

Core Service Report

Daily Living Aids

Consumer Category:
With / At Risk of Health Conditions

Primary Consumer Group:
**Persons with Physically
Disabling Conditions**



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>.

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This report was written by a team under contract with MCS Consulting Service, LLC including the following in alphabetical order:

- Renee Aten, Aten Enterprises
- Edwin A. Balcerzak, Strategic Consultants
- Carey Wiant Nyberg
- Marlene C. Stoiber, MCS Consulting Service, LLC.

This report reflects the comments from reviewers and United Way Community Investment Committee cluster volunteers.

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SNAPSHOT

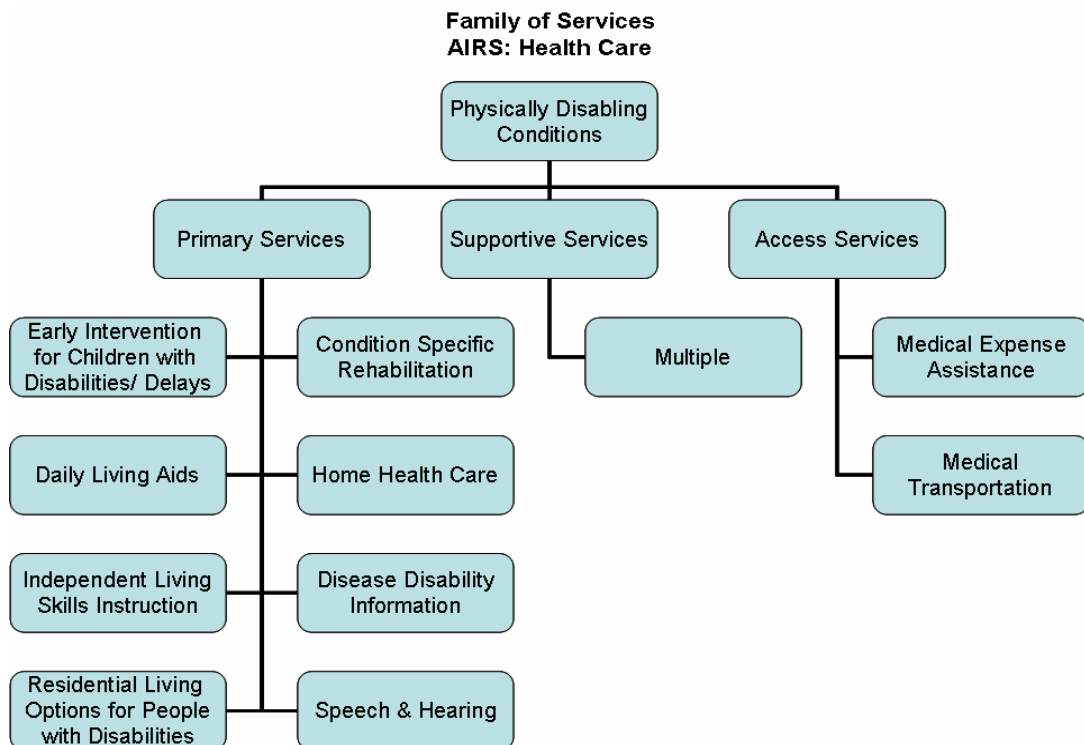
AIRS Code Level I: Health Care (L)
AIRS Code Level II: Health Support Services (LH)
Core Service: Daily Living Aids (LH-060.170)

Investment Committee: Health & Caring for All
Cluster: Health and Medical Supportive Services

AIRS Definition: Programs that provide equipment that has been especially designed or adapted to assist physically disabled people to bathe, shave, dress, brush their teeth, comb their hair, prepare their meals, eat, drink, clean their homes, and perform other daily tasks.

Special Note: There are eight core services related to persons with physical disability conditions. The core services are organized as a continuum across the services along two dimensions: rehabilitation services (early intervention for children with disabilities/delays, condition-specific rehabilitation, daily living aids, independent living skills instruction, and speech and hearing) and long term care services (home health care and residential living options for people with disabilities). Disease/disability information is primarily related to rehabilitation services, but crossed into other physical disease categories that are not considered disabilities. To avoid duplication, early Intervention for children with disabilities/delays addresses the needs of children birth to three years and condition-specific rehabilitation goes from ages 4 to 20 years.

Daily Living Aids is one of eight core services in a family of services for persons with physically disabling conditions. In addition, medical expense assistance and medical transportation help consumers access those services. (See figure below.)





Core Service Environment

Designing appropriate, cost-effective community-based care for disabled adults is a priority in society. Daily living aids often remove at least some of the burden from personal care that must be given formally or informally. They empower individuals to maximize independence and reduce unmet need through the performance of self-care. Most disabled adults use some kind of assistive device (most often to aid mobility) and the number has been growing over time, especially among the elderly. Multiple studies have found that the use of assistive technology (which includes daily living aids) is associated with greater reduction of difficulty in either ADLs (activities of daily living) or mobility impairments. Additionally, studies suggest that increased use of technology may slow functional declines, lower health care costs, and increase efficacy among some caregivers (Agree & Freedman, n.d.).

Home- and community-based services are essential to allowing individuals with disabilities and older adults live in settings they prefer. Though many scholars note that the federal Medicaid program has a long-established institutional bias (Johnson et al., 2001), nationally, and in the State of Ohio, consumer choice and home- and community-based services are expanding. PASSPORT, the state's commitment to home-based care and Ohio's Medicaid waiver for home-based care for older adults, has been expanded recently to allow for more clients (although there is still a waiting list). There are also several waiver programs in Ohio for persons with disabilities. Increasing reliance on—and clear consumer preference for—community-based services will increase the demand for daily living aids.

Participants in United Way of Greater Cleveland's core service focus group discussions (Spring 2005) identified livable wages for qualified staff and the lack of long-term workers as other public policy issues affecting long-term care and daily living aids programs. Reimbursement from Medicare and Medicaid for daily living aids is also of great concern.

Core Service Consumers

The target population addressed in this core service report is physically disabled people five years and older who need equipment especially designed or adapted to assist them to bathe, shave, dress, brush their teeth, comb their hair, prepare their meals, eat, drink, clean their homes, and perform other daily tasks.

Nationally and locally, the impact of the aging of the largest cohort of the population—the baby boomer generation (individuals born between 1946 and 1964 who began turning 60 in 2006)—is expected to be enormous.

Several variables are related to the prevalence of disability as people age, therefore influencing the need for daily living aids. These variables include higher poverty, racial and ethnic background (African-Americans are more often institutionalized), marital status (single individuals are more often institutionalized), living alone, and lower educational attainment (Mehdzadeh, Roman, Wellen, Ritchey & Kunkel, 2001).

In the U.S. in 2004, 51.2 million people (18 percent) had disabilities (American Network of Community Options and Resources, 2006).

People have a physically severe functional limitation if they are unable to perform a physical function or if they need the help of another person to perform the function. An estimated 7.8 percent of those age 15 and older (15.2 million people) are severely limited in the functions of seeing, hearing,



having speech understood, lifting or carrying, walking, or using stairs.
(Chartbook on Disability in the U.S., 1996)

Per the U.S. Census in 2000, 36,785 individuals 5 and older had a physical disability in Cuyahoga County. By 2015 this number is expected to decrease to 34,776 as the result of population shifts.

Core Service Delivery

The definition of daily living aids for this report is as follows: programs that provide equipment especially designed or adapted to assist physically disabled people to bathe, shave, dress, brush their teeth, comb their hair, prepare their meals, eat, drink, clean their homes, and perform other daily tasks.

Daily living aids are identified by a variety of terms: *assistive technology*, *durable medical equipment*, *environmental assistive devices*, *self-help products*, and others. They include such products as single-handed button fasteners, walkers and canes, hands-free faucets, reachers, and toilet safety bars. Basically, daily living aids are any type of tool that promotes a convenient, comfortable, and safe home environment for a person with a disability.

Assistive technology is often confused with durable medical equipment. *Durable medical equipment* includes such items as prosthetics, orthotics, wheelchairs, communication devices, and other devices deemed medically necessary. *Assistive technology* includes durable medical equipment, but it covers a far broader array of devices and equipment. The distinction between durable medical equipment and assistive technology devices is important because insurance carriers, including Medicare and Medicaid, typically cover only medically necessary services. The majority of assistive technology solutions individuals need to achieve their greatest level of independence at home, school, work, and play are not considered medically necessary. This means that alternative funding strategies often come into play (Willkomm, n.d.).

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 5 daily living aids providers, all of which are nonprofit. United Way of Greater Cleveland did not fund this core service from 2000-2004 and currently does not fund the core service. FCFH data shows a general decrease in the number of total requests for daily living aids in the county: from 49 in 2000 to 43 in 2004 (12 percent). Over the same five-year period FCFH had 211 requests for information for daily living aids. Of these requests, they were able to make referrals to 99 percent of callers.

Daily living aids are primarily paid for by public and private insurances. Medicaid and Medicare are the major funders among the public funders. Medicaid funding for home care, which includes daily living aids and home health care, increased from \$11.3 million in CY 2002 to \$17.8 million in CY 2004.

Funding information specifically for daily living aids was found only for PASSPORT, an Ohio Medicaid waiver for home- and community-based care. PASSPORT funding for daily living aids dropped by more than half from 2002 to 2003 and, though increasing above 2003 levels, was at only 67 percent of 2002 levels.

As of May 11, 2006, \$951,958 in revenues for daily living aids programs has been identified countywide. This includes information from foundations, federated fundraising organizations, and government. Ninety percent of the identified revenues come from contracts or grants from government organizations. Nine percent of identifiable revenue came from foundations, and about 1.5 percent was provided by federated fundraising organizations.



There are tens of thousands of daily living aids products available for people with disabilities. Costs vary greatly among products. While some daily living aids programs provide devices at no or reduced cost to consumers, many other programs lend necessary aids and consumers return them when they are no longer needed.

Medicare (and most private insurance companies in general) does not cover most personal care products such as bathroom safety, kitchen aids, recreation aids, and reading or writing aids. However, with proper documentation, Medicare does cover selected mobility aids (walkers, canes), hospital beds and accessories, and toilet aids (bedside commodes, raised toilet seats) (DS Medical, n.d.). In Ohio, all Medicaid waivers cover environmental accessibility and adaptations; and PASSPORT, Transitions, Ohio Home Care Waiver, and Individuals Options waivers cover adaptive and assistive devices (Ohio Legal Rights Service, n.d.).

What Works; What Doesn't

Daily living aids enable individuals to avoid premature institutionalization and remain living independently in the community. They also can save individuals and their caregivers money by removing or reducing the need for personal care. Additionally, daily living aids help relieve some of the responsibilities placed on caregivers, who can continue to provide help and support without “burn out.”

Providing daily living aids without appropriate training commonly results in individuals not taking full advantage of devices or not using them at all (often referred to as “abandonment” in the assistive technology field).

The Rehabilitation Engineering & Assistive Technology Society of North America (RESNA), an interdisciplinary association for the advancement of rehabilitation and assistive technology, has a credentialing program for providers in the field of assistive technology. In addition, RESNA has a list of 21 standards of practice for assistive technology practitioners and suppliers that focus on professionalism, non-discrimination, and competency in field (RESNA, n.d.b).

Gap Analysis

The estimated universe of possible consumers is 31,267, including both realized access (7,144) and unrealized access (24,123).

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

Historically, the philosophy for assisting disabled individuals was to segregate them into specialized institutions (commonly referred to as “institutionalization”). Disabilities were “medicalized,” with a focus on treatment and cure (as opposed to rehabilitation or education to accommodate disability). Disability was framed as a series of physiological, psychological, and functional pathologies originating within the bodies of individuals (Baynton, 2004). Within the past several decades, “disability” has begun to be defined more in social terms and understood as a socially constructed concept that varies from time to time and culture to culture, and less as fixed and rooted in biology (Baynton, 2004). The Disability Rights and Independent Living Movement of the 1960s and 1970s created a major change in the way disabled individuals were viewed and treated as a group. Five key social movements in the 1960s and 1970s contributed to the evolving movement for independent living for people with disabilities: civil rights movement, consumerism, self-help, de-medicalization, and de-institutionalization (Shreve, n.d.). Daily living aids play an essential role under this revised philosophy of disability that focuses on self determination and supporting highest level of independent function.

Ohio has traditionally relied heavily on institutional long-term care. For example, in 1992 Ohio had 628 nursing home beds per 1,000 persons 85 and above, compared to a national average of 527 beds per 1,000. During the 1980s institutional care grew rapidly, with the number of nursing home days of care increasing by 47 percent. Only 10 other states had higher growth during this time period (Mehdizadeh et al., 2000). Following the national trend of consumer choice and supporting individuals with disabilities to live in the least restrictive environment (most often at home), Ohio is beginning to shift previous utilization patterns regarding institutionalization. Home care is increasingly being used as an alternative to institutional care for some individuals. Again, daily living aids are an important component of providing successful home care.

The aging of the population will impact the demand for daily living aids as older adults choose to “age in place” in the community. According to “Older Americans 2004: Key Indicators of Well-Being,” nationally, the majority of older Americans live in traditional community-based settings (93 percent), while only 2.5 percent live in community housing with services and 4.4 percent live in long-term care facilities. According to a national public opinion survey conducted by the Association of Aging and Retired Persons (AARP, 2005), an overwhelming majority of older adults want to stay in their own homes as long as possible or want to continue living in the home of a family member.

The number of older individuals and their life expectancy is growing substantially. With increasing age comes increasing risk of physical disability. In the future, a greater proportion of the older population will reach the advanced ages at which the need for long-term care is greatest. In 1999, about 12 percent of the 65 and over population were 85 years or older. By 2050, this segment of the older population will grow to 34 percent of the total older population (Mehdizadeh & Murdoch, 2003).

The number of disabled adults is large and continues to grow despite reductions in disability rates among older adults in the last two decades. Currently about 15 percent of the adult U.S. population (18 percent total), or 40 million people, are limited in activities due to a chronic health condition (Agree & Freedman, n.d.).



Family, friends, and neighbors remain the backbone of the long-term care system; they provide essential support to younger and older disabled adults to enable them to remain in the community. Estimates consistently report that the informal system, particularly adult children and spouses, provides more than 80 percent of all long-term care delivered in the home. However, because of demographic changes (an increase in the oldest-old and a decrease in the birth rate), pressure on future caregivers will continue to grow (Mehdizadeh & Murdoch, 2003).

Designing appropriate, cost-effective community-based care for disabled adults is a priority in society. Daily living aids often remove at least some of the burden from personal care that must be given formally or informally. Daily living aids empower individuals to maximize independence and reduce unmet need through the performance of self-care. Most disabled adults use some kind of assistive device (most often to aid mobility) and the number has been growing over time, especially among the elderly. Multiple studies have found that the use of assistive technology (which includes daily living aids) is associated with greater reduction of difficulty in either ADLs (activities of daily living) or mobility impairments. Additionally, studies suggest that increased use of technology may slow functional declines, lower health care costs, and increase efficacy among some caregivers (Agree & Freedman, n.d.).

PUBLIC POLICY ISSUES

NATIONAL

Livable Wages for Long-Term Care Workers

Participants in United Way of Greater Cleveland's core service focus group discussions (Spring 2005) identified livable wages for qualified staff and the lack of long-term workers as other public policy issues affecting long-term care and daily living aids programs. Because the level of disability will increase among both home-care clients and nursing home residents, and because the absolute numbers of persons needing some sort of assistance with activities of daily living will increase, the number of staff needed to care for them is expected to increase. In Ohio, an estimated 24,000 additional full-time equivalent (FTE) direct-care staff will be needed in long-term care between 2000 and 2010. However, due to fewer people ages 25 to 34, the growth of the labor force is projected to slow down until about 2040. The American Medical Association predicts that, by 2020, there will be 20 percent fewer registered nurses than will be needed. The Bureau of Labor Statistics predicts that personal and home care assistance will be the fourth fastest-growing occupation by 2006 (Mehdizadeh & Applebaum, 2003). Daily living aids are often viewed as an alternative (or supplement) to formal or informal personal care, perhaps reducing demand for long-term care workers.

Reimbursement from Medicare and Medicaid

Reimbursement from Medicare and Medicaid for daily living aids is also of great concern. This issue is further addressed in Section IV: Core Service Delivery - Reimbursement/Cost.

STATE

Ohio ACCESS

Ohio has modified policies to accommodate consumer choice and home- and community-based care. "Ohio Access for People with Disabilities," a plan prepared by seven state departments and presented to Governor Robert Taft in 2001, suggests a policy shift in addressing the long-term care

needs of Ohio's frail elderly and disabled. As states, along with the federal government, are key funders of public health plans, this state-level support is essential. Expected outcomes of this new vision include enhanced consumer 1) independence, 2) personal dignity and responsibility, 3) access to community services and decreased reliance on institutional care settings, 4) quality of life, 5) health and safety, as well as 6) the most efficient use of limited funds. The plan emphasizes the role of informal networks of care including family, friends, and neighbors who are noted to provide 80 percent of all long term care. The plan supports an approach that will drive the development of home- and community-based care where such options should be the norm rather than the exception in support of health, wellness, and prevention of unnecessary, premature institutionalization. Additionally, the following goals have been established:

- Elders and persons with disabilities live with dignity in settings they prefer.
- Elders and persons with disabilities receive safe, high-quality long-term care, services, and supports wherever they live.
- Relatives, neighbors, and friends who care for and support elders and persons with disabilities receive the information and services they need to plan for their future and support their caregiver role (Ohio Office of Budget and Management, 2001).

Home- and community-based services are essential to allowing individuals with disabilities and older adults live in settings they prefer. Though many scholars note that the federal Medicaid program has a long-established institutional bias (Johnson et al., 2001), nationally and in the state of Ohio consumer choice and home- and community-based services are expanding. PASSPORT, the state's commitment to home-based care is exemplified by Ohio's Medicaid waiver for home-based care for older adults, which has been expanded recently to allow for more clients (although there is still a waiting list). There are also several waiver programs in Ohio for persons with disabilities. Increasing reliance on—and clear consumer preference for—community-based services will increase the demand for daily living aids.



III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The definition of the target population for this core service report builds on the AIRS definition: physically disabled people five years and older who need equipment especially designed or adapted to assist them to bathe, shave, dress, brush their teeth, comb their hair, prepare their meals, eat, drink, clean their homes, and perform other daily tasks.

DEMOGRAPHIC CHARACTERISTICS

In the U.S. in 2004, 51.2 million people (18 percent) had disabilities (American Network of Community Options and Resources, 2006).

People have a physically severe functional limitation if they are unable to perform a physical function or if they need the help of another person to perform the function. An estimated 7.8 percent of those age 15 and older (15.2 million people) are severely limited in the functions of seeing, hearing, having speech understood, lifting or carrying, walking, or using stairs. (Chartbook on Disability in the U.S., 1996)

In Cuyahoga County in 2000, 254,830 persons 5+ years had one or more disabilities, 19.8 percent of the 5+ population. Of the 135,658 persons with one disability, employment-related disabilities were most prevalent, followed by physical disabilities. Among those 119,172 with two or more disabilities, 81,708 did not include self-care issues. (See Table 1.)

Table 1: Persons 5+ with Disabilities, by Disability Type, Non-Institutionalized, Cuyahoga County, 2000

	Total Population	With Disability	Specific Disability	Percent of Age Cohort
5 to 15 years:	219,309	14,245		6.5%
With one type of disability:		11,336		5.2%
Sensory disability			1,111	
Physical disability			949	
Mental disability			8,884	
Self-care disability			392	
With two or more types of disability:		2,909		1.3%
Includes self-care disability			1,749	
Does not include self-care disability			1,160	
16 to 20 years:	84,679	11,289		13.3%
With one type of disability:		7,546		8.9%
Sensory disability			401	
Physical disability			301	
Mental disability			2,048	
Self-care disability			26	
Go-outside-home disability			1,627	
Employment disability			3,143	
With two or more types of disability:		3,743		4.4%
Includes self-care disability			555	
Does not include self-care disability:			3,188	
Go-outside home and employment only			1,571	
Other combination			1,617	
21 to 64 years:	775,695	143,094		18.4%
With one type of disability:		75,046		9.7%
Sensory disability			7,675	
Physical disability			16,274	
Mental disability			6,614	
Self-care disability			360	
Go-outside-home disability			6,886	
Employment disability			37,237	
With two or more types of disability:		68,048		8.8%
Includes self-care disability			15,021	
Does not include self-care disability:			53,027	
Go-outside home and employment only			20,442	
Other combination			32,585	
65 years and over:	205,938	86,202		41.9%
With one type of disability:		41,730		20.3%
Sensory disability			6,937	
Physical disability			19,261	
Mental disability			2,002	
Self-care disability			310	
Go-outside-home disability			13,220	
With two or more types of disability:		44,472		21.6%
Includes self-care disability			20,139	
Does not include self-care disability:			24,333	
Total	1,285,621	254,830		19.8%
With one type of disability:		135,658		10.6%
Sensory disability			16,124	
Physical disability			36,785	
Mental disability			19,548	
Self-care disability			1,088	
Go-outside-home disability			21,733	
Employment disability			40,380	
With two or more types of disability:		119,172		9.3%
Includes self-care disability			37,464	
Does not include self-care disability:			81,708	
Go-outside home and employment only			22,013	
Other combination			34,202	

* "Disability" is defined by the US Census as a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business.

Source: U.S. Census 2000, SF3 (PCT26)

Nationally and locally, the impact of the aging of the largest cohort of the population—the baby boomer generation (individuals born between 1946 and 1964 who began turning 60 in 2006)—is expected to be enormous. In 2000, 35 million Americans were over age 65, and almost 4.5 million were over age 85. By 2030, the numbers of older Americans will more than double, and 9 million older adults will be over age 85.

In Ohio, there were approximately 1.4 million adults over 65 in 1990, or 13 percent of the total state population. In 2000, about 1.5 million older adults (or 13.3 percent) lived in the state. Between 1990 and 2000, the state’s 65+ population grew 7.2 percent while the general population grew 4.7 percent.

In Cuyahoga County, 15.6 percent of the population was over 65 in both 1990 (221,066) and 2000 (217,161). In that decade, both the county’s general population and its 65+ older adult population fell by approximately the same amount (minus 1-2 percent). The number of residents ages 75 and older, however, experienced net increases ranging from 11 percent (ages 75-79) to 33 percent (ages 85+) during the same period. Given that chronic disease and disability often increase with age, this suggests that, locally, there will be an increasing number of adults who will face challenges to remain living independently in the community and will be seeking daily living aids.

Several variables are related to the prevalence of disability as people age, therefore influencing the need for daily living aids. These variables include higher poverty, racial and ethnic background (African-Americans are more often institutionalized), marital status (single individuals are more often institutionalized), living alone, and lower educational attainment (Mehdizadeh et al., 2001).

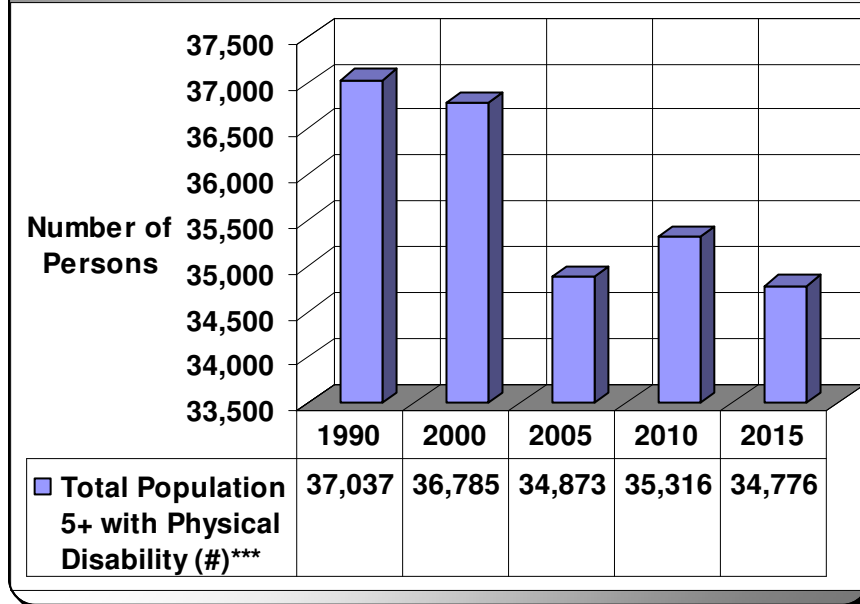
Facilitating disabled adults’ independence so they may live and work independently in the community is a central goal for rehabilitation scientists and public health practitioners. Assistive technology is one of the most important avenues for research in this regard. Equipment is the most common means of managing day-to-day tasks for adults. However, with fewer disabled persons likely to use devices alone, and the most disabled using a combination of assistive technology and personal care, the way assistive technology and personal care are combined is closely related to the amount of functional difficulty reported.

Estimated Persons in Need

Per the U.S. Census in 2000, 36,785 individuals 5 and older had a physical disability in Cuyahoga County. By 2015 this number is expected to decrease to 34,776 as the result of population shifts. (See Figure 1.)

Experts suggest, however, that in general the estimated number of older disabled adults within this population is expected to increase, mainly due to the aging of the baby boomer cohort (which is most prone to disabling injury and disease) and continued life-saving and life-prolonging medical advances for all ages. The number of individuals with disabilities will increase for older adults, but the prevalence rate of disabilities in the population is expected to remain constant (Mehdizadeh et al., 2001).

**Figure 1: Daily Living Aids
Estimated Persons in Need
Cuyahoga County, 1990-2015**



Sources:

* US Census: 1990, STF 1 (P11); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).

** U.S. Census: 2000, SF3 (PCT26); Other years prorated using 2000 proportion of "Population 5+ Reporting a Disability " to "Total Population 5+" (19.56%)

*** U.S. Census SF3 (PCT26); Other years prorated using 2000 proportion of "Population 5+ with Physical Disability" to "Population 5+ Reporting a Disability " (14.4%).

We recognize that this is a conservative estimate of persons in need of daily living aids; however, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

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 government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

United Way did not fund this program in FY 2004. The number of actual annual consumers of daily living aids programs through PASSPORT is 7,144 individuals. (See Attachment 3.)

In Cuyahoga County in 2000, 45 percent of individuals 5 and older with a disability (gender of individuals with a physical disability is not available) were male and 55 percent female. Daily living aids consumers funded by PASSPORT were 16 percent male and 84 percent female.

Racially, 67 percent of physically disabled individuals 5 and older were Caucasian, 31 percent were African-American, and 0.7 percent Asians. Daily living aids consumers funded by PASSPORT were 42 percent Caucasian and 55 percent African-American.

Ethnically, 2 percent of physically disabled individuals 5 and older were Hispanic. Daily living aids consumers under PASSPORT were also 2 percent Hispanic.

Income information was not available for daily living aids consumers under PASSPORT but, since this is a Medicaid program, all consumers would be low income.

Geographically, 36 percent of physically disabled persons 5 and older resided in Cleveland and the remaining 64 percent in the suburbs. Geographical information available for PASSPORT consumers shows that 46 percent were known to be from Cleveland, 54 percent were known to be from the suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

Building on the AIRS definition, daily living aids programs provide equipment especially designed or adapted to assist physically disabled people to bathe, shave, dress, brush their teeth, comb their hair, prepare their meals, eat, drink, clean their homes, and perform other daily tasks.

BACKGROUND ON CORE SERVICE

Early on, advocates of barrier-free design and architectural accessibility recognized the legal, economic, and social power of a concept that addressed the common needs of people with and without disabilities. As architects began to wrestle with the implementation of standards, it became apparent that segregated accessible features were “special,” more expensive, and usually ugly. It also became apparent that many of the environmental changes needed to accommodate people with disabilities actually benefited everyone. Recognition that many such features could be commonly provided and thus less expensive, unlabeled, attractive, and even marketable, laid the foundation for the universal design movement. (The Center for Universal Design, 2006)

Rehabilitation engineering and assistive technology emerged in the middle of the 20th century. Efforts to improve prosthetics and orthotics intensified with the return of thousands of disabled veterans from World War II in the 1940s. During the 1950s, engineering research centers sponsored by the Veterans Administration and other federal organizations were established to address other technological problems of rehabilitation, including communication, mobility, and transportation. Rehabilitation engineering centers expanded during the 1960s and 1970s. (The Center for Universal Design, 2006)

Rehabilitation engineering became a specialty that applied scientific principles and engineering methodologies to these problems. The label, “assistive technology,” was applied to devices for personal use created specifically to enhance the physical, sensory, and cognitive abilities of people with disabilities and to help them function more independently in environments oblivious to their needs. (The Center for Universal Design, 2006)

Though coming from quite different histories and directions, the purpose of universal design and assistive technology is the same: to reduce the physical and attitudinal barriers between people with and without disabilities. (The Center for Universal Design, 2006)

Universal design strives to integrate people with disabilities into the mainstream and assistive technology attempts to meet the specific needs of individuals, but the two fields meet in the middle. In fact, the point at which they intersect is a gray zone in which products and environments are not clearly “universal” or “assistive,” but have characteristics of each type of design. A number of products have enjoyed crossover success, often starting as assistive devices and becoming mainstream products, such as the kitchen utensils with thick grips popularized by Oxo International in their “Good Grips” line. A few products have moved the other way, typically conceived as high-tech devices for small markets that find new application in the rehabilitation arena, such as voice recognition software. (The Center for Universal Design, 2006)

The potential benefit of cooperation between professionals in both fields is exciting but mostly untapped. Commercial designers have much to learn from rehabilitation technologists familiar with the ergonomics of disability and aging. Rehabilitation technologists and their clients can benefit from designers' expertise in creating products and environments that are functional, safe, attractive, and marketable for a wide diversity of users. (The Center for Universal Design, 2006)

The economic downturn of the 1980s had a negative impact on funds for rehabilitation engineering research and the removal of environmental barriers. At the same time, product manufacturers were beginning to recognize the market-broadening potential of more accommodating products. (The Center for Universal Design, 2006)

In 1988, New York City's Museum of Modern Art exhibit, “Designs for Independent Living,” featured products selected for their beauty as well as their consideration of the needs of older adults and people with disabilities. Selections included products from the United States, Denmark, England, Italy, Netherlands, and New Zealand. It was clear that the commercial world was beginning to acknowledge aging individuals and people with disabilities as viable customers. (The Center for Universal Design, 2006)

In 1990, Oxo International introduced its Good Grips kitchen utensils for people who were limited by arthritis. These upscale products immediately found an enthusiastic audience, even though their advantages over utensils with oversized handles sold through assistive technology suppliers were primarily aesthetic. Oxo International grew at a 40 percent to 50 percent annual rate from 1990 to 1995, to \$20 million a year. Other companies quickly copied their approach. (The Center for Universal Design, 2006)

Another emerging economic trend is the increasing “globalization” of the marketplace. Consumer businesses hoping to remain successful in the coming decades must recognize the opportunities and challenges inherent in global competition. While the size of potential customer markets is growing, the diversity of the consumer base is expanding at the same time to include differences in language and culture, customs, experiences, and historical design precedents. All of these increase the need for design that is



sensitive to individual abilities and preferences. (The Center for Universal Design, 2006)

Because reasonable cost is a fundamental issue in any design and production process, universal design has become a very marketable approach, since it addresses the diverse needs of a majority of consumers. (The Center for Universal Design, 2006)

Throughout history, community attitudes and physical barriers in the built environment have prevented people with disabilities from fully participating in society. Access to education, employment, housing, recreation, cultural events, and transportation has been denied many people. Along with the growth in the disabled population, the quest for independence and equal rights has grown, as well. (The Center for Universal Design, 2006)

Buyers of assistive technology now demand that products be designed with concern for their impact on the image, as well as the function, of the user. Devices are expected to be appropriate for use at the office or school, at home, in the community, and on vacation. (The Center for Universal Design, 2006)

Similarly, aging members of the baby-boom generation (those born between the years 1946 and 1964) have begun to see the usefulness of products conceived for people with limitations. In a 1990 issue of *Capturing Customers*, Peter Francese noted, “As more Americans age, products that offer youthfulness without denigrating aging will do well. These consumers are not like their parents — they don't feel that older is ugly.” (American Association of Retired Persons, 1992;The Center for Universal Design, 2006)

At the end of the 20th century, the world is very different than 100 years ago. People are living longer and surviving better. Potential consumers of design who may be functionally limited by age or disability are increasing at a dramatic rate. These populations are no longer an insignificant or silent minority. (The Center for Universal Design, 2006)

The current generation of children, baby boomers entering middle age, older adults, people with disabilities, and individuals inconvenienced by circumstance, constitute a market majority. All of these constituencies and indeed, all consumers, deserve to be recognized and respected. Facilities, devices, services, and programs must be designed to serve an increasingly diverse clientele. (The Center for Universal Design, 2006)

The demographic, legislative, economic, and social changes that brought us to this point are increasing the momentum that will propel us into a 21st century that will need to be more accommodating of individual differences. Universal design provides a blueprint for maximum inclusion of all people. (The Center for Universal Design, 2006)

Daily living aids are identified by a variety of terms: *assistive technology, durable medical equipment, environmental assistive devices, self-help products*, and others. Daily living aids



include such specific products as single-handed button fasteners, walkers and canes, hands-free faucets, reachers, and toilet safety bars. Daily living aids are basically any type of tool that promotes a convenient, comfortable, and safe home environment.

Assistive technology is often confused with durable medical equipment. *Durable medical equipment* includes such items as prosthetics, orthotics, wheelchairs, communication devices, and other devices deemed medically necessary. *Assistive technology* includes durable medical equipment, but it covers a far broader array of devices and equipment. The distinction between durable medical equipment and assistive technology devices is important because insurance carriers, including Medicare and Medicaid, typically cover only medically necessary services. The majority of assistive technology solutions individuals need to achieve their greatest level of independence at home, school, work, and play are not considered medically necessary. This means that alternative funding strategies often come into play (Willkomm, n.d.).

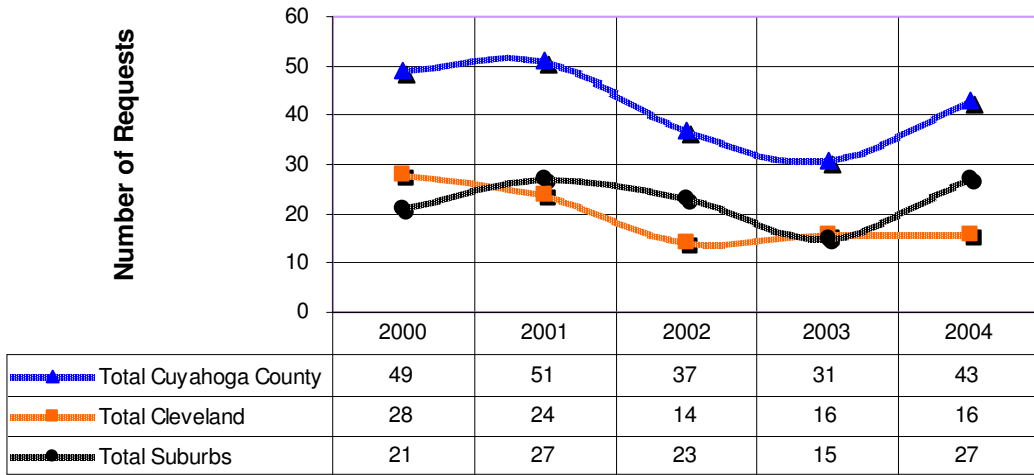
While some daily living aids programs provide devices at no or reduced cost to consumers, many other programs lend necessary aids and consumers return them when they are no longer needed. This is a helpful solution when equipment is needed for only a short time, for example while recovering from surgery and disability is expected to be time-limited, and for individuals who are unable to pay for required products and must wait for insurance approval or reimbursement. Additionally, lending programs are helpful for individuals who want to try out equipment before purchasing, to use while other equipment is being repaired, or while waiting for equipment to be made (some daily living aids need to be customized and can take weeks to months to make).

United Way - First Call for Help Call Data

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 5 daily living aids providers, all of which are nonprofit. United Way of Greater Cleveland did not fund this core service from 2000-2004 and currently does not fund the core service. (See Attachments 5 and 6.)

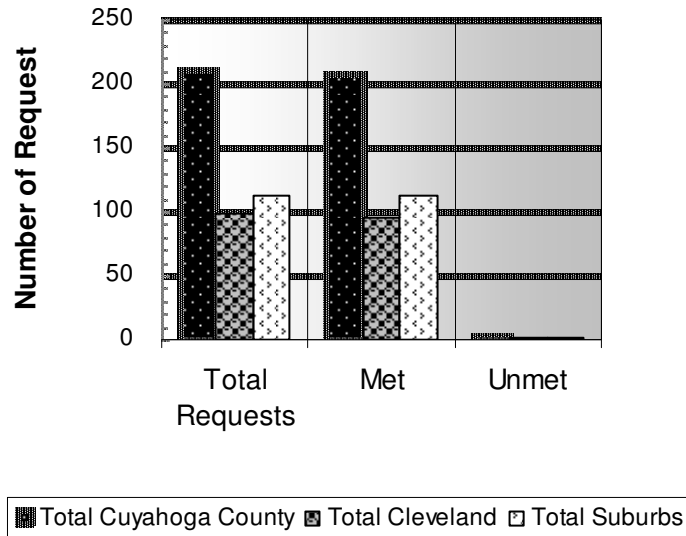
United Way - First Call for Help call data shows a general decrease in the number of total requests for daily living aids in the county: from 49 in 2000 to 43 in 2004 (12 percent) with a 43 percent decrease in Cleveland (28 to 16 requests), but a 29 percent increase in the suburbs (21 to 27 requests). (See Figure 2 and Attachment 7.)

**Figure 2: Daily Living Aids
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)**



Over the same five-year period, United Way - First Call for Help had 211 requests for information about daily living aids. Of these requests, they were able to make referrals to 99 percent of callers; however, one percent of all Cuyahoga County callers (3) had an unmet need, meaning there was no agency to which to refer the caller. Callers from the City of Cleveland (98) had a two percent unmet need rate and callers from the suburbs (113) had a one percent unmet need rate. (See Figure 3 and Attachment 8.)

Figure 3: Daily Living Aids
United Way - First Call for Help Requests 2000-2004
 (TOTAL REQUESTS: n=211, TOTAL UNMET NEED: n=3)



FUNDING OF CORE SERVICES

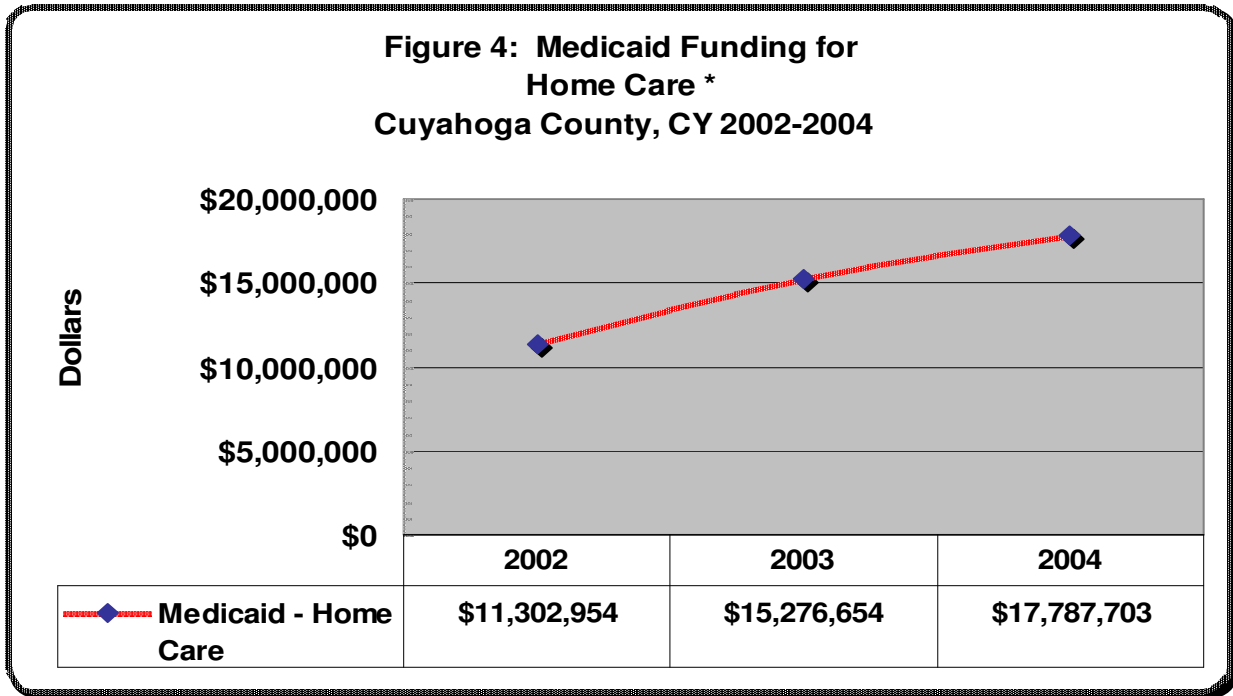
Major Government Funders

The major sources of government funding for daily living aids are:

- Medicaid
- Medicare

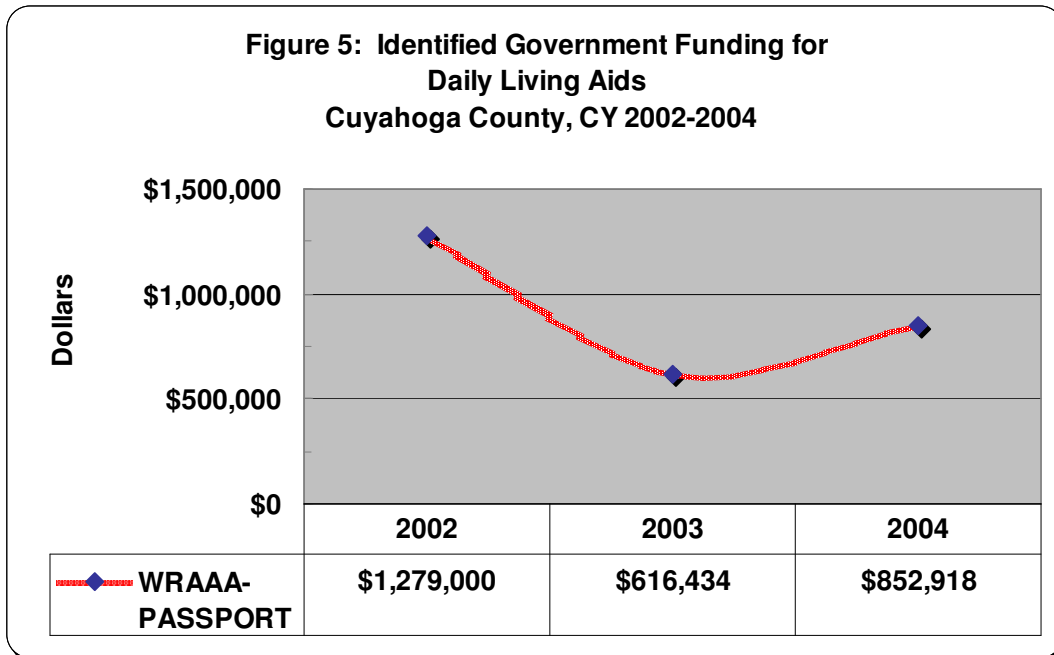
Trends of Government Funders

Medicaid funding for home care, which includes daily living aids and home health care, increased from \$11.3 million in CY 2002 to \$17.8 million in CY 2004. (See Figure 4.)



* Includes the following core services: Daily Living Aids and Home Health Care

Funding information specifically for daily living aids was found only for PASSPORT, an Ohio Medicaid waiver for home- and community-based care. (See Figure 5.)



Source: Western Reserve Area Agency on Aging

Note that Medicare funding information is not available at the county level.

IDENTIFIED REVENUES

As of May 11, 2006, \$951,958 in revenues for daily living aids programs has been identified countywide. (See Table 2.) This includes information from foundations, federated fundraising organizations, and government.

Daily living aids are primarily paid for by public and private insurances. Ninety percent of the identified revenues are from contracts or grants from government organizations. The largest government funder with available information was PASSPORT. Note that other Medicaid dollars are not included because not all Medicaid services are a one-to-one match with core services. Nine percent of identifiable revenue came from foundations, and about 1.5 percent was provided by federated fundraising organizations. United Way does not fund this core service.

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland for Daily Living Aids, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars County-wide		Total Dollars UW-Funded Agencies (Actual)	
		Amount	% of Total (A)	Amount	% of Total (B)
Deaconess Community Foundation	2004	10,000			
Prentiss Foundation, Elisabeth Severance	2003	75,000			
Total - Foundations & Trusts		85,000	8.93%	0	N/A
United Black Fund of Greater Cleveland	FY2005	14,000			
Total - Federated Fundraising Organizations		14,000	1.47%	0	N/A
PASSPORT	2004	852,918			
Subtotal State of Ohio		852,918	89.60%	0	N/A
Total - Contracts/grants from government organizations		852,918	89.60%	0	N/A
Subtotal Non - UWGrCle Support		951,918	100%	0	N/A
Total Support/Revenue		951,918	100%	0	N/A

* Medicaid dollars have not been entered under County-wide total for this Core Service because not all Medicaid Services are a one-to-one match with United Way Core Services. Medicaid Service - Home Care (\$17,787,703 in 2004) - Falls into AIRS 1 Health Care and has been entered as an aggregate total for that AIRS Level. Home Care includes the following Core Services: Daily Living Aids and Home Health Care.

REIMBURSEMENT/COST

There are tens of thousands of daily living aids products available for people with disabilities. Costs vary greatly among products. ABLEDATA data, found at www.abledata.com, is a comprehensive information source on assistive technology. Organized by major categories of service (for example, orthotics, transportation, deaf and hard of hearing, etc.), ABLEDATA contains objective information on more than 32,000 assistive products and provides a detailed description of the product's functions and features, price information (when available), and contact information for the product's manufacturer and any distributors. ABLEDATA most specifically addresses daily living aids and has information on personal care products that aid activities of daily living such as bathing, carrying, child care, clothing, dispenser aids, dressing, drinking, feeding, grooming/hygiene, handle padding, health care, holding, reaching, smoking, toileting, and transfer.

Reimbursement for daily living aids is a major issue for Medicare and Medicaid. While these public plans often cover durable medical equipment (such as wheelchairs and motorized lift chairs), Medicare (and most private insurance companies in general) does not cover most personal care products such as bathroom safety, kitchen aids, recreation aids, and reading or writing aids. However, with proper documentation, Medicare does cover selected mobility aids (walkers, canes), hospital beds and accessories, and toilet aids (bedside commodes, raised toilet seats) (DS Medical, n.d.). Medicaid coverage varies from state to state. In Ohio, all Medicaid waivers cover environmental accessibility and adaptations; and PASSPORT, Transitions, Ohio Home Care Waiver, and Individuals Options waivers cover adaptive and assistive devices (Ohio Legal Rights Service, n.d.). Going through the process of purchasing an assistive device to be reimbursed by a public health plan can be complicated and time consuming. For example, under Medicare, in most instances vendors require individuals to purchase a product first, and then Medicare will reimburse within 30-45 days. If an individual is eligible for Medicaid, then Medicaid will pay the Part B insurance premiums plus the co-insurance and deductible amounts and other charges sponsored by Medicaid (Creative Mobility, n.d.).

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

Daily living aids enable individuals to avoid premature institutionalization and remain living independently in the community. They also can save individuals and their caregivers money by removing or reducing the need for personal care. Additionally, daily living aids help relieve some of the responsibilities placed on caregivers, who can continue to provide support to help without “burn out.”

What Works

When choosing daily living aids, consumers and providers should view “independence” not only in terms of functional performance but also from a broader view of participation in, and full access to, community life. So it is important to consider how environmental adaptations make self-care, work, and play activities possible.

What Doesn't Work

Providing daily living aids without appropriate training commonly results in an individual not taking full advantage of the device or not using it at all (often referred to as “abandonment” in the assistive technology field). If assistive technology takes too much time, or is too physically or cognitively demanding, individuals may find it easier to have an assistant perform the task than to do it themselves. Selecting the most appropriate assistive technology solution often involves trade-offs or sacrifices. Also, consumers may expect much more from a device than it is able to provide (Willkomm, n.d.). A thorough analysis of individuals’ needs and current abilities, and helping them to understand how to use a device is essential for success.

IMPACT ON COMMUNITY

By supporting older adults to remain living in their homes, fewer may need high-cost taxpayer-financed hospitalizations or care in places such as long-term care facilities or nursing homes. Additionally, daily living aids enable individuals to care more for themselves and reduce demand on personal care, thereby reducing demands on an already strained long-term care work force.

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

The Rehabilitation Engineering & Assistive Technology Society of North America (RESNA), an interdisciplinary association for the advancement of rehabilitation and assistive technology, has a credentialing program for providers in the field of assistive technology in three areas:

- *Assistive Technology Practitioner (ATP)* - For service providers who are involved in analysis of a consumer’s needs and have training in the use of a particular assistive technology device.
- *Assistive Technology Supplier (ATS)* - For service providers who are involved with the sale, including determination of consumer needs and service of rehabilitation equipment, assistive technology and commercially available products and devices.

- *Rehabilitation Engineering Technologist (RET)* - For service providers who apply engineering principles to the design, modification, customization and/or fabrication of assistive technology for persons with disabilities (RESNA, n.d.).

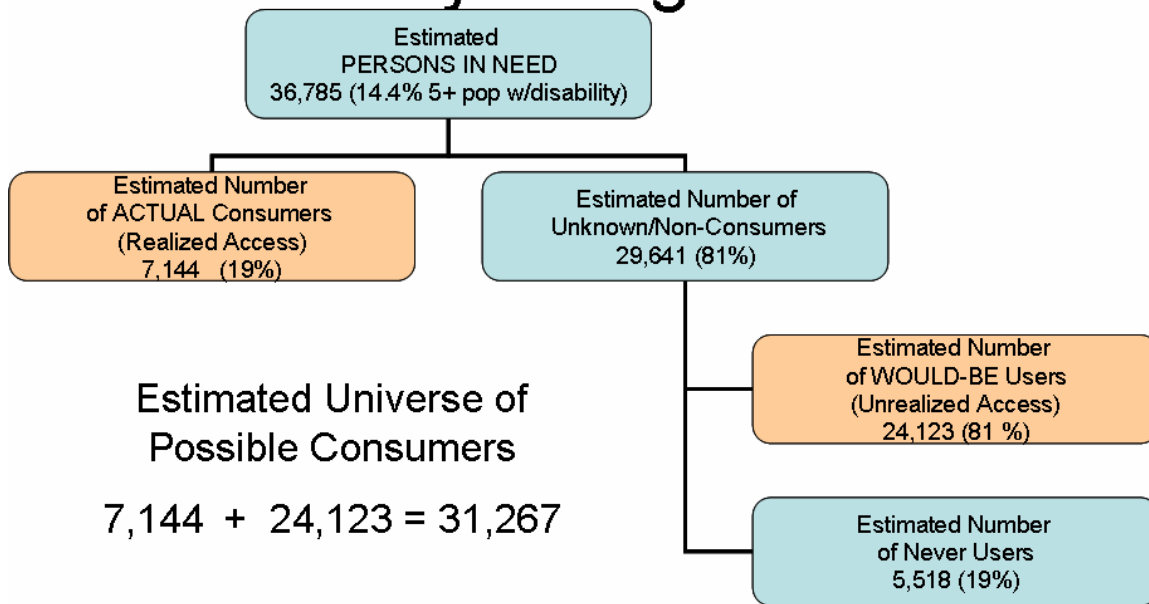
In addition, RESNA has a list of 21 standards of practice for assistive technology practitioners and suppliers that focus on professionalism, non-discrimination, and competency in field (RESNA, n.d.).

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Daily Living Aids:

- A conservative estimate of 36,785 physically disabled persons 5 and older need daily living aids.
- Based on available information about actual consumers, approximately 7,144 persons have realized access to daily living aids, which is the number of individuals PASSPORT identified as receiving daily living aids.
- This leaves a net estimate of 29,641 individuals who are either receiving services from unaccounted-for sources or are not receiving daily living aids (36,785 – 7,144).
- Assuming that 85 percent of persons in need will use assistive devices either alone or in conjunction with personal care (Federal Interagency Forum on Aging Related Statistics, 2004), this leaves 5,518 individuals (36,785 x 15%) who would never be users.
- Including both realized (7,144) and unrealized (24,123) access, the estimated universe of possible consumers for daily living aids is 31,267 persons. (See Figure 6.)

Figure 6 - Consumer Estimates: Daily Living Aids



Service Site Index

There is no service site index for this service because it is a countywide service. In addition, there are many other for-profit providers that do not show up on United Way - First Call for Help's data base.

VII. SUMMARY

The following are the major findings from the research on daily living aids:

- Home- and community-based services are essential to allowing individuals with disabilities and older adults live in settings they prefer. Although many scholars note that the federal Medicaid program has a long-established institutional bias, nationally and in the state of Ohio, consumer choice and home- and community-based services are expanding. Increasing reliance on—and clear consumer preference for—community-based services will increase the demand for daily living aids.
- Most disabled adults use some kind of assistive device (most often to assist with mobility) and the number has been growing over time, especially among the elderly. Multiple studies have found that the use of assistive technology (which includes daily living aids) is associated with greater reduction of difficulty in either ADLs (activities of daily living) or mobility impairments. Additionally, studies suggest that increased use of technology may slow functional declines, lower health care costs, and increase efficacy among some caregivers.
- Participants in United Way of Greater Cleveland’s core service focus group discussions (Spring 2005) identified livable wages for qualified staff and the lack of long-term workers as other public policy issues affecting long-term care and daily living aids programs. Reimbursement from Medicare and Medicaid for daily living aids is also of great concern.
- Daily living aids are primarily paid for by public and private insurances. Medicaid and Medicare are the major funders among the public funders. Medicaid funding for home care, which includes daily living aids and home health care, increased from \$11.3 million in CY 2002 to \$17.8 million in CY 2004.
- PASSPORT funding for daily living aids dropped by more than half from 2002 to 2003 and, though increasing above 2003 levels, was at only 67 percent of 2002 levels.
- Medicare (and most private insurance companies in general) does not cover most personal care products such as bathroom safety, kitchen aids, recreation aids, and reading or writing aids. However, with proper documentation, Medicare does cover selected mobility aids (walkers, canes), hospital beds and accessories, and toilet aids (bedside commodes, raised toilet seats).
- As of May 11, 2006, \$951,958 in revenues for daily living aids programs has been identified countywide.
- When choosing daily living aids, consumers and providers should view “independence” not only in terms of functional performance but also from a broader view of participation in, and full access to, community life. It is important to consider how environmental adaptations make self-care, work, and play activities possible.
- Providing daily living aids without appropriate training commonly results in an individual not taking full advantage of the device or not using it at all (often referred to as “abandonment” in the assistive technology field)
- The estimated universe of possible consumers is 31,267, including both realized access (7,144) and unrealized access (24,123).

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ATTACHMENTS

Attachment 1: Researcher List

MCS

CONSULTING SERVICE

CORE SERVICE RESEARCH TEAM

Co-Lead Consultants

Marlene C. Stoiber, Ph.D. President, MCS Consulting Service, LLC
Bette S. Meyer, M.A.

Research Team

Renee Aten, CFRE, Aten Enterprises, Associate, MCS Consulting Service, LLC
Edwin A. Balcerzak, Ph.D., Associate, MCS Consulting Service, LLC
Louis B. Burroughs, M.S.U.S., Associate, MCS Consulting Service, LLC
Elsie Day, J.D., Associate, MCS Consulting Service, LLC
Jennifer M. Forshey, M.P.P., IntelliSolve, Inc.

Karen Gillooly, M.Ed., IntelliSolve, Inc.
Sue E. Grant, Ella & Associates, IntelliSolve, Inc.
Gary Harris, B.A., M.B.A., IntelliSolve, Inc.
Jeffry D. Harris, M.P.A., J.D., IntelliSolve, Inc.
Kristen Haskell, M.A., Associate, MCS Consulting Service, LLC

Dion Lau, B.A., Associate, MCS Consulting Service, LLC
Kitty Leung, M.S.S.A., Associate, MCS Consulting Service, LLC
Marcy Hunt- Morse Ph.D., Ella & Associates, IntelliSolve, Inc.
Carey Wiant Nyberg, M.U.P., Associate, MCS Consulting Service, LLC
RNR Consulting, Inc.

Jeremy Shapiro, Ph.D., IntelliSolve, Inc.
Jennifer Slusser, J.D., IntelliSolve, Inc.
Sarah Stilgenbauer, M.N.O., Associate, MCS Consulting Service, LLC
Kola Sunmonu, Ph.D., Associate, MCS Consulting Service, LLC
Jamie Watkins, B.A., IntelliSolve, Inc.

Jacqueline Kirby Wilkins, Ph.D., CFLE - President/Director, IntelliSolve, Inc.
Debra Zanglin, Ella & Associates, IntelliSolve, Inc.

Thanks to *The Center for Community Solutions* for providing multiple sources of information.

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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- Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis*. New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Daily Living Aids LH-060.170						
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ^{*****}	
	Total Population (%) [*]	Total Population 5+ (%) ^{**}	Total Population 5+ Reporting a Disability (%) ^{***}	Total Population 5+ with Physical Disability (%) ^{***}	UW Program Report Data Cnty Only (%)	PASSPORT (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004
5-15 years			14,245	949		
16-20 years			11,289	301		
21-64 years			143,094	16,274		
65+ years			86,202	19,261		
TOTAL	1,393,978	1,303,066	254,830	36,785	N/A	7,144
Percent		93.5%	19.6%	14.4%		
GENDER						
Male	47.2%	47.0%	45.3%	N/A	N/A	15.6%
Female	52.8%	53.0%	54.7%	N/A	N/A	84.4%
Unknown Data ^{*****}					N/A	0.0%
Missing Data ^{*****}					N/A	0.0%
RACE^{*****}						
White alone	67.1%	68.1%	61.3%	66.8%	N/A	42.0%
Black or African American alone/combination	27.9%	27.5%	34.3%	30.6%	N/A	54.6%
Asian alone/combination	2.1%	2.1%	1.6%	0.7%	N/A	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.7%	1.1%	1.0%	N/A	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.1%	0.1%	0.1%	N/A	0.0%
Some other race alone/combination	2.1%	2.0%	2.4%	1.6%	N/A	0.9%
Unknown Data ^{*****}					N/A	0.4%
Missing Data ^{*****}					N/A	2.1%
HISPANIC^{*****}						
	3.3%	3.2%	3.7%	2.0%	N/A	2.1%
AGE						
0-4					N/A	0.0%
5-9	7.3%	7.8%	N/A	N/A	N/A	0.0%
10-14	7.1%	7.6%	N/A	N/A	N/A	0.0%
15-19	6.4%	6.8%	N/A	N/A	N/A	0.0%
20-34	19.1%	20.4%	N/A	N/A	N/A	0.0%
35-54	29.3%	31.4%	N/A	N/A	N/A	0.0%
55-64	8.7%	9.3%	N/A	N/A	N/A	34.1%
65-74	7.8%	8.3%	N/A	N/A	N/A	
75+	7.8%	8.4%	N/A	N/A	N/A	65.9%
Unknown Data ^{*****}					N/A	0.0%
Missing Data ^{*****}					N/A	0.0%
INCOME^{*****}						
Average Household Size	2.4	N/A	N/A	N/A	N/A	N/A
\$0-\$9,999	11.3%	N/A	N/A	N/A	N/A	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	N/A	N/A	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	N/A	N/A	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	N/A	N/A	0.0%
\$30,000 and above	61.5%	N/A	N/A	N/A	N/A	0.0%
Unknown Data ^{*****}					N/A	0.0%
Missing Data ^{*****}					N/A	100.0%
Totals	100.0%	N/A	N/A	N/A	N/A	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
** U.S. Census 2000, SF3 (P8), SF3 (PCT26); SF4 (PCT69)
*** U.S. Census 2000, SF3 (PCT26); SF4 (PCT69)
**** 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." 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: Daily Living Aids LH-060.170								
Period	City/Town (% Cleveland)	Total Population (%)*		Total Population 5+ (%)**		Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source *****	
		1/1/2000-12/31/2000	1/1/2000-12/31/2000	Total Population 5+ Reporting a Disability (%)***	Total Population 5+ with Physical Disability (%)****	UW Program Report Data (%)	PASSPORT Cuy Cty Only (%)	
		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	
5-15 years				14,245	949			
16-20 years				11,289	301			
21-64 years				143,094	16,274			
65+ years				86,202	19,261			
TOTAL		1,393,978	1,303,066	254,830	36,785	N/A	7,144	
Percent			93.5%	19.6%	14.4%			
44017	Berea	1.4%	1.4%	1.1%	1.1%	N/A	0.8%	
44022	Bentleyville	1.3%	0.8%	0.5%	0.6%	N/A	0.1%	
44040	Gates Mills/Mayfield Village	0.2%	0.2%	0.1%	0.2%	N/A	0.0%	
44070	North Olmsted	2.4%	2.5%	1.8%	2.2%	N/A	0.7%	
44101	Cleveland (100%)	0.0%	0.0%	0.0%	0.0%	N/A	0.0%	
44102	Cleveland/Brooklyn (95%)	3.7%	3.7%	5.2%	3.8%	N/A	0.5%	
44103	Cleveland (100%)	1.8%	1.8%	2.8%	2.6%	N/A	5.0%	
44104	Cleveland (100%)	2.1%	2.0%	2.9%	2.6%	N/A	4.7%	
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	3.9%	5.1%	5.1%	N/A	4.8%	
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.3%	2.6%	2.5%	N/A	8.9%	
44107	Lakewood/Cleveland	4.1%	4.1%	3.1%	3.7%	N/A	1.8%	
44108	Cleveland/Bratenahl (90%)	2.6%	2.6%	3.8%	3.7%	N/A	6.6%	
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.2%	4.1%	3.6%	N/A	3.1%	
44110	Cleveland/East Cleveland (98%)	1.9%	1.9%	2.5%	2.2%	N/A	5.7%	
44111	Cleveland (100%)	3.1%	3.0%	3.2%	2.9%	N/A	1.7%	
44112	East Cleveland/Cleveland	2.4%	2.3%	3.1%	2.6%	N/A	8.1%	
44113	Cleveland (100%)	1.4%	1.4%	1.8%	1.7%	N/A	1.3%	
44114	Cleveland (100%)	0.3%	0.3%	0.5%	0.3%	N/A	0.6%	
44115	Cleveland (100%)	0.6%	0.5%	0.6%	0.3%	N/A	0.8%	
44116	Rocky River	1.5%	1.5%	1.2%	1.5%	N/A	0.3%	
44117	Euclid/Cleveland	0.9%	0.9%	1.3%	1.1%	N/A	3.3%	
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	3.3%	2.5%	2.5%	N/A	4.5%	
44119	Cleveland/Euclid (50%)	1.0%	1.0%	0.9%	0.9%	N/A	0.5%	
44120	Shaker Hts/Cleveland	3.4%	3.3%	3.8%	2.7%	N/A	6.6%	
44121	University Hts/South Euclid	2.5%	2.5%	2.1%	1.5%	N/A	2.9%	
44122	Beachwood/Highland	2.5%	2.6%	2.1%	2.2%	N/A	1.7%	
44123	Euclid	1.3%	1.3%	1.1%	1.0%	N/A	0.8%	
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.0%	2.8%	3.3%	N/A	2.9%	
44125	Valley View/Garfield Hts	2.1%	2.2%	2.3%	2.4%	N/A	0.7%	
44126	Fairview Park/Cleveland	1.2%	1.2%	0.9%	1.4%	N/A	0.5%	
44127	Cleveland (100%)	0.6%	0.6%	1.0%	0.8%	N/A	0.4%	
44128	Warrensville Hts/Cleveland	2.4%	2.4%	3.0%	3.0%	N/A	4.9%	
44129	Brooklyn/Parma/Cleveland	2.1%	2.1%	1.8%	2.1%	N/A	0.4%	
44130	Parma/Cleveland	3.8%	3.9%	3.7%	4.6%	N/A	0.8%	
44131	Independence/Seven	1.5%	1.5%	1.4%	1.5%	N/A	0.1%	
44132	Euclid	1.1%	1.1%	1.2%	1.0%	N/A	0.0%	
44133	North Royalton	2.1%	2.1%	1.4%	1.3%	N/A	0.3%	
44134	Parma/Cleveland	2.9%	2.9%	2.7%	3.0%	N/A	1.5%	
44135	Cleveland/Linddale (90%)	2.0%	2.0%	2.3%	2.4%	N/A	1.2%	
44136	Strongsville	3.1%	3.2%	1.8%	2.3%	N/A	0.6%	
44137	Maple Hts/Cleveland	1.9%	1.9%	1.7%	2.2%	N/A	1.2%	
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	1.0%	1.7%	N/A	0.4%	
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	0.9%	0.7%	N/A	0.5%	
44140	Bay Village	1.2%	1.2%	0.6%	0.8%	N/A	0.2%	
44141	Brecksville	1.0%	1.0%	0.6%	0.7%	N/A	0.0%	
44142	Brookpark/Cleveland	1.5%	1.5%	1.4%	1.7%	N/A	0.4%	
44143	Highland Hts/Richmond Heights	1.7%	1.7%	1.3%	1.2%	N/A	2.6%	
44144	Brooklyn/Cleveland	1.6%	1.6%	1.6%	1.8%	N/A	0.8%	
44145	Westlake	2.3%	2.3%	1.5%	1.5%	N/A	0.3%	
44146	Walton Hills/Oakwood/Bedford	2.3%	2.3%	2.5%	2.7%	N/A	2.6%	
44147	Broadview Hts	1.1%	1.1%	0.7%	0.8%	N/A	0.3%	
44149	Strongsville				0.0%	N/A	0.4%	
Unknown Cuyahoga County Zip Codes*****						N/A	0.0%	
Missing*****						N/A	0.0%	
Unknown*****						N/A	0.0%	
Total Cuyahoga County*****		100.0%	100.0%	100.0%	100.0%	N/A	100.0%	
Total Known Cleveland		30.5%	30.2%	39.2%	35.6%	N/A	45.9%	
Total Known Suburbs		69.5%	69.8%	60.8%	64.4%	N/A	54.1%	
Unknown & Missing						N/A	0.0%	

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census SF1 (P1)
** U.S. Census SF3 (P8)
*** U.S. Census SF3 (PCT26)
**** 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 zipcodes because some zipcodes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	5	-
Number of Providers by Type		
Nonprofit	5	-
For-profit	-	-
Government	-	-
Other	-	-
Total Number of Sites	5	-
Number of Service Sites per Provider		
1	5	-
2 – 5	-	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 - Berea	-	-
44022 - Bentleyville	-	-
44040 - Gates Mills/Mayfield Village	-	-
44070 - North Olmsted	-	-
44101 - Cleveland (100%)	-	-
44102 - Cleveland/Brooklyn (95%)	-	-
44103 - Cleveland (100%)	-	-
44104 - Cleveland (100%)	-	-
44105 - Cleveland/NewburghHts/GarfieldHts (75%)	-	-
44106 - Cleveland/Cleveland Hts (60%)	-	-
44107 - Lakewood/Cleveland	1	-
44108 - Cleveland/Bratenahl (90%)	-	-
44109 - Cleveland/Brooklyn Hts (98%)	-	-
44110 - Cleveland/East Cleveland (98%)	-	-
44111 - Cleveland (100%)	-	-
44112 - East Cleveland/Cleveland	-	-
44113 - Cleveland (100%)	-	-
44114 - Cleveland (100%)	-	-
44115 - Cleveland (100%)	3	-
44116 - Rocky River	-	-
44117 - Euclid/Cleveland	-	-
44118 - ClevelandHts/UniversityHts/ShakerHts	1	-
44119 - Cleveland/Euclid (50%)	-	-
44120 - Shaker Hts/Cleveland	-	-
44121 - University Hts/South Euclid	-	-
44122 - Beachwood/Highland Hills/ShakerHts	-	-
44123 - Euclid	-	-
44124 - Pepper Pike/MayfieldHts/Lyndhurst	-	-
44125 - Valley View/Garfield Hts	-	-
44126 - Fairview Park/Cleveland	-	-
44127 - Cleveland (100%)	-	-
44128 - Warrensville Hts/Cleveland	-	-

Attachment 5: Profile of Core Service Providers – 2005 (continued)

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44129 - Brooklyn/Parma/Cleveland	-	-
44130 - Parma/Cleveland	-	-
44131 - Independence/Seven Hills/BrooklynHts	-	-
44132 - Euclid	-	-
44133 - North Royalton	-	-
44134 - Parma/Cleveland	-	-
44135 - Cleveland/Linndale (90%)	-	-
44136 - Strongsville	-	-
44137 - Maple Hts/Cleveland	-	-
44138 - Olmsted Twp/Olmsted Falls	-	-
44139 - Bentleyville/Glenwillow/Solon	-	-
44140 - Bay Village	-	-
44141 - Brecksville	-	-
44142 - Brookpark/Cleveland	-	-
44143 - Highland Hts/Richmond Heights	-	-
44144 - Brooklyn/Cleveland	-	-
44145 - Westlake	-	-
44146 - Walton Hills/Oakwood/Bedford	-	-
44147 - Broadview Hts	-	-
44149 - Strongsville	-	-
Total Cuyahoga County	5	0
Total Cleveland	3	0
Total Suburbs	2	0

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
ALS Association - Northeast Ohio Chapter	Medical Equipment Loan Bank
Matthew's Lending Library	Adaptive Equipment Lending Library
Multiple Sclerosis Association of America	Mobility/Safety Aids
National Multiple Sclerosis Society - Ohio Buckeye Chapter - Northeast Ohio Office	Loan Programs
United Labor Agency	Medical Equipment Loan

Bold represents agencies funded by United Way for this service. United Way does not fund this core service.

**Attachment 7: United Way - First Call for Help Daily Living Aids Requests – 2000-2004:
Greatest Increase/Greatest Decrease**

LH-060.170 Daily Living Aids								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change* 00&04	Avg. # Calls 00-04
		2000	2001	2002	2003	2004		
44114	Cleveland	1	0	1	1	4	300%	1
44102	Cleveland/Brooklyn	4	0	0	2	5	25%	2
44120	Shaker Hts/Cleveland	0	1	5	1	5	N/A	2
44143	Highland Hts/Richmond Heights	0	1	1	1	3	N/A	1
44113	Cleveland	0	4	1	1	2	N/A	2
44118	ClevelandHts/UniversityHts/ShakerHts	0	0	2	1	2	N/A	1
44107	Lakewood/Cleveland	0	2	3	1	2	N/A	2
44111	Cleveland	0	0	0	2	1	N/A	1
44146	Walton Hills/Oakwood/Bedford	0	5	1	0	1	N/A	1
44122	Beachwood/Highland Hills/Shaker Hts.	1	0	1	0	0	(100%)	0
44103	Cleveland	3	3	1	4	0	(100%)	2
44104	Cleveland	2	3	1	2	0	(100%)	2
44108	Cleveland/Bratenahl	5	3	3	1	0	(100%)	2
44123	Euclid	1	0	0	3	0	(100%)	1
44117	Euclid/Cleveland	1	0	0	0	0	(100%)	0
44126	Fairview Park/Cleveland	2	0	0	0	0	(100%)	0
44131	Independence/Seven Hills/Brooklyn Hts	1	1	0	0	0	(100%)	0
44070	North Olmsted	1	0	2	2	0	(100%)	1
44124	Pepper Pike/Mayfield Hts./Lyndhurst	2	3	0	0	0	(100%)	1
44128	Warrensville Hts/Cleveland	1	1	1	1	0	(100%)	1
44109	Cleveland/Brooklyn Hts	5	1	0	0	1	(80%)	1
44110	Cleveland/East Cleveland	3	1	1	0	1	(67%)	1
44105	Cleveland/Newburgh Hts/Garfield Hts	3	3	1	2	1	(67%)	2
44106	Cleveland/Cleveland Hts	2	4	0	0	1	(50%)	1
44134	Parma/Cleveland	2	0	0	0	1	(50%)	1

**Total Cuyahoga County	49	51	37	31	43	(12%)	42
**Total Cleveland	28	24	14	16	16	(43%)	20
**Total Suburbs	21	27	23	15	27	29%	23

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

LH-060.170 Daily Living Aids United Way - First Call for Help Requests 2000-2004 Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44106	Cleveland/Cleveland Hts	7	6	1	14%
44105	Cleveland/Newburgh Hts/Garfield Hts	10	9	1	10%
44112	East Cleveland/Cleveland	15	14	1	7%

*Total Cuyahoga County	211	208	3	1%
*Total Cleveland	98	96	2	2%
*Total Suburbs	113	112	1	1%

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% 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**

1331 Euclid Avenue

Cleveland, Ohio 44115

uws.org/CoreServicesPlanning