, Population Division, Vintage File 2023. Release date: June 2024; National Health and Aging Trend Study. Produced and distributed by www.NHATS.org with Funding from The National Institute on Aging (grant #N/A UO1AG32147; IPUMS 2023 5 year American Community Survey (ACS).

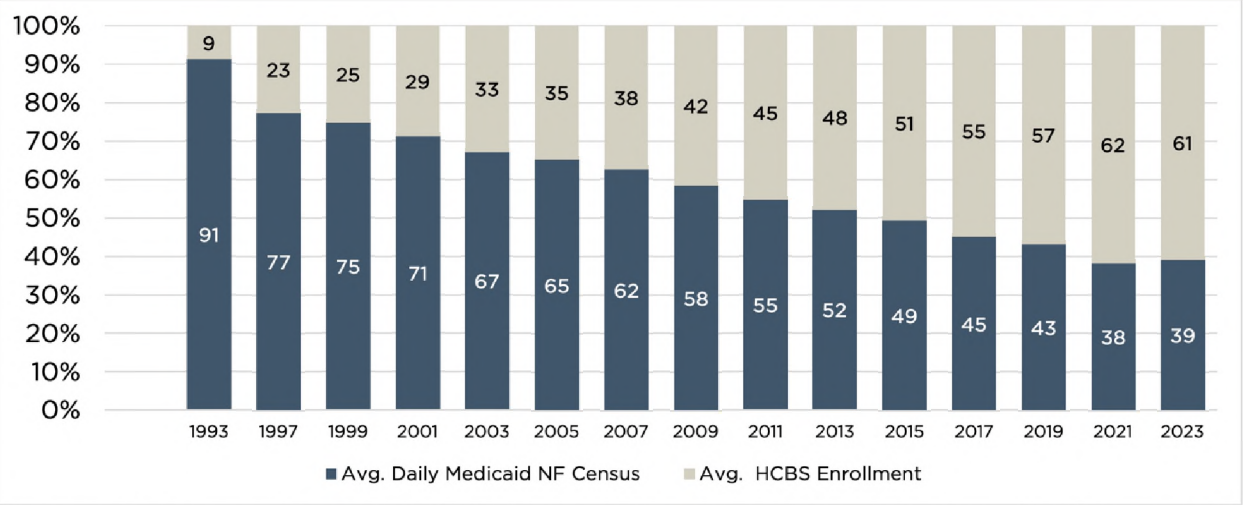
TRACKING THE CHANGING LONG-TERM SERVICES SYSTEM

STUDY METHODOLOGY

This study uses an array of sources. The population and disability numbers come from the U.S. Census 2023 Vintage files, the Ohio Department of Development, Office of Research, and the Scripps Gerontology Center Population Research website. Data describing residential care facilities are from our Biennial Survey of Long-Term Care Facilities, distributed to all residential care facilities (RCFs) operating in 2023 (92% response rate). Data on the characteristics of home- and community-based (HCBS) waiver participants are available from the AGE PIMS database.

The major demographic changes experienced in Ohio have been accompanied by considerable shifts in how long-term services and supports (LTSS) are delivered. As shown in Figure 1 in 1993, the first year of our longitudinal study, nine in 10 Ohioans age 60 and older with high levels of disability who were supported by Medicaid received services in the nursing home setting. Over the last 30 years Ohio has shifted its approach, and by 2023, six in 10 (61%) of those age 60 and over with high levels of disability and supported by Medicaid received home- and community-based services (HCBS), rather than nursing home care. The 2023 numbers represent a very slight change from 2021, as nursing home census had increased in the post-pandemic period. However, the overall changes are dramatic. Once ranked as the 47th-least-balanced state in the nation, Ohio's LTSS balance ranking of 14th (50 would be state using HCBS least) reflects the state's commitment to HCBS expansion.

FIGURE 1. PROPORTION OF OHIO'S NURSING HOME AND HCBS USE BY INDIVIDUALS AGE 60 AND OLDER, 1993-2023

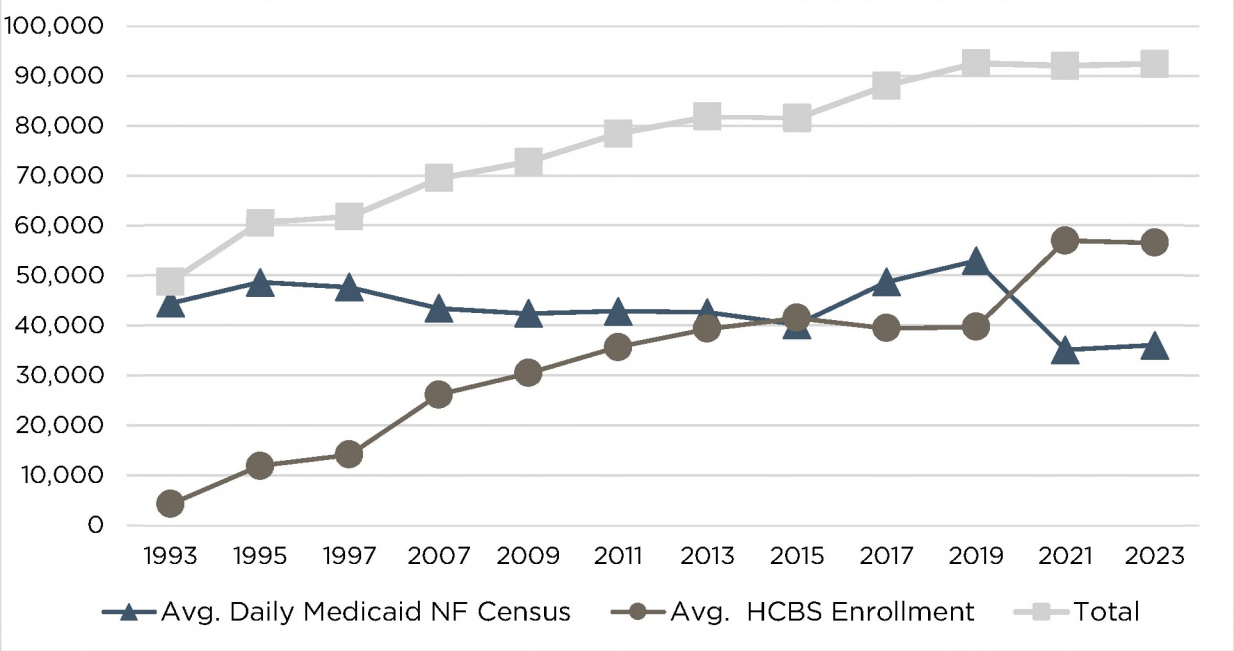


Source: Data come from PASSPORT Information Management System (PIMS) and Ohio Biennial Survey of Nursing Homes.[2,3]

As shown in Figure 2, in 2023, 92,460 Ohioans age 60 and older received long-term services through the federal/state Medicaid program. More than 36,000 older Ohioans were nursing home residents using Medicaid-supported care. Ohio's HCBS waiver programs served just under 56,450 individuals age 60 and older, accounting for 61% of older people receiving Medicaid LTSS (See Figure 1). Older Ohioans receive these home- and community-based waiver services in their own homes, in the home of family or friends, or in assisted living facilities, which are classified as HCBS by the Centers for Medicare and Medicaid Services (CMS). These services are provided through three Medicaid programs. For older Ohioans living in the urban counties of the state, who are dually eligible for Medicaid and Medicare, HCBS are provided as part of an integrative care demonstration known as MyCare Ohio. In the MyCare Ohio program, five health plans across the state's urban counties receive a capitated reimbursement from both Medicaid and Medicare and are required to fund a comprehensive package of acute and long-term services. Older people in non-MyCare counties and those age 60 and over not yet eligible for Medicare remain in the fee-for-service Medicaid program and receive services through Ohio's PASSPORT and Assisted Living Medicaid Waiver Program. On a typical day, the PASSPORT program serves about 24,000 older individuals, and the Assisted

Living Waiver Program serves about 4,000 Ohioans. MyCare Ohio provides care to 29,000 older Ohioans receiving HCBS each day. The MyCare Ohio demonstration phase will end on December 31, 2025, and the Next Generation MyCare program will begin January 1, 2026.

FIGURE 2. MEDICAID NURSING HOME AND HCBS WAIVER USE FOR INDIVIDUALS AGE 60 AND OLDER, 1993-2023



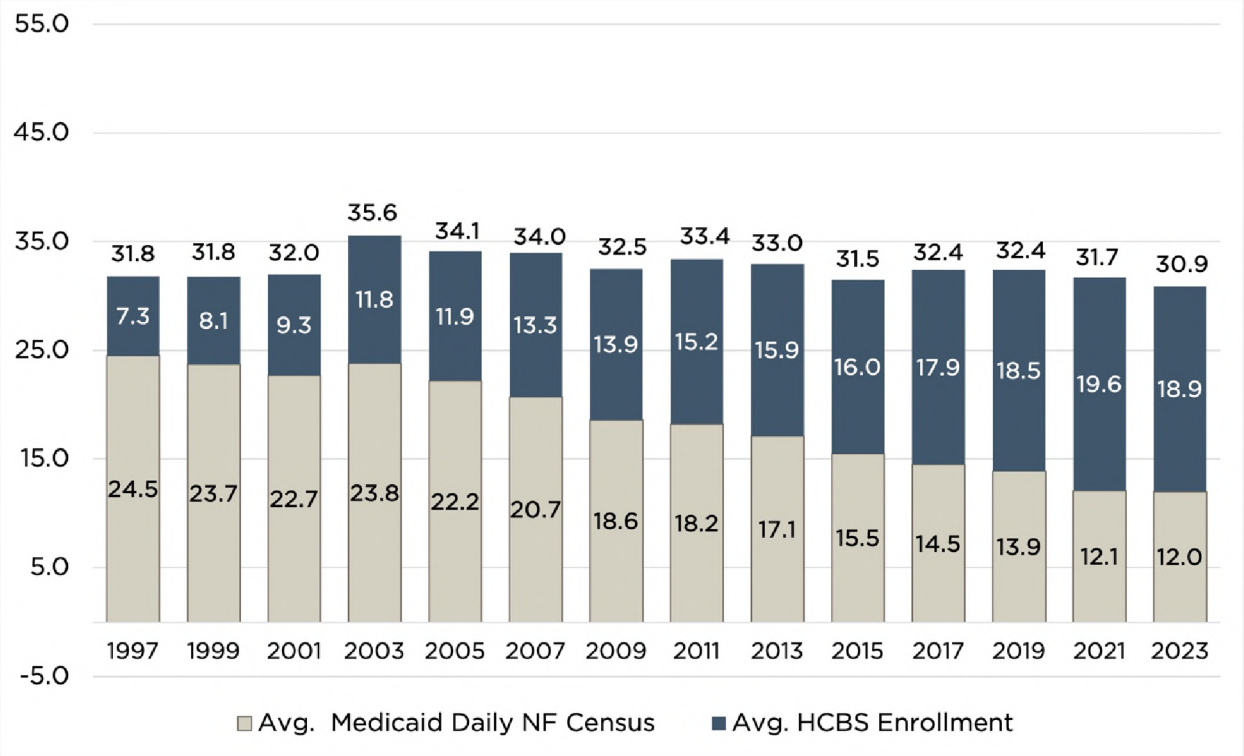
Source: Data from PASSPORT Information Management System (PIMS) and Ohio Biennial Survey of Nursing Homes.[4,5]

While the expansion of HCBS was widely supported by policymakers in Ohio, the initial policy changes were accompanied by cost concerns. The question raised was, if HCBS access was increased, would these expenditures result in net new additional public expenditures, or would they be offset by reductions in nursing home costs? The debate about "add-on" costs received considerable attention, but limited empirical evidence existed to address the question. Figure 3 provides longitudinal data examining nursing home and home-care utilization as a proportion of the total population age 60 and older. In 1997, the proportion of Ohioans age 60 and older using Medicaid long-term services was 31.8 out of every 1,000 individuals age 60 and older. In that year, the majority of use occurred in the nursing home setting, 24.5 out of every 1,000 individuals,

compared to 7.3 out of every 1,000 individuals for HCBS. As Ohio expanded the use of HCBS the overall utilization rate did not change and in 2023 that rate was 30.9 out of every 1,000 individuals. However, the nursing home utilization rate was cut in half, dropping to 12.0 out of every 1,000 individuals (from 24.5 out of every 1,000 individuals), while the HCBS use rate increased to 18.9 out of every 1,000 individuals. The constant utilization rate from 1997 to 2023 indicates that the HCBS expansion was offset by a corresponding reduction in nursing home use, rather than representing a service add-on, which had been the concern three decades ago.

Ohio also has an additional HCBS program supported by funding generated at the county level. Seventy-four of Ohio's 88 counties (and a few municipalities) use local funding to support aging services. Almost all of this funding comes from property taxes, and in 2020 these programs generated more than $218 million in local revenue. In a national survey done in 2019, Scripps found that 15 states were using this local funding approach and Ohio generated more funding than the remaining 14 states combined. These programs are designed for the non-Medicaid population, particularly those with moderate income and moderate levels of disability. A recent Scripps study in Ohio found that counties with large levy programs had fewer low-care nursing home residents and a lower use of Medicaid HCBS.

FIGURE 3. LTSS USE RATE PER 1000 INDIVIDUALS AGE 60 AND OLDER ON MEDICAID RESIDING IN A NURSING FACILITY OR ENROLLED IN HCBS, 1997-2023



Source: Home- and Community-Based Services data from PASSPORT and Ohio Department of Medicaid.[6]
Source: Nursing Home data from the Ohio Biennial Survey of Nursing Homes, Ohio Department of Medicaid, and Health Policy Institute of Ohio.[7]

HCBS PARTICIPANT CHARACTERISTICS

With the expansion of HCBS under Medicaid, Ohio now has one of the largest waiver programs in the nation. PASSPORT, which was expanded across the state in 1993, serves individuals age 60 and older who meet the nursing home level of care and Medicaid financial eligibility criteria. To implement the program, the state receives a waiver under Medicaid from CMS to serve nursing-home-eligible individuals with HCBS. The Assisted Living Waiver Program, implemented in 2007, serves individuals age 18 and older who meet the Medicaid nursing home and financial eligibility criteria. In 2014, Ohio implemented the MyCare demonstration as part of the CMS Financial Alignment Initiative. MyCare provides HCBS to individuals who are dually

eligible for Medicare and Medicaid, who meet the nursing home level of care criteria, and who live in one of 29 urban counties of the state. MyCare also serves individuals who are eligible for Medicaid and Medicare who do not need long-term services. Ohio is now planning a statewide expansion of the initiative beginning in 2026. Under the new plan, the majority of PASSPORT and Assisted Living Waiver Program participants (those that are eligible for both Medicare and Medicaid) will be served through the managed care health plans operating across the state. Individuals receiving coverage only through the Medicaid program will continue to receive services from PASSPORT and the Assisted Living Waiver Program.

Table 4 presents the characteristics of participants in the three programs. A review of participant characteristics shows some differences across programs. The Assisted Living Waiver Program serves an older population with almost half of the participants (45%) age 80 and older, compared to one in four in the PASSPORT and MyCare Ohio programs. Participants in the Assisted Living Waiver Program are more likely to be widowed with 44% falling into this category, compared to 27% in MyCare Ohio and 29% in PASSPORT. These differences reflect the differences in age and the residential nature of assisted living. Four in five MyCare Ohio and PASSPORT participants live in their own home or apartment and seven in 10 are female. A higher proportion of MyCare, Ohio participants were Black compared to PASSPORT and the Assisted Living Waiver Program (37%, MyCare vs. 20%, PASSPORT and 9% AL).

TABLE 4. CHARACTERISTICS OF HCBS PARTICIPANTS IN PASSPORT, MYCARE AND ASSISTED LIVING WAIVER PROGRAM, 2022

Characteristics	PASSPORT (%)	MyCare (%)	AL Waiver (%)
Age			
46-59	0.0	13.8	20.1
60-64	20.0	11.0	8.8
65-69	21.8	17.7	7.0
70-79	33.6	31.4	19.0
80-89	19.7	19.7	26.2
90-plus	4.9	6.3	18.8
Average Age	73.2	71.6	78.1
Gender			
Female	70.2	71.2	72.2
Race			
White	66.1	55.5	88.9
Black	19.6	37.4	9.0
Other	14.3	7.1	2.1
Marital Status			
Never Married	16.6	26.7	20.4
Widowed	29.3	26.5	44.6
Divorced/Separated	31.2	31.4	26.2
Married	23.0	15.3	8.9
Usual Living Arrangement			
Own home/apartment	78.4	79.4	NA
Relative or friend	19.5	20.5	3.2
Nursing Home	0.5	0.1	4.3
Number of Consumers Served	23,800	32,000	6,274

Source: Passport Information System FY 2022 July 1, 2021-June 30, 2022.

RESIDENTIAL CARE FACILITIES IN OHIO

While the number of nursing home beds in Ohio has dropped over the last two decades, the number of RCFs and the supply of RCF beds/units have seen considerable growth. In 1992, Ohio had 250 licensed RCFs and fewer than 10,000 licensed beds. By 1997, Ohio had 327 licensed RCFs; by 1999, the number had grown to 438, with 27,052 licensed beds. By the end of 2023, Ohio had 796 RCFs with more than 68,000 licensed beds (See Table 5). While RCFs are typically licensed for dual occupancy, most are used for one person, so in our analysis of the industry, we examine RCFs at the unit level. In 2023, Ohio had more than 50,400 units. Most of Ohio's RCFs operate as assisted living facilities (92%), with the remaining RCFs (8%) not meeting the state's definition of an assisted living residence. These RCFs do not offer such elements as a private room and bathroom, locking door, and temperature controls.

Five in 10 RCFs (52%) participate in the Assisted Living Medicaid Waiver Program, an increase from 43% in 2021, suggesting the impacts of the increased reimbursement rate in Ohio's Assisted Living Medicaid Waiver program enacted in the state's 2023-25 budget. One in five RCFs (20.8%) are part of a continuing care retirement community (CCRC) and four in 10 are free-standing residences, not part of an independent living or nursing home provider. Three in four RCFs are for profit (75%) and four in five are located in an urban environment (80.5%). Almost six in 10 residences (59.2%) are part of a chain. Less than half of RCFs (47.7%) report having residents using the telehealth care option, a drop from 57% in 2021 and possibly reflecting post-COVID changes in practice. Three in four report having an infection control preventionist at the facility. Almost all residences (96%) report an organized resident group, an increase from 83% in 2021. The average private pay rate in 2023 was $5,428 per month an increase of 13.6% from 2021 (private pay nursing home rate increase for the same 2021 to 2023 time period was 11%).

TABLE 5. PROFILE OF RESIDENTIAL CARE FACILITIES IN OHIO, 2021, 2023

Facility Characteristic	2021	2023
Number of units	50,124	50,424
Number of licensed Beds	67,403	68,123
Facilities meeting the Assisted Living Definitions (%)	94.0	92.3
Facilities participating in AL Medicaid Waiver Program (%)	43.4	52.2
Facilities part of a Continuing Care Retirement Community (CCRC) (%)	20.7	20.8
Free-standing facilities without independent living and NH (%)	40.3	40.1
Facility has a specific memory care unit or only serves residents with dementia (%)	42.3	46.0
Some facility residents use telehealth	57.2	47.7
Facility reports having an organized resident group	83.0	96.2
Facility Ownership (%) for profit	73.0	75.1
Part of chain (multiple facilities not on site) (%)	56.4	59.2
Facility has an Infection Preventionist (%)	70.4	74.9
Facility location (%) urban	77.5	80.5
Private monthly pay rate (dollars)	4,778	5,428

Source: Biennial Survey of Long-Term Care Facilities, 2021, 2023

As noted, we calculate the proportion of occupied RCF units instead of RCF beds (See Table 6). The 2023 occupancy rate was 77.9%, an increase from the 2021 occupancy rate of 72.1%. The 2021 occupancy rate reflected the impacts of the pandemic and was a substantial drop from 2019. However, the RCF industry occupancy rates had been dropping prior to the pandemic, from 88.9% in 2015 to 85.3% in 2017 and 81.3% in 2019, but the COVID-19 pandemic, as it had for nursing home occupancy rates, had a dramatic impact on the industry. Contributing to the drop in occupancy rates over time has been the continued increase in the number of facilities. As an example, more than 4,000 new units were added between 2019 and 2021. Very few assisted living residences (5) were added between 2021 and 2023.

TABLE 6. OCCUPANCY RATES IN OHIO'S RESIDENTIAL CARE FACILITIES, 2013-2023						
Year	**2013**	**2015**	**2017**	**2019**	**2021**	**2023**
Number of Facilities	606	655	708	759	791	796
Number of Units	33,182	35,979	40,450	45,931	50,124	50,424
Unit Occupancy (%)	87.8	88.9	85.3	81.3	72.1	77.9

Source: Department of Health Biennial Survey of Long-Term Care Facilities 2013-2023.

CHARACTERISTICS OF RCF RESIDENTS

To get a better understanding of the RCF industry, the biennial survey also tracks annual admissions and discharges to and from facilities. About six in 10 admissions (58.5%) to RCFs in 2023 came from individuals living in the community (See Table 7). One in five (22.8%) individuals admitted came from a nursing home. One in 10 new admissions (10.9) came from another assisted living facility. Just under 8% were admitted following a hospital stay, in contrast to the 86% of admissions to nursing homes that came after a hospitalization.

In looking at individuals who leave RCFs, we found that residents passing away (42.7%) was the largest category. One in four residents (26.8%) left the facility to relocate to a nursing home. Sixteen percent moved back into the community and 9% moved to another RCF. Five percent left the residence when they went to a hospital or hospice (See Table 8).

TABLE 7. SOURCE OF ADMISSIONS TO OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Where residents admitted from	Percent	
	2021	2023
Home, apartment or other independent living outside this community	55.0	52.9
Independent living associated with this RCF	5.9	5.6
Another assisted living/RCF facility	10.3	10.9
A nursing home independent of this RCF	10.4	11.1
A nursing home associated with this RCF	11.1	11.7
Directly admitted from a hospital	7.2	7.8

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

TABLE 8. DISCHARGES FROM OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

RCF discharge outcomes	Percent	
	2021	2023
Home, apartment or other independent living outside this community	14.4	15.2
Independent living associated with this RCF	1.1	1.1
Another assisted living/RCF facility	8.0	9.4
A nursing home independent of this RCF	10.6	12.0
A nursing home associated with this RCF	15.4	14.8
Hospital	4.7	3.4
Death	43.8	42.7
Hospice	1.8	1.5
Another place	3.2	2.9

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

RCFs do not have the same resident minimum data set requirements as nursing homes, so there is no systematic information on residents. The biennial survey asks facilities to provide a snapshot of their resident profile on the day the survey is completed, and those findings are reported in this section. We provide data for the industry overall and broken down by whether a facility met the assisted living waiver criteria (See Table 9). Overall more than half of the residents (50.6%) were reported to be age 85 and older, with the next largest grouping between 71 and 84 (36.7%). Seven in 10 residents were female (68.8%). Two-thirds of residents reported needing assistance with bathing (65.3%) and half (51.2%) required assistance with dressing. Three in 10 residents (31.6%) have a cognitive impairment, and just under half (45.6%) have two or more impairments, which approximates the nursing home level of care admission criteria under Medicaid. One in 12 residents is reported to have behavioral problems and/or severe mental illness (8.1%). There are some notable differences between the RCFs that are classified as assisted living and those categorized as a traditional RCF. The traditional RCF residents are more likely to be under age 60 (13.9% vs. 4.1%), and much more likely to experience a cognitive impairment (52% vs. 30%). The traditional RCF residents were also more likely to have behavioral health and/or severe mental illness (18.8%, 15.6% vs. 7.3%, 7.5%).

TABLE 9. CHARACTERISTICS OF OHIO'S RESIDENTIAL CARE FACILITIES RESIDENTS, 2021, 2023						
Characteristics	Overall (%)		RCF not AL (%)		Meet Assisted Living Requirements (%)	
Year	**2021**	**2023**	**2021**	**2023**	**2021**	**2023**
Percentage of Facilities	100	100	6.0	7.7	94.0	92.3
Residents Age						
Under 60	4.8	4.7	16.3	13.9	4.1	4.1
Between 60 (61) and 70	10.3	10.9	8.2	8.8	10.5	11.1
Between 71 and 84	35.8	36.7	40.2	36.8	35.6	36.7
85+	51.3	50.6	41.5	45.0	51.9	51.0
Gender						
Female	70.5	68.8	63.1	65.6	71.0	69.0
Functioning						
Bathing	67.0	65.3	68.8	69.4	66.9	65.0
Dressing	50.6	51.2	62.0	59.4	50.0	50.5
Transferring	31.3	31.4	33.8	40.7	31.2	30.7
Toileting	41.0	41.0	51.2	52.5	40.5	40.1
Eating	11.1	10.2	23.6	18.2	10.4	9.6
Medication	83.6	83.1	82.1	79.6	83.6	83.5
Walking	27.6	29.2	37.5	39.6	27.1	28.4
Cognitive Impairment	30.4	31.6	47.0	51.8	29.5	30.0
With two or more activities of daily living impairments or cognitive impairments	45.5	45.6	51.3	57.5	45.1	44.7
Behavior Problems	10.8	8.1	25.1	18.8	10.1	7.3
SMI	8.0	8.1	23.1	15.6	7.5	7.5

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

RCF STAFFING LEVELS, CHALLENGES AND STRATEGIES

Data on Ohio RCF and assisted living facilities showed that about half of the residents met the nursing home level of care criteria. Additionally, one-third had cognitive impairments and one in 10 had behavior problems. Seven in ten need bathing assistance, one-half need assistance with dressing and four in 10 need assistance getting to the bathroom. While RCF residents experience lower levels of disability when compared to nursing home residents, these individuals have a high need for direct-care services. Recruiting and retaining staff across the long-term services spectrum has been a consistent challenge.

In 2023, the one-year retention rate for full-time direct care workers (DCWs) was 68.5%, an increase from 66% in 2021 (See Table 10). Our measure is calculated by taking the proportion of the same employees working on January 1, 2023, who were still employed on December 31, 2023. The turnover rate, which examines the number of employees who leave the organization over the course of the year adjusted for the total number of workers was also examined. In 2023, the DCW turnover rate was 69.9%, a slight increase from 2021 and in contrast to the improved retention rate. The LPN/RN retention rate for 2023 was 75.2%, just slightly higher than the 2021 rate of 74.7%.

An overview of the ratio of residents-to-direct care workers shows that the highest proportion of direct care staff are deployed on the daytime shift (39%), with a resident to staff ratio of 15:1. One in four staff worked the overnight shift, where the resident to worker ratio was 23:1. For registered nurses (RN) and licensed practical nurses (LPN) when combined, almost half (49%) were staffed on the day shift, with a 27:1 resident to staff ratio. One in five RNs/LPNs were used on the overnight shift, and the ratio was 46 residents per worker. The 2023 staff-to-resident ratios were slightly higher compared to the 2021 results, indicating slightly worse staffing rates.

TABLE 10. DIRECT-CARE STAFFING IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Staffing rates	Full-time (%)		Part-time (%)	
Year	2021	2023	2021	2023
Retention rates				
DCWs	66.0	68.5	55.0	56.5
LPNs/RNs	74.7	75.2	67.6	72.9
Turnover rates				
DCWs	67.9	69.9	89.7	85.3
LPNs/RNs	48.1	48.4	65.8	60.9
Shift Times	**Resident-to-Staff Ratio (mean)**		**Proportion of Nursing Staff Type by Shift (%)**	
DCWs				
10 a.m.	14:1	15:1	40	39
7 p.m.	16:1	17:1	35	35
4 a.m.	23:1	23:1	24	26
LPNs/RNs				
10 a.m.	24:1	27:1	46	49
7 p.m.	32:1	35:1	33	32
4 a.m.	43:1	46:1	21	19
Hourly wages (dollars)	**Starting**		**Highest**	
DCWs	$13.20	$15.04	$16.20	$18.38
LPNs	$23.30	$26.35	$27.20	$30.88
RNs	$28.60	$31.34	$33.30	$36.54

Retention Problems	DCW		LPN 2021	LPN 2023	RN 2021	RN 2023
Rate seriousness of retention problems (1-10 with 10 worst)	7.1	6.6	6.3	5.5	8.5	8.2
Rate seriousness of recruitment problems (1-10 with 10 worst)	7.5	6.2	8.1	8.5	9.1	6.9

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023

Both the average starting wages and the highest wages paid to DCWs and LPN/RNs increased between 2021 and 2023. In 2023, starting DCW wages were reported at $15.04 per hour, representing an increase from $13.20 in 2021. The highest DCW wages were reported to be $18.38, an increase from $16.20 in 2021. LPN and RN wages also showed increases. For example, LPN starting wages increased to $26.35 in 2023, from $23.30 in 2021 and RN starting wages increased to $31.34 from $28.60.

Survey respondents, continue to report recruitment and retention challenges with the DCW retention and recruitment ratings as a serious problem of 6.6 out of 10 and 6.2 out of 10, respectively. These ratings did represent improvements from 2021 when the serious problem ratings were 7.1 out of 10 and 7.5/10, respectively. Overall the LPN and RN recruitment and retention problems were rated to be a bit more serious. The ratings of serious problems with RN recruitment improved, decreasing from 9.1 out of 10 in 2021 to 6.9 out of 10 in 2023. LPN recruitment was considered more of a problem in 2023 (increasing from 8.1 out of 10 to 8.5 out of 10). The seriousness of the retention problem for LPNs was reduced from 6.3 out of 10 to 5.5 out of 10, and for RNs from 8.5 out of 10 to 8.2 out of 10.

The survey also asked about administrator turnover at the RCF (See Table 11). The 2023 findings indicated that more than half (53.9%) of Ohio's RCFs had hired a new administrator in the three-year time period covered by the survey, compared to 40% in 2021.

TABLE 11. ADMINISTRATOR TURNOVER RATES IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Administrator Turnover Last Three Years	2021 (%)	2023 (%)
How many administrators (including the current one) has your facility had over the last three years?	39.5	53.9

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023

Because retention of direct-care workers is critical for RCFs, the biennial survey asked a series of questions about the strategies used by facilities to retain these individuals. Strategies were classified into financial and organizational groups. RCFs reported major changes in financial benefits between 2021 and 2023 (See Table 12). Almost all RCFs report offering paid vacation (97.7%), an increase from 88.6% in 2021. There was an increase in the proportion of residences offering a 401K retirement plan, from 76% to 83.7%. RCFs also reported an increase in paid sick leave with 77% of RCFs offering this benefit in 2023, representing an increase from two-thirds reported in 2021. More than seven in 10 reported offering extra pay for shift differentials, up from six in 10 in 2021. RCFs also reported expanding merit wage increases (increasing from 60.4% to 76.8%), tuition reimbursement (57.2% to 64.1%), other work perks such as free meals (52.2% to 68.6%), longevity increases (50.7% to 63.7%), offering career ladders (48.8% to 64.4%), and offering financial assistance such as gas cards or assistance with vehicle repair (17.9% to 25.9%). Nine in 10 offered health insurance (94.8%), and this did not change from 2021, although the proportion of DCWs that signed up for the health insurance benefit was less than four in 10 (37.4%).

RCFs also use a series of organizational strategies to better retain workers (See Table 12). RCFs reported enhancing their efforts to retain DCWs in a number of areas. Nine in 10 RCFs (92.5%) had staff work together to cover shifts, offered schedule flexibility (87.4%), offered employee recognition programs (89.5%) and informed DCWs about a change in the resident's plan of care (92.2%). In each of these areas the 2023 rates represented an increase from 2021 (80.7%, 73.6%, 69.6% 56.3%, respectively). More than eight in 10 (85.6%) cross-trained staff, and reported assigning staff to the same residents (82%). These categories also recorded increases from 2021, (69.6%, 63.7%, respectively). Strategies designed to better involve direct-care workers in the care process also showed enhancement in 2023. For example, two-thirds of residences involved DCWs in resident care plan meetings, an increase from four in 10 in 2021. More than half (54.9%) used DCWs on quality improvement teams, an increase from three in 10 in 2021. Four in 10 had DCWs involved with scheduling, an increase from one in four in 2021. One in four had DCWs

TABLE 12. STRATEGIES FOR RETENTION OF DIRECT-CARE WORKERS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023		
Financial Strategies for Retention	**2021 (%)**	**2023 (%)**
Offer health insurance (Take up rate was 37.4% in 2021 and 35.5% in 2023)	94.6	94.8
Provide paid vacation	88.6	97.7
Offer 401K or other retirement plan	76.0	83.7
Paid sick leave	66.2	77.1
Extra pay for shift differential	62.3	72.5
Provide merit wage increases	60.4	76.8
Offer tuition reimbursement	57.2	64.1
Offer other work perks (birthday giftcards, free meals)	52.2	68.6
Provide longevity wage increases	50.7	63.7
Offer career ladders	48.8	64.4
Offer bonuses for attendance	48.7	47.1
Offer hiring bonus after time on the job	43.3	41.4
Offer bonuses, raises, for completing extra training	42.2	45.6
Offer financial assistance (gas cards, help with car repair)	17.9	25.9
Workplace Organizational Strategies for Retention		
Staff work together to cover shifts	80.7	92.5
Offer scheduling flexibility	73.6	87.4
Staff are cross-trained to perform tasks outside their regular duties	69.6	85.6
Offer employee recognition programs	69.6	89.5
DCWs are consistently assigned to the same group of residents	63.7	82.0
DCWs are informed within one day when a resident's care plan is changed	56.3	92.2
DCWs participate in resident care planning meetings	38.5	65.6
DCWs participate on quality improvement teams	31.2	54.9
Staff scheduling is managed by staff teams	24.9	38.6
DCWs participate in interviews of direct care applicants	15.1	25.5
DCWs choose which residents they care for	7.0	11.5
Residents participate on hiring teams for selecting new staff	5.4	10.8
Other Factors Related to Retention		
Facilities with Unionized DCWs	2.7	3.2
Administrator knows all DCWs by name		
All	66.7	67.2
90-99%	20.1	20.9
75-89%	7.5	7.5
50-75%	4.5	3.4
Fewer than half	1.3	1.0

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

participate in DCW hiring interviews, an increase from 15% in 2021. About 3% of facilities reported being unionized and two-thirds of administrators reported knowing all of their DCWs by name.

Successful recruitment of DCWs is also critical to meet the staffing challenges faced by RCFs (See Table 13). Nine in 10 RCFs (96.5%) reported using online platforms, such as Monster.com. Seven in 10 RCFs participate in job fairs (74.3%), and one-third of RCFs work with employment agencies. More than eight in 10 RCFs (84.1%) reported offering referral bonuses to existing staff, and half offer signing bonuses. The signing bonus rate was a drop from six in 10 in 2021. Seven in 10 RCFs (74.1%) partner with community colleges. Eight in 10 RCFs (79.9%) offer flexible scheduling options, an increase from two-thirds in 2021. Six in 10 RCFs (62.9%) offer tuition reimbursement, an increase from 54% in 2021. One third of RCFs offer same-day pay, an increase from 18% in 2021. Four in 10 RCFs reported not requiring drug tests.

TABLE 13. RECRUITMENT STRATEGIES FOR DIRECT-CARE WORKERS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Strategy	2021 (%)	2023 (%)
Work with online platforms (e.g., Monster, Indeed)	91.8	96.5
Offer staff referrals bonuses	83.2	84.1
Participate in job fairs	68.2	74.3
Partner with community colleges and/or vocational schools	68.0	74.1
Offer flexible scheduling	66.3	79.9
Offer bonuses to new employees	62.6	51.0
Offer tuition reimbursement	53.6	62.9
Work with employment agencies	34.0	34.1
Provide same-day pay	17.9	33.0
Stopped or do not require drug testing	17.9	40.0

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

MEMORY CARE FACILITIES AND SPECIAL CARE UNITS

With the growth in the number of individuals with Alzheimer's Disease and other forms of dementia, there has been an increase in the number of RCFs offering specialty memory care (See Table 14). In 2023, more than four in ten RCFs (46%) reported being 100% memory care or having a special memory care unit within the RCF, an increase from 43% in 2021. Memory care units represent one-quarter of the RCF system capacity. On average, facilities charged an additional $1,481 per month for care in the memory unit, an increase of 19% from the 2021 rate. Occupancy rates of memory care units increased to 83.9% in 2023 from 74% in 2021. Memory care occupancy rates were also higher than overall RCF occupancy rates which were 77.9%. One in six RCFs (15.7%) accept only individuals with advanced dementia and four in five (83%) require a recommendation from a physician.

Memory care units/facilities report higher staffing. The resident-to-staff ratios on the day shift were 8:1 where 38% of DCW are used (See Table 15). The overnight shift used 26% of the total DCW staff, reporting a 12:1 resident-to-staff ratio. The LPN/RN staffing reflected the same patterns with 37% of nursing staff on the day shift with an 18:1 resident-to-staff ratio. The overnight shift had 29% of nursing staff with a 20:1 ratio of residents to staff. The memory care units had higher staffing across shifts than the overall RCF staffing reported in Table 10 (DCW memory unit daytime ratio of 8:1 vs. 15:1; nursing memory care unit daytime shift 18:1 vs. 27:1; night shift DCW memory care unit 12:1 vs. 23:1; and nursing memory care unit 20:1 vs. 46:1). This indicates that the memory care residents require 24-hour care more often than the typical RCF resident and may have implications for future staffing patterns.

TABLE 14. DESCRIPTION OF DEDICATED MEMORY CARE FACILITIES AND UNITS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Characteristics	2021	2023
Number of memory care units	11,967	12,600
Number and % of facilities serving only memory care or with memory care units	274	328
	42.7	46.0
Proportion of units in the state (%)	23.9	24.6
Number of residents in memory care	8,863	10,566
Statewide memory care unit occupancy rate (%)	74.0	83.9
Additional private pay payment per month for memory care unit ($)	1,243	1,481
Admission criteria (%)		
Facility only takes individuals with advanced dementia	17.5	15.7
Physician recommendation required for admission	75.0	83.0
Characteristics of the memory care facility/unit (%)		
Individualized therapeutic recreation plan	69.0	77.8
Written procedures to follow in the event of resident elopement	91.2	99.4
Visual cues or landmarks in the physical environment to assist with wayfinding	74.1	94.3
Environmental triggers are studied and eliminated	68.2	94.6
Display (or encouraging residents to display) meaningful objects in resident/patient personal areas	85.0	98.4
Consistent nursing staff assigned to memory care unit	90.5	97.8
Consistent nursing staff assigned for each resident within memory care unit	57.3	77.1
Higher staffing levels within memory care	79.2	93.6
Locked unit	89.8	97.5
Secured outdoor area	85.8	94.3
Room/unit alarms	45.6	71.0
Elopement alarms	72.6	83.4

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

TABLE 15. RESIDENT-TO-STAFF RATIOS IN MEMORY CARE FACILITIES/UNITS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Nursing staff (shifts)	Resident-to-staff ratio average		Proportion of Nursing staff type on shift (%)	
Years	2021	2023	2021	2023
Direct care workers				
10:00 a.m.	8 to 1	8 to 1	45	38
7:00 p.m.	9 to 1	9 to 1	41	35
4:00 a.m.	12 to 1	12 to 1	14	26
Licensed practical nurses/Registered nurses				
10:00 a.m.	16 to 1	18 to 1	41	37
7:00 p.m.	18 to 1	19 to 1	31	34
4:00 a.m.	19 to 1	20 to 1	28	29

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

Many experts have identified the need for specialized training for staff working with individuals with dementia. The majority of facilities have incorporated such specialized training for memory care employees (See Table 16). Three in four require training before individuals start their work in memory care, and nine in 10 require that training be done within the first 14 days. Almost all (98%) requiring ongoing in-service training for memory care staff. Approaches to physical monitoring varies by facility with three in 10 requiring weekly or more monitoring checks for residents using psychotropic medications, four in 10 monthly and one in five quarterly. The most common monitoring of behavioral symptoms by physicians occurs either weekly (38%) or monthly (30%).

TABLE 16. TRAINING AND MONITORING IN MEMORY CARE FACILITIES/UNITS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023		
Characteristics	**2021 (%)**	**2023 (%)**
Nursing staff training requirements		
Required special memory care training to start work on unit	64.2	75.5
Special training is required within first 14 days	81.1	91.8
Requires continuing education and training on best practices	96.6	98.1
Frequency of a physician monitoring of psychotropic medications		
At least 2-3 times per week	5.0	7.0
Weekly	23.9	24.0
Monthly	43.9	42.8
Quarterly	19.2	20.8
Semi-annually	2.7	1.3
Yearly	1.2	1.6
No monitoring is done by a physician	4.2	2.6
Frequency of a physician monitoring of behavioral symptoms		
At least 2-3 times per week	9.3	13.2
Weekly	39.9	37.9
Monthly	33.3	30.2
Quarterly	8.5	11.6
Semi-annually	0.4	0.6
Yearly	1.6	1.3
No monitoring done by a physician	7.0	5.1

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

SPECIAL SERVICES

Telehealth

One of the changes in response to the COVID-19 pandemic was an increase in telehealth opportunities. To examine this area, the biennial survey asked RCFs about their experience (See Table 17). Just under half of facilities (47.7%) reported using telehealth, a drop from 57% in 2021, but well above the 17% pre-pandemic rate. RCFs reported that video in the resident's room was the most likely approach used. Residents used telehealth with their personal physician about three-quarters of the time–up from 47% in 2021. This suggests that

telehealth is more likely to be used with a physician known by the resident, rather than for specialists which might have been more common during the pandemic. Six in 10 RCFs (61.8%) reported using telehealth with a mental health professional, an increase from one in four in 2021. More than one-quarter (28.7%) of RCFs reported using telehealth for evaluation or therapy visits for physical therapy, occupational therapy or speech therapy. The telehealth visits were most likely scheduled and attended by the RCF nurse (80%, 88% respectively).

RCF administrators identified a series of barriers to the use of telehealth (See Table 18). About half of the facilities identified physical or cognitive limitations of the residents (54.2%) and limited resident interest (53%) as a moderate or substantial barrier to the use of telehealth. Another one-third identified family resistance (32.2%). Lack of facility staff to support telehealth was seen as a moderate or substantial barrier for one in five (22.2%) facilities. Lack of financial support for the RCF was identified as a moderate or severe barrier by 18% of administrators. One in seven residences identified bandwidth and equipment as a moderate or substantial barrier. One in five RCFs (19.9%) reported difficulty finding physicians as a moderate or substantial barrier.

TABLE 17. CHARACTERISTICS OF TELEHEALTH USE IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Characteristics	2021 (%)	2023 (%)
Proportion of facilities using telehealth	57.2	47.7
Telehealth use prior to the COVID-19 pandemic	17.8	17.8
Telehealth method used		
Telephone (Audio only)	14.3	12.6
Video	81.7	84.4
Other method	3.9	3.1
Location of telehealth visit		
Residents go to a dedicated room	9.8	8.0
Telehealth is brought to the resident's room	88.5	89.2
Other location	1.7	2.8
How telehealth is used		
Resident's personal physician or physician chosen by resident/family	47.0	73.9
Behavioral or mental health professional	27.4	61.8
Evaluation by therapist (speech, physical, occupational therapy)	4.9	16.4
Therapy visit (by speech, physical, occupational therapist)	3.4	12.3
Emergency department	0.9	4.4
Other use	2.8	20.8
Scheduling a telehealth visit involves		
Registered Nurse or Licensed Practical Nurse	70.9	79.1
Direct Care Worker	22.2	28.2
Family/Friend	6.9	38.0
Telehealth visit technical assistance involves		
Registered Nurse or Licensed Practical Nurse	70.9	79.1
Direct Care Worker	22.2	28.2
Family/Friend	6.9	38.0
Participates in the telehealth visit (e.g., blood pressure check)		
Registered Nurse or Licensed Practical Nurse	86.9	88.5
Direct Care Worker	9.3	17.3
Family/Other	3.8	24.0

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

TABLE 18. BARRIERS TO USING TELEHEALTH IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Barrier Levels	Not a Barrier (%)		Somewhat (%)		Moderate (%)		Substantial (%)	
	2021	2023	2021	2023	2021	2023	2021	2023
Hard to find physicians offering telehealth	63.7	63.0	19.1	17.0	12.2	13.0	5.0	6.9
Residents don't want telehealth	31.9	31.6	22.4	15.4	20.5	21.3	25.2	31.7
Residents have a hard time participating (cognitive/physical limitations)	25.1	28.0	22.0	17.7	20.8	23.4	32.0	30.8
Family members resistant to telehealth	53.3	48.5	21.9	19.3	14.1	18.6	10.8	13.6
Internet bandwidth	63.6	75.1	16.1	10.5	10.1	7.8	10.1	6.6
Privacy and legal concerns regarding personal health information (i.e. HIPAA)	80.4	78.7	11.7	10.8	5.6	7.5	2.4	2.9
Lack of access to proper technology or equipment	69.0	73.5	14.7	11.8	10.2	8.5	6.1	6.2
Lack of reimbursement to the facility for technology and equipment	69.0	74.1	11.8	8.8	7.7	7.6	11.5	8.4
Lack of facility staff to support telehealth	53.7	62.9	21.5	14.9	12.5	12.8	12.3	9.4
Lack of reimbursement to the facility for staff to assist residents	66.6	72.3	11.3	9.3	7.8	9.0	14.3	9.4
Ownership/management of facility resistant to telehealth	89.2	89.0	5.6	4.8	3.7	3.9	1.6	2.3

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

Transportation Services

In response to feedback from our provider advisory group, we included questions about non-emergency transportation (See Table 19). Results were mixed, with one-half of RCF administrators reporting that transportation access, quality, or reimbursement for Medicaid beneficiaries (Assisted Living Waiver Program or MyCare Ohio) was not a problem. Conversely, about one in five reported transportation quality and reimbursement as a severe or very severe problem and 16% classified access as a severe or very severe problem. Example problems included the client reporting having to wait for long periods of time to be picked up after the completion of a medical appointment, or a provider not being reimbursed for delivering the service. More than six in 10 reported no problems in access or quality of transportation for those residents paying privately. Additionally, one in 10 reported severe or very severe problems in access and quality. For both Medicaid and private pay residents, the proportion with no problems increased between 2021 and 2023 and the proportion with severe or very severe problems dropped.

TABLE 19. ACCESS AND QUALITY OF NON-EMERGENCY TRANSPORTATION IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Type of Problem	Not a Problem (%)		Somewhat (%)		Moderate (%)		Severe/ Very Severe (%)	
	2021	2023	2021	2023	2021	2023	2021	2023
AL Waiver or MyCare								
Access	45.0	50.1	14.5	15.8	18.3	18.6	22.2	15.5
Quality of transportation	44.4	49.6	18.1	17.4	14.2	13.5	23.4	19.6
Reimbursement	50.0	51.7	13.7	12.0	15.0	17.2	21.3	19.1
Private Pay								
Access	58.1	61.8	16.3	17.3	12.7	11.3	12.9	9.5
Quality of transportation	60.6	66.4	16.0	15.3	10.7	8.9	12.8	9.4

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023

Infection Prevention

Given the impact that the COVID-19 pandemic had on long-term residential settings, the survey also asked about infection prevention (See Table 20). Three quarters of residences reported having an infection preventionist, who was most commonly a registered or licensed practical nurse. RCFs reported that these individuals spend about 25% of their time allocated to this task.

TABLE 20. CHARACTERISTICS OF INFECTION PREVENTIONISTS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Preventionist staffing	Percentage	
	2021	2023
Proportion that has infection preventionist	70.4	74.9
Primary professional background of infection preventionist		
Registered nurse	56.6	47.3
Licensed practical nurse	38.9	48.5
Medical training (non-nurse)	0.5	0.6
Other	4.1	3.6
Infection preventionist receives special training	81.4	83.3
Proportion of time per week infection preventionist spends on		
Infection prevention tasks	31.0	25.0
All other tasks	69.0	75.0

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023

COMPLAINTS

One of the trends observed in both RCFs and nursing homes across the nation has been an increase in formal complaints. To better understand how RCFs are responding to this increase, a series of questions were asked about policies and strategies used when a complaint is presented directly to the RCF (See Table 21). In a number of areas, more than nine in 10 RCFs reported common policies including requiring staff members to report complaints to their supervisor (99%), meeting with the individual lodging the complaint (95%), and requiring a supervisor to meet with the individual who lodged the complaint (92%). Seven in 10 reported requiring an interdisciplinary meeting to address the complaint. In looking at the actual strategies implemented to respond to complaints, nine in 10 RCFs reported meeting with the resident or family member (99%),

consulting with the ombudsman (93%), creating a mechanism for investigating complaints or including complaint investigation as part of the quality improvement process (93%). More than eight in 10 RCFs (86%) reported discussing internal complaints with their resident council. Three in four reported surveying residents and family members. Seven in 10 have a dedicated staff member assigned to handle complaints and have an anonymous system to report complaints. Six in ten hold public meetings with residents and families, and more than half have an internal hotline for reporting complaints.

TABLE 21. STRATEGIES OF OHIO'S RESIDENTIAL CARE FACILITIES TO RESPOND TO COMPLAINTS RECEIVED, 2023

If a resident or family member complains to a staff member in your facility, does your facility currently have the following policies?	%
Staff members are required to report the complaint to their supervisor	99.3
Meet with complainant to discuss a facility response	95.4
Supervisors are required to meet with the complainant	91.9
Facility is required to hold an interdisciplinary team meeting to address complaint	69.1
What strategies to address complaints does your facility use?	
Meet with family/resident	99.3
Consult/work with long-term care ombudsman	93.4
Formal and internal complains are systematically reviewed as part of quality improvement process	92.5
Discuss internal complaints with resident council	85.8
Survey residents and family members	75.5
Internal hotline	55.8
Have a dedicated staff member to handle internal complaints	72.5
Have an anonymous system to report complaints	69.4
Hold public meetings with residents and families	61.3
Mechanism for conducting internal investigations related to internal complaints	92.7

Source: Biennial Survey of Long-Term Care Facilities 2023.

TABLE 22. EXPERIENCE OF OHIO'S RESIDENTIAL CARE FACILITIES WITH THE OHIO DEPARTMENT OF HEALTH COMPLAINT SURVEY PROCESS, 2023

Facility experience	Poor (%)	Neutral (%)	Positive (%)	No experience (%)
Consistency of survey	9.7	43.4	37.4	9.5
Timeliness of survey	6.6	40.6	42.4	10.4
Survey improved quality	8.8	44.4	34.1	12.7

Source: Biennial Survey of Long-Term Care Facilities 2023.

RCF administrators were also asked to rate the Ohio Department of Health complaint survey process (See Table 22). Four in 10 provided a neutral rating to the three areas examined: consistency (43%), timeliness (41%), and whether the survey improved the quality of care (44%). About four in 10 provided a positive rating to the three areas; consistency (37%), timeliness (42%) and improving quality (34%). Less than one in 10 provided a poor rating in the three areas; consistency (9.7%) timeliness (6.6%) improving quality (8.8%).

Technical Assistance and Innovations

In an effort to identify opportunities for quality improvement, the survey asked administrators to identify areas where their RCFs could benefit from technical assistance (See Table 23). While the list of technical assistance areas was generated by our advisory group, seven in 10 RCFs reported not needing technical assistance in any of the areas listed. Fire drills and evacuation (14%), infection control (13%), and medication assistance (13%) were the three areas that had the highest "very necessary" rating for assistance by survey respondents, with more than 10% of RCFs rating all of the areas listed as "very necessary".

Administrators were also asked about innovative practices in their residences (See Table 24). Thirty-four respondents reported following the small/greenhouse design, an increase from 19 in 2021. In this design residents are grouped into small houses with about 10 individuals per home. Seventeen RCFs reported the use of robotics, an increase from four in 2021. Sixteen

residences reported using staff swipe tags to track staff time with residents, an increase from seven in 2021.

TABLE 23. RESIDENTIAL CARE FACILITY ADMINISTRATORS RATING OF TECHNICAL ASSISTANCE NEEDS, 2023

Where facility could benefit	Not Necessary	Necessary	Very Necessary
Fire-drills and self-evacuation	70.0	16.1	14.0
Food storage and contamination	71.1	16.6	12.4
Medication is given as prescribed and medication administration	70.7	16.2	13.1
Resident rights – freedom from abuse	74.0	14.6	11.4
Infection control	68.0	18.7	13.3
Quality of care	70.0	18.1	11.9
Monitoring resident health status	68.3	20.0	11.7

Source: Biennial Survey of Long-Term Care Facilities, 2023.

TABLE 24. INNOVATIONS IN OHIO'S RESIDENTIAL CARE FACILITIES, 2021, 2023

Involved in any of the following practices	Number of RCFs Reporting	
Year	**2021**	**2023**
Small house or green house design	19	34
Use of robotics	4	17
Staff swipe tags to monitor the amount of time staff spends in resident rooms	7	16

Source: Biennial Survey of Long-Term Care Facilities 2021, 2023.

FUTURE OPPORTUNITIES AND CHALLENGES FOR OHIO

Despite Ohio's improvement in creating an extensive array of home- and community-based care options, the path forward includes a number of challenges. The size of Ohio's older population today is unprecedented in our history, but a 24% increase in those age 85 and older over the next decades will continue to have an impact. These demographic shifts alone would present challenges to the state, but with additional system complications such as workforce shortages, individual and public funding concerns, quality of care critiques, and family caregiving pressures, efforts to make Ohio the best place to grow old will require continued policy attention. To meet the future needs of Ohio's older population policy makers, consumers, family members, advocates, and providers will need to work together to address current issues and future needs. To this end, we offer the following ideas for consideration.

Ohio's long-term services system, as has been true for almost all of the states, has been shaped by the federal/state Medicaid program. Medicaid is typically the largest single expenditure in almost every state in the nation, but it is critical to recognize that nine in 10 older people in Ohio are not eligible for the Medicaid program. However, very few older Ohioans have private long-term care insurance, and many Ohioans cannot afford the premiums. More than one-third of older Ohioans with long-term service needs end up on Medicaid. For individuals needing nursing home care, more than two-thirds will eventually require assistance from the Medicaid program. The question is whether Ohio can do anything to lower the current utilization rate of Medicaid LTSS moving forward. We continue to explore the major ideas that have been brought forward to address this question including: (1) preventive actions, (2) expanded support services, (3) better support for caregivers, both informal and formal, (4) harnessing technological innovation, and (5) encouraging both community and individual responsibility for LTSS.

Preventive Actions

As a nation, we spend a substantial amount of resources through both the Medicare and Medicaid programs to assist individuals with medical care and long-term services. While we recognize the importance of helping older people

in need, providing assistance to individuals prior to a crisis could pay dividends. Evidence-based practices, now supported by the Ohio Department of Aging through the federal Older Americans Act, have been shown to have an impact on disability rates of older people. If Ohio were able to reduce the sheer number of older people with high need for LTSS by just 10%, that could mean 26,000 fewer older people with high level of disability. The Older Americans Act resources used to support these types of programs for the entire nation totaled $44 million, in comparison to the more than $1.6 billion spent on Medicare and Medicaid. While states are heavily reliant on the federal Older Americans Act to support such activities, the overall investment has not kept pace with the dramatic population increases that have occurred.

Expanded Support Services

Medicaid is the major state funding source for LTSS; however, individuals need to have high levels of disability and meet strict income and asset criteria to receive assistance. There are a sizable number of older people (estimated at more than 90,000) in Ohio who experience moderate levels of disability and are likely to be Medicaid eligible as their health trajectory continues to decline. Several recent studies have shown that states with fewer supportive services, such as home-delivered meals and personal care, have a higher proportion of low-care residents in nursing homes. Another study found that individuals receiving congregate meals were less likely to be admitted to nursing homes or hospitals compared to a group of older people not receiving meals. Finally, some recent work has highlighted the success of combining supportive services in partnership with health care services. Area agencies on aging that had partnerships with health care organizations had significantly lower hospital readmission rates and significantly fewer low-care residents in nursing homes in the regions served.

Ohio's Healthy Aging Grants Program, supported in the last biennial budget, is an example of a strategy designed to serve older Ohioans in an effort to prevent or delay the need for support from Medicaid. One-third of the funds were allocated to food assistance, and an additional one-quarter of the funds were used for housing assistance, such as home repairs or adaptation of the home for individuals experiencing disability. About 12% of funds were allocated to

internet access or digital literacy for older individuals in the community. The Healthy Aging Grants Program provided an array of other support services such as transportation, caregiver assistance, emergency response systems and efforts to combat social isolation. Communities reported a number of examples where these funds led to individuals being able to remain independent in their local communities. This is an example of how Ohio can help individuals avoid spending down to Medicaid eligibility.

Better Support of Caregivers, Both Informal and Formal

While we celebrate increased longevity and the unprecedented number of older people in Ohio, we also recognize that families and friends provide more long-term services assistance today than ever before. Studies consistently indicate that for individuals with severe disability, family and friend caregivers provide about 80% of all the assistance received.

The major support for caregivers in the United States comes though the National Family Caregiver Support Program under the Older Americans Act. As was the case for prevention and supportive services, this component of the act has limited funding, with $145 million allocated annually nationwide for this program. Family and friend caregiver support is critical in efforts to support older people living independently in the community. In particular, when families, who are providing the bulk of care in this country, are no longer able to provide the needed support, nursing home or assisted living care is required.

Another challenge in Ohio and the nation overall involves the LTSS formal workforce. While workforce quality and shortages have improved in the post-pandemic era, serious challenges remain. States and providers are exploring options to address the workforce challenges, but there is no one answer that will solve this problem. There is certainly a clear recognition by state policymakers and the industry that this problem must be addressed. Ohio's legislation allocating additional funds to address this challenge in home care and RCFs has been an important response, and both sectors have reported recruiting and retention improvements. However, the rise in the need for long-term services means that this challenge will continue. A plan to form a short-term and long-term response to the workforce issues is an important step.

Harnessing Technological Innovation

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

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

CONCLUSION

Ohio's progress in LTSS system reform has been significant. The changes that have occurred were almost unimaginable three decades ago. However, the demographic and service hurdles of tomorrow will continue. What our experiences have taught us is that we can respond to these new challenges associated with population aging, but it will take creativity, commitment, and

cooperation to succeed. Designing an efficient and effective system of long-term services is no small task – but countless Ohioans, including our family, our friends, are counting on Ohio being a good place to grow old.

REFERENCES

[1] AARP 2023. Long-Term Services Scorecard 2023 edition.

[2] PASSPORT Information Management System (PIMS) 1993-2017, and Ohio Department of Medicaid Waiver Comparison Charts- Enrollment Figures for May 2019, and Ohio Department of Medicaid Caseload report Actual versus Estimated Medicaid Eligibles FY 2021, 2023.

[3] Ohio Biennial Survey of Nursing Homes, 1993-2021; Ohio Department of Medicaid, Medicaid Claims data SFY 2005-2013;Health Policy Institute of Ohio. 2015. 'Ohio Medicaid Basics 2015' Retrieved on 7/21/2015 from: http://www.asiaohio.org/wp-content/uploads/2011/07/MedicaidBasics_2015_Final.pdf. Ohio Department of Medicaid Caseload Report Actual Versus Estimated Medicaid Eligibles 2017-2023 https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/caseload-reports/caseload-reports. Nursing Home Minimum Data Set (MDS) 2013- 2020.

[4] PASSPORT Information Management System (PIMS) 1993-2017, and Ohio Department of Medicaid Waiver Comparison Charts- Enrollment Figures for May 2019, and Ohio Department of Medicaid Caseload report Actual versus Estimated Medicaid Eligibles FY 2021, 2023.

[5] Ohio Biennial Survey of Nursing Homes, 1993-2021; Ohio Department of Medicaid, Medicaid Claims data SFY 2005-2013;Health Policy Institute of Ohio. 2015. 'Ohio Medicaid Basics 2015' Retrieved on 7/21/2015 from: http://www.asiaohio.org/wp-content/uploads/2011/07/MedicaidBasics_2015_Final.pdf. Ohio Department of Medicaid Caseload Report Actual Versus Estimated Medicaid Eligibles 2017-2023 https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/caseload-reports/caseload-reports. Nursing Home Minimum Data Set (MDS) 2013- 2020.

[6] PASSPORT Information Management System (PIMS) 1993-2017, and Ohio Department of Medicaid Waiver Comparison Charts- Enrollment Figures for May 2019, and Ohio Department of Medicaid Caseload report Actual versus Estimated Medicaid Eligibles FY 2021, 2023.

[7] Ohio Biennial Survey of Nursing Homes, 1993-2021; Ohio Department of Medicaid, Medicaid Claims data SFY 2005-2013;Health Policy Institute of Ohio. 2015. 'Ohio Medicaid Basics 2015' Retrieved on 7/21/2015 from: http://www.asiaohio.org/wp-content/uploads/2011/07/MedicaidBasics_2015_Final.pdf. Ohio Department of Medicaid Caseload Report Actual Versus Estimated Medicaid Eligibles 2017-2023 https://medicaid.ohio.gov/stakeholders-and-partners/reports-and-research/caseload-reports/caseload-reports. Nursing Home Minimum Data Set (MDS) 2013- 2020; Annual Estimates of the Resident Population for Selected Age Groups by Sex for Ohio: April 1, 2020 to July 1, 2023 (SC-EST2023-AGESEX-39),U.S. Census Bureau, Population Division, Release Date: June 2024.