

# Core Service Report

## Case / Care Management

Consumer Category:  
**Multiple Services**

Primary Consumer Group:  
**Consumers of Multiple Services**



February 2007

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## COMPANION REPORTS

In addition to the information included in this report, a report of the other core services (80 in total), community leader key informant interviews, United Way - First Call for Help staff focus groups, consumer snapshots, and e-survey of United Way funded executive directors, board presidents, and United Way Community Investment staff are available at <http://www.uws.org>.

## ACKNOWLEDGEMENTS

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## SNAPSHOT

**AIRS Code Level I: Individual & Family Life (P)**

**AIRS Code Level II: Individual & Family Support Services and Family Support Services (PH)**

**Core Service: Case/Care Management (PH-100)**

**Investment Committee: Health & Caring for All and Senior Success**

**Cluster: Medical Family Support Services and Basic Subsistence/Supportive Services**

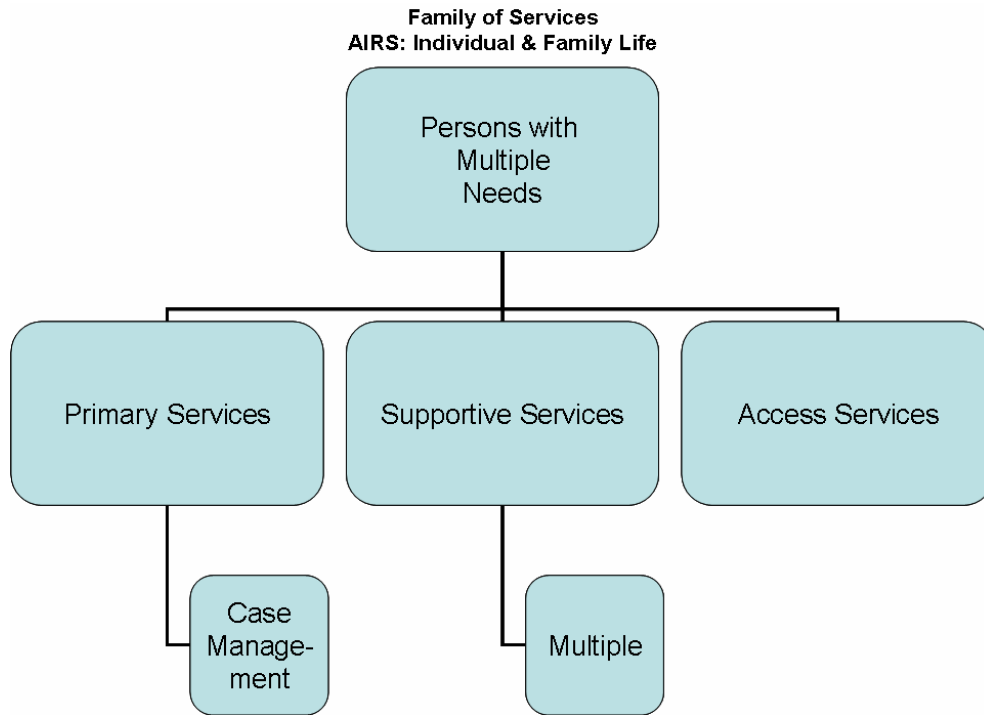
**AIRS Definition:** Programs that develop plans for the evaluation, treatment and/or care of individuals who, because of age, illness, disability or other difficulties, need assistance in planning and arranging for services; that assess the individual's needs; coordinate the delivery of needed services; ensure that services are obtained in accordance with the case plan; and follow up and monitor progress to ensure that services are having a beneficial impact on the individuals.

**Special Note:** Reporting about case management in general may be misleading as it is possible to gloss over much relevant information. Providers of case management do not serve a uniform population. In addition to the differences in consumers' incomes, there are differences in age, condition, and service needs. The type of case management utilized in a setting will also differ in structure (e.g. combination and intensity of functions), focus of the service, and the professional expertise of the service provider. The case management process implemented in a community setting with older adults (such as those services funded by area agencies on aging) will not be identical to those implemented in an inpatient clinical setting with the severely mentally ill (such as those provided in a public or private hospital).

Additionally, case management can operate within the siloed social service delivery system. Thus, included in this report is information about the integrated children and family service model, which could be a context for case management services for individuals and families with multiple health and social service issues.

Because of the uniqueness of this service, the typical core service report model has not been utilized in the areas of estimated persons in need and gap analysis.

Case/Care Management is part of the family of services for consumers with multiple services with multiple providers. It is the only service in this group. (See figure below.)



*Core Service Environment*

Case management, also known as “care management,” is a process that involves service referral and coordination for an individual needing multiple services. Many clients who use social and health services use more than one service. In fact, when economic and acute care medical programs are added to behavioral health and criminal justice programs, one often sees a constellation of needs for both individuals and families. The goal of case/care management is generally to provide services and supports to individuals to help them move toward greater independence while promoting the health and well-being of all family members. The service array is intended to focus not only on immediate crisis needs of families, but also to provide prevention and early intervention services that help families avoid reaching a crisis (Hutson, 2004).

In 1981, the Social Security Act was amended for the purpose of providing matching federal funds for various services, including case management, for Medicaid-eligible people (Davis, Fox-Grage, & Gehshan, 2006). Ohio offers several Medicaid waiver programs that provide case management services for those enrolled in the various programs administered by the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Department of Job and Family Services, and the Ohio Department of Aging (Ohio Legal Rights Services [OLRS], n.d.).

Section 6052 of the Deficit Reduction Act of 2005 (DRA), signed on 2/8/06, includes a provision to tighten the definition of what qualifies as Medicaid-targeted case management (TCM). Congress has failed to reauthorize the act, which expired September 30, 2005. Since then, programs have been running with the same levels of funding as they had in the previous year (Ryan White Action Campaign [RWAC], 2006).

Long-term care issues for the aging and the need to address the growing number of chronic conditions may increase their influence on the development of public policy, which will also influence the nature of case management. If the population of adults and older adults grows and continues to prefer aging in place, case management will be essential to the long-term care system.

Case management will need to continue achieving cost containment in order to be able to demonstrate its value in the political realm. Case management has proven itself useful in a managed-care world that emphasizes controlling costs of care (U.S.DHHS, n.d.b).

*Core Service Consumers*

The definition of the target population for this core service is individuals or families who are unable to arrange for services on their own behalf because of age, illness, disability or other difficulties. Several populations of individuals that may benefit from case management services include those who are frail and aging, physically handicapped, developmentally disabled, ill, persistently mentally ill, in the foster care system, homeless, and those with HIV/AIDS and other chronic conditions. Specifically, those who need multiple services may benefit most from case management if it is provided in an integrated system.

Several populations that may receive case management services include children in the care of protective services, mentally ill individuals (as well as those in psychiatric rehab), persons with severe mental disabilities, substance abusers, homeless adults and children, individuals who require medical attention, individuals with HIV/AIDS or at risk for HIV and other chronic conditions, and older adults.

Child Welfare Case Management. As of December 2005, there were 2,553 children in custody of the Cuyahoga County Department of Children and Family Services (DCFS, 2006).

Substance Use Disorders/ Chemical Dependency Case Management. Approximately 5.6 percent of individuals in Cuyahoga County aged 12 or older were current illicit drug users, 45 percent were current alcohol users (DHHS, 2006a).

Case management for individuals with or at risk of HIV/AIDS. Between July 2003 and June 2004, 156 individuals from Cuyahoga County were diagnosed with HIV, and 3,321 were then living with HIV/AIDS (Ohio Department of Health [ODH], 2004).

Case management for individuals with developmental disabilities. Approximately 27,880 to 41,820 individuals in Cuyahoga County had some degree of mental retardation and/or developmental disability in 2000.

Psychiatric case management. According to the National Mental Health Association (NMHA) (2006a), “the most serious and disabling conditions” affect five to ten million adults (2.6 to 5.4 percent) and three to five million children ages five to seventeen (5 to 9 percent) nationwide.

Case management for homeless individuals. In January 2005, a point-in-time count of homeless persons in Cuyahoga County suggests there were over 2,208 homeless persons (Cuyahoga County Office of Homeless Services, 2005).

Case management with older adults. In 1990, there were 293,461 older adults 60+ in Cuyahoga County; by 2000, this amount had decreased to 273,378.

*Core Service Delivery*

The definition of the core service for this report is: programs that develop plans for the evaluation, treatment and/or care of individuals who need assistance in planning and arranging for services; that assess the individual’s needs; that coordinate the delivery of needed services; that ensure that services are obtained in accordance with the case plan; and that follow up and monitor progress to ensure that services are having a beneficial impact.

Case management makes it possible for service providers working in different agencies or organizations to coordinate efforts so they may work with the client more efficiently and as a team. In addition to these benefits, case management is seen as the most effective strategy to reduce and control costs of health and human services (Murer, 2000).

The primary goal of case management is to optimize client functioning by providing quality services in the most efficient and effective manner to individuals with multiple complex needs. Like all methods of social work practice, case management rests on a foundation of professional training, values, knowledge, theory, and skills used in the service of attaining goals that are established in conjunction with the client and the client’s family, when appropriate. Such goals include: enhancing developmental, problem-solving, and coping capacities of clients; creating and promoting the effective and humane operation of systems that provide resources and services to people; linking people with systems that provide them with resources, services, and opportunities; improving the scope and capacity of the delivery system; and contributing to the development and improvement of social policy. (NASW, 2006)

Based on United Way - First Call for Help’s (FCFH) database (February 2005), there are 31 case/care management service providers operating from 54 different sites, 26 of which are nonprofit and 5 are government. In FY 2004 (July 2003 to June 2004), United Way funded 8 of these providers. FCFH call data shows an increase in the number of total requests for case management services in the county: from 166 in 2000 to 239 in 2004 (44 percent). Over the same five-year period, FCFH had 932 requests for information about case management. Of these, they were able to make referrals to 99 percent of callers.

There are several sources of funding for case management services, including federal community development block grants; Medicaid; Medicare and Supplementary Security Income for disabled individuals; Older American’s Act; Ohio Medicaid waiver programs, including PASSPORT; Cuyahoga County Options for Elders; Ryan White CARE Act; migrant health funds; private foundations or funds; state and/or local tax dollars; and private insurance (DHHS, n.d.a).

As of May 11, 2006, \$1.15 million in revenues for case management has been identified countywide. Forty-one percent of the identified revenues are from contracts or grants from government organizations, 57 percent from United Way of Greater Cleveland through Investment Committee allocation and designated gifts, and the remainder comes from foundations and federated fundraising organizations.

Actual fees for case management services vary by type of case management and the profession and level of professionalism of the case manager.

#### *What Works; What Doesn't*

Although growing in popularity, case management has not been studied extensively (Sullivan, 2002). The evidence that supports its use in addiction services also shows only a modest impact (Sullivan, 2002)

Findings specific to substance abuse and addiction treatment indicate that case management is important in client compliance with treatment as well as the rate of recovery (Sullivan, 2002), as supported by research from the Wright State School of Medicine.

There are a number of best practices identified for case management services and its focus on specific consumer groups.

Morse (n.d.), in an article about working with homeless individuals, stated from his brief analysis that case management seemed to be less effective with certain groups of clients, including males, individuals with more psychotic symptoms, individuals with longer histories of homelessness, and dual-diagnosed individuals.

Accrediting agencies that issue authorizations for businesses, organizations, and institutions include the Accreditation Commission for Health Care (ACHC), Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance (NCQA), and Utilization Review Accreditation Commission (URAC).

#### *Gap Analysis*

The typical gap analysis was not conducted for this service. There are a number of challenges social service providers experience when doing case management and consumers experience in accessing services. The following is an overview of some of the issues.

- The need for multi-lingual and culturally-competent case managers;
- A need for a centralized information bank;
- High staff turnover and staff shortages;
- Complexity of client needs;
- Interagency cooperation;
- Disintegrated structure and function of case management;
- Transportation needs;
- Lack of continuity in the American health care system;
- Recidivism in treatment of substance abuse and chemical dependency; and
- Dependency of clients on case managers.

# I. FOREWORD

## INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community’s safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of “safety net” services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

## METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn’t work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line. The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve are located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

## II. THE CORE SERVICE ENVIRONMENT

### CORE SERVICE ENVIRONMENT

#### *Need for a Comprehensive, Integrated Children and Family Services System*

Many clients who use social and health services use more than one service. In fact, when economic and acute care medical programs are added to behavioral health and criminal justice programs, one often sees a constellation of needs for both individuals and families. However, just as often, service delivery systems are highly specialized into discrete disorders, needs, rules and regulations. Too often, state and federal programs create artificial barriers to efficient and effective service delivery that present complex challenges for the local delivery systems, which directly serve clients....The front door to enter many state and local social services is often the crisis system. Unfortunately because of lack of resources, misinformation, lack of communication between systems, the mental health crisis system and/or local criminal justice system becomes the provider of last resort. (Washington State Association of Counties (n.d.)

The problem described in the State of Washington is not unique. In recognition of the universality of this issue, a collaborative effort between the National Governors Association Center for Best Practices (NGA), the Center for Law and Social Policy (CLASP), and the Hudson Institute (Hudson) that was funded by the Annie E. Casey Foundation, initiated the “Increasing State and Local Capacity for Cross-Systems Innovation” project. Its purpose is to gain a clearer understanding of the flexibility, opportunities, and barriers that exist under current federal law with respect to cross-program integration both within human services programs and across the welfare and workforce systems. Working in consultation with state and local officials, the partner organizations developed three models of cross-system integration focusing on comprehensive services for children and families; integration of the Workforce Investment Act (WIA) and Temporary Assistance for Needy Families (TANF); and benefits simplification. The components of these models were then analyzed to determine whether current federal laws or regulations permitted, prohibited, or hindered the implementation of the models. (Hutson, 2004)

Over the past several years, social service providers have increasingly recognized that families seeking assistance often face multiple, complex needs and that they require the services of more than one program. For example, Temporary Assistance to Needy Families (TANF) workers who have focused on helping move clients into jobs, often find that in addition to needing basic job skills, their clients may face substance abuse, domestic violence, or mental health issues that interfere with successfully obtaining and keeping a job. Child welfare workers are increasingly recognizing that in addition to mental health, substance abuse, and domestic violence

challenges, their clients frequently need economic supports and assistance to more effectively manage their lives and provide adequate care for their children. (Hutson, 2004)

In order to access the range of services they need, these families must often go to multiple locations and interact with a range of rules and regulations and a variety of caseworkers and case plans. Some caseworkers may have inconsistent expectations and obligations in different case plans or programs may conflict. In addition, agencies often face limitations (actual or perceived) on the type of services they can fund. The fragmentation and complexity of such service delivery makes it extremely difficult, if not impossible, for many families to obtain the services they need. Ironically, the most vulnerable families, those who need the most help, are the least likely to be able to navigate such a complex, fragmented system. Thus, a number of states and localities have begun experimenting with ways to provide a more family-centered, seamless service delivery system, a system that offers a broad continuum of services and tailors these services to the strengths and needs of individual families. (Hutson, 2004)

The goal is generally to provide services and supports to families to help them move towards greater independence while promoting the health and well-being of all family members. The service array is intended to focus not only on immediate, crisis needs of families, but also to provide prevention and early intervention services that help families avoid reaching a crisis. (Hutson, 2004)

The following report deals with case/care management in the traditional mode. It must be noted that case managers often function within these fragmented siloed systems and thus cannot work holistically with an individual or family. Thus, we will describe elements of the integrated service model throughout this report to establish a context for case management.

Case management, also known as “care management,” is a process that involves service referral and coordination for an individual needing multiple services. There is no established agreed-upon definition of case management because the practice depends on the needs of the client population, the frame of reference adopted by the case manager, the prior training of individuals implementing case management (e.g. social workers, nurses, or case management specialists), and the system and setting within which the plan is created and implemented (which dictates the organizational structure and the environmental reality) (U.S. Department of Health and Human Services ( DHHS), n.d.). Authors on the subject seem to agree, though, that its functions usually involve seeking, planning, coordinating, and monitoring services (Murer, 2000; Giddens, Ka’opua, & Tomaszewski, 2002; Rothman, 2002; Barker, 2003; Ford et al., 2004). The Case Management Society of America (2006b) defines case management as a “collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.” Several authors, including Rothman (2002), Sullivan (2002), and Ford et al. (2004), also include a component of advocacy as a part of the process. Case managers may advocate on behalf of their client so that they can receive services or have other needs met that may be unfairly withheld from them, or receive services that fit their needs (DHHS, n.d.).

Because cost containment is one of the benefits of case management, it may have a slightly negative connotation because it is expected that case management decreases the quality of services for recipients. On the other hand, case management is also regarded as a comprehensive approach to address both acute and chronic needs of individuals through their health care trajectory. It provides the client populations continuity of care in a seemingly fragmented American health service delivery system (Rothman, 2002).

Client needs and practice settings (e.g. where individuals are to receive services) are major determinants of the model of case management to be implemented. General process steps include recording the case findings, developing and implementing a comprehensive assessment and care plan, arranging and coordinating services, and reassessing the situation (Barker, 2003).

Rothman (2002) outlines one basic model of case management describing the various components of its sequential and intermittent functions. Sequential functions of case management include accessing the agency, performing intake duties, assessing the situation, goal-setting, intervention-planning, identifying and indexing resources, creating formal and informal linkages, monitoring and reassessing the situation, and evaluating outcomes (Rothman, 2002). Being a part of a complete process, these functions are normally initiated and implemented in an orderly fashion. Intermittent functions are supportive and include coordinating among agencies, counseling, providing therapy, and advocating for the client (Rothman, 2002). Rothman also placed emphasis on the empowerment and active participation of the client in each phase.

#### Description of the Sequential Functions (Rothman, 2002)

- *Access to the agency* – Clients can come into contact with the organization providing case management through referrals or from other outreach methods.
- *Intake* – This function includes the identification of the client’s problem and its solution, the determination of the appropriate agency/-ies and the client’s eligibility for services, the appraisal of the client’s financial situation, and education of the client regarding agency services, requirements, and limitations.
- *Assessment* (could encapsulate one or a combination of psychological, social, and medical assessment) – The problem is further examined in order to identify its causes and dynamics. Most of the time, the case manager will also gauge the family’s potential benefit to the client in terms of reaching the goals and objectives of the management plan, as well as family members’ abilities to cope with a long-term client.
- *Goal setting* – Short- and long-term service goals are formulated. During this stage of planning, it is important that these goals remain realistic.
- *Intervention-planning* – This includes treatment planning, service planning, recognizing methods of achieving short- and long-term goals, and identifying resources. Treatment planning may entail counseling and therapy and service planning entails linking clients to informal or formal external supports.
- *Resource identification and indexing* – The case manager obtains information on relevant service resources and organizes the data for easy access.
- *Formal linkage to agencies and programs* – Service needs are clarified so that clients can be matched to appropriate agencies. Initial telephone contact with these agencies is also established and the client is also oriented to those agencies and services that he/she may receive.

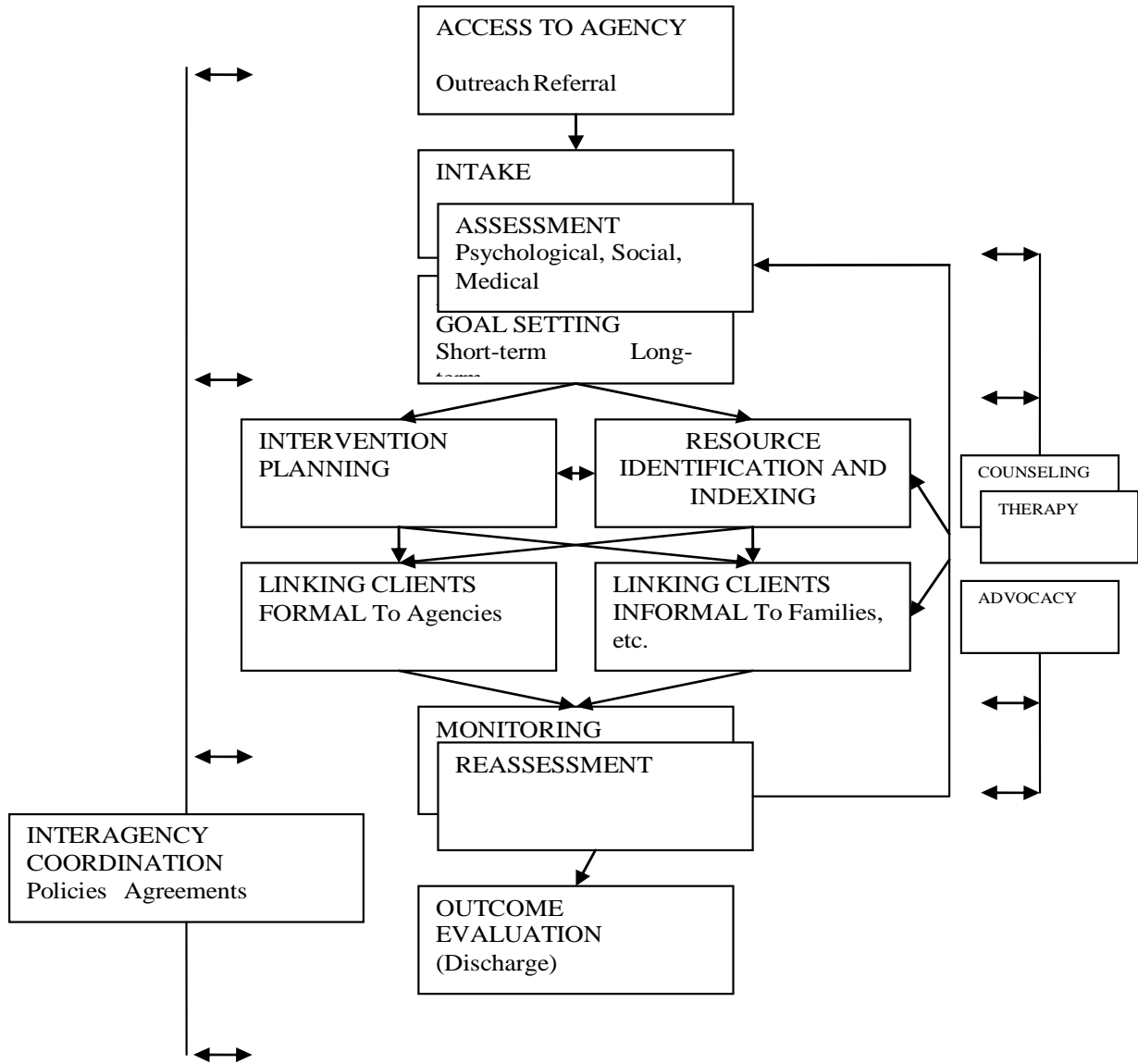
- *Informal linkage to families and social networks* – The purpose of this function is to draw on the range of natural helping networks. This includes family, friends, and other individuals (e.g. neighbors and community groups) which may have the potential to be helpful. These individuals are also assessed for their abilities to withstand the pressures that they may face in helping the individual establish their goals.
- *Monitoring and reassessment* – This involves the systematic contact with the agency service providers and other informal support, as well as the recurrent appraisal of the situation.
- *Outcome evaluation* – This evaluation involves termination or discharge of case management services.

Description of the Intermittent Functions (Rothman, 2002)

- *Interagency coordination* – Relationships are established among the agencies to facilitate linkages.
- *Counseling* – This function involves giving information and advice.
- *Therapy* – This may be long- or short-term, and helps clients to cope with everyday living situations.
- *Advocacy* – This involves an assertive approach in assisting the client in receiving services or amenities that are being unfairly withheld.

Figure 1 describes a general model for case management. Other models that exist may stress certain components of this basic model over others.

Figure 1: Basic Model of Case Management



Source: Rothman, J. (2002). An overview of case management. In A.R. Roberts and G.J. Greene (Eds.), *Social Workers' Desk Reference* (467-472). New York: Oxford University Press.

## PUBLIC POLICY ISSUES

### ***NATIONAL and STATE***

Included below are several key public policy issues that are affecting the delivery of case management.

#### *Comprehensive, Integrated Children and Family Service System*

After analyzing the legal ramifications of an integrated children and family service model, Huston (2004) concluded:

Many see federal law regarding the purposes and uses of funds, the eligibility requirements of various programs, and federal confidentiality provisions as creating barriers to integrated social services delivery. In reality, these federal statutes and regulations do not prevent states and localities from developing comprehensive, integrated services for children and families. However, other barriers remain. By beginning with an examination of the legal (federal and state) barriers facing their particular state or locality, administrators and policy makers can provide an opportunity—a forum, format, and process—for building the foundation of cross program integration. As members of different programs come together to discuss whether and how they can combine their resources, they can begin to see how much their missions and goals overlap. As they struggle to align program eligibility requirements, they can work together to build a common vision. Finally, as they work to obtain consent from families about sharing information to better provide services, they have the opportunity to practice working with families in a family-centered, strength-based manner. All of these are important steps towards developing an integrated child and family service model.

What follows is a description of specific public policies that can affect case management services in the traditional mode.

#### *Medicaid Cuts*

In 1981, the Social Security Act was amended for the purpose of providing matching federal funds for various services, including case management, for Medicaid-eligible people (Davis, Fox-Grage, & Gehshan, 2006). In addition, Ohio offers several Medicaid waiver programs that allow the regulatory requirements of Medicaid to be waived in specific instances so that a state can cover a broad array of home- and community-based services (HCBS) for targeted populations as an alternative to institutionalization. The Ohio Department of MR/DD administers three HCBS waivers: the Level 1 Waiver, the Residential Facility Waiver (RFW), and the Individual Options (IO) Waiver. The Department of Job and Family Services (ODJFS) provides case management services for persons enrolled in Core, Ohio Home Care Waiver, and Transitions Waiver plans (ODJFS, n.d.). The PASSPORT Medicaid waiver program is administered by the Department of Aging. The program is estimated to have cost more than \$222 million for 2006 (Candisky, 2006). In 2006, state officials in Ohio were considering the reduction of wages for home care nurses that would have saved around \$8 million annually in the Ohio Home Care program (Candisky, 2006), but the plan has since been abandoned.

Section 6052 of the Deficit Reduction Act of 2005 (DRA), signed on 2/8/06, includes a provision to tighten the definition of what qualifies as Medicaid-targeted case management (TCM). This proposal specifies foster care related activities that cannot qualify for Medicaid reimbursement (The Henry J. Kaiser Foundation, 2006). The National Mental Health Association (2006) states that DRA “allows for reduced federal Medicaid funding for TCM by \$760 million over five years and more than \$2 billion over 10 years” and that federal assistance will only be available for services if there are no third parties liable to pay for such services. Voices for America's Children (2005) states that the provisions for TCM in the DRA are presumed to allow shifting of costs over to the federal foster care program and the subsequent increase of federal Title IV-E spending. Because federal Medicaid funding for services available through third-party payment will be cut, Voices believes that this will “likely limit the ability of state child welfare agencies to connect children in foster care or with severe disabilities to the health and mental health services they need.”

*Ryan White CARE Act Reauthorization*

Case management is one of the most often used services provided through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which funds health care and support services for persons living with HIV (DHHS, n.d.a). Title I of the act provides outpatient health care and other support services including case management, home health care, hospice care, and housing, transportation, and nutrition services (Johns Hopkins AIDS Services [JHAS], 2004). Congress has failed to reauthorize the act, which expired September 30, 2005. Since then, programs have been running with the same levels of funding as they had in the previous year (Ryan White Action Campaign [RWAC], 2006). Funding specifics are addressed in Section IV of this report.

*Long-term and chronic care needs must be addressed*

Long-term care issues for the aging and the need to address the growing number of chronic conditions may increase their influence on the development of public policy, which will also influence the nature of case management. As the population of adults and older adults grows and continues to prefer aging in place, case management will be essential to the long-term care system. Policy analysts believe that the United States faces a crisis in which the working generations will be saddled with the burden of providing security for a large cohort of retirees by 2025. Thus, much of the dialogue around policymaking has been about how to cushion the effects of the aging population.

Because of changes in the home care system, the number of older adults with higher levels of disability and more complex medical conditions is increasingly, leading to growth in the number of consumers of case management and a higher demand for case management services. This prompts the use of case management services and, as a result, puts additional stress on an already taxed system of health and human services.

*Case management needs to demonstrate cost containment*

Case management will need to continue achieving cost containment in order to demonstrate its value in the political realm. Case management has proven itself useful in a managed-care world that emphasizes controlling costs of care (DHHS, n.d.b). The greatest challenge that case management faces is the need to develop a system that is both flexible and has the resources necessary to show tangible savings (DHHS, n.d.b).

### III. THE CORE SERVICE CONSUMERS

#### DEFINITION OF TARGET POPULATION

The target population of case management for this core service report is individuals or families who are unable to arrange for services on their own behalf because of age, illness, disability, or other difficulties. Several populations of individuals that may benefit from case management services include those who are frail and aging, physically handicapped, developmentally disabled, ill, persistently mentally ill, in the foster care system, homeless, and those with HIV/AIDS and other chronic conditions. Specifically, those who need multiple services may benefit most from case management if provided in an integrated system.

#### DEMOGRAPHIC CHARACTERISTICS

##### Comprehensive, Integrated Children and Family Service System

Some argue that integration of services is hampered by federal restrictions on who can be served by different programs and funding streams. It is true that several programs contain detailed eligibility requirements, particularly around income and household composition, that restrict who may be served with program funds. However, many of the programs and funding streams, alone and in combination, can serve a wide range of individuals and families. (Hutson, 2004).

There are essentially three clusters of programs and funding streams. First, there are those with detailed prescriptive eligibility requirements. These include food stamps, Medicaid, and foster care and adoption assistance. Second, there are programs and funding streams that create broad eligibility parameters and permit states to establish more explicit eligibility criteria within those parameters. These include TANF (Temporary Assistance for Needy Families), CCDF (Child Care Development Fund), and SCHIP (State Children’s Health Insurance Program). Finally, the remaining programs and funding streams essentially have no federal eligibility criteria regarding income and household composition. For example, the Child Support Grant, Community Service Block Grant (CSBG), Social Service Block Grant (SSBG), the Substance Abuse Grant, the Mental Health Grant, the Family Violence Grant, the CAPTA Grants, the Child Welfare Services Grant, and the PSSF Grant have even broader flexibility regarding the people they serve. These programs and funding streams have no income or household composition eligibility requirements. They may be targeted towards specific goals (e.g. preventing or treating substance abuse, treating mental health, reducing poverty, preventing child maltreatment) that create some limits. However, states and localities have extremely broad discretion in whom to serve with funds from these programs and funding streams (Hutson, 2004).

What follows is a description of the consumers of case management in the traditional mode.

The differing needs of the populations that use case management services contribute to the approach used and the combination, as well as the intensity, of case management functions. Case management for developmentally disabled individuals may depend mainly on creating formal linkages with health and human services agencies, whereas case management for children in the

custody of protective services may support kinship care through the use of informal networks. Several populations that may receive case management services include children in the care of protective services, mentally ill individuals (as well as those in psychiatric rehab), persons with severe mental disabilities, substance abusers, homeless adults and children, individuals who require medical attention, individuals with HIV/AIDS or at risk for HIV and other chronic conditions, and older adults.

#### Child Welfare Case Management

Child welfare case management involves the negotiation and coordination of services intended to prevent abuse or strengthen families, family reunification programs, and other services that exist to remedy the effects of abuse or neglect, foster care and relative home placement (or other out-of-home care programs), and services that provide for the permanent removal of children from homes (e.g. adoptions, legal guardianship, and kinship care). A case manager also coordinates visitations and assists families and children with the development of support services (Mather & Hull, 2002).

National, state and local demographics show that the number of children entering foster care during the last 20 years has skyrocketed. The number has almost doubled since 1982, when roughly 262,000 children were living in foster homes. The most recent data reported by the Adoption and Foster Care Analysis and Reporting System (AFCARS) is for the period October 1, 2004 to September 30, 2005. As of September 2005, AFCARS reports that there were 513,000 children in the foster care system. After remaining relatively stable from FY 2000 through FY 2003, the number of children entering care increased in both FY 2004 and FY 2005 (DHHS, 2006).

As of December 2005, there were 2,553 children in custody of the Cuyahoga County Department of Children and Family Services (DCFS, 2006). Of those children, 945 were in temporary commitment where it is still possible to reunify children with their birth families or primary caregiver. Another 1,121 children will never return to their biological families. These children have been reported as in permanent commitment and “waiting for adoption in the public system.” The remaining 487 children were in planned permanent living arrangements or long-term foster care.

#### Substance Use Disorders/ Chemical Dependency Case Management

In the 1960s, with the deinstitutionalization of individuals in psychiatric care, the responsibility of care provision turned to the communities. The role of case management was to preserve a continuum of care for this population. Although persons with substance abuse issues were not normally institutionalized, case management services that dealt with treating individuals with substance use disorders developed in conjunction with those individuals in psychiatric care. These services were usually delivered in nontraditional settings by members of the clergy or persons working in detoxification centers and halfway houses (DHHS, n.d.). Since the 1980s, substance abuse disorders have been seen as “multifaceted, chronic, and relapsing disorders” (Vanderplasschen et al., 2004). Thus, the preservation of a continuum of care for individuals in recovery encouraged and supported substance-free living in society (DHHS, n.d.b).

Case management for substance abuse treatment in the United States has been effective in increasing treatment participation and retention of individuals with substance abuse issues. As opposed to the programs in Europe, most of the programs in the United States place emphasis on abstinence while European programming focuses on the harm reduction perspective (Vanderplasschen et al., 2004).

The 2004 National Survey on Drug Use and Health, conducted by the Office of Applied Studies in the Substance Abuse and Mental Health Services Administration, estimated that 191 million Americans (7.9 percent of the population) aged 12 or older used illicit drugs during the month before their interviews (DHHS, 2005). This includes any use of marijuana, cocaine, heroin, hallucinogens, and inhalants; and the non-medical use of prescription pain relievers, tranquilizers, stimulants, and sedatives (DHHS, 2005).

The survey also measured current use of alcohol (defined as having at least one drink in the past 30 days). A “drink” is defined as a can/bottle of beer; glass of wine or wine cooler; a shot of liquor; or a mixed drink with liquor. Over half of Americans aged 12 and older reported current alcohol use, or about 121 million people (DHHS, 2005). The survey also recorded binge use and heavy use, the former being defined as having “five or more drinks on the same occasion ... at least once in the past 30 days” and the latter defined as having “five or more drinks on the same occasion on at least 5 different days in the past 30 days” (DHHS, 2005). In 2004, 22.8 percent of Americans at or over the age of 12 (or around 55 million people) had participated in binge drinking (DHHS, 2005). 6.9 percent of Americans aged 12 or over (around 16.7 million people) reported themselves to drink heavily (DHHS, 2005).

Disaggregated state estimates in Ohio for 2004 (from National Survey on Drug Use and Health data) reported 7.9 percent of individuals aged 12 or older as participating in illicit drug use in the past month, 51.4 percent of Ohioans as participating in past month alcohol use, 23.6 percent of individuals binge drinking within the past month, and 38.3 percent of individuals as perceiving great risk of drinking five or more drinks once or twice a week (DHHS, 2006a). The state of Ohio was also divided into designated treatment planning areas, with Cuyahoga County represented by Board 18 (DHHS, 2006a). It was estimated that around 5.6 percent of individuals in Boards 18 (Cuyahoga County) and Boards 47 (Lorain County) aged 12 or older were current illicit drug users, 45 percent were current alcohol users, 18.8 percent of individuals had participated in binge alcohol use within the past month, and 46.7 percent of individuals perceived themselves as at great risk of having five or more drinks once or twice a week (DHHS, 2006a).

Case management for individuals with or at risk of HIV/AIDS

Since the 1980s, multipurpose (“one stop”) treatment centers have been developing as a response to the AIDS epidemic. Case management for individuals with HIV/AIDS integrated the medical case management model that had been developed for working with older adults and the physically disabled with the care coordination models developed for working with chronically mentally ill (Grube & Chernesky, 2001). The treatment centers housing these programs often offer a multiplicity of services to meet social, medical, and psychological needs of individuals with HIV/AIDS or those at risk for the disease (Giddens, Ka’opua, & Tomaszewski, 2002).

Giddens, Ka’opua, and Tomaszewski (2002) have noted three trends that have influenced the nature of case management in the treatment of HIV/AIDS: 1) new medications that have been created require complex treatment regimens and an assessment of individuals’ ability to adhere to a more stringent treatment plan; 2) management of chronic illness has become the priority of managed care organizations; and 3) an increasing number of socio-economically disadvantaged individuals require HIV/AIDS case management services (Giddens, Ka’opua, & Tomaszewski, 2002).

It is expected that case management services in this context will increasingly be relied upon because the disease affects those who are least likely to be able to access services and manage the disease on their own (Grube & Chernesky, 2001). African Americans make up 57 percent of the

population in the United States with HIV/AIDS (Grube & Chernesky, 2001). Thirty-three percent of individuals with the illness were drug users and many of these individuals were women and children (Grube & Chernesky, 2001). As with the case for individuals with chemical dependency disorders, those who need AIDS/HIV-related case management services also present other problems such as poverty, homelessness, hunger, substance abuse issues, mental illness, unemployment, and poor education (Grube & Chernesky, 2001).

In a 1999 report, Chernesky and Grube (2001) stated that case management activities for individuals with or at risk of HIV/AIDS included services such as managing client health, obtaining and maintaining an array of essential entitlements and services, acquiring skills, developing a support system, improving the client's quality of life, and increasing his/her self-esteem.

Between July 2003 and June 2004, there were 966 individuals diagnosed with HIV in Ohio (Ohio Department of Health, 2004). These include individuals with (736) and without (230) AIDS at the initial diagnosis. One hundred fifty-six individuals from Cuyahoga County were diagnosed with HIV during that time period, and 3,321 were then living with HIV/AIDS (Ohio Department of Health [ODH], 2004).

#### Case management for individuals with developmental disabilities

Developmental disabilities are defined as a “diverse group of severe chronic conditions that are due to mental and/or physical impairments” (DHHS, n.d.c). Also characteristic of individuals with developmental disabilities are “problems with major life activities such as language, mobility, learning, self-help, and independent living” (DHHS, n.d.c). The Cuyahoga County Board of Mental Retardation and Developmental Disabilities (CCBMR/DD) (2003) adds the qualifier “before age 22” to this definition. That is, an individual is considered to have a developmental disability if the mental or physical impairment occurs before this age. The Department of Health and Human Services considers the following conditions as those under this category:

- Autism Spectrum Disorders;
- Kernicterus;
- Hearing Loss;
- Mental Retardation;
- Vision Loss; and
- Cerebral Palsy.

The Ohio Department of Mental Retardation and Developmental Disabilities (n.d.) defines the activities of case management as linking “individuals and families to needed services and supports in ... information, referral and linkage; eligibility determination and assessment; individual service plan development and revision; service access and/or placement; assistance in provider selection; service coordination; monitoring and individual quality assurance; and crisis intervention.”

According to the Centers for Disease Control and Prevention, about 17 percent of individuals under 18 years of age are affected by developmental disabilities (DHHS, 2006b). Another estimate given by the Cuyahoga County Board of Mental Retardation and Developmental Disabilities (2003) is that two to three individuals out of one hundred have some level of mental retardation and/or developmental disability. Between one and three percent of individuals in the United States are affected by mental retardation (The Arc, 2004). According to the U.S. Census Bureau data, as

indicated by the NEO CANDO database<sup>1</sup>, the population of Cuyahoga County in 2000 was 1,393,978. From the estimates on the rate of individuals with mental retardation and/or developmental disabilities given by OBMR/DD, approximately 27,880 to 41,820 individuals in Cuyahoga County had some degree of mental retardation and/or developmental disability.

Psychiatric case management

Though the psychiatric service system has undergone reorganization toward community-based services, the long-term mentally ill have been unable to access services needed for basic community survival (Bjorkman & Hansson, 2000). Several types of disorders are categorized under the umbrella term “mental illness,” including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, borderline personality disorder, and others (NAMI, 2006).

Intensive Case Management (ICM), a poorly-defined and poorly-operationalized concept, has evolved into a method of case management commonly “used” for persons working with the mentally ill (Schaedle & Epstein, 2000). Common to proponents of the method are the functions (e.g. outreach, assessment, planning, etc.) and principles (Schaedle & Epstein, 2000). In a study of Intensive Case Management by Schaedle and Epstein (2000), the authors posit that Intensive Case Management may focus more on the client than conventional case management. That is, it may be less systems-driven and more client-driven. Another model of case management used in treating the severely mentally ill is the Assertive Community Treatment approach (Schaedle et al., 2002). This approach, unlike that of ICM, is evidence-based: it is known to be effective in reducing hospital use, increasing housing stability, controlling psychiatric symptoms, and improving quality of life (Schaedle et al., 2002). From a study of a panel of experts on these case management models, Schaedle et al. (2002) found mostly organizational and structural differences between them. The authors also claim that the Assertive Community Treatment model “mirrors the medical model of care” as a “comprehensive treatment and rehabilitation approach that does not broker services” (Schaedle et al., p. 210). On the contrary, the ICM approach places emphasis on linkage and coordination of services, as well as on client empowerment (Schaedle et al., p. 210).

The National Mental Health Association (NMHA) (2006a) noted that over 54 million Americans have a mental disorder in one year, though a relatively small number of them seek treatment. According to NMHA (2006a), “the most serious and disabling conditions” affect five to ten million adults (2.6 – 5.4 percent) and three to five million children ages five to seventeen (5 – 9 percent) nationwide. Co-occurring conditions such as homelessness, chronic illness, and substance abuse are not unknown. For instance, 33 percent of individuals with HIV were drug users and many of these individuals were women and children (Grube & Chernesky, 2001). Around 15 percent of all mentally ill adults in one year also suffer from a substance abuse disorder (NMHA, 2006).

Medical case management

The use of case management has increased in the health care system as inflation has forced cost containment measures. The cost of health care has exceeded payers’ ability to keep up with the growth. Therefore, legislation had been created to encourage the development of case management services within the health care system (Berger, 2002).

<sup>1</sup> NEO CANDO system, Center on Urban Poverty and Social Change, MSASS, Case Western Reserve University (<http://neocando.case.edu>)

In 1973, the Health Maintenance Act encouraged a comprehensive care approach and the continuity of care within the health services sector. The Omnibus Budget Reconciliation Act of 1981 and the Consolidated Omnibus Budget Reconciliation Act of 1985 that followed attempted to reduce duplication of services and to further cost containment measures. Another factor that influenced the prevalence of case management in the health care system was the treatment of chronic illness in health care delivery. The community became the center of care for the chronically ill, which required coordination of services across multiple venues (Berger, 2002). Managed care was also looking into preventive care, and case management was effective in coordinating and monitoring compliancy.

#### Case management for homeless individuals

Mental disorders and medical morbidity and mortality are prevalent among the homeless (Desai & Rosenheck, 2005). These additional needs and risks associated with homelessness, including other mental health issues, housing needs, occupational needs, and emergency service needs, has prompted the use of case management. It has also been a belief that persons who are homeless are more likely to be “markedly mistrustful and suspicious of service providers” and “highly value their autonomy” (Morse, n.d.). Case managers are seen as able to develop a trusting and engaging relationship with their clients (Morse, n.d.). Since the 1980s, services for the homeless have grown with the rapid development of case management (Morse, n.d.). Case management was also tailored for various subgroups of the homeless population, such as those with mental illness, homeless families, and individuals with dual diagnoses (Morse, n.d.).

The predominant models of case management used for the homeless population include the Intensive Case Management (ICM) and the Assertive Community Treatment (ACT) models (Morse, n.d.). The former has been used with a variety of homeless subpopulations, including those with severe mental illness and substance abuse disorders, as well as homeless families (Morse, n.d.). The latter has been used mainly for the homeless population with severe mental illness (Morse, n.d.), and has been adapted from its original form in order to increase its efficacy among this population (Morse, n.d.). Also being used are the strengths-based model and the critical time intervention approach (Morse, n.d.).

Dual diagnosis describes an individual with both severe mental illness and a substance abuse disorder (Morse, n.d.; NMHA, 2006b), a condition that is prevalent among homeless individuals. Around 50 percent of severely mentally ill homeless adults also have a substance abuse disorder (NMHA, 2006b). This condition is associated with a “greater propensity for violence, medication noncompliance, and failure to respond to treatment” (NMHA, 2006b). Dual diagnosis also results in poor functioning and a higher rate of recidivism, as well as greater likelihood to have tardive dyskinesia and more often are ill physically (NMHA, 2006b). Services for dual-diagnosed individuals focus on providing assistance for recovering from both conditions at the same time (NMHA, 2006b). Although many homeless are dually diagnosed, individuals who are not homeless can also have co-occurring disorders. In fact, NMHA (2006b) states that around 50 percent of the severely mentally ill are also substance abusers; 37 percent of individuals abuse alcohol and 53 percent of those who abuse drugs are also seriously mentally ill; and 39 percent of those diagnosed with a mental illness also abuse alcohol or drugs.

Primary health care for homelessness has been well-addressed with the use of case management as the approach that helped enhance and supplement this population’s use of primary health services (Morse, n.d.). No specific model of primary care case management for homeless individuals has been noted in Morse’s study, though.

Homeless children, pregnant teenagers, and families are also considered special subpopulations and there is still a wealth of information to be discovered in regard to the efficacy of case management in working with them (Morse, n.d.).

According to the National Law Center on Homelessness and Poverty (as cited by the National Coalition for the Homeless [NCH], 2006), approximately 3.5 million people experience homelessness in a given year. In January 2005, a point-in-time count of homeless persons in Cuyahoga County suggests there were over 2,208 homeless persons (Cuyahoga County Office of Homeless Services, 2005).

#### Case management with older adults

The development of case management work with older adults has depended upon the recognition of the challenges of living with chronic illness as faced by older adults as well as their caregivers (Austin and McClelland, 2002). Older adults also experience declines in certain faculties as they age, including their ability to pick up and process auditory or visual stimuli (Austin & McClelland, 2002). The National Center for Health Statistics (NCHS) and the Centers for Disease Control (CDC) (2001) state that around one-fifth of the population over the age of 70 have visual impairments and that around one-third of the population of older adults in the United States are hearing-impaired (and this percentage increases with age).

The increase in the number of older adults has also spurred the development of case management services for this population. In 2000, over 35 million Americans were over 65 years old and 4.5 million were over 85 years old. These numbers are expected to increase two-fold by 2030. Longer life spans contribute to the increasing proportion of older adults, which is anticipated to have a large impact on the nature of long-term care.

During the early 1970s to mid-1980s, community-based long-term care programs absent of health care services were developed in a series of pilot projects (Austin & McClelland, 2002). These projects did not adequately address health care needs of individuals with chronic illnesses as case managers could only coordinate community-based and in-home services (Austin & McClelland, 2002). This led to the integration of services across a continuum of care that included primary, acute, in-home, community-based, and long-term care services (Austin & McClelland, 2002).

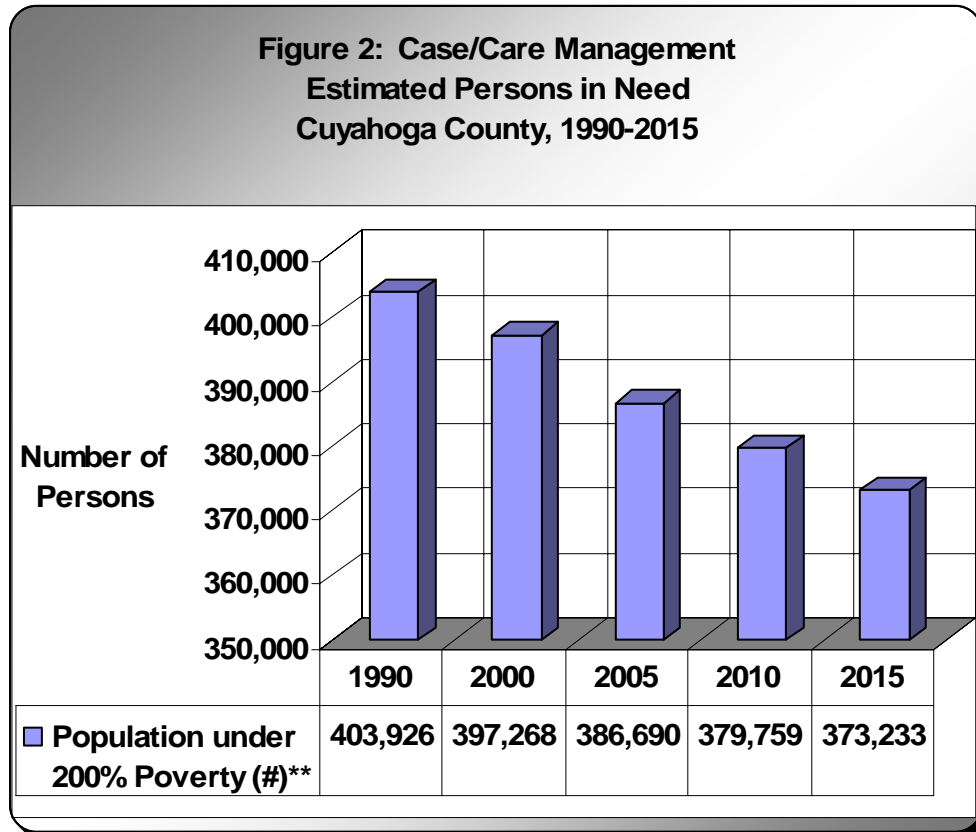
Case management for older adults has historically been executed in a clinical setting and case managers for older adults have been advanced practice nurses (APNs) who identify newly admitted frail older adults and monitor their progress through discharge (Smyth et al., 2001). As health care professionals, they are called to understand the complexity of acute and chronic health conditions that these older adults face (Smyth et al., 2001). More recently, care for the older adult has shifted from acute service delivery to a more holistic approach, and focuses on biological, psychological, social, and environmental needs (Alkema, Reyes, & Wilber, 2006). The picture still remains unfinished, though, as older adults with multiple numbers of chronic diseases continue to face challenges in the fragmented American health care system and its historical emphasis on acute care (Cigolle et al., 2005).

Geriatric care managers assist in a variety of ways. In a 2000 survey completed by 712 geriatric care managers, the primary services included locating services (95 percent); arranging services (94 percent); assessing family and social support (94 percent); developing the care plan (93 percent); assessing functional abilities (90 percent); and providing on-going management of the care plan (90 percent) (Enguidanos, Davis & Katz, 2005).

In 1990, there were 293,461 older adults 60+ in Cuyahoga County; by 2000, this amount had decreased to 273,378.

*Estimated Persons in Need*

It is impossible to derive an estimate of the number of persons in need because of the breadth of the various populations that can benefit from case management services as described in the previous section. Figure 2 sets an outer boundary of those with incomes under 200 percent of poverty, i.e., the working poor. In 2000, the number was 397,268 and it is expected to decrease to 373,233 by 2015.



Sources:  
 \* US Census: 1990, STF3 (P11); 2000 SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).  
 \*\* US Census: 1990: STF3 (P117); 2000, SF3 (PCT50); 2005-2015, estimated using 2000 Proportion population under 200% Poverty (28.5%)

**REALIZED ACCESS TO SERVICE**

Realized access to service is represented by the number of consumers actually served. It includes the actual number of consumers reported by the United Way funded agencies and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving the service.

United Way of Greater Cleveland funded case management services for 18,301 individuals in Cuyahoga County during the 2004 fiscal year. (See Attachment 3.) Males represented 37 percent of these individuals, while slightly less (35 percent) were female. The gender of the remainder (28.3 percent) is unknown. The majority of these individuals funded by United Way were African American (60 percent), while whites made up the next highest (32 percent) and only 0.2 percent was Asian. Four percent were Hispanic.

Seventy-nine percent of United Way funded service recipients had incomes equal or less than \$9,999, while only 0.2 percent has an annual household income of at or above \$30,000. No annual household income was reported for 11.5 percent of individuals receiving services funded by the United Way.

During calendar year 2004, the Western Reserve Area Agency on Aging funded case management services for 259 older adults, with the majority (74 percent) being female. Individuals who were white comprised 80 percent of total cases, followed by 16 percent black, and 0.4 percent Asian. Racial data for 3 percent of those served were missing. Close to 3 percent were Hispanic. Sixteen percent of the individuals were over the age of 75, and there was missing data regarding age on the remaining 84 percent of cases. There is no data available on average annual income for these individuals.

Ryan White Title I funded 1,339 persons of which 73 percent were male and 25 percent female. Slightly under half (49 percent) were white, and 36 percent black. Eleven percent were Hispanic. Most (98 percent) were under the age of 65 years and household income was not reported.

Eighty percent of consumers funded by United Way resided in Cleveland and 20 percent in the suburbs. There was no zip code data available for WRAAA or Ryan White-funded consumers. (See Attachment 4.)

## IV. CORE SERVICE DELIVERY

### CORE SERVICE DEFINITION

For this core service report, case management is defined as programs that develop plans for the evaluation, treatment and/or care of individuals who need assistance in planning and arranging for services; that assess the individual’s needs; that coordinate the delivery of needed services; that ensure that services are obtained in accordance with the case plan; and that follow up and monitor progress to ensure that services are having a beneficial impact on the individuals.

### BACKGROUND ON CORE SERVICE

#### *Comprehensive, Integrated Children and Family Service System*

There are a variety of ways to integrate social services across programs, but five components are generally present when integration is sought. These components may vary in emphasis and may be approached in different ways, but they seem to be core components to integrated systems of social service delivery. (Hutson, 2004)

- *Single Point of Entry*  
The first element of most models of integrated service delivery is a single point of entry for families. The notion here is that “there is no wrong door,” that wherever a family first interacts with the social services system, family members can be connected to a broad range of services.
  
- *Comprehensive Family Assessment*  
A second element involves a comprehensive assessment of the family’s needs in order to develop an appropriate service plan. This may mean a preliminary screening of all family members, followed by a more intensive assessment of particular concerns identified in the screening. Alternatively, comprehensive assessments may be initiated for all family members from the outset. The goal is to identify the strengths and needs of a family early on and connect them with relevant services and supports as quickly as possible.
  
- *Joint Case Planning*  
A third component of many cross-program integration models involves a single case plan or service plan for the family and a primary caseworker who coordinates with a multidisciplinary team made up of staff from all relevant programs. Alternatively, a family may have more than one plan, but the plans are jointly developed across programs, with input from the family, so that the resulting plans are complementary, not conflicting. Under such circumstances, the family generally has a primary caseworker or team member who ensures that the plans are coordinated.

- *Co-Location*  
Co-location of services is often a fourth element of integrated service delivery. This enables a family to obtain all needed services at a single location. When co- location is not feasible, it becomes important that the case manager or some other member of the family’s team ensure that referrals are made and received and that the family can access services at other locations. Facilitating coordinated services in such situations often requires the provision of ongoing contact with and support for the family.
- *A Sense of Partnership*  
A fifth element of cross-program integration is often a new way of doing business for staff. As the previous components indicate, staff’s day-to-day interactions with families under integrated models of service delivery differ from the more typical fragmented, “silo,” or “stove-pipe” program-specific model. Rather than trying to determine if a family meets the requirements to participate in a program, staff work with the family to determine what the family needs and then look to what programs and funding streams are available to address those needs (Hutson, 2004).

Staff interactions across programs also differ in an integrated model. Staff need cross-training and knowledge about the variety of services and supports available to families, not just those available in their program. Staff need to share information, but do so in a way that is respectful of families’ privacy. Staff from different programs and agencies also share accountability and joint responsibility for the success of the families they serve and for compliance with relevant statutes, regulations, and policies. The traditional boundaries and “turf” lines no longer apply. (Hutson, 2004)

States and localities may choose to coordinate or integrate a variety of programs in different ways, and there are a number of potential combinations of service delivery. In consultation with state and local administrators and other experts in the field, NGA, Hudson, and CLASP agreed upon a critical set of programs we felt many states and localities are attempting to coordinate or considering coordinating. These programs fall into four basic clusters:

- Programs that provide basic income and other economic supports (e.g. Temporary Assistance for Needy Families [TANF], Food Stamps, and Child Support).
- Programs and funding streams that provide services to meet the other basic needs most families have (e.g. Medicaid, State Children’s Health Insurance Program [SCHIP], and the
- Child Care and Development Fund (CCDF).
- Programs that provide more specialized services and supports to families who need them [e.g. the Substance Abuse Prevention and Treatment Block Grant (Substance Abuse Grant); the Mental Health Services Block Grant (Mental Health Grant); the Family Violence

Prevention and Services grant (Family Violence Grant); the Child Abuse Prevention and Treatment Act grants (CAPTA Grants); the Child Welfare Services grant (Child Welfare Services Grant); the Promoting Safe and Stable Families grant (PSSF Grant) and the Foster Care and Adoption Assistance program (Foster Care and Adoption Grants) and

- Funding streams that provide a wide range of services and can often serve as “glue money” in patching together a comprehensive set of services for a family (e.g. the Community Services Block Grant [CSBG] and the Social Services Block Grant [SSBG]). (Hutson, 2004)

### *History of case management in the United States*

In 1922 Mary Ellen Richmond, the director of the Charity Organization Department of the Russell Sage Foundation, published *What is Social Case Work?*, which introduced case work and the social work profession. In this work, she stressed the importance of coordination and consumer direction in case work (NASW, 1992).

It was not until the latter half of the twentieth century that the importance of case management was emphasized in legislation and recognized by the federal government. The Federal Community Mental Health Centers Act of 1963 was one of the first such legislative efforts that responded to the deinstitutionalization of individuals in psychiatric care by emphasizing preventive and community-based outpatient services (which included case management) (DHHS, n.d.). The independent living movement began in the next decade and was supplemented with the call to respond to the augmenting numbers of individuals with complex health care needs, both of which created a high demand for long-term care case management. By the 1980s, the federal government was providing coverage for these services through the national Medicaid program.

### *Why case management?*

Case management has been seen as a way to integrate a continuum of care for the client within the complex and fragmented system of health and social services in America (Austin & McClelland, 2002). According to the Department of Health and Human Services (n.d.a), fragmentation of services arises from the following factors:

- Differences in streams of funding for health and human services programs;
- Differences in requirements or goals of health and human services programs, which can result in a piecemeal approach to programming;
- A focus on funding programs rather than systems;
- The focus of funding on single modalities rather than a continuum of care;
- An inadequate amount of funding, as a result of missing pieces on the care continuum;
- Waiting lists caused by inadequate funding;
- Barriers between systems;
- The lack of incentives geared toward measurement of client outcome;
- Eligibility/admission criteria which exclude certain clients;
- The lack of agreement on priorities for admission/treatment; and
- The lack of incentives for programs to work together.

Case management makes it possible for service providers who work in different agencies or organizations to coordinate efforts so that they may work with the client more efficiently and as a team. In turn, these expand the range of needed services offered, filling the gaps in care that may

have created undue burdens on the client (Barker, 2003). To achieve this, case managers must place their clients in the most appropriate place of care in a timely fashion and make decisions that are based on the medical and social needs of the individuals (Murer, 2000; Austin & McClelland, 2002). In addition to these benefits, case management is seen as the most effective strategy to reduce and control costs of health and human services (Murer, 2000).

### *Goals*

The primary goal of case management is to optimize client functioning by providing quality services in the most efficient and effective manner to individuals with multiple complex needs. Like all methods of social work practice, case management rests on a foundation of professional training, values, knowledge, theory, and skills used in the service of attaining goals that are established in conjunction with the client and the client's family, when appropriate. Such goals include:

- Enhancing developmental, problem-solving, and coping capacities of clients;
- Creating and promoting the effective and humane operation of systems that provide resources and services to people;
- Linking people with systems that provide them with resources, services, and opportunities;
- Improving the scope and capacity of the delivery system;
- Contributing to the development and improvement of social policy. (NASW, 2006)

### *Tasks and Functions*

Although the roles and responsibilities of individual social work case managers can vary considerably depending on program or system objectives, social work case managers perform a range of common tasks related to client- level intervention and system-level intervention (NASW, 2006).

- Client-Level Intervention  
Once the social work case manager has identified and engaged clients as a result of outreach or referral activities, he or she conducts a face-to-face comprehensive assessment with each client of that client's strengths and limitations and of the social, financial, and institutional resources available to the client. The social work case manager focuses particularly on how these resources relate to the principal concerns identified during the assessment. On the basis of this assessment, the social worker develops an individualized service plan with the client that identifies priorities, desired outcomes, and the strategies and resources to be used in attaining the outcomes. The responsibilities of the social worker, the client, and others should be clarified throughout development of the plan. The direct contact between social worker and client is essential to effectively accomplish the assessment and service plan development. (NASW, 2006)

Additional social work case management tasks related to client intervention include implementing the service plan aimed at mobilizing the formal and informal resources and the services needed to maximize the client's physical, social, and emotional well-being, and coordinating and monitoring service delivery. The social work case manager also advocates on behalf of the plan for needed client resources and services; periodically reassesses client status, the effectiveness of interventions, and the attainment of outcomes with revision of the service plan as indicated; and terminates the case. (NASW, 2006)

At all stages of client intervention, it is crucial that the social work case manager be granted sufficient authority to access, allocate, monitor, and evaluate service and fiscal resources. Such authority is a prerequisite of effective case management practice. Optimal control over and management of scarce resources may be more readily achieved in delivery systems structured with a single point of entry and integrated funding. Case managers will be more effective in delivery systems that are designed to reduce fragmentation. (NASW, 2006)

- System-Level Intervention

An organization's structure, policies, and budget as well as the community network of services should adequately provide for the implementation of client-centered case management. The social work case manager is responsible for understanding how the agency and environmental systems can both positively and negatively affect clients and to intervene at the system level to optimize these conditions. To this end, the social work case manager engages in a range of tasks that support and enhance the system in which case management exists. For example, the social work case manager:

- analyzes the strengths and limitations of environmental systems;
- delineates desired outcomes;
- selects strategies to improve systems;
- assesses the effectiveness of strategies; and
- continues to revise, as indicated, desired outcomes and strategies.

Specific activities include, but are not limited to, resource development, financial accountability, social action, agency policy formation, data collection, information management, program evaluation, and quality assurance. Like client intervention, system intervention occurs along a continuum and comprises an ongoing, uninterrupted cycle of tasks that are performed by the social work case manager. (NASW, 2006)

### *Several models of case management*

Several case management models have been identified (Bjorkman & Hansson, 2000) and the type that is used depends upon the populations involved, the setting in which the service takes place, the professional knowledge of the individuals offering the service, and the goals of the service (Mather & Hull, 2002; Giddens, Ka'opual, & Tomaszewski, 2002). This results in differences in terms

of fiscal responsibility, authority, and intensity of the functions. In addition, there are constraints that may be attributed to the program within which the case management service is embedded, specifically, those related to program financing, the scope of care, and the balancing/blending of advocacy and cost containment responsibilities (Austin & McClelland, 2002). Physicians, advanced practice nurses, social workers, or case management specialists may be involved in this process of managing. Refer to Attachment 5 for a description of several case management models.

#### *Case management trends*

- Redefining case management  
Within the last two decades of the 20<sup>th</sup> century, the idea behind case management has shifted from the vague organization of services around an individual towards the development of specific and varying practice models (Mather & Hull, 2002).
- Toward the use of informal networks  
As the practice of case management evolved, the community became increasingly incorporated into the care plan (Moxley, 2002). Originally, more emphasis was placed on the coordination of services than aiding the client in establishing the requirements for daily living—such as a decent standard of living and quality of life. The service integration movement that occurred in the 1970s and 1980s encouraged the incorporation of informal, resource-laden social and community networks (Moxley, 2002). The definition of client was also broadened to include partners or spouses who maximized the access of the service providers to the primary recipient of services (Ford et al., 2004).
- Acknowledging the role of the consumer  
The call for accountability in health and social service provision transformed the practice of case management (Mather & Hull, 2002). The field of health and human services increasingly focused on the importance of client choice and control in their own care and, as a result, case management was transformed from being systems-driven to consumer-driven (Scala & Mayberry, 1997; Mather & Hull, 2002). This shift was based on the premise that clients have the ability to “assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services they receive” (National Institute of Consumer-Directed Long-Term services, p.4, as cited by Scala & Mayberry, 1997).

In the 1970s and 1980s, case management for individuals in psychiatric rehabilitation experienced this growing movement in that service recipients became actively involved in their own rehabilitation process (Moxley, 2002). The patients were seen less as patients and more as consumers making informed choices in regard to their care needs based on their own values and desires (Moxley, 2002). Consumer direction has also been encouraged in the management of long-term care services for older adults (Scala & Mayberry, 1997).

Consumer choice and control may be exercised in a variety of ways, all reflecting differing degrees of client responsibility. In a study of younger and older home care consumers, consumer direction meant that consumers had complete responsibility for the management of their care plan, or that they were given adequate information regarding services and service providers, or that they selected their care management team, or that they provided feedback about a worker’s performance (Eustis & Fischer, 1992; Scala & Mayberry, 1997).

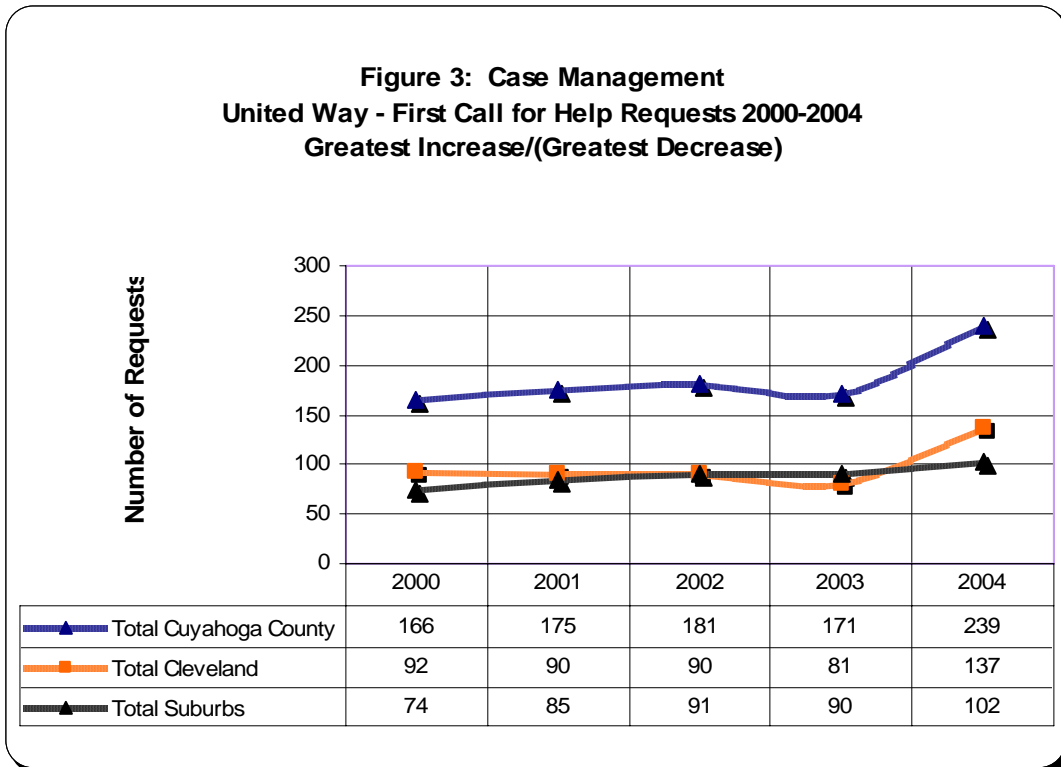
- Disease-focused to strengths-focused

As practice becomes more consumer-driven, a strengths-based practice has emerged in which clients are seen as having the ability to learn and grow in order to change their situation (Sullivan, 2002). This practice of empowering the consumer is counter to one that treats the consumer as a client under the complete control of the debilitating condition (e.g. alcoholism). This “disease model” is still frequently used in health and human services, especially in work with addiction. These individuals are seen as helpless victims of the disease and case managers must protect them from the consequences of their own actions. This encourages dependence upon service professionals not unlike the patient-physician relationship that exists in the American medical system today.

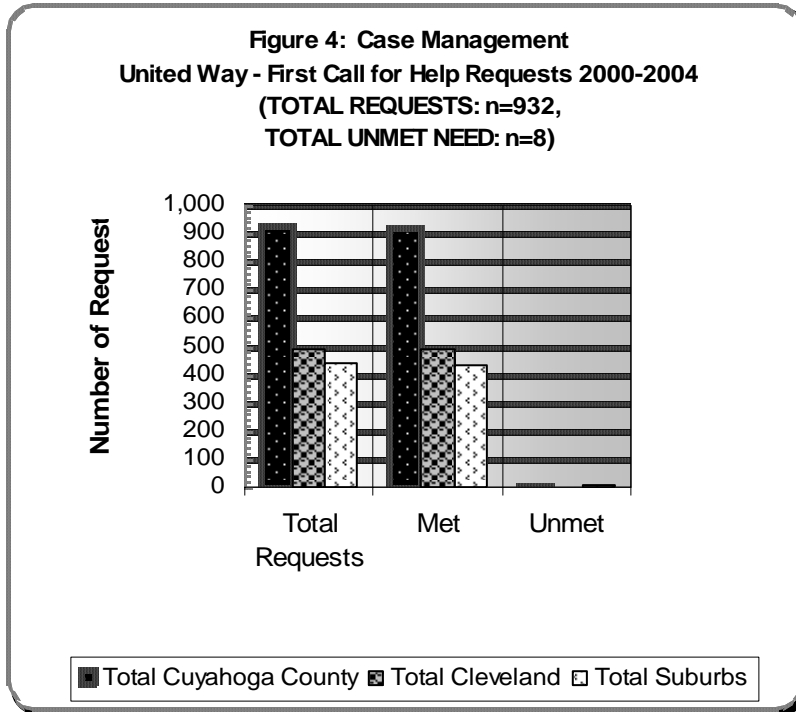
*United Way First Call For Help Call Data*

Based on United Way - First Call for Help’s (FCFH) database (February 2005), there are 31 case management service providers operating from 54 different sites, 26 of which are nonprofit and 5 are government. (See Attachments 6 & 7.) In FY 2004 (July 2003 to June 2004), United Way funded 8 of these providers.

United Way - First Call for Help call data shows a general increase in the number of total requests for case management services in the county: from 166 in 2000 to 239 in 2004 (44 percent increase) with a 49 percent increase in Cleveland (92 to 137 requests) and a 38 percent increase in the suburbs (74 to 102 requests). (See Figure 3 and Attachment 8.)



Over the same five-year period, United Way - First Call for Help had 932 requests for information about case management. (See Figure 4 and Attachment 9.) Of these requests, they were able to make referrals to 99 percent of callers; however, 1 percent of all Cuyahoga County callers (8) had an unmet need, meaning there was no agency to which to refer the caller.



**FUNDING OF CORE SERVICES**

*Major Government Funders*

There are several sources of government funding for case management services including the following:

- Older American’s Act;
- Ryan White CARE Act Title I;
- Ohio Medicaid waivers; and
- Cuyahoga County Health and Human Services Levies.

Other funding comes from federal community block grants and migrant health funds; private foundations or funds; state and/or local tax dollars; and private insurance (DHHS, n.d.). Some of them are described in the subsequent sections.

**NATIONAL**

Older Americans Act

Title III of the Older Americans Act of 1965, “authorizes an array of community services such as the meals programs, transportations, home health care and homemaking assistance, adult day care, case management, home repair, and legal assistance which enable many older Americans to remain

in their own homes and communities, thereby avoiding unnecessary and costly institution” (Area Agency on Aging [AAA], n.d.). Area agencies on aging act as the fiscal agents by distributing Title III funds nationwide and among twelve regions in Ohio, as well as provide information and referral services, including case management (Ohio Department of Aging [ODA], 2006). Cuyahoga County is part of the Western Reserve Area Agency on Aging, which also includes Geauga, Lake, Lorain, and Medina counties (ODA, 2006).

Results from the analysis of 2001–2004 NAPIS SPR (National Aging Program Information Systems – State Program Reports) data required by the Administration on Aging and 2003 and 2004 national data on case management indicate that:

- Title III-B case management serves the targeted population: the oldest old (those aged 75 and over), frail individuals, women, and those living alone.
- Frailty of the population served increases over time; the proportion of case management participants with three or more ADL (activities of daily living) limitations increased between 2001 and 2004, as did the proportion living alone.
- Older adults receive about 10 hours of case management per person per year, consistent with Title III-B case management’s role as a brokerage service that links individuals to other supportive services rather than providing a direct service that is needed every week.

According to the “Evaluation of the Select Consumer, Program, and System Characteristics under the Supportive Service Program (Title III-B) of the Older Americans Act: Interim Quantitative Report” (Rabiner et al., 2006), Title III funds provided case management services for 402,254 individuals nationwide, with 3,799,026 direct service hours in FY 2004. Total funds used to support case management services increased considerably during this 4-year period, ranging from \$85.5 million in 2001 to almost \$114 million (unadjusted for inflation) in 2004. The amount of funds spent on case management within the counties serviced by the Western Reserve Area Agencies on Aging was \$39,114 in FY 2002, \$103,697 in FY 2003, and \$73,307 in FY 2004.

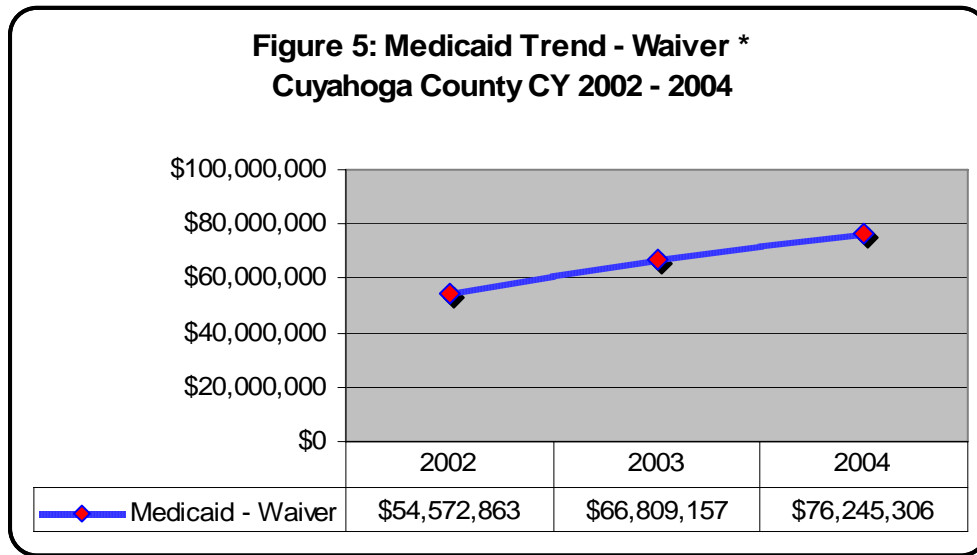
#### Ryan White CARE Act Title I

Case management is one of the most often-used services provided through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which funds health care and support services for those living with HIV (DHHS, n.d.). The Ryan White Title I program is a part of the Ryan White CARE Act of 1990, which funds health care and support services for persons living with HIV (DHHS, n.d.). Title I of the act provides outpatient health care and other support services, including case management, home health care, hospice care, and housing, transportation, and nutrition services (JHAS, 2004). Eligibility is limited to large metropolitan areas most affected by HIV/AIDS (also called eligible metropolitan areas, or EMAs) (DHHS, n.d.), filling the gaps in the continuum of medical and essential social services (including primary care services, medications, substance abuse and mental health treatment, case management, and support services) (DHHS, n.d.). From FY 2002 to FY 2004, the amount of assistance provided by the Title I grant for Cleveland, Ohio, had increased from \$337,857 in FY 2002 to \$403,662 in FY 2004.

**STATE**

Ohio's Medicaid Waiver Programs

As described in Section II, Ohio offers several Medicaid waiver programs administered by the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Department of Job and Family Services, and the Ohio Department of Aging (Ohio Legal Rights Services [OLRS], n.d.). Medicaid Waiver provides funding for case/care management. (See Figure 5.) PASSPORT dollars were removed from the totals. In addition to case/care management, Medicaid Waiver includes adult day programs, home delivered meals, in-home assistance, and residential living options for people with disabilities. Funding increased from \$54.6 million in 2002 to \$76.2 million in 2004.



\* PASSPORT dollars were removed from totals. Waiver includes the following core services: Adult Day Programs, Case/Care Management, Home Delivered Meals, Home Health Care, In-Home Assistance, and Residential Living Options for People with Disabilities.

PASSPORT, a program designed to provide “in-depth screening and comprehensive in-home geriatric assessments” and “case-managed home care services for Medicaid-eligible persons 60 years of age or older” (Western Reserve Area Agencies on Aging [WRAAA], 2002) is provided by the Ohio Department of Aging’s PASSPORT waiver program (OLRS, n.d.) and implemented by the Western Reserve Area Agencies on Aging. This program provides long-term care services for Medicaid-eligible individuals over the age of 60 (WRAAA, 2002). Currently, there are nearly 25,000 older Ohioans who are able to receive home-based services through PASSPORT (Johnson, 2006). \$800 million of WRAAA’s \$2 billion budget is used for PASSPORT (Johnson, 2006).

**LOCAL**

Cuyahoga County Health and Human Services Levies

The Cuyahoga County Department of Senior and Adult Services administers the OPTIONS home support program that provides in-home care to older Cuyahoga County residents who, because of income and/or assets, are not eligible for PASSPORT or other Medicaid waiver programs. Funding for this program comes from the Cuyahoga County Commissioners through the county’s Health and Human Services levies. There are currently two Cuyahoga County Health and Human Services (HHS)

levies—one at 2.9 mils set to expire in 2011 (as passed in November 2006 as Issue 19), and the other at 4.9 mils set to expire in 2008. The levy provides a flexible source of funds for the county. The amount of money generated through these levies has been increasing: in 2002 \$119.3 million was available, in 2006 \$168.4 million is expected to be available. The replacement levy of November 2006 will generate an additional \$27.3 million annually.

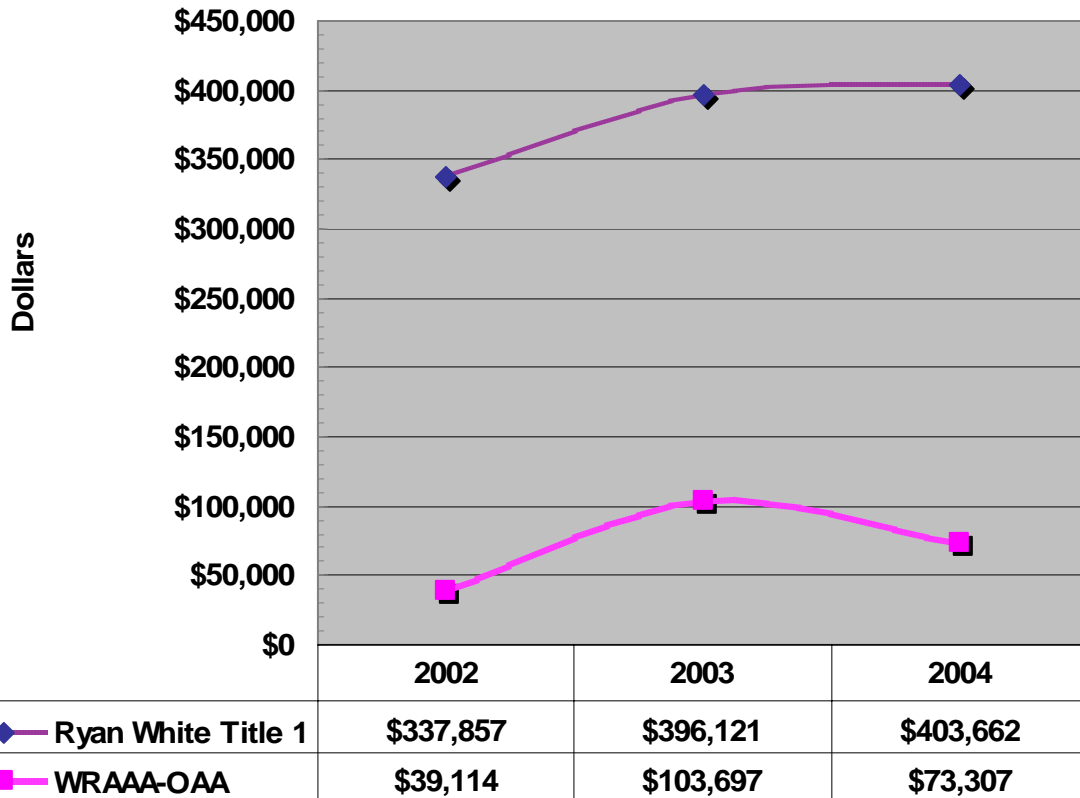
Case managers do an assessment and work with the older adult and his/her spouse or caregiver to determine an affordable package of services to help the person remain in his or her home. The following is the total budget for Options, which includes the staff case managers as well as contract services from the Cuyahoga County Budget (2006). Funding has been increasing steadily since 2002 and is expected to increase through 2008.

- 2002 Actual: \$576,109;
- 2003 Actual: \$1,096,640;
- 2004 Actual: \$1,969,221;
- 2005 Actual: \$3,197,894;
- 2006 Budget: \$6,951,393;
- 2002 Estimate: \$7,014,957; and
- 2008 Estimate: \$7,080,884.

*Trends of Government Funding in Cuyahoga County*

Between 2002 and 2004, Title III of the Older American’s Act funding for case management, administered by WRAAA, increased and then decreased. Ryan White Title I dollars have increased consistently over the same time period. (See Figure 6.)

**Figure 6: Identified Government Funding for Case Management  
Cuyahoga County, CY 2002-2004**



Source: Ryan White Title I and Western Reserve Area Agency on Aging Older American’s Act

**IDENTIFIED REVENUES**

As of May 11, 2006, \$1.15 million in revenues for case management has been identified countywide. (See Table 1.) This includes information from foundations; federated fundraising organizations; and regional, county, and municipal government.

Forty-one percent of the identified revenues are from contracts or grants from government organizations, 57 percent from United Way of Greater Cleveland through Investment Committee allocation and designated gifts, and the remainder comes from foundations and federated fundraising organizations.

**Table 1: Identified Annual Revenue for Core Services: County-wide and United Way of Greater Cleveland Case/Care Management, 2003/2004.**

Funder	Period	A		B	
		Amount	% of Total (A)	Amount	% of Total (B)
<b>Total - Contributions and dues (less UW designations)</b>			<b>0.00%</b>	<b>34,349</b>	<b>1.17%</b>
Bruening Foundation, Eva L. and Joseph M.				2,040	
Cleveland Foundation, The				7,500	
Deaconess Community Foundation				39,880	
Mt. Sinai Health Care Foundation, The	2003	14,047			
Saint Luke's Foundation				2,074	
Other Private Foundations - Not Elsewhere Classified				34,000	
<b>Total - Foundations &amp; Trusts</b>		<b>14,047</b>	<b>1.22%</b>	<b>85,494</b>	<b>2.91%</b>
<b>Total - Special Events - Growth</b>			<b>0.00%</b>	<b>120,783</b>	<b>4.11%</b>
United Black Fund of Greater Cleveland	FY2005	5,000			
<b>Total - Federated Fundraising Organizations</b>		<b>5,000</b>	<b>0.43%</b>	<b>0</b>	<b>0.00%</b>
Other United Ways - Not Elsewhere Classified				101	
<b>Total - Other United Ways</b>		<b>0</b>	<b>0.00%</b>	<b>101</b>	<b>0.00%</b>
Other Federal Funders - Not Elsewhere Classified				867,259	
<b>Subtotal Federal Government</b>		<b>0</b>	<b>0.00%</b>	<b>867,259</b>	<b>29.53%</b>
Department of Health				420,232	
Department of Job and Family Services				27,684	
Department of Mental Retardation and Developmental Disabilities				3,455	
<b>Subtotal State of Ohio</b>		<b>0</b>	<b>0.00%</b>	<b>451,371</b>	<b>15.37%</b>
WRAAA-OAA- Title III E	CY2004	73,307			
<b>Subtotal Regional Funding Sources</b>		<b>73,307</b>	<b>6.37%</b>	<b>0</b>	<b>0.00%</b>
County Commissioners				30,000	
Cuyahoga Metropolitan Housing Authority (CMHA)				133,270	
HIV Services Planning Council Ryan White Title I	2004	403,662			
<b>Subtotal Cuyahoga County Funding Sources</b>		<b>403,662</b>	<b>35.09%</b>	<b>163,270</b>	<b>5.56%</b>
Summit County Department of Job and Family Services				7,930	
<b>Subtotal Summit County Funding Sources</b>		<b>0</b>	<b>0.00%</b>	<b>7,930</b>	<b>0.27%</b>
Community Development Block Grant				120,239	
Other City of Cleveland Funders - Not Elsewhere Classified				120,345	
<b>Subtotal City of Cleveland Funding Sources</b>		<b>0</b>	<b>0.00%</b>	<b>240,584</b>	<b>8.19%</b>
All Other Funding - Not Elsewhere Classified				25,665	
<b>Subtotal Other Govt Funding Sources</b>		<b>0</b>	<b>0.00%</b>	<b>25,665</b>	<b>0.87%</b>
<b>Total - Contracts/grants from government organizations</b>		<b>476,969</b>	<b>41.46%</b>	<b>1,756,079</b>	<b>59.79%</b>
<b>Total - Membership dues under \$150</b>				<b>429</b>	<b>0.01%</b>
<b>Total - Investment Income</b>				<b>26,788</b>	<b>0.91%</b>
<b>Total - All Other Revenue</b>				<b>244,779</b>	<b>8.33%</b>
<b>Total - Prior Period balances/interfund transfers</b>				<b>13,663</b>	<b>0.47%</b>
<b>Subtotal Non - UWGrCle Support</b>		<b>496,016</b>	<b>43.12%</b>	<b>2,282,465</b>	<b>77.72%</b>
<b>Total - UWGrCle designations applied to program</b>		<b>38,440</b>	<b>3.34%</b>	<b>38,440</b>	<b>1.31%</b>
<b>Total - UWGrCle investment committee allocation</b>		<b>615,955</b>	<b>53.54%</b>	<b>615,955</b>	<b>20.97%</b>
<b>Subtotal UWGrCle Support - 4001, 4701 &amp; 4703</b>		<b>654,395</b>	<b>56.88%</b>	<b>654,395</b>	<b>22.28%</b>
<b>Total Support/Revenue</b>		<b>1,150,411</b>	<b>100%</b>	<b>2,936,860</b>	<b>100%</b>

\* Medicaid dollars NOT ENTERED under countywide total because not all Medicaid services are a one-to-one match with United Way core services and AIRS Level 1. Medicaid Service - Waiver (\$128,921,354 in 2004 - PASSPORT dollars were removed from totals.) - Falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: Adult Day Programs, Case/Care Management, Home Delivered Meals, Home Health Care, In-Home Assistance, and Residential Living Options for People with Disabilities.

## REIMBURSEMENT/COST

Reimbursement for case management may come from one or more of the following sources (DHHS, n.d.):

- Private managed-care organizations (MCOs);
- Fee-for-service clients;
- Private payers such as corporate employee assistance programs, foundation, and grant funding;
- Volunteer and local sources;
- Courts and criminal justice funding;
- Social service providers (e.g. child welfare); and
- User taxes and State- and Federally-appointed funds.

Actual fees for case management services vary by type of case management and the profession and level of professionalism of the case manager.

## V. WHAT WORKS; WHAT DOESN'T

### IMPACT ON INDIVIDUALS/FAMILIES

#### *What Works*

Although growing in popularity, case management has not been studied extensively (Sullivan, 2002). The evidence that supports its use in addiction services also shows only a modest impact (Sullivan, 2002). A meta-analysis of 24 evaluation studies published between 1980 and 1996 showed that 75 percent of clients who participated in case management programs fared better than those who did not in terms of functional status, rate of hospital readmission, access and utilization of health and human services, cost containment, range of services received, number of emergency room visits, intervention compliance, time spent incarcerated, and establishment of social networks (Gorey et al. (1998), as cited in Walsh (2002)). Another analysis of 75 case management studies showed that case management was effective in reducing the time required for hospitalization, improving housing stability, reducing symptoms of illness, and improving quality of life (Mueser et al. (1998), as cited in Walsh, (2002)). Contrary to the Gorey et al. (1998) analysis, this study also showed that case management had little effect on social functioning, number of arrests, time spent incarcerated, and vocational functioning.

Currently, there is no prevailing model of case management (Grube & Chernesky, 2001; Rapp, 2002) and a paucity of existing research in terms of service content and how they are actually provided in typical settings, monitoring of case management, and the impact on outcome (Bjokman & Hansson, 2000; Brune & Chernesky, 2001; Sullivan, 2002). A meta-analysis presented by Gorey et al. (1998) and cited in Walsh (2002) indicated that there were no differences among models of case management in terms of success.

Because of selection bias, outcome measurement might require a nontraditional approach. For example, clients undergoing treatment for addiction are also likely to have extensive criminal backgrounds and a higher rate of recidivism (Sullivan, 2002) that must be taken into account.

Findings specific to substance abuse and addiction treatment indicate that case management is important in client compliance with treatment as well as the rate of recovery (Sullivan, 2002), as supported by research from the Wright State School of Medicine.

There are a number of best practices identified for case management services and its focus on specific consumer groups. The following is a description of some of these.

#### Case Management Best Practices - General

According to the Aging and Disabilities Services of Multnomah County (2005), best practices include:

- Client-centered and strengths-based approaches/models;
- Commitment to quality and continuous innovation;
- Non-fragmented or single-entry services;
- Broad array of services with flexible service options;
- Comprehensive assessment and care planning;

- Coordinated care with easy and timely communication with other providers;
- Electronic systems for sharing information with partners, esp. medical providers;
- Quality standards;
- Continuous review and quality assurance, including cost effectiveness and utilization review;
- Outcome measurement; and
- Consistent training and support.

Case Management Best Practices – Working with the Homeless

Morse (n.d.) had found that frequent service contact led to positive treatment retention and housing outcomes for individuals, especially the homeless. Service principles of best practices in working with the homeless include:

- Assertive and persistent outreach to meet the homeless on own terms and on own turf;
- Active assistance to help clients access needed resources;
- Following the client’s own self-directed priorities and timing for services;
- Respecting client autonomy;
- Nurturing trust and a therapeutic working alliance; and
- Small case loads for case management staff.

Case Management Best Practices - Models

In a 2000 study, Bjorkman and Hansson noted that the most effective models for reducing the number of individuals in inpatient treatment, increasing compliance, stabilizing housing, and increasing patient satisfaction were the Assertive Community Treatment and the Intensive Case Management models. The Assertive Community Treatment approach is an evidence-based model that is known to be effective in reducing hospital use, increasing housing stability, controlling psychiatric symptoms, and improving the quality of life (Schaedle et al., 2002).

Case Management Best Practices – Psychiatric Case Management

In a study of psychiatric case managers’ roles and patterns of service and their relationship to client outcomes, Bjorkman and Hansson (2000) found that specific interventions were related to specific outcomes. Brokerage, intervention planning, and interventions in activities of daily living resulted in decreased care needs of the patient. Also, the more time spent on indirect work on the client’s behalf, the better the outcome as related to client psychiatric symptoms and social networking.

Case Management Best Practices – Working with Individuals with Developmental Disabilities

Limited observations of the effectiveness of strengths-based case management have shown its efficacy in work within the domain of alcohol and drug treatment, as well as with individuals with severe mental disabilities (Sullivan, 2002; Rapp, 2002). Breaking down the larger goals into a series of manageable steps has further increased the rates of completion. Additionally, years of research in strengths-based case management with the severely mentally disabled has shown reductions in the use of psychiatric hospitalization, increases in independence of daily living, vocational achievement, and increases in social support (Rapp, 2002).

### Case Management Best Practices – Working with Individuals with Substance Abuse/Chemical Dependency Disorders

The housing of substance abuse case managers within the facility was also associated with increased service use (Vanderplasschen et al., 2004). It has frequently been observed that case management for individuals with substance abuse disorders is similar to that of those with mental illness. Therefore, best practices in both domains include the identification and implementation of broad-based supports that aid in the integration of individuals into their community and encourage growth and development (Moxley, 2002).

#### *What Doesn't Work*

In an article about working with homeless individuals, Morse (n.d.) stated from his brief analysis that case management seemed to be less effective with certain groups of clients, including males, individuals with more psychotic symptoms, individuals with longer histories of homelessness, and dually-diagnosed individuals.

A “one size fits all” model of case management does not work. The individual needs and preferences of the client as well as the system in which services must be provided must be taken into account in managing a client’s access to services.

### **IMPACT ON COMMUNITY**

Case management is a critical component of the coordination of home- and community-based services for older adults and individuals with disabilities. Enabling individuals to access needed services that contribute to their physical and mental well-being and supporting caregivers in their efforts to enable a disabled older adult to remain independent can have considerable cost savings for tax-payer financed health services. As the American Health Care Association asserts, comparisons of the cost of home and community-based services against institutional care are inherently difficult. But while no definitive conclusions have been made, some studies have shown that they can be more cost-effective than institutional care under certain circumstances, especially in cases where the individual is not profoundly disabled or requiring highly intensive medical care (American Health Care Association, 2003). PASSPORT, Ohio’s Medicaid waiver to provide home-based community services for low income individuals 60 and older, has been shown to have significant cost savings. The average per-person cost of PASSPORT, which has the same eligibility criteria as nursing home placement, is \$1,100 a month which is one-fourth that of a nursing home (Ohio Department of Aging, 2006). A national study conducted by AARP shows that the large majority of older Americans want to stay living in their homes for as long as possible (AARP, 2003). Investing in services that allow older adults to remain living independent also contributes to enabling the individual retain dignity and choice as they age.

### **ACCREDITATIONS/STANDARDS/CERTIFICATIONS**

According to the Case Management Society of America (2006a), there are two distinct and important organizations: the Case Management Society of American (CMSA) and the Commission for Case Manager Certification (CCMC). The CMSA is not a certifying body for any case management credential, but the CCMC authorizes the certified case manager (CCM) designation.

Accrediting agencies that issue authorizations for businesses, organizations, and institutions include the Accreditation Commission for Health Care (ACHC), Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Healthcare Organizations

(JCAHO), National Committee for Quality Assurance (NCQA), and Utilization Review Accreditation Commission (URAC).

Certifications include:

- Continuity of Care Certification – Advanced [A-CCC];
- American Association of Occupational Health Nurses [AAOHN];
- American Board of Disability Analyst [ABDA];
- Advanced Oncology Nursing Certification [AOCN];
- Certified Advanced Social Work Case Manager [CASWCM];
- Certified Case Manager [CCM];
- Certification in Critical Care Nursing [CCRN];
- Certified Disability Management Specialist [CDMS];
- Case Management Administrator Certification [CMAC];
- Care Manager Certified [CMC];
- Certified Managed Care Nurse [CMCN];
- Certified Orthotist [CO];
- Certified Occupational Health Nurse [COHN];
- Certified Prosthetist [CP];
- Certified Prosthetist-Orthotist [CPO];
- Certified Professional in Disability Management [CPDM];
- Certified Professional in Healthcare Quality [CPHQ];
- Certified Pediatric Oncology Nurse [CPON];
- Certified Professional in Utilization Management [CPUM];
- Certified Professional in Utilization Review [CPUR];
- Certified Rehabilitation Counselor [CRC];
- Certified Rehabilitation Registered Nurse [CRRN];
- Certified Social Work Case Manager [CSWCM];
- Health Care Quality and Management [HCQM]; and
- Registered Nurse, Certified [RN, C].

An example is standards identified by the National Association of Social Workers (NASW, 2006):

- *Standard 1.* The social work case manager shall have a baccalaureate or graduate degree from a social work program accredited by the Council on Social Work Education and shall possess the knowledge, skills, and experience necessary to competently perform case management activities.
- *Standard 2.* The social work case manager shall use his or her professional skills and competence to serve the client whose interests are of primary concern.
- *Standard 3.* The social work case manager shall ensure that clients are involved in all phases of case management practice to the greatest extent possible.
- *Standard 4.* The social work case manager shall ensure the client's right to privacy and ensure appropriate confidentiality when information about the client is released to others.
- *Standard 5.* The social work case manager shall intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families.

- *Standard 6.* The social work case manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services.
- *Standard 7.* The social work case manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities.
- *Standard 8.* The social work case manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability.
- *Standard 9.* The social work case manager shall carry a reasonable caseload that allows the case manager to effectively plan, provide, and evaluate case management tasks related to client and system interventions.
- *Standard 10.* The social work case manager shall treat colleagues with courtesy and respect and strive to enhance inter-professional, intra-professional, and interagency cooperation on behalf of the client.

## VI. GAP ANALYSIS

As was said in Section II, it is impossible to derive an estimate of the number of persons in need because of the breadth of the various populations that can benefit from the case management services described in the previous section. An outer boundary that could be utilized is those with incomes under 200 percent of poverty, i.e., the working poor. Thus we could not do a gap analysis or service site index for this service.

### *Service Capacity*

There are a number of challenges social service providers experience in doing case management and consumers experience in accessing services. The following is an overview of some of the issues.

#### The need for multi-lingual and culturally-competent case managers

Bilingual and multilingual service professionals can provide more appropriate and cost-effective services for the non-English-speaking population (Minnesota Senior Health Options [MSHO], 1997). Culturally competent case managers must be sensitive to the culture of the service recipient, have cross-cultural communication skills, and understand the different cultural attitudes toward medical care and human services (MSHO, 1997).

#### The use of alternative and complementary care strategies

Coordination of traditional and alternative therapies is a more holistic approach to caring for the non-traditional client of case management services (MSHO, 1997).

#### Difficulties in navigating the current system

According to the United Way focus groups for core service planning (2005), service providers in Cuyahoga County admitted that it was difficult for them to navigate such an elaborate system in order to determine the most appropriate programs for their clients. In response, they confessed that they tend to use the programs they are familiar with. They also believe that consumers have similar difficulties, which makes it difficult for them to access the services that they need.

These service providers suggested that increasing the number of professional social workers in the area would aid agencies and clients in obtaining and learning about available basic services before the severity of their clients' conditions reach volatile levels.

#### A need for a centralized information bank

Service providers in Cuyahoga County voiced their desire for a centralized location where agencies can come together to share information regarding available services (United Way focus groups, 2005). One individual stated: *"I wish there was a central point where everyone can post or go to just exchange information about things that are going on within their particular program."* This statement supports their comments about the challenges of navigating the system as well as indicates the lack of coordination of services required to ensure continuity of care.

#### Improving access to services for difficult-to-reach populations

The populations that are most difficult to reach are the ones in extreme need of case management services. According to Cuyahoga County health and human service providers, these include the homeless, the impoverished and needy, and individuals with language barriers or who are illiterate (United Way focus groups, 2005). The homeless population has had difficulties in accessing care

because of the inability to access resources that would allow access to care, such as a telephone, transportation, or financial support to pay for medicine or care. Candidates for case management may also be ashamed or embarrassed to ask for help because of their financial or social situation. As previously mentioned, there is a need for bilingual and multilingual case managers for those who have difficulties accessing care due to language barriers. Illiteracy not only creates a challenge for individuals to find the care they need, it also may be an indicator of need.

Insufficient reimbursement for health and human services providers

The deficiency in monetary compensation for direct service providers in this field has promoted high turnover in such areas as nursing homes and intermediate care facilities for the mentally retarded (ICF-MR) (United Way focus groups, 2005). This, in turn, has become an encumbrance to those who remain in the field, as caseloads increase or once-eligible service recipient candidates are turned down.

High staff turnover and staff shortages

Because of the lack of appropriate reimbursement in the form of livable wages, there is high staff turnover and not enough staff coverage to complete the work that needs to be done. The staff members who do remain must take higher caseloads or individuals may not be able to receive needed services. Agencies that cannot retain qualified staff are concerned about having enough professionals to perform their work (United Way focus groups, 2005).

Complexity of client needs

The needs of service recipients have also changed, becoming more complex due to the presence of co-morbidities, longer life spans, and the range of needs that would allow older adults to remain independent, including home maintenance and daily living needs (United Way focus groups, 2005).

Interagency cooperation

Austin and McClelland (2002) noted that the growth in the availability of case management services has resulted in the controversy in selecting the most appropriate organization location, professional group, or programmatic affiliation. Rather than working with what would be the most suitable service provider, case managers may choose to work among only those they know.

Disintegrated structure and function of case management

Individuals who may claim to be case managers and compete for its designation might, in this struggle for recognition, be creating different and controversial pictures of it (Austin & McClelland, 2002). Service providers must understand the limitations of case management and instead work toward a comprehensive and integrated health and human services delivery system (Austin & McClelland, 2002).

Transportation needs

Transportation issues have also contributed to the barriers of accessibility of services. These include problems with accessing transportation during non-work hours (e.g. late evening or early morning); accessing transportation from the places that service recipients reside; the affordability of public transportation (e.g. buses, taxicabs, etc.); the unfulfilled demands for specialized services (e.g. paratransit); and the inability of friends and family members of lower income to take the time off to transport individuals to the agencies providing the services (United Way focus groups, 2005).

### *System-related barriers*

Case managers and service recipients experience several problems while working with local agencies and organizations that provide community services, including the problems resulting from overtaxed health and human services providers and use of automated answering systems. According to service providers in Cuyahoga County, the demand for services exceeded their supplies and the capacity for agencies to provide these services. As a result, a waiting list of individuals in need was created. One individual blithely noted that the easiest and surest way to get inpatient drug treatment in Cleveland is to go to prison and be sentenced to treatment.

Some agencies end up providing uncompensated care, but “*every agency has a limit to what they provide for free, basically*” (United Way focus groups, 2005). The focus group participants were also concerned with the use of automated answering systems that create frustration for those putting services together. The use of an automated answering machine becomes time-consuming and creates a challenge in the orchestration of service-weaving.

Other barriers created by the system result from inconsistent diagnoses, as well as opposing viewpoints, from different health and human services providers (Vanderplasschen et al., 2004).

### *Lack of continuity in the American health care system*

The lack of a comprehensive health care system in America creates difficulties in establishing a care continuum, especially for older adults (Applebaum, Straker, Mehdizadeh, Warshaw & Gothelf, 2002). A sudden change for the worse makes patients more difficult to manage because these older adults present with multiple co-morbidities. This phenomenon, coupled with the existing health care system, results in inadequate and costly care (Applebaum et al., 2002).

### *Recidivism in treatment of substance abuse and chemical dependency*

A challenge in the field of substance abuse, and perhaps an indication of the need to look more closely at case management in treatment, is the fact that there is a great chance for individuals to need repeat treatment (Sullivan, 2002). It must be understood, though, that individuals with substance abuse problems also have a higher probability of having multiple co-morbidities (Sullivan, 2002). In addition to being addicted to a drug, individuals may experience social and relational instabilities, perform poorly in their occupation, have unstable living conditions, be involved in criminal activities, and be victim to mental or physical illness (DHHS, n.d.). Many substance abusers are unemployed or lack the skills or work experience they need to become employed (DHHS, n.d.). Substance abusers may also suffer from health-related problems that may have been caused, transmitted, or exacerbated by the immediate problem of drug or alcohol use (DHHS, n.d.b). A depressive disorder during any part of a person’s lifetime is present in up to 70 percent of individuals treated for substance abuse (DHHS, n.d.b). Twenty-three to 56 percent of individuals with diagnosable Axis I disorders also present with a substance abuse or substance dependence disorder (DHHS, n.d.b).

### *Dependency of clients on case managers*

The disease model is still prevalent within the practice of case management, although there is an increased focus on the use of strengths-based principles. Because of the notion that clients are completely controlled by their illness, these individuals are at-risk of becoming totally dependent on their case managers (Vanderplasschen et al., 2004).

## VII. SUMMARY

The following are the major findings from the research on Case Management:

- Case/care management, also known as “care management,” is a process that involves service referral and coordination for an individual needing multiple services. Many clients who use social and health services use more than one service. In fact, when economic and acute care medical programs are added to behavioral health and criminal justice programs, one often sees a constellation of needs for both individuals and families.
- The goal of case/care management is generally to provide services and supports to families to help them move towards greater independence while promoting the health and well-being of all family members. The service array is intended to focus not only on immediate, crisis needs of families, but also to provide prevention and early intervention services that help families avoid reaching a crisis.
- Ohio offers several Medicaid waiver programs that provide case management services for those enrolled in the various programs administered by the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Department of Job and Family Services, and the Ohio Department of Aging.
- As the population of adults and older adults grows and continues to prefer aging in place, case management will be essential to the long-term care system.
- Case management has proven itself useful in a managed-care world that emphasizes controlling costs of care.
- There are several sources of funding for case management services, including federal community block grants; Medicaid; Medicare and Supplementary Security Income for disabled individuals; Older American’s Act; Ohio Medicaid waiver programs including PASSPORT; Cuyahoga County Options for Elders, Ryan White CARE Act, migrant health funds; private foundations or funds; state and/or local tax dollars; and private insurance.
- As of May 11, 2006, \$1.15 million in revenues for case management has been identified countywide.
- Although growing in popularity, case management has not been studied extensively. The evidence that supports its use in addiction services also shows only a modest impact.
- Findings specific to substance abuse and addiction treatment indicate that case management is important in client compliance with treatment as well as the rate of recovery, as supported by research from the Wright State School of Medicine.
- Morse (n.d.), in an article about working with homeless individuals, stated from his brief analysis that case management seemed to be less effective with certain groups of clients, including males, individuals with more psychotic symptoms, individuals with longer histories of homelessness, and dual-diagnosed individuals.
- The typical gap analysis was not conducted for this service.

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## ATTACHMENTS

### Attachment 1: Researcher List

# MCS

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## Attachment 2: Technical Notes

### Technical Notes: Methodology, Caveats, Limitations of Data

The following provides descriptions, definitions, methodologies, caveats, or limitations of data for the following components of the core service reports:

- Unit of Analysis
- First Call for Help Data
- Funding Information for Core Services
- Consumer and Financial Data: Caveats
- Gap Analysis Methodology & Limitations
- Service Site Index

#### Unit of Analysis

The core service is the unit of analysis. United Way of Greater Cleveland either funds or could fund 80 core services. These are the object and subject of the research, specific to Cuyahoga County. A separate report has been developed for each service. It must be noted that the aggregate of any quantifiable data across all of the reports does not comprise a picture of the totality of health and human services in Cuyahoga County because there are many more than 80 services that comprise the community's safety net.

The unit of analysis for estimates of service consumers is the individual, the family, or the household.

#### United Way - First Call for Help Data

For most core services, United Way First Call for Help (FCFH), the community's resource and referral service data, was used in tables that show the number of service providers and service sites, the geographic location of service providers by zip code, the service area by zip code as reported by providers of the respective services, and to show unmet need and greatest increase/decrease in calls received by FCFH for a particular core service.

It is important to remember that FCFH receives calls from a variety of sources that include people calling on behalf of a prospective consumer such as social workers, provider agencies, relatives, etc. Not all calls come directly from a prospective consumer, so some of the zip codes are for hospitals and business addresses, although the numbers for these zip codes are relatively small.

Calls also may be from people who are not interested in receiving a service, but wish instead to make a contribution to a program such as clothing, household items, food, books, crafts supplies, etc.

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services, however,

seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

- Adolescent/Youth Counseling: A caller asking about help with their troubled teenager would be referred by the type of counseling rather than age. (Example: counseling for drugs, family, sexual abuse, etc.)
- Advocacy: FCFH does not receive calls from people about advocacy.
- Child Care: Calls are directed to Starting Point.
- Condition Specific Rehabilitation Services: FCFH would refer caller back to their primary care physician for a referral.
- Early Intervention for Mental Illness: FCFH does not receive calls for this, but if they did, they would refer to the county’s Help Me Grow program.
- Family Support Centers: FCFH defines data by specific service rather than type of agency. Depending on the call, the caller may be referred to General Counseling or Early Intervention for Infants and Toddlers with Disabilities, and so on.
- Preschools: Calls are directed to Starting Point.

A different match was used for other services that had no crosswalk.

- Medical Transportation and Senior Ride: FCFH uses “Paratransit” as they do not differentiate between senior transportation, medical transportation, and transportation for the disabled.
- Outpatient Mental Health Facilities: FCFH uses “Mental Health Drop-in Centers.”

It must also be noted that, for the most part, the FCFH database does not include for-profit agencies. In the case of home health care providers, we contacted the Long Term Care Ombudsman for a more complete list of provider agencies which includes for-profit organizations.

There were several instances where the FCFH database did not code a United Way-funded agency with the core service for which they were receiving funding. In these instances, the agency was added manually to the Service Provider Table along with their site locations. The core services with the respective United Way of Greater Cleveland agencies that were added are:

- Case/Care Management – Care Alliance, Cystic Fibrosis, Epilepsy Foundation, Golden Age Centers
- Comprehensive Outpatient Substance Abuse Treatment – The Covenant
- Disease/Disability Information – The Muscular Disease Society of Northeastern Ohio
- Early Intervention for Infants and Toddlers with Disabilities – United Cerebral Palsy
- Medical Expense Assistance – North Coast Health Ministry
- Medical Transportation (Paratransit in FCFH) – Kidney Foundation of Ohio
- Senior Centers – Catholic Charities Services Corporation, Jewish Community Center of Cleveland, Jewish Family Service Association of Cleveland, University Settlement House.
- Volunteer Development – Neighborhood Leadership Institute

It must also be noted that when numbers are low for trend data reported, the high percentages are slightly exaggerated.

## Funding Information for Core Services

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

### *Foundation Funding*

We attempted to obtain foundation funding amounts for each core service from the latest annual report or 990 PF (foundation tax return to the IRS) of each major foundation that funds social services in Greater Cleveland. Wherever a description of the grant purpose was given, we used our best judgment to match the grant to the appropriate core service. If the grant fell within more than one core service area, it was not listed. When no description was given, the grant was treated like a general operating grant and assigned to a core service only when the mission of the grant recipient fell mainly within one particular core service. In-kind donations, grants for capital and equipment expenses and administrative salaries were not used. When grants were \$10,000 or greater, they were listed by name of the foundation. All others were placed under Other Foundations and not listed. Typically, we did not attempt to provide trend financial data for foundation funding of core services because of the changing nature of funded programs from year to year.

### *Federated Funding Sources*

We approached the major federated funders of core services in Greater Cleveland for funding and consumer information. Some data provided was for a single point in time; others provided three years of trend data. We often had to do a cross walk of United Way of Greater Cleveland funded core services against those funded by federated agencies to agree on the services.

### *Government Funding*

We approached every major government funder for funding amounts for each core service and also did Internet searches for some federal government sources. Due to the constant state of change in government funding, it is important to note that the data provided is a snapshot in time and that many of the programs funded in 2004 have changed definition, are funded through different revenue sources, or no longer exist at all due to a lack of funding. This is particularly true of Community Development Block Grant dollars which have decreased due to shifting federal priorities.

Every effort was made to appropriately match government funding data to the correct core service area; however, this was not always possible as frequently the service definitions were not a one-to-one match. It was necessary, in some instances, to take the closest match or use the sore service which represented a majority of the services being provided.

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases

where Medicaid is a significant source of revenue, the data was entered as an aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

Every effort was made to include data from municipalities. However, many did not respond after repeated requests for information. We would like to thank those who took the time to help with this project.

*Medicaid Funding*

A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

**Entered as Aggregate Total Under Appropriate AIRS Level**

- Medicaid Service - Home Care (\$17,787,703 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: daily living aids and home health care.
- Medicaid Service - CADAS (\$8,522,183 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: comprehensive outpatient substance abuse treatment, residential substance abuse treatment programs, substance abuse education and prevention.
- Medicaid Service - Therapy (\$2,257,394 in 2004) - Falls into AIRS 1 Health Care and includes the following core services: condition specific rehabilitation, and speech & hearing.
- Medicaid Service - CMH (\$67,773,487 in 2004) - Falls into AIRS 1 Mental Health Care & Counseling and includes the following core services: supportive therapies, adolescent/youth counseling, children's residential treatment facilities, early intervention for mental illness, general counseling services (outpatient mental health facilities), and psychiatric day treatment.

**Entered as Aggregate Total Under Third Party Payee/Direct Bill**

- Medicaid Service - Inpatient Hospital (\$188,329,269 in 2004) - Falls into two different AIRS 1 categories: Basic needs and health care. It includes the following core services: condition specific rehabilitation and medical expense assistance.
- Medicaid Service - Waiver (\$128,921,354 in 2004) – This category included all PASSPORT services. Since we reported PASSPORT separately, in order to avoid duplication, we deducted the PASSPORT total of \$52,676,048 from this number and reported the remaining \$76,245,306. This total falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: adult day care, home-delivered meals, home health care and in-home assistance.
- Medicaid Service - Habilitation (\$55,550,307 in 2004) - Falls into AIRS 1 Health Care and Individual & Family Life and includes the following core services: condition specific rehabilitation services, early intervention for infants and toddlers with disabilities/delays, and residential living options for people with disabilities.

*United Way of Greater Cleveland Funding*

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

*United Way Agency Revenues*

Annually United Way-funded agencies submit revenue budgets to United Way for each funded core service. This information for FY 2004 is reported. However, all of the agency data may not be included in the countywide data as agencies may have assigned dollars from unrestricted grants to a specific core service, or allocated a portion of grant monies that fell within two or more core service areas. It was not always possible to match countywide government or foundation funding with that reported by the agencies and that gathered from other funding sources.

**Consumer and Financial Data: Caveats**

The following applies to revenue sources on tables and graphs and their corresponding consumer data used in the consumer demographics and zip code tables.

*All Core Services*

Data was self-verified by the funder/provider. Whenever data provided by a funder appeared to be inconsistent or incorrect, an attempt was made to contact the funder. If the funder responded, the data was either adjusted according to their instructions, or the reason for discrepancies footnoted. If they did not respond, or if they said it was correct, the data was left as submitted.

Demographic and zip code data provided by the funder/provider is frequently taken from consumer intake forms which may have missing or incomplete data, or from provider agency databases which contain data entry errors or incomplete consumer intake forms. Whenever possible, the funder was asked for corrected data. In cases where a correction was not possible, the data was counted as either unknown or missing. The usage of these terms is footnoted at the bottom of each table and is explained more fully in the Gap Analysis section of this attachment.

It was not always possible to get information in the format requested as each funder tracks data differently, using different service definitions, terminology and variables. Wherever possible, data was matched to a consistent report format.

When a funder could not provide consumer demographics, but could provide an estimated percentage of consumers by category, we took the total number of consumers and applied the percentages to come up with estimated numbers for the consumer tables. For example, Medicaid tracks individual recipients throughout the year, entering new data if there is a change, each time a claim occurs. Thus, a consumer who has a birthday between claims will appear in the system for that year with two different ages.

To resolve this, the percentage of consumers in each age range was determined for the total number of duplicated consumer ages. Those percentages were then applied to the total number of unduplicated consumers for the year in order to reach a total number of unduplicated consumers for each age range.

The time periods for both revenue and consumers vary by funder/provider. United Way Program Report data is for FY 2004 (July 2003 to June 2004). Other funder/provider data is for either a January to December or July to June fiscal year.

### Gap Analysis Methodology & Limitations

Based on Anderson’s (1964) seminal needs assessment model, realized access is defined as the number of consumers who receive service while unrealized access is the estimated number of consumers who need and would utilize a service, but are not currently receiving it. This could be considered the service gap. Unrealized consumer access to services drives the need for change in the social service delivery system. Ensuring unrealized consumer access to services requires new models of service delivery related to access, effective use of resources, data management, and funding. There were multiple steps used to conduct a gap analysis:

- *Estimate of persons in need of the service:* Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.
- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
  - In some cases data was “unknown,” defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
  - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, “missing” represents data funders/providers were unable to provide.
  - There was no check of the accuracy of data submitted by agencies.
  - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
  - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
  - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.

- *Estimate of number of “unknown/non-consumers”*: This is the difference between the estimated number of actual consumers and the estimate of persons in need.
- *Estimate of number of “would-be users” (unrealized access)*: This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of “never users”*: This is the difference between the estimated number of unknown/non-consumers and would-be users.
- *Estimate of “universe of possible consumers”*: This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

We recognize that this is not a perfect method for assessing either realized or unrealized access to core services. However, we opted to use an imperfect method rather than no method to demonstrate both the complexity and the usefulness of quantifying realized and unrealized access to services as a first step toward a more rigorous methodology. In the business sector this would be a form of market analysis. We also recognize that actual consumer numbers are not unduplicated across funders, or across core services. Thus, there is much work yet to be done to gain realistic estimates of needs.

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

### Service Site Index

For many services a service site index was developed. It provides a ratio of estimated consumers per service site on a countywide level and for each zip code within the county. The ratio is based on the number derived from the gap analysis described in the previous section and on the number of providers who reported to United Way – First Call for Help whether a specific service site includes a given zip code in its service area. A provider site is located in a single zip code, but could serve multiple zip codes. The ratio is a measure of potential service accessibility by estimated universe of service consumers per zip code area. This measure does not include the capacity of providers to offer the service, for example, the number of consumers that can be served on a daily basis. It is only capturing whether there is a possibility of being a consumer. The lower the ratio, the greater is the chance of receiving service. The index also gives an indication of which zip codes have higher ratios which means that consumers have a lower probability of receiving a service as well as any patterns in zip codes that have high percentages of African Americans, Asians, or Hispanics. A map is also attached which provides a graphic picture of the estimated consumers by zip code.

Based on the numbers of providers that report to FCFH whether they serve a given zip code, we had assumed that there would be greater variability across zip codes. In reality, many report that they serve the entire county. Thus the variability across zip codes is often primarily because of

differences in the population numbers rather than in service sites that offer service in a given zip code.

### Specific Service Issues

#### *Senior Services*

“Senior Centers” was used as a catch-all category when the funder-defined service covered more than one senior success core service and could not be accurately allocated among the separate core services. Often, funding for transportation and home-delivered meals was not broken out from senior activities and supportive services at the municipal level, so it was placed under Senior Centers. Because the core services for congregate and home-delivered meals and senior ride were tracked separately, funding for these core services was not included under Senior Centers to avoid duplication of resources, even though senior center activities can and do include congregate meals.

Senior Ride includes disabled individuals of all ages as well as seniors for most funders with the notable exception of Western Reserve Area Agency on Aging (WRAAA) that requires an individual to be 60 years of age or older in order to receive services. If the transportation service was not provided by a senior center, the number of consumers reflects the number of riders using the system and contains duplicates (e.g. paratransit).

Home improvement/accessibility data includes programs for low-income families and people of all ages with disabilities, as well as seniors.

### References

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### Attachment 3: Actual Consumer Demographics

Core Service: Case/Care Management PH-100					
PERIOD	Total Population (%) <sup>*</sup> 1/1/2000-12/31/2000	Estimated Persons In Need Population under 200% Poverty (%) <sup>**</sup> 1/1/2000-12/31/2000	Actual Number/Percent of Consumers by Funding Source <sup>***</sup>		
			UW Program Report Data Cuy Cnty Only 83.4% (%) 7/1/2003-6/30/2004	WRAAA (%) CY2004	Ryan White Title I (%) CY2004
<b>TOTAL</b>	<b>1,393,978</b>	<b>397,268</b>	<b>18,301</b>	<b>259</b>	<b>1,339</b>
<b>Percent</b>		<b>28.5%</b>			
<b>GENDER</b>					
Male	47.2%	N/A	36.6%	26.3%	73.3%
Female	52.8%	N/A	35.1%	73.7%	24.9%
Unknown Data <sup>****</sup>			28.3%	0.0%	1.7%
Missing Data <sup>*****</sup>			0.0%	0.0%	0.0%
<b>RACE<sup>*****</sup></b>					
White alone	67.1%	45.8%	31.7%	79.9%	49.1%
Black or African American alone/combination	27.9%	47.5%	60.2%	16.2%	36.4%
Asian alone/combination	2.1%	1.9%	0.2%	0.4%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.9%	0.0%	0.4%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	3.9%	1.9%	0.0%	1.1%
Unknown Data <sup>****</sup>			6.0%	0.0%	13.4%
Missing Data <sup>*****</sup>			0.0%	3.1%	0.0%
<b>HISPANIC<sup>*****</sup></b>	<b>3.3%</b>	<b>5.8%</b>	<b>4.0%</b>	<b>2.7%</b>	<b>11.4%</b>
<b>AGE</b>					
0-4	6.5%	N/A	0.3%	0.0%	
5-11	7.3%	N/A	0.6%	0.0%	
12-14	7.1%	N/A	0.7%	0.0%	
15-17	6.4%	N/A	2.5%	0.0%	98.3%
18-34	19.1%	N/A	15.5%	0.0%	
35-54	29.3%	N/A	46.6%	0.0%	
55-64	8.7%	N/A	14.0%	0.0%	
65-74	7.8%	N/A	8.8%	0.0%	1.7%
75+	7.8%	N/A	7.9%	16.2%	
Unknown Data <sup>****</sup>			3.1%	0.0%	0.0%
Missing Data <sup>*****</sup>			0.0%	83.8%	0.0%
<b>INCOME<sup>*****</sup></b>					
<b>Average Household Size</b>	<b>2.4</b>	<b>N/A</b>			
\$0-\$9,999	11.3%	N/A	79.2%	0.0%	0.0%
\$10,000-\$14,999	6.9%	N/A	7.2%	0.0%	0.0%
\$15,000-\$19,999	6.7%	N/A	1.5%	0.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	0.5%	0.0%	0.0%
\$30,000 and above	61.5%	N/A	0.2%	0.0%	0.0%
Unknown Data <sup>****</sup>			11.5%	0.0%	0.0%
Missing Data <sup>*****</sup>			0.0%	100.0%	100.0%
<b>Totals</b>	<b>100.0%</b>	<b>N/A</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

### Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census SF1(P1); SF4(PCT144)
** U.S. Census SF4 (PCT144)
*** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
***** The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone," all racial categories are "... alone or in combination with some other race." This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category, which may result in more conservative estimates for children, and the "old old," which may actually have larger proportions of persons in the lower income categories.

### Attachment 4: Actual Consumer Zip Codes

Core Service: Case/Care Management PH-100						
Period	City/Town (% Cleveland)	Total Population (%) <sup>*</sup>	Estimated	Actual Number/Percent of Consumers by Funding Source <sup>***</sup>		
			Persons in Need	UW Program Report Data (%)	WRAAA (%)	Ryan White Title I (%)
			Population under 200% Poverty (%) <sup>**</sup>	7/1/2003-6/30/2004	CY2004	CY2004
			1/1/2000-12/31/2000			
<b>TOTAL</b>		<b>1,393,978</b>	<b>397,268</b>	<b>18,301</b>	<b>259</b>	<b>1,339</b>
<b>Percent</b>			<b>28.5%</b>			
44017	Berea	1.4%	0.7%	0.1%	0.0%	0.0%
44022	Bentleyville	0.8%	0.2%	0.1%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.0%	0.1%	0.0%	0.0%
44070	North Olmsted	2.4%	1.2%	0.4%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	0.1%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	7.3%	10.4%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	4.3%	9.1%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	5.1%	2.3%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts (75%)	3.9%	7.1%	8.1%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	3.9%	5.3%	0.0%	0.0%
44107	Lakewood/Cleveland	4.1%	3.4%	3.6%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	5.2%	5.0%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	5.0%	4.4%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	3.5%	12.7%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	3.2%	5.6%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	4.4%	2.2%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	2.5%	6.4%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.5%	1.4%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	1.5%	1.8%	0.0%	0.0%
44116	Rocky River	1.5%	0.5%	0.3%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	1.0%	0.6%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerHts	3.3%	2.3%	0.9%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	0.8%	1.9%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	4.7%	2.1%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	1.6%	0.6%	0.0%	0.0%
44122	Beachwood/Highland Hills/ShakerHts	2.5%	1.3%	0.3%	0.0%	0.0%
44123	Euclid	1.3%	1.1%	0.5%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	1.6%	0.3%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	1.7%	0.5%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	0.6%	0.6%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	1.4%	1.4%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.6%	1.3%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	1.3%	0.3%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	2.5%	0.4%	0.0%	0.0%
44131	Independence/Seven Hills/BrooklynHts	1.5%	0.6%	0.1%	0.0%	0.0%
44132	Euclid	1.1%	1.0%	0.2%	0.0%	0.0%
44133	North Royalton	2.1%	0.7%	0.3%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	1.7%	0.4%	0.0%	0.0%
44135	Cleveland/Linddale (90%)	2.1%	2.0%	4.2%	0.0%	0.0%
44136	Strongsville	3.1%	0.9%	0.3%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.4%	0.4%	0.0%	0.0%
44138	Olmsted Twsp/Olmsted Falls	1.3%	0.6%	0.3%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	0.5%	0.2%	0.0%	0.0%
44140	Bay Village	1.2%	0.3%	0.3%	0.0%	0.0%
44141	Brecksville	1.0%	0.2%	0.1%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	0.8%	0.1%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	0.8%	0.2%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.3%	0.2%	0.0%	0.0%
44145	Westlake	2.3%	0.8%	1.1%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	1.8%	0.3%	0.0%	0.0%
44147	Broadview Hts	1.1%	0.5%	0.1%	0.0%	0.0%
44149	Strongsville			0.1%	0.0%	0.0%
	Unknown Cuyahoga County Zip Codes****			0.0%	0.0%	0.0%
	Missing*****			0.0%	100.0%	100.0%
	Unknown ****			20.0%	0.0%	0.0%
	<b>Total Cuyahoga County</b> *****	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>0.0%</b>	<b>0.0%</b>
	<b>Total Known Cleveland</b>	<b>30.7%</b>	<b>53.3%</b>	<b>80.4%</b>	<b>0.0%</b>	<b>0.0%</b>
	<b>Total Known Suburbs</b>	<b>69.3%</b>	<b>46.7%</b>	<b>19.6%</b>	<b>0.0%</b>	<b>0.0%</b>
	<b>Unknown &amp; Missing</b>			<b>20.0%</b>	<b>100.0%</b>	<b>100.0%</b>

#### Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000 SF1 (P1)
**U.S. Census 2000 SF3 (PCT 50)
*** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
***** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zip codes because some zip codes include data from adjacent counties.

## Attachment 5: Models of Case Management

Model of Case Management	Population	References	Description
Advocacy Model	<ul style="list-style-type: none"> <li>• Homeless and Mentally Ill</li> </ul>	<ul style="list-style-type: none"> <li>• Morse (n.d.)</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasis on providing case-specific advocacy to facilitate clients gaining needed resources and services while promoting consumer involvement</li> <li>• Staff are generalists, with training in mediation, negotiation, and mental health law</li> <li>• Advocacy services designed to be ongoing, as needed</li> </ul>
Assertive Community Treatment Model	<ul style="list-style-type: none"> <li>• Mentally Ill</li> <li>• Homeless and Mentally Ill</li> </ul>	<ul style="list-style-type: none"> <li>• DHHS (n.d.b)</li> <li>• Morse (n.d.)</li> <li>• Saleh et al. (2006)</li> </ul>	<ul style="list-style-type: none"> <li>• Originally developed and implemented in State of Wisconsin in Program of Assertive Community Treatment [PACT]</li> <li>• Aims of PACT: Contact clients in homes and other natural settings; focus on practical problems of daily living; advocate assertively; be able to work with manageable case load sizes; maintain frequent contact with client; incorporate team approach, sharing caseloads; maintain long-term commitment with clients</li> <li>• In working with homeless clients who are mentally ill, emphasis on providing intensive treatment and support services <i>in vivo</i>, for ongoing, open-ended period of time. Staffing intensive and utilizes inter-disciplinary team that includes psychiatrist and nurse. Shares caseload.</li> </ul>
Benefit Case Management Model (see also: Healthcare/Acute Care Case Management Model)			<ul style="list-style-type: none"> <li>• Focuses on health care benefits and most appropriate use of resources</li> <li>• Used primarily by insurance agencies</li> <li>• Cost-efficacy as goal</li> </ul>
Brokerage Model (a.k.a. Broker-Generalist Model)	<ul style="list-style-type: none"> <li>• Substance Abuse/ Chemical Dependency</li> <li>• HIV/AIDS</li> <li>• Homeless and Mentally Ill</li> </ul>	<ul style="list-style-type: none"> <li>• DHHS (n.d.b)</li> <li>• Morse (n.d.)</li> <li>• Bjorkman &amp; Hansson (2000)</li> </ul>	<ul style="list-style-type: none"> <li>• Functions: assessment, planning, referring, advocacy, linking, and monitoring. Monitoring, if any, is short-lived. Also (sometimes): outreach.</li> <li>• Does not include <u>active</u> advocacy by manager on behalf of client</li> </ul>

Attachment 5: Models of Case Management (continued)

Model of Case Management	Population	References	Description
			<ul style="list-style-type: none"> <li>• Identify client needs and help them access resources to respond to those needs. Case manager does not act as therapist</li> <li>• No long-term relationship developed between case manager and client. Client limited by early contact with case manager and contact tends to be less intensive and office-based</li> <li>• Model allows case manager more time to provide services to larger number of individuals. May manage heavy caseloads (between 50 and 85 clients per manager)</li> <li>• Works best when clients are not impoverished and have sufficient amount of resources available to them</li> <li>• Small agencies and organizations with narrowly-defined services may be best place to offer Brokerage-type case management. Model used mainly by public agencies</li> </ul>
Clinical Case Management	<ul style="list-style-type: none"> <li>• Mentally Ill</li> <li>• Substance Abuse</li> <li>• HIV/AIDS</li> <li>• Homeless and Mentally Ill</li> </ul>	<ul style="list-style-type: none"> <li>• DHHS (n.d.b)</li> <li>• Moxley (2002)</li> <li>• Walsh (2002)</li> <li>• Morse (n.d.)</li> </ul>	<ul style="list-style-type: none"> <li>• Integrates role of social worker as clinician with that of service coordinator</li> <li>• In working with individuals with mental illness, involves medication and symptom management. Individuals learn to accept limitations that illness has created and are encouraged to manage illness and lower expectations in order to achieve growth and improvement</li> <li>• In working with individuals who are homeless with mental illness, emphasis on individual, therapeutic relationship between primary clinical case manager and client. Services provided in community and in office</li> </ul>
Community-based Case Management Model	<ul style="list-style-type: none"> <li>• Mentally Ill</li> <li>• Child Welfare</li> </ul>		<ul style="list-style-type: none"> <li>• First identified in 1970s, when more attention paid to working with mentally ill because of deinstitutionalization</li> <li>• Seeks to involve all community partners in client's well-being</li> </ul>

Attachment 5: Models of Case Management (continued)

Model of Case Management	Population	References	Description
Critical Time Intervention [CTI] Model	<ul style="list-style-type: none"> <li>Homeless and Mentally Ill</li> </ul>	<ul style="list-style-type: none"> <li>Morse (n.d.)</li> </ul>	<ul style="list-style-type: none"> <li>In working with homeless who are mentally ill, focus is on strengthening long-term ties to other services and supports while providing emotional and practical support during critical period of transition from shelter to housing. Time-limited intervention lasts through “critical period” – limited to about nine months. Activities similar to ICM, but focus on assisting clients in developing stable, ongoing relationships within natural and service support systems</li> </ul>
Differentiated Care Management Model		<ul style="list-style-type: none"> <li>Devon.gov (1999)</li> </ul>	<ul style="list-style-type: none"> <li>Originated in Devon, England. Model has been implemented in United States in projects such as Robert Wood Johnson Foundation’s Cash and Counseling Initiative; Wisconsin Family Care Program; Texas’ Family Care and STAR+PLUS Programs; and Ohio’s PASSPORT Program</li> <li>Noted for well-defined system of protocols (systematic), which includes three levels of assessment and care coordination (“Care Management Pathways”): Care Coordination; Self Care Management; and Personal Care Management.</li> <li>Care Coordination: Used when people are assessed as needing intermittent support to manage their care needs/services; Provides coordinating and reviewing for clients, caregivers, service providers, and other related institutions; All contact regarding care plans and changes in needs will take place with Help Desk; Service providers will monitor care plans and be in touch with Help Desk; Reviews and reassessments may take place through variety of communication methods, including face-to-face, telephone, or written communication; Changes required to care plan must be within parameters</li> </ul>

Attachment 5: Models of Case Management (continued)

Model of Case Management	Population	References	Description
			<ul style="list-style-type: none"> <li>• Self Care Management: Designed to enable people to manage their own or relative’s care needs and services with support from Help Desk; No named allocated worker; Clients and caretakers manage own care plans within agreed parameters; Reviews and reassessments may take place through variety of communication methods, including face-to-face, telephone, or written communication</li> <li>• Personal Care Management: For individuals whose care needs are such that they require the ongoing involvement of a named, allocated worker to ensure safe and effective coordination and implementation of care plan; can be undertaken on time-limited or long-term basis, to reflect changing needs over time; contact and casework with clients should be purposeful, solution-focused, and task-centered, with clearly-defined outcomes set within care plan; Reviews and reassessments will be face-to-face</li> <li>• Establishment of Help Desk that will provide initial point of contact for public and other agencies on local level</li> </ul>
Healthcare/Acute Care Case Management Models		<ul style="list-style-type: none"> <li>• Berger (2002)</li> </ul>	<ul style="list-style-type: none"> <li>• There are several approaches to case management in the health care/acute care setting, including Primary Care Case Management Model, Medical Case Management Model, Social Case Management Model, Medical-Social Case Management Model, and Benefit Case Management Model</li> </ul>
Integrated Care Model/Integrated Case Management			<ul style="list-style-type: none"> <li>• Involves multidisciplinary approach in providing services through organization of services around clients’ needs (as opposed to organizing services by virtue of professions’ needs)</li> </ul>

Attachment 5: Models of Case Management (continued)

Model of Case Management	Population	References	Description
Intensive Case Management [ICM] Model	<ul style="list-style-type: none"> <li>• Mentally Ill</li> <li>• Substance Abuse</li> <li>• Dual Diagnosis</li> <li>• Homeless</li> <li>• Homeless and Substance Abuse</li> <li>• Homeless and Mentally Ill</li> <li>• Homeless Families</li> </ul>	<ul style="list-style-type: none"> <li>• Schaedle &amp; Epstein (2000)</li> <li>• Schaedle et al. (2002)</li> <li>• Morse (n.d.)</li> </ul>	<ul style="list-style-type: none"> <li>• Poorly-defined and poorly-operationalized concept</li> <li>• Common to proponents of the method are the functions (e.g. outreach, assessment, planning, etc.) and principles</li> <li>• Schaedle and Epstein (2000) posit that ICM may focus more on client than conventional case management (less systems-driven and more client-driven)</li> <li>• Emphasis on linkage and coordination of services, as well as client empowerment. Also characteristic are assertive and persistent outreach, reduced number of caseloads, and active assistance in accessing resources</li> <li>• In working with homeless who have substance abuse disorder, emphasis placed on outreach in assisting clients to access needed services and providing advocacy</li> <li>• In working with homeless who are mentally ill, emphasis on linking clients to services, monitoring their involvement, and assisting clients in problem-solving and recovery strategies. Also focuses on aggressive outreach, develop trusting relationships, counseling, and practical assistance</li> <li>• In working with homeless families, intensive case management frequently remains open-ended. There is also an average of 15 contacts and 15 hours of direct service in the first year</li> <li>• Case loads are moderate (around 15 to 30 individuals to one case worker)</li> </ul>
Medical Case Management Model (see also: Healthcare/Acute Care Case Management Model)			<ul style="list-style-type: none"> <li>• Nurses or social workers typically manage these cases and focus on select group of patients with severe mental illness/injuries that require intensive coordination and service monitoring</li> </ul>

Attachment 5: Models of Case Management (continued)

Model of Case Management	Population	References	Description
Medical-Social Case Management Model (see also: Healthcare/Acute Care Case Management Model)	<ul style="list-style-type: none"> <li>• HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>• Giddens, Ka'opua, &amp; Tomaszewski (2002)</li> </ul>	<ul style="list-style-type: none"> <li>• Aims to provide a more holistic approach to health care provision</li> <li>• Ecological approach underlies goals – emphasizes synthesis of medical, social, economic, and cultural dimensions of client</li> <li>• Recognizes impact of different aspects of individual on each other, specifically non-medical aspects on medical aspects</li> <li>• Case manager may adopt various roles, including educator/counselor, service broker, advocate, and monitor</li> </ul>
Monitoring (or Gate-Keeping) Approach/Managed Care Model		<ul style="list-style-type: none"> <li>• Saleh et al. (2006)</li> </ul>	<ul style="list-style-type: none"> <li>• Used by managed care and insurance industries</li> </ul>
Primary Care Case Management Model (see also: Healthcare/Acute Care Case Management Model)			<ul style="list-style-type: none"> <li>• Primary care provider (usually a physician) is service coordinator for client. Oversees all health care-related interventions and synthesis of medical information</li> <li>• Concentrates on management of disease, rather than all aspects of health care needs</li> </ul>
Rehabilitation/Recovery-based Case Management model	<ul style="list-style-type: none"> <li>• Mentally Ill</li> <li>• Substance Abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Moxley (2002)</li> </ul>	<ul style="list-style-type: none"> <li>• Requires clients to gain control over each aspect of process, as well as be active in own treatment</li> <li>• Assumes individuals are motivated</li> <li>• Not supposed to result in return to pre-morbid state but rather actualization and achievement of goals of recovery</li> <li>• Client determines goals so that they may find supports that bring them closer to them</li> </ul>
Social Case Management Model (see also: Healthcare/Acute Care Case Management Model)	<ul style="list-style-type: none"> <li>• Frail Elderly</li> <li>• Chronic Illness</li> </ul>		<ul style="list-style-type: none"> <li>• Services provided primarily by social workers who coordinate and monitor non-medical aspects of patient care, especially those of environment which impinge upon ability to maximize access to health care services</li> <li>• Usually for non-acute, community-based clients</li> </ul>

Attachment 5: Models of Case Management (continued)

Model of Case Management	Population	References	Description
Social Network Case Management	<ul style="list-style-type: none"> <li>• Homeless and Mentally Ill</li> </ul>	<ul style="list-style-type: none"> <li>• Morse (n.d.)</li> </ul>	<ul style="list-style-type: none"> <li>• In working with homeless who are also mentally ill, emphasis on increasing capacity of clients' social networks to interact and support client while also performing intensive case management functions of outreach and service linkage. Services provided in community and in office</li> </ul>
Strengths-based Case Management Model	<ul style="list-style-type: none"> <li>• Mentally Ill</li> <li>• Child Welfare</li> <li>• Substance Abuse</li> <li>• Developmental Disabilities</li> </ul>	<ul style="list-style-type: none"> <li>• Sullivan (2002)</li> <li>• Rapp (2002)</li> </ul>	<ul style="list-style-type: none"> <li>• Developed at University of Kansas' School of Social Welfare</li> <li>• Idea that individuals have skills needed to change situation for better and encourages them to use resources available through informal helping networks</li> <li>• Provides support for clients for asserting direct control over search for resources, as well as examining client strengths and assets to acquire necessary resources</li> <li>• Principles of model: Strength-based focus; recognizes community as having plethora of resources; emphasizes client self-determination; maintains and nourishes case manager-client relationship; aggressive outreach as intervention; recognizes that individuals can grow, learn, and change</li> <li>• In working with mentally ill, this model is similar to community-based case management. Both were created in order to help with individuals with persistent mental illness as tool to transition from institutionalized care to independent living. Based upon idea that people suffering from mental illnesses can continue to grow, learn, and change</li> <li>• In working in child welfare, service providers adopted idea that families and children have skills to make changes in their lives</li> <li>• Popular to use in most human services programs, particularly substance abuse. Also incorporated in work with individuals with mental disabilities</li> </ul>

**Attachment 6: Profile of Core Service Providers – 2005**

<b>PROFILE OF CORE SERVICE PROVIDERS - 2005</b>		
<b>Source: United Way - First Call for Help Refer Database February 2005</b>		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	31	8
Number of Providers by Type		
Non-profit	26	8
For-profit	-	-
Government	5	-
Other	-	-
Total Number of Sites	54	29
Number of Service Sites per Provider		
1	27	5
2 – 5	2	1
6 – 10	1	1
11+	1	1
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	-	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	2	-
44103 – Cleveland	2	2
44104 – Cleveland	3	3
44105 – Newburgh Hts/Garfield Hts	3	1
44106 – Cleveland Hts/Cleveland	9	4
44107 – Cleveland/Lakewood	-	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	2	1
44110 – Cleveland/Bratenahl	1	1
44111 – Cleveland	2	2
44112 – Cleveland/East Cleveland	2	-
44113 – Cleveland	4	2
44114 – Cleveland	6	2
44115 – Cleveland	7	3
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	-	-
44119 – Cleveland/Euclid	1	1
44120 – Cleveland/Shaker Hts	1	1
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	1	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	1	1
44125 – Valley View/Garfield Hts	-	-

Attachment 6: Profile of Core Service Providers – 2005 (continued)

<b>PROFILE OF CORE SERVICE PROVIDERS - 2005</b>		
<b>Source: United Way - First Call for Help Refer Database February 2005</b>		
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	1	1
44128 – Cleveland/Warrensville Hts	-	-
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	1	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	3	3
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	1	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	1	1
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-
<b>Total Cuyahoga County</b>	<b>54</b>	<b>29</b>
<b>Total Cleveland</b>	<b>46</b>	<b>26</b>
<b>Total Suburbs</b>	<b>8</b>	<b>3</b>

## Attachment 7: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
<b>AIDS Taskforce of Greater Cleveland</b>	<b>Case Management and Referral Services</b>
Alta House	Case Management
Benjamin Rose	Social Work Services
<b>Care Alliance</b>	<b>Prescription Drugs for Homeless and Public Housing Residents, Healthcare Clinics for Homeless and Public Housing Residents</b>
Catholic Charities Health and Human Services - Parish and Community Ministries	Assessment and Case Management for Homebound Older Adults
Catholic Charities Services of Cuyahoga	Case Management - Older Adults, Outpatient Substance Abuse Treatment for Hispanics, Wraparound Voucher Pool for Youth Chemical Dependency
<b>Center for Mental Retardation</b>	<b>Advocacy/Support/Referral - MR/DD</b>
Children's Rights Council of Cleveland	Information and Case File Review - Child Support/Custody
City of Cleveland Department of Aging	Advocacy/Outreach
<b>Cleveland Sight Center</b>	<b>Deaf - Blind Services</b>
Council for Economic Opportunities In Greater Cleveland	Perinatal/Early Childhood Health
Cuyahoga Board of Mental Retardation and Developmental Disabilities	Residential Services, Quality Assurance
Cuyahoga Department of Justice Affairs	Comprehensive Substance Abuse Services - Offenders
Cuyahoga Department of Senior & Adult Services	Home Care Assistance / Coordination - Elderly
<b>Cystic Fibrosis Foundation - Rainbow Chapter</b>	<b>Health Information - Cystic Fibrosis</b>
Empowerment Center of Greater Cleveland	Asthma Education and Management
<b>Epilepsy Association</b>	<b>Counseling and Outpatient Psychiatric Care, Special Services for Young Adults</b>
Free Clinic of Greater Cleveland	Disease Specific Treatment - HIV/Aids
<b>Golden Age Centers of Greater Cleveland</b>	<b>Social Services - Seniors, Home Delivered Meals</b>
HUMADAOP	HIV Testing and Counseling, AIDS / HIV Counseling and Case Management
Jewish Family Service Association of Cleveland	Eldercare - Counseling / Case Management
MetroHealth Medical Center	Community HIV Services
Muscular Disease Society of Northeastern Ohio	Health Care Coordination - Muscular Disease
Northeast Ohio Neighborhood Health Services (Neon)	Perinatal Outreach
Proyecto Luz	Case Management for those with HIV/Aids
Recovery Resources	Substance Abuse Counseling/Case Management - Mr/Dd
<b>The Salvation Army</b>	<b>Social Services - Social Work Services</b>

Attachment 7: Providers and Functions – 2005 (continued)

<b>Service Providers &amp; Functions</b>	
<b>Source: United Way - First Call for Help Refer Database February 2005</b>	
<b>Agency</b>	<b>Services</b>
Southwest General Health Center	Support Services - Older Adults
United Cerebral Palsy Association of Greater Cleveland	In-Home Supportive Services
Visiting Nurse Association Healthcare Partners of Ohio	Medication Management
Western Reserve Area Agency on Aging*	Information, Assessment and Home Care Services

**Bold** represents agencies funded by United Way for this service.

**Attachment 8: United Way - First Call for Help Case Management Requests – 2000-2004: Greatest Increase/Greatest Decrease**

<b>PH-100 Case Management</b>								
<b>United Way - First Call for Help Requests 2000-2004</b>								
<b>Greatest Increase/(Greatest Decrease)</b>								
Zip Code		TOTAL REQUESTS					%Change <sup>*</sup>	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44120	Shaker Hts/Cleveland	1	1	1	1	4	300%	2
44113	Cleveland	0	1	1	0	3	N/A	1
44115	Cleveland	0	0	0	3	3	N/A	1
44102	Cleveland/Brooklyn	0	3	0	1	2	N/A	1
44125	Valley View/Garfield Hts	0	0	0	0	2	N/A	0
44108	Cleveland/Bratenahl	0	1	0	0	1	N/A	0
44110	Cleveland/East Cleveland	0	2	0	0	1	N/A	1
44143	Highland Hts/Richmond Heights	0	0	0	1	1	N/A	0
44129	Brooklyn/Parma/Cleveland	1	1	0	0	0	(100%)	0
44109	Cleveland/Brooklyn Hts	2	3	1	0	0	(100%)	1
44106	Cleveland/Cleveland Hts	3	2	0	0	0	(100%)	1
44105	Cleveland/Newburgh Hts/Garfield Hts	3	0	1	2	0	(100%)	1
44107	Lakewood/Cleveland	3	0	0	3	1	(67%)	1
<b>**Total Cuyahoga County</b>		<b>166</b>	<b>175</b>	<b>181</b>	<b>171</b>	<b>239</b>	<b>44%</b>	<b>186</b>
<b>**Total Cleveland</b>		<b>92</b>	<b>90</b>	<b>90</b>	<b>81</b>	<b>137</b>	<b>49%</b>	<b>98</b>
<b>**Total Suburbs</b>		<b>74</b>	<b>85</b>	<b>91</b>	<b>90</b>	<b>102</b>	<b>38%</b>	<b>88</b>

\* Extremely high percentages are due to low numbers.

\*\* These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.

**Attachment 9: United Way - First Call for Help 2000-2004: Unmet Need**

PH-100 Case Management					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44142	Brookpark/Cleveland	5	4	1	20%
44146	Walton Hills/Oakwood/Bedford	17	16	1	6%
44125	Valley View/Garfield Hts	19	18	1	5%
44134	Parma/Cleveland	20	19	1	5%
44130	Parma/Cleveland	23	22	1	4%
44118	ClevelandHts/UniversityHts/ShakerHts	28	27	1	4%
44106	Cleveland/Cleveland Hts	31	30	1	3%
44108	Cleveland/Bratenahl	49	48	1	2%

<b>*Total Cuyahoga County</b>	<b>932</b>	<b>924</b>	<b>8</b>	<b>1%</b>
<b>*Total Cleveland</b>	<b>490</b>	<b>488</b>	<b>2</b>	<b>0%</b>
<b>*Total Suburbs</b>	<b>442</b>	<b>436</b>	<b>6</b>	<b>1%</b>

**FCFH DATA NOTES**

**Met** = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)

**Unmet** = service request for which there was no referral.

**Note:** Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50 percent and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.

\* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.



**United Way of  
Greater Cleveland**

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Cleveland, Ohio 44115

[uws.org/CoreServicesPlanning](https://uws.org/CoreServicesPlanning)