

# Consumer Group Snapshot

## Persons Who Are Chronically Ill

Consumer Category:  
**With/At Risk of Health Conditions**



February 2007

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**CONSUMER GROUP: Persons who are chronically ill**

<p><b>Definitions</b></p>	<p><i>Chronic health conditions:</i> a general term that encompasses both chronic diseases and impairments.<sup>1</sup> They tend to be influenced by behavioral risk factors, requiring a shift away from the traditional medical model that focuses on pathogens and disease processes.</p> <p>A chronic condition is one lasting 3 months or more, by the definition of the U.S. National Center for Health Statistics. In ancient Greece, the “father of medicine” Hippocrates distinguished diseases that were acute (abrupt, sharp and brief) from those that were chronic. The term “sub-acute” has been created to designate the middle-ground between acute and chronic illnesses.<sup>2</sup></p>
<p><b>THE CONSUMERS</b></p>	<p>See Attachment 1: Family of Services &amp; Attachment 2: Consumer Matrix</p>
<p><i>Stage One: At Risk</i> (Estimated Number/ Percent County Population)</p>	<p><i>Prevention is a major issue and consideration for all chronic illness. Chronic conditions are inherent in most diseases with a varying impact across all social and economic sectors.</i></p> <ul style="list-style-type: none"> <li>• Tobacco use is the single largest cause of preventable premature mortality in the United States.<sup>3</sup></li> <li>• Limited physical exercise &amp; obesity. Most Americans are sedentary: only 25 percent of adults and 27 percent of adolescents get moderate exercise regularly. Obesity: 1 in 4 American children today is obese and at risk of related health problems.<sup>4</sup></li> <li>• Disparities according to the American Association for Health Education:<sup>5</sup> despite great improvements in the overall health of the nation, racial and ethnic minority groups—including African Americans, Alaska Natives, Native Americans, Asian Americans, Hispanic Americans, and Pacific Islanders—are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:             <ul style="list-style-type: none"> <li>○ <b>CARDIOVASCULAR DISEASE:</b> Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. Rates of death from diseases of the heart were 29 percent higher among African American adults than among white adults, and death rates from stroke were 40 percent higher.</li> <li>○ <b>DIABETES:</b> Prevalence of diabetes is 70 percent higher among African Americans and about 100 percent higher among Hispanics than whites of similar age. In Native Americans/Alaskan Natives, prevalence of diabetes is more than twice that of the total population.</li> <li>○ <b>HIV/AIDS:</b> Although African Americans and Hispanics represented only 25 percent of the U.S. population, they accounted for roughly 55 percent of adult AIDS cases and 82 percent of pediatric AIDS cases reported through 1999.</li> <li>○ <b>BREAST CANCER:</b> African American women are more likely to die of breast cancer than are women of any other racial or ethnic group.</li> <li>○ <b>IMMUNIZATIONS:</b> Rates of immunizations are lowest among minorities.</li> </ul> </li> </ul>

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- INFANT MORTALITY: African American, Native American, and Puerto Rican infants have higher death rates than white infants.

*Stage Two: In Crisis*  
[with condition]  
(Estimated Number/  
Percent County  
Population)

Cuyahoga County Population per 2000 U.S. Census: 1,393,978

In 2000, according to a survey on chronic care in America by Harris Interactive (June 2003), 125 million of 276 million people (45 percent of the population) living in the United States had some type of chronic illness.<sup>6</sup> This translates into an estimated 627,290 persons in Cuyahoga County, or 45 percent of the population.

- Four particular conditions (asthma, depression, diabetes, and congestive heart failure) affect nearly half of all Americans with chronic conditions. Asthma, depression, and diabetes each affect about 5.4 percent of the population. This translates into an estimated 75,275 persons in Cuyahoga County for each disease. An additional 1.8 percent of the population suffers from congestive heart failure, an estimated 25,091 persons in Cuyahoga County.
- Of the 125 million persons with long-term illnesses, 44 percent have co-morbid conditions to manage, i.e., are experiencing more than one chronic condition. This translates into an estimated 276,008 in Cuyahoga County.
- Some of these conditions are nonfatal chronic illnesses (e.g., arthritis and hearing or vision problems); some are serious, eventually fatal, chronic conditions (e.g., cancers, organ system failures, including those affecting the heart, liver, kidney, or respiratory system, dementia, and strokes); others are considered frailty, i.e., the fragility of multiple body systems as their customary reserves diminish with age and disease.<sup>7</sup>
- The uninsured and underinsured report poorer quality of life, fewer visits to doctors, less adequate knowledge of how to care for their illness, poorer relationships with their doctors, and less complete benefit from modern standards of care.<sup>8</sup>
- One-third of the chronically ill in America simply are not receiving the information and services needed to manage their illness successfully<sup>9</sup>

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The Ohio Department of Health tracks the leading causes of mortality. In Cuyahoga County, they were the following:

**2002-2004 Leading Causes of Death in Cuyahoga County**

Disease	Death Count	Cuyahoga Age-Adjusted Rate*	Ohio Age-Adjusted Rate*
<b>Diseases of Heart</b>	14,825	283.8	243
<b>Malignant Neoplasms</b>	10,241	208	203.3
<b>Cerebrovascular Disease</b>	2,507	47.2	54.7
<b>Chronic Lower Respiratory Disease</b>	1,776	34.1	48
<b>Accidents</b>	1,119	25.5	34
<b>Diabetes Mellitus</b>	1,207	23.9	30.2
<b>Alzheimer's Disease</b>	943	16.6	22.1
<b>Influenza/Pneumonia</b>	764	14.1	18.5
<b>Nephritis, Nephrotic Syndrome, &amp; Nephrosis</b>	922	17.8	16
<b>Septicemia</b>	728	14.2	12.6

\* Age-adjusted rate per 100,000 people.<sup>10</sup>

*Stage Three: Recently Stabilized (Estimated Number/ Percent County Population)*

Persons who are successfully managing their chronic illness.

Age by Generation

Crosses generations

Risk Factors

Same as list in Stage One.

Historic Trend Line

↑

Influencing Factors Underlying Historic Trend Line (+/-)<sup>11</sup>

- The age of infectious disease has become the age of chronic disorders according to Harris Interactive (June 2003).<sup>12</sup> The major causes of death today are heart and vascular disease, chronic degenerative diseases and cancer, largely incurable and increasing in incidence (but controllable to some extent, and people live years with them). The strategies that worked so well for all but eliminating acute infectious diseases just don't seem to work for chronic and degenerative conditions.
- Life expectancy for adults is increasing.

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Life Trajectory	Symptoms ⇒ Diagnosis and treatment ⇒ Ongoing healthy lifestyle practices & management of chronic illness, maximizing function, and alleviating symptoms ⇒ Management at end of life
Consumer Impact Strategy	<p>Healthy People 2010 &amp; Steps to a Healthier U.S.: Leading Prevention:<sup>13</sup></p> <p>VISION: Envisions a community where diseases are <b>prevented</b> when possible, <b>controlled</b> when necessary, and <b>treated</b> when appropriate</p> <p>STRATEGIES:</p> <ul style="list-style-type: none"> <li>• Increase the quality and years of healthy life.</li> <li>• Eliminate health disparities</li> </ul>
Future Projection	Increasing chronic illness as the population ages.
<b>THE SAFETY NET:</b> Which of the 80 safety net core services are needed to empower consumers to positively alter their life trajectory?	
<i>Stage One:</i> At Risk	<p><b>Primary Service</b></p> <ul style="list-style-type: none"> <li>• Disease Disability Information</li> </ul> <p><b>Access Services</b></p> <ul style="list-style-type: none"> <li>• Medical Expense Assistance</li> <li>• Medical Transportation</li> </ul> <p><b>Supportive Services</b></p> <ul style="list-style-type: none"> <li>• Care/Case Management</li> <li>• Early Intervention for Children with Disabilities/Delays</li> </ul>
<i>Stage Two:</i> In Crisis	<p><b>Primary Service</b></p> <ul style="list-style-type: none"> <li>• Disease Disability Information</li> </ul> <p><b>Access Services</b></p> <ul style="list-style-type: none"> <li>• Medical Expense Assistance</li> <li>• Medical Transportation</li> </ul>

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	<p><b>Supportive Services</b></p> <ul style="list-style-type: none"> <li>• Care/Case Management</li> <li>• Early Intervention for Children with Disabilities/Delays</li> </ul>
<p><i>Stage Three: Recently Stabilized</i></p>	<p><b>Primary Service</b></p> <ul style="list-style-type: none"> <li>• Disease Disability Information</li> </ul> <p><b>Access Services</b></p> <ul style="list-style-type: none"> <li>• Medical Expense Assistance</li> <li>• Medical Transportation</li> </ul> <p><b>Supportive Services</b></p> <ul style="list-style-type: none"> <li>• Care/Case Management</li> <li>• Early Intervention for Children with Disabilities/Delays</li> </ul>
<p>Intended or Unintended Philosophy Underlying Service Delivery (i.e., assumptions about what will work)</p>	<p><i>Old Paradigm:</i> U.S. health care system is designed mainly to treat illness and to engineer dramatic rescues from injury or illness – mostly with surgery and medication. This works well for younger, basically healthy people. However, the system has been slow to adapt to the new challenge of chronic illness in old age.</p> <p><i>New Paradigm:</i> Self-management model of health care for chronic conditions; prevention; promotion of healthy life style; education about behaviors that are high risk factors</p>
<p>What Works?</p>	<p>Per Guides to Community Preventive Services (Tobacco Use Prevention and Control; and Promoting Physical Activity):</p> <ul style="list-style-type: none"> <li>• Methods for tobacco use prevention and control for which there is strong or sufficient evidence:<sup>14</sup> <ul style="list-style-type: none"> <li>○ Strategies to reduce exposure to environmental tobacco smoke (smoking bans and restrictions);</li> <li>○ Strategies to reduce tobacco use initiation by children, adolescents, and young adults (increasing the unit price for tobacco products; mass media education (campaigns) when combined with other interventions);</li> <li>○ Strategies to increase tobacco cessation (increasing the unit price for tobacco products; mass media education campaigns when combined with other interventions); and</li> <li>○ Strategies to increase tobacco cessation appropriate for health care systems (provider reminder systems to individuals; those plus provider education, reducing patient out-of-pocket costs for effective treatments for tobacco use and dependence, patient telephone support quit lines when combined with other interventions.</li> </ul> </li> <li>• Methods for promoting physical activity for which there is strong or sufficient evidence<sup>15</sup>: <ul style="list-style-type: none"> <li>○ Informational approaches (community-wide campaigns; “point-of-decision” prompts);</li> <li>○ Behavioral and social approaches (individually-adapted behavior change, school-based physical education, non-</li> </ul> </li> </ul>

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	<ul style="list-style-type: none"> <li>family social support); and             <ul style="list-style-type: none"> <li>o Environmental and policy approaches (creation and/or enhanced access to places for physical activity.)</li> </ul> </li> <li>• Diabetics who tightly control their blood sugar levels can cut their risk of heart attacks and strokes in half.<sup>16</sup></li> <li>• Health promotion is another critical factor in optimizing outcomes for older adults, by delaying the onset of diseases, managing chronic illnesses, maximizing function, and alleviating symptoms. Even in late life, health promotion matters.<sup>17</sup></li> <li>• Efforts to integrate and standardize information systems across settings and providers will improve access to timely and relevant information, promoting optimal care.<sup>18</sup></li> </ul>
<p>What Doesn't Work</p>	<p>Per Rand Health White Paper (2003):<sup>19</sup></p> <p><i>Need for coordination across specialties:</i></p> <ul style="list-style-type: none"> <li>• Commonplace experience, buttressed by studies of current care arrangements for the chronically ill elderly, suggests that these patients must navigate a fragmented care system, offering them a patchwork of uncoordinated services that do not meet their needs. The experience of an increasing number of families confirms the point that health care arrangements for persons with chronic illness often do not work smoothly, reliably, or well.</li> <li>• Our current health care delivery system is organized by setting: nursing home, hospital, home, and doctor's office. This determines how insurance pays bills, providers meet patients, and regulations are applied. Each care provider generally works in only one setting. Patients needing chronic care change settings often and may do so for several years; however, they have an overriding need for continuity of care, both across settings and across the changing challenges of worsening illness.</li> </ul> <p><i>Gaps in treatment to certain demographics: Asian, Hispanic, African American<sup>20</sup></i></p>
<p>Community-wide Strategies to Impact Life Trajectories</p>	<p>Healthy People 2010 &amp; Steps to a Healthier U.S.: Leading Prevention:<sup>21</sup></p> <ul style="list-style-type: none"> <li>• Reducing the burden of disease:             <ul style="list-style-type: none"> <li>o Obesity;</li> <li>o Diabetes;</li> <li>o Asthma;</li> <li>o Cancer; and</li> <li>o Heart Disease &amp; Stroke.</li> </ul> </li> <li>• Addressing risk factors:             <ul style="list-style-type: none"> <li>o Physical inactivity;</li> </ul> </li> </ul>

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- Poor nutrition;
- Tobacco use; and
- Youth risk taking.

REACH is a federal initiative that includes a goal of eliminating racial and ethnic disparities in health by the year 2010. This goal is one of two that parallel the focus of Healthy People 2010, which describes the nation's health objectives for the decade.<sup>22</sup> The racial and ethnic minority populations in the United States experiencing these disparities include the following:

- African Americans;
- Alaska Natives;
- American Indians;
- Asian Americans;
- Hispanic Americans; and
- Pacific Islanders.

REACH is part of the national initiative to eliminate disparities in health status experienced by racial and ethnic minority populations in the following six priority areas:

- Infant Mortality;
- Breast and Cervical Cancer;
- Cardiovascular Diseases;
- Diabetes;
- HIV Infections/AIDS; and
- Child and Adult Immunizations.

First Call for Help

Between 2000 and 2004, there were 813 requests for disease/disability information services. Of these, 9 (1 percent) were unmet, meaning that there was no agency to which to refer callers. See Attachment 3: First Call for Help for more detail.

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**RESOURCES**

Identified Resources  
(2003-04)

Identified Chronically Ill Revenues		
As of 5/11/06		
	Community	UW*
Disease Disability Information	4,409,395	2,311,497
<b>Total</b>	<b>\$4,409,395</b>	<b>\$2,311,497</b>

\* UW revenues are included in community totals.

NOTE: This does not include all monies for this consumer group. See Attachment 4 for details and Attachment 5 for Revenue Checklist.

Government Resource  
Trend Line

Mixed

Future Direction of  
Government Funding

Unknown

Return on Investment

Per the World Health Organization report: *World Health Statistics 2006*.<sup>23</sup>

The world will experience a dramatic shift in the distribution of deaths from younger to older ages and from communicable diseases to non-communicable diseases during the next 25 years. In 2005, 19 percent of all deaths were among children, 29 percent were among adults aged 15–59 years and 53 percent were among people aged 60 years and older. By 2030, the respective proportions will have changed to 9 percent, 29 percent and 62 percent.

The proportion of all deaths due to communicable, maternal, perinatal and nutritional causes is expected to decrease from 30 percent in 2005 to 22 percent in 2030, while the share of non-communicable disease is likely to increase from 61 percent to 68 percent. Injuries are estimated to account for 9 percent in 2005 and in 2030. These are the results of WHO's updated mortality projections, based on projections of economic and social development, and using the historically-observed relationships of these with cause-specific mortality rates, including separate projections for HIV/AIDS, tuberculosis, lung cancer and diabetes.

Years of life lost (YLL) take into account the age at which deaths occur by giving greater weight to deaths at younger age and lower weight to deaths at older ages. Results for broad cause projections are shown as cause-specific YLL rate for 2005, 2015 and 2030 in the world. While the total deaths and crude death rates for cancers and cardiovascular diseases

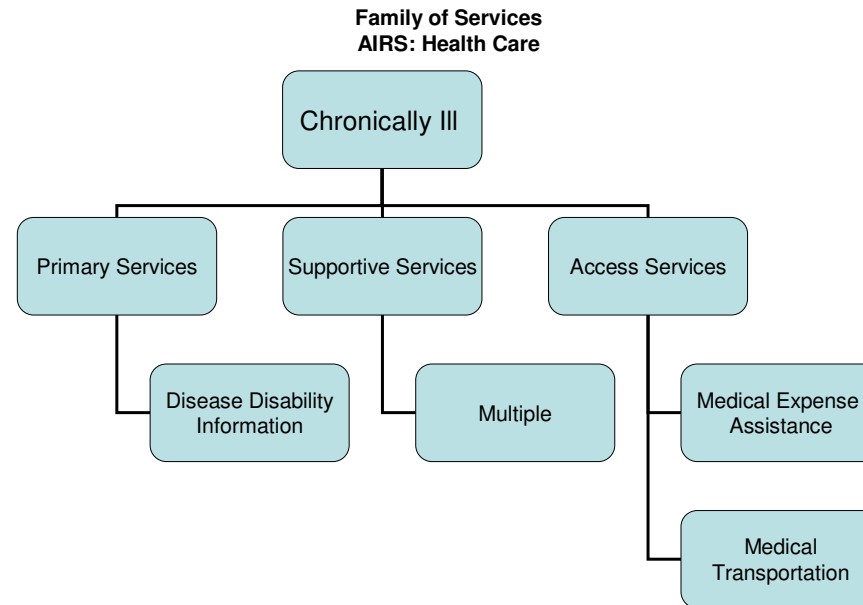
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are projected to increase, YLL rates are projected to increase only slightly for cancers, and to decline for cardiovascular diseases. This is because more deaths occur at older ages, leading to fewer lost years of life.

# ATTACHMENTS

## Attachment 1: Family of Services



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Attachment 2: Consumer Matrix

CORE SERVICES	SUB-CONSUMER GROUPS	ESTIMATED PERSONS IN NEED			ESTIMATED UNIVERSE OF POSSIBLE CONSUMERS		
		Description	Number	% of Total Population Families Households	Description	Number	% of Total Population Families Households
Disease/Disability Information	Consumers of health information.	Estimated population 18+ who are consumers of health information, 38 percent. (Source: Issue Brief, Center for Studying Health System Change, March 2003: Details a 2001 survey of US households that found only 38 percent of adults sought health information from a source other than their doctor.); Assume 100 percent children/youth 5-17.	654,175	46.9% Population	This includes 100 percent of children and youth five through 17 years and 38 percent of adults 18 years and older, the percentage of adults who sought health information from a source other than their doctor, according to a 2001 survey of U.S. households.	654,175	46.9% Population

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Attachment 3: First Call for Help

Persons who are chronically ill											
CORE SERVICES	TOTAL REQUESTS					%Change*	MET				
	2000	2001	2002	2003	2004		2000	2001	2002	2003	2004
Disease/Disability Information	114	165	172	175	187	64%	113	163	168	174	186
<b>Total</b>	<b>114</b>	<b>165</b>	<b>172</b>	<b>175</b>	<b>187</b>	<b>64%</b>	<b>113</b>	<b>163</b>	<b>168</b>	<b>174</b>	<b>186</b>

Persons who are chronically ill									
CORE SERVICES	UNMET					TOTALS 00-04			%
	2000	2001	2002	2003	2004	Req.	Met	Unm.	
Disease/Disability Information	1	2	4	1	1	813	804	9	1%
<b>Total</b>	<b>1</b>	<b>2</b>	<b>4</b>	<b>1</b>	<b>1</b>	<b>813</b>	<b>804</b>	<b>9</b>	<b>1%</b>

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Attachment 4: Revenue Tables

Disease/Disability Information					
Revenues as of May 11, 2006					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
<b>Total - Contributions and dues (less UW designations)</b>			<b>0.00%</b>	<b>726,213</b>	<b>10.52%</b>
Britton Fund	2004	10,000			
Bruening Foundation, Eva L. and Joseph M.	2003	25,000			
Cleveland Foundation, The	2004	281,391		66,625	
Mandel Foundation	2003	1,000			
McGregor Foundation, The	2004	57,923			
Mt. Sinai Health Care Foundation, The	2003	285,000			
Murphy Foundation, The John P	2004	1,000			
Nord Family Foundation, The	2003	17,500			
Reuter Foundation, The	2004	20,000			
Saint Luke's Foundation	2004	30,265			
Sisters of Charity Foundation of Cleveland	2004	40,000			
Other Private Foundations - Not Elsewhere Classified				724,746	
The Sherwick Fund (of The Cleveland Foundation)	2004	38,000			
Cleveland Electric Illuminating Co. Foundation	2004	22,150			
Eaton Charitable Fund	2003	18,500			
Key Foundation	2003	48,305		6,000	
Sherwin-Williams Foundation, The	2004	3,500			
Other Corporate Foundations - Not Elsewhere Classified				20,000	
Forest City Enterprises	2003	72,333			
<b>Total - Foundations &amp; Trusts</b>		<b>971,867</b>	<b>22.04%</b>	<b>817,371</b>	<b>11.84%</b>
<b>Total - Special Events - Growth</b>			<b>0.00%</b>	<b>1,717,422</b>	<b>24.89%</b>
Combined Federal Campaign				10,887	
Jewish Community Federation				20,500	
<b>Total - Federated Fundraising Organizations</b>		<b>0</b>	<b>0.00%</b>	<b>31,387</b>	<b>0.45%</b>

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Attachment 4: Revenue Tables (continued)

<b>Disease/Disability Information</b>					
<b>Revenues as of May 11, 2006</b>					
Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
United Way of Summit County				24,749	
Other United Ways - Not Elsewhere Classified				12,000	
<b>Total - Other United Ways</b>		<b>0</b>	<b>0.00%</b>	<b>36,749</b>	<b>0.53%</b>
Department of Job and Family Services				194,697	
<b>Subtotal State of Ohio</b>		<b>0</b>	<b>0.00%</b>	<b>194,697</b>	<b>2.82%</b>
WRAAA - OAA - III-D	CY2004	2,039			
<b>Subtotal Regional Funding Sources</b>		<b>2,039</b>	<b>0.05%</b>	<b>0</b>	<b>0.00%</b>
Cuyahoga County Board of Health	2004	1,123,992			
<b>Subtotal Cuyahoga County Funding Sources</b>		<b>1,123,992</b>	<b>25.49%</b>	<b>0</b>	<b>0.00%</b>
Community Development Block Grant				23,605	
<b>Subtotal City of Cleveland Funding Sources</b>		<b>0</b>	<b>0.00%</b>	<b>23,605</b>	<b>0.34%</b>
All Other Funding - Not Elsewhere Classified				75,436	
<b>Subtotal Other Govt Funding Sources</b>		<b>0</b>	<b>0.00%</b>	<b>75,436</b>	<b>1.09%</b>
<b>Total - Contracts/grants from government organizations</b>		<b>1,126,031</b>	<b>25.54%</b>	<b>293,738</b>	<b>4.26%</b>
<b>Total - Membership dues under \$150</b>			<b>0.00%</b>	<b>99,695</b>	<b>1.44%</b>
<b>Total - Investment Income</b>			<b>0.00%</b>	<b>432,549</b>	<b>6.27%</b>
<b>Total - All Other Revenue</b>			<b>0.00%</b>	<b>434,550</b>	<b>6.30%</b>
<b>Subtotal Non - UWGrCle Support</b>		<b>2,097,898</b>	<b>47.58%</b>	<b>4,589,674</b>	<b>66.51%</b>
<b>Total - UWGrCle designations applied to program</b>		<b>276,308</b>	<b>6.27%</b>	<b>276,308</b>	<b>4.00%</b>
<b>Total - UWGrCle investment committee allocation</b>		<b>2,033,689</b>	<b>46.12%</b>	<b>2,033,689</b>	<b>29.47%</b>
John K. Mott Youth Fund Distribution Grant		1,500		1,500	
<b>Total - Special UWGrCle grants applied to programs</b>		<b>1,500</b>	<b>0.03%</b>	<b>1,500</b>	<b>0.02%</b>
<b>Subtotal UWGrCle Support - 4001, 4701 &amp; 4703</b>		<b>2,311,497</b>	<b>52.42%</b>	<b>2,311,497</b>	<b>33.49%</b>
<b>Total Support/Revenue</b>		<b>4,409,395</b>	<b>100%</b>	<b>6,901,171</b>	<b>100%</b>

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Attachment 5: Revenue Checklist

Persons who are chronically ill					
Category	Administrator of Funding	✓	x		
Private Foundation	Britton Fund	✓			
Private Foundation	Bruening Foundation, Eva L. and Joseph M.	✓			
Private Foundation	Cleveland Foundation, The	✓			
Private Foundation	Mandel Foundation	✓			
Private Foundation	McGregor Foundation, The	✓			
Private Foundation	Mt. Sinai Health Care Foundation, The	✓			
Private Foundation	Murphy Foundation, The John P	✓			
Private Foundation	Nord Family Foundation, The	✓			
Private Foundation	Reuter Foundation, The	✓			
Private Foundation	Saint Luke's Foundation	✓			
Private Foundation	Sherwick Fund, The (of The Cleveland Foundation)	✓			
Private Foundation	Sisters of Charity Foundation of Cleveland	✓			
Corporate Foundation	Cleveland Electric Illuminating Co. Foundation	✓			
Corporate Foundation	Eaton Charitable Fund	✓			
Corporate Foundation	Forest City Enterprises	✓			
Corporate Foundation	Key Foundation	✓			
Corporate Foundation	Sherwin-Williams Foundation, The	✓			
Regional	Western Reserve Area Agency on Aging (WRAAA)	✓			
Cuyahoga County	Board of Health	✓			
United Way Greater Cleve	John K. Mott Youth Fund Distribution Grant	✓			
United Way Greater Cleve	United Way of Greater Cleveland designations applied to program	✓			
United Way Greater Cleve	United Way of Greater Cleveland investment committee allocation	✓			
✓ = Revenue was identified specifically for this core service and the amount allocated in Cuyahoga County appears in the revenue table of the core service report.					
x = Revenue was identified from these sources, but no dollar amount is available because either it was not possible to obtain data for Cuyahoga County alone, or it was not possible to obtain data specifically for this core service because funding covers multiple core services.					

**NOTES**

- 1 Harris Interactive; GlaxoSmithKline. (2003, June). Chronic care in America: Improving the patient-physician interaction – findings from a comprehensive survey in the U.S.
- 2 Retrieved on May 7, 2006 from <http://www.medterms.com/script/main/art.asp?articlekey=2728>
- 3 Guide to Community Preventive Services: Systematic Reviews and Evidence Based Recommendations. (2004). Tobacco use prevention and control. Retrieved on April 17, 2006 from <http://www.thecommunityguide.org/tobacco/>
- 4 Guide to Community Preventive Services: Systematic Reviews and Evidence Based Recommendations. (2004). Promoting physical activity. Retrieved on April 17, 2006 from <http://www.thecommunityguide.org/pa/>
- 5 American Association for Health Education. Fact sheet: Eliminating racial and ethnic health disparities
- 6 Harris Interactive; GlaxoSmithKline. June 2003.
- 7 Lynn, Joanne, David M. Adamson. (2003). Living well at the end of life: Adapting health care to serious chronic illness in old age.
- 8 The Robert Wood Johnson Foundation. (2001). A portrait of the chronically ill in America. Retrieved on April 18, 2006 from <http://www.rwjf.org/files/publications/other/ChronicIllnessChartbook2001.pdf#search='portrait%20of%20the%20chronically%20ill%20in%20america'>
- 9 Ibid.
- 10 Source: Ohio Department of Health. (2007). Deaths: Leading causes, Cuyahoga County, 2002-2004. Health Information Warehouse. Retrieved March 7, 2008, 2007 from <http://dwarehouse.odh.ohio.gov/datawarehousev2.htm>
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