**Grantee:** Ohio Department of Aging
**Title of Project:** Ohio's Unified Prevention and Long-term Care System Initiative
**Grantor:** Administration on Aging
**Time frame**: 3 Years beginning October 1, 2011
**Grant Total**: $2,342,066

**GOAL**: Ohio's Unified Prevention and Long-term Care System Initiative will ensure that older adults, individuals with disabilities and family caregivers have access to a sustainable, integrated system of high quality, evidence-based services that can help them remain independent and healthy in the community.

**IMPLEMENTATION:** Statewide

**OBJECTIVES:**

1) coordinate collection of data elements to support portability of data across systems;

2) expand Ohio Benefit Bank to be inclusive of HCBS and preventive services;

3) expand capacity to offer Care Transitions Interventions;

4) identify and implement new evidence-based prevention initiatives that support individuals receiving in-home care and un-paid caregivers;

5) identify and develop new reimbursement streams for evidence-based services;

6) identify and implement common consumer satisfaction tools statewide; and,

7) make HCBS systems more disability, dementia, person-centered capable by providing consistent training at all levels.

**PARTNERS:**

Job and Family Services, Office of Health Transformation, Area Agencies on Aging, Centers for Independent Living, Ohio Association of Second Harvest Foodbanks/ Ohio Benefit Bank, Scripps Gerontology Center, Ohio Association of Gerontology and Education (OAGE), more to be identified

**Grantee:** Ohio Department of Aging
**Project Title:** Partners in Dementia Care
**Grantor:** Administration on Aging
**Time frame:** 3 Years, beginning October 1, 2011
**Grant total:** $ 691,243

**GOAL:** Partners in Dementia Care (PDC): A Dementia Capable System of Care for Ohio Veterans and their Caregivers will establish formal working partnership between VA Medical Centers and community service organizations. PDC is an evidenced-based care coordination program, designed specifically for persons with dementia and their caregivers, that links the partnering entities and creates an integrated system of care that includes primary and specialty health care services from the VA and the full range of community-based health, social, and support services from the aging services network. The goal of this project is to advance this evidence-based program to a large-scale implementation outside of a research context.

**IMPLEMENTATION:**

Sites in Cleveland and Akron will conduct full implementation of the partnership model and deliver PDC care coordination to 200 veterans and their family caregivers.

**PARTNERS**: Benjamin Rose Institute (lead), the Ohio Department of Aging, Western Reserve Area Agency on Aging, East Ohio Alzheimer's Association Chapter and the Cleveland VA Medical Center.

**OUTCOMES:** The project will have three sets of outcomes: 1) Outcomes organized by the Stress Process Conceptual Model that will be measured from interviews with veterans and caregivers; 2) Outcomes that measure VA service use and service costs; and 3) Outcomes that will be abstracted from the Care Coordination Information System (CCIS), which guides the delivery of PDC Care Coordination.