

Core Service Report

Disease / Disability Information

Consumer Category:
With / At Risk of Health Conditions

Primary Consumer Group:
**Persons Who Are
Chronically Ill**



February 2007

TABLE OF CONTENTS

Companion Reports	ii
Acknowledgements	ii
Snapshot	iii
I. Foreword	1
Introduction	1
Methodology	1
II. The Core Service Environment	3
Core Service Environment.....	3
Public Policy Issues	4
III. The Core Service Consumers	9
Definition Of Target Population.....	9
Demographic Characteristics.....	9
Realized Access To Service	13
IV. Core Service Delivery	15
Core Service Definition	15
Background On Core Service	15
Funding of Core Services	20
Identified Revenues	23
Reimbursement/Cost	24
V. What Works; What Doesn't	25
Impact On Individuals/Families	25
Impact On Community	27
Accreditations/Standards/Certifications	27
VI. Gap Analysis	28
VII. Summary	30
References	31
Attachments	38
Attachment 1: Researcher List	38
Attachment 2: Technical Notes	39
Attachment 3: Chronic Diseases – Incidence And Prevalence	47
Attachment 4: Actual Consumer Demographics.....	55
Attachment 5: Actual Consumer Zip Codes.....	57
Attachment 6: Profile Of Core Service Providers – 2005	59
Attachment 7: Providers And Functions – 2005	61
Attachment 8: United Way - First Call For Help Requests – 2000-2004	64
Attachment 9: United Way - First Call For Help 2000-2004: Unmet Need	65



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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SNAPSHOT

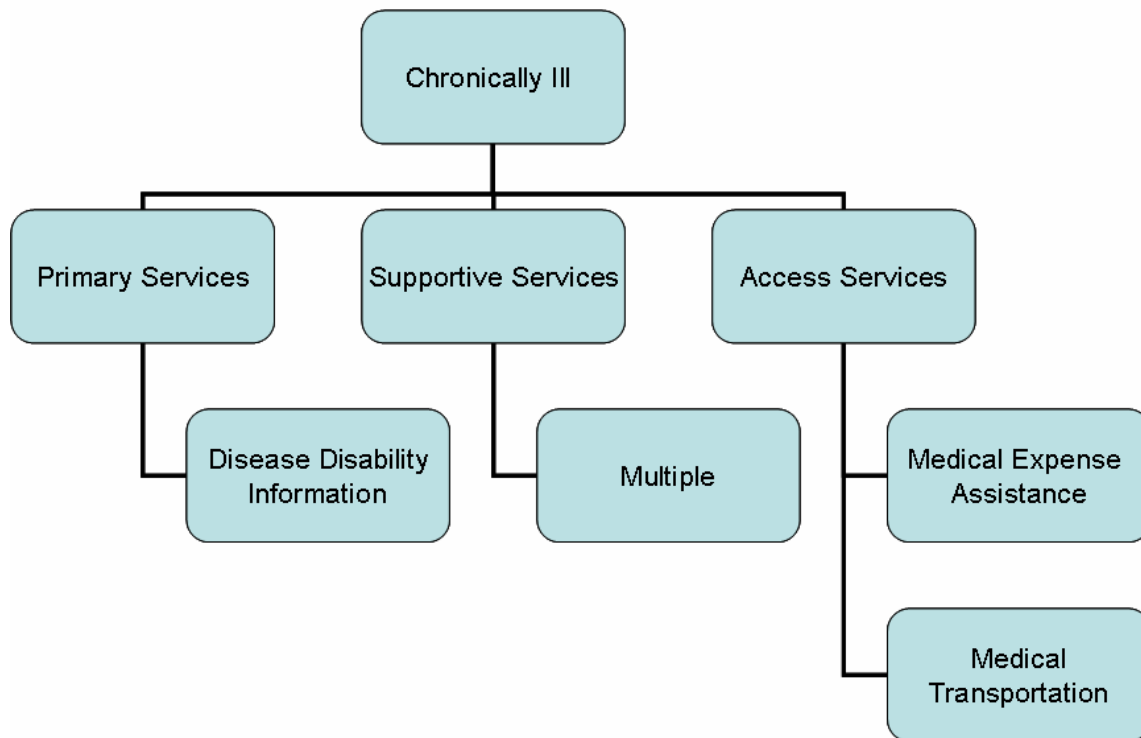
AIRS Code Level I: Health Care (L)
AIRS Code Level II: Health Supportive Services (LH)
Core Service: Disease/Disability Information (LH-270.170)

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

AIRS Definition: Programs that provide information about the etiology, symptoms, preventive measures, screening/diagnostic procedures, and/or methods of treatment or management for specific illnesses or disabling conditions; and/or that disseminate information about the latest research with regard to a particular illness or condition. Included are programs that maintain disease registries; i.e., databases that contain information about people diagnosed with a specific type of disease and have been treated by a particular hospital or live within a particular geographic area. Registry information is used by public health authorities to identify and investigate unusual patterns of occurrence of the disease and can help communities plan for and deliver needed medical services.

Disease/Disability Information is a service for those with or at risk of a chronic illness. It is the only service in this family of services. Medical expense assistance and medical transportation are also services that help the chronically ill access needed services. (See figure below.)

Family of Services
AIRS: Health Care



Core Service Environment

The old paradigm was the U.S. health care system's design to mainly treat illness and engineer dramatic rescues from injury or illness—mostly with surgery and medication. This works well for younger, basically healthy people. However, the system has been slow to adapt to the new challenge of chronic illness in old age. The new paradigm is a self-management model of health care for chronic conditions; prevention; promotion of healthy life style; and education about high-risk behaviors.

For most, seeking information about a disease arises from a concern or a crisis involving that disease; when this occurs, people tend to seek information from sources identified with that disease.

The major public policy agenda related to health in the U.S. is articulated in the “Healthy People 2010 & Steps to a Healthier U.S.: Leading Prevention.” The vision is of a community where diseases are prevented when possible, controlled when necessary, and treated when appropriate.

Racial and Ethnic Approaches to Community Health (REACH) is a federal initiative with a goal of eliminating racial and ethnic disparities in health by the year 2010. REACH is working in the following six priority areas: infant mortality, breast and cervical cancer, cardiovascular diseases, diabetes, HIV infections/AIDS, and child and adult immunizations.

A principal public policy issue related to disease is the decreasing and/or elimination of tobacco use, which causes a variety of diseases—heart and cancer being the two primary ones.

Core Service Consumers

The target population addressed in this core service report is health information consumers. Consumers of disease/disability information can include persons who are or suspect they are at risk for, have symptoms of, or are diagnosed with a disease or illness (primarily a chronic illness). Disease knows no specific race, ethnic group, gender, or age. However, the prevalence of many diseases is greater among minority populations. This may be due to lack of access, insurance, education, and lifestyle. Furthermore, there has been an increase in the number of patients who are uninsured, underinsured, and unemployed (without a COBRA).

Two key trends directly affect health care information consumers:

- The increasingly more popular cost containment strategy of consumer driven health care plans; and
- The emergence of the self-management model of health care for chronic conditions.

Two recent studies differ significantly in the reported number of consumers seeking information:

- Per a 2001 report by the Center for Studying Health System Change, 38 percent of adults sought health information from a source other than their doctor in the previous year for a personal health concern. Among individuals with chronic conditions, 44 percent were reported to seek health information (Ha and Hargraves, 2003).
- According to a 2005 RAND Corporation report, more than 60 percent of American consumers have searched for information to help them make treatment decisions in the last 12 months, with about one-third saying the information they found affected either their treatment choices or their choice of a health care facility.

- Per the Health System Change report, consumers who neither saw a doctor nor sought health information tend to have less education and lower incomes, are disproportionately uninsured, male, and members of racial or ethnic minority groups.

In 2000, according to a survey on chronic care in America by Harris Interactive (June 2003), 125 million of 276 million people living in the United States had some type of chronic illness. The uninsured and underinsured report poorer quality of life, fewer visits to doctors, less adequate knowledge about how to care for their illness, poorer relationships with their doctors, and less benefit from modern standards of care (The Robert Wood Johnson Foundation, 2001). One-third of the chronically ill in America simply are not receiving the information and services needed to manage their illness successfully (The Robert Wood Johnson Foundation, 2001).

In 2000, an estimated 654,175 individuals 5 and older in Cuyahoga County were health information consumers. This includes 38 percent of the 18 and older population and 100 percent of persons 5 to 18 years. The number of estimated consumers is projected to decrease to 618,453 by 2015 because of shifts in the population.

Core Service Delivery

The definition of disease/disability information for this report is: programs that provide information about the etiology, symptoms, preventive measures, screening/diagnostic procedures, and/or methods of treatment or management for specific illnesses or disabling conditions; and/or that disseminate information about the latest research with regard to a particular illness or condition.

The provision of information can actively or passively occur in several ways: (1) print materials are available and/or given to a consumer to read; (2) web based information resources; (3) audio-visual presentations viewed by the consumer; (4) print and/or audio-visual materials coupled with a dialogue with the consumer; and (5) informed-choice counseling by trained personnel.

The provision of information to a consumer can occur (1) prior to symptom development as preventive education, (2) with the occurrence of symptoms as diagnostic education and/or for decision-making about treatment, and (3) post diagnosis and acute treatment for chronic disease management. The method of information provision, reception, and utilization of information is related to the consumer's socio-economic status, educational achievement, age, culture, and health literacy. Health information needs to be presented differently to various populations in culturally competent ways and according to disease.

There are two levels of health promotion at the community level: the individual level and the community or public health level. Information dissemination at the community level is frequently the purview of public health organizations such as governmental public health departments while disease-focused organizations are most likely to operate at the individual level.

Contemporary health promotion at the community level involves more than simply educating individuals about healthy practices. It includes efforts to change the organizational behavior as well as the physical and social environment of communities. It is also about developing and advocating policies, such as economic incentives, that support health. Health promotion programs seeking to address health problems across this spectrum employ a range of strategies and operate on multiple levels (Rimer & Glanz, 2003).

Based on United Way - First Call for Help's (FCFH) database (2004), there are 66 disease/disability information providers operating from 72 different sites, 5 of which are government and 61 are nonprofits. In FY 2004, United Way funded 9 providers. FCFH call data shows a slight increase in the number of total requests for disease/disability information in the county: from 114 in 2000 to 187 in 2004. Over the same five-year period, United Way – First Call for Help had 813 requests for disease/disability information. Of these requests, referrals were made to 99 percent of callers.

The Preventive Health and Health Services Block Grant (PHHS) is used to support public education among other things. States invest their PHHS Block Grant dollars in a variety of public health areas. The PHHS Block Grant appropriations have been decreasing regularly the all-time high of \$158 million in 1995 to \$99 million in FY 2006. In FY 2005, the appropriation was \$131 million. Substantial portions of the funding were related to chronic diseases and health education. In Ohio in FY 2005, \$5.5 million was available from the PHHS Block Grant. Of this, just over \$3.1 million was spent on chronic illness-related programs.

The 2005 Omnibus Appropriations Bill gives increased funding to several prevention efforts, including prevention programs at the Centers for Disease Control and Prevention (CDC) as well as some demonstration projects in various states. Chronic-disease prevention appropriations to the CDC increased by approximately \$55 million over funding for 2004.

As of May 11, 2006, over \$4.4 million in revenues for disease/disability information has been identified countywide. Over twenty-five percent of the revenues are from contracts or grants from government organizations. The United Way of Great Cleveland contributed 52.4 percent of the total identified revenues.

What Works; What Doesn't

There are a number of methods for encouraging tobacco use prevention and control and promoting physical activity for which there is strong or sufficient evidence. In addition it has been found that diabetics who tightly control their blood sugar levels can cut their risk of heart attacks and strokes in half; that efforts to integrate and standardize information systems across settings and providers can improve access to timely and relevant information, thereby promoting optimal care.

Improving outcomes for frail older adults starts with primary prevention to improve general health, delay the onset of disability, and increase productivity and well-being (Young, 2003).

The prevalence of some diseases in some geographic areas may be related to racial disparities in health. While there are some efforts underway to study these disparities, there seems to be little coordination of effort.

Current approaches to health promotion and prevention of cardiovascular disease, cancer, and diabetes do not approach the potential of the existing state of knowledge. A concerted effort to increase application of public health and clinical interventions of known efficacy and to increase utilization of screening tests for their early detection could substantially reduce the human and economic costs of these diseases (Eyre et al., 2004).

Gap Analysis

The estimated universe of possible consumers is 654,175 including realized (171,600) and unrealized (482,575) access.

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

In poll after poll, disease and health care are Americans' top concerns. However, most of the polls focus on health care costs more than prevention and management of disease and illness or the management of a healthy lifestyle to prevent disease. Lifestyle behaviors—tobacco use, overeating, lack of balanced diet, alcohol and drug use, and lack of exercise—as well as age are all important factors in the prevalence of disease and in the control of health care costs.

According to the Centers for Disease Control and Prevention (CDC), life expectancy at birth for Americans reached an all-time high at 77.9 in 2004. This compares to 77.6 years in 2003 and 77.3 in 2002 (NCHS & CDC, 2001). With greater life expectancy, there is a larger percentage of persons with chronic disease, as well as increased costs for managing the diseases of these persons.

The frequently documented gaps in economic and cultural access to the health system are magnified for the chronically ill. First, the uninsured and underinsured report poorer quality of life, fewer visits to doctors, less adequate knowledge about how to care for their illness, poorer relationships with their doctors, and less benefit from modern standards of care. Similarly, African-Americans, Hispanics, and women often report receiving less good care (The Robert Wood Johnson Foundation, 2001). Secondly, about one-third of the chronically ill in America simply are not receiving the information and services needed to manage their illness successfully. Remarkably high rates of dangerous health behaviors among people with distinctively high risks for complications of their illness have been found. Almost two-thirds of diabetics do not exercise regularly, and 38 percent have never had a doctor observe them monitoring their blood sugar; 26 percent of coronary disease sufferers surveyed still smoke—and only half of them have had a doctor advise them to quit; 40 percent of those with hypertension say they have not been advised to limit salt intake or control their weight (The Robert Wood Johnson Foundation, 2001).

Prevention is a major issue and consideration for all chronic illnesses. Chronic conditions are inherent in most diseases, with a varying impact across all social and economic sectors. According to Harris Interactive (June 2003), the age of infectious disease has now become the age of chronic disorders. Today, the major causes of death are heart and vascular disease, chronic degenerative diseases, and cancer—all largely incurable and increasing in incidence (but controllable to some extent, and people live years with them). The strategies that worked so well to eliminate acute infectious diseases do not seem to work for chronic and degenerative conditions.

The old paradigm was the U.S. health care system's design to mainly treat illness and engineer dramatic rescues from injury or illness—mostly with surgery and medication. This works well for younger, basically healthy people. However, the system has been slow to adapt to the new challenge of chronic illness in old age. The new paradigm is a self-management model of health care for chronic conditions; prevention; promotion of healthy life style; and education about high-risk behaviors.

Addressing people’s concerns about chronic illness in the context of the new paradigm is one of the functions of organizations focused on specific chronic illnesses. Prevention education is their other focus. For most, seeking information about a disease arises from a concern or a crisis involving that disease; when this occurs, people tend to seek information from sources identified with that disease.

A study by the Center for Health System Change...

...asked adults whether, during the past 12 months, they had looked for or obtained information about a personal health concern from a variety of sources other than their doctor, including books or magazines, television or radio, friends or relatives, and the Internet. Only one in six consumers turned to the Internet for health information (16 percent or 30 million adults). In contrast, nearly one in four adults relied on books or magazines for information (23 percent or 44 million adults), and another 20 percent or 37 million adults turned to friends or relatives. (Tu and Hargraves, 2003)

Persons with chronic illness were more likely to seek information than those who were healthy. Furthermore,...

...some 32 million people, or 17 percent of all adults, neither sought health information nor saw a doctor in the past year. And 9 million adults had health problems – either reporting a chronic condition or fair or poor health status – yet did not see a doctor and sought no health information”. Such consumers tend to have less education and lower incomes and are disproportionately uninsured, male and minority. These hard-to-reach people will be at a distinct disadvantage in a health care system that demands more consumer involvement unless aggressive education strategies are targeted toward them. (Tu and Hargraves, 2003)

Chronic diseases, the nation’s leading causes of death, illness, and disability, cause over 70 percent of deaths and account for roughly an equivalent proportion of total health care costs in the United States – and if current trends continue, the proportion of deaths and health care costs attributable to chronic diseases will grow even higher as the population ages. . . Reasonably, public health activities might be only minimal if there was little that could be done besides intensive clinical care. . . Vigorous, aggressive public health efforts are able to have great impact in preventing or greatly delaying chronic disease and associated disabilities. (Centers for Disease Control and Prevention, 2003)

PUBLIC POLICY ISSUES

NATIONAL

Laws and Regulations

Preventive Health and Health Services (PHHS)

The Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) authorized a series of health and social services block grants to states for carrying out programs that were previously

authorized separately. The final version was signed into law on August 13, 1981, amending the PHS Act to create the Preventive Health and Health Services Block Grant (PHHSBG). The PHHS Block Grant is a mandatory grant given to 61 grantees (50 states, the District of Columbia, 2 American Indian Tribes, and the 8 U.S. Territories) by Congress annually. The original legislation placed in the PHHS Block Grant the following categorical programs:

- Emergency Medical Services
- Hypertension
- Home Health Services
- Health Incentive Grants (314d)
- Urban Rodent Control
- Health Education/Risk Reduction
- Fluoridation

The PHHS Block Grant consolidated funds from these programs into a proportional formula based grant. With the exception of allotments for services for rape victims, which is a population-based formula, each grantee's proportion of PHHS Block Grant funds is equal to the percentage of funds received by the grantee during fiscal year (FY) 1981 under the former categorical program. State departments of health administer these funds.

The block grant has been amended several times since its initiation, and is the primary source of flexible funding that provides states the latitude to fund any of 265 national health objectives available in the nation's Healthy People 2010 health improvement plan. The PHHS Block Grant is used to support clinical services, preventive screening, laboratory support, outbreak control, workforce training, public education, data surveillance, and program evaluation targeting such health problems as cardiovascular disease, cancer, diabetes, emergency medical services, injury and violence prevention, infectious disease, environmental health, community fluoridation, and sex offenses. Because of the variance in the allowable uses of the funds, no two states allocate their block grant resources in the same way, and no two states provide similar amounts of funding to the same program or activities. A strong emphasis is being placed on adolescents, communities with little or poor health care services, and disadvantaged populations. The states depend on the block grant to support public health funding where no other adequate resources are available.

Title III-D of the Older Americans Act

The Administration on Aging administers the Older Americans Act, Title III-D funds to support disease prevention and health promotion services. This portion of the Older Americans Act requires that disease prevention and health promotion services and information be provided at senior centers, meal sites, and other appropriate locations, giving priority to areas of the state that are medically underserved and in which there are large numbers of older individuals with the greatest economic need for these services. Designated funding for these activities is intended to provide seed money for developing health promotion and disease prevention programs with other community partners and to serve as a catalyst in developing health promotion and disease prevention activities. In 2003, Congress appropriated a total of \$21.9 million for Title III-D preventive health services as part of a Title III budget of \$1.25 billion. In addition, the Administration on Aging supports other health promotion activities by hosting a national summit on health promotion; funding the National Resource Center on Nutrition and Physical Activity and the National Resource Center for Evidence Based Programs; and working with the Centers for Disease Control and Prevention, the National Institute on Aging, the Agency

for Health Care Research and Quality and the Centers for Medicare and Medicaid Services to develop coordinated health promotion strategies.

Specifics of funding are outlined in Section IV of the report.

Policies

There are many public policy components to educate the public about health care issues, especially the importance of prevention. Below are some of the key policies and regulations.

Healthy People 2010

The major public policy agenda related to health in the U.S. is articulated in the “Healthy People 2010 & Steps to a Healthier U.S.: Leading Prevention.”

The Vision of Healthy People 2010 is a community where diseases are **prevented** when possible, **controlled** when necessary, and **treated** when appropriate.

Strategies to achieve this vision are:

- Increase the quality and years of healthy life.
- Eliminate health disparities.
- Reduce the burden of disease:
 - Obesity;
 - Diabetes;
 - Asthma;
 - Cancer; and
 - Heart Disease & Stroke.
- Address risk factors:
 - Physical inactivity;
 - Poor nutrition;
 - Tobacco use; and
 - Youth risk taking.

REACH

Racial and Ethnic Approaches to Community Health (REACH) is a federal initiative with a goal of eliminating racial and ethnic disparities in health by the year 2010. REACH is working in the following six priority areas: infant mortality, breast and cervical cancer, cardiovascular diseases, diabetes, HIV infections/AIDS, and child and adult immunizations.

Centers for Disease Control and Prevention & Public Health Efforts

The Centers for Disease Control and Prevention (CDC) focus on what and how public health efforts should be structured. At the same time, private nonprofit health organizations engaged in specific disease-focused consumer health education can be (and are) similarly focused. Marks suggests that...

...the actions of public health practitioners should be in accordance with four key principles: primacy for prevention, dependence on science, quest of equity and social justice, and interdependence ... Primacy for prevention means that people would rather not develop chronic illnesses or would like to delay their development as long as possible ... Dependence on science means that all public health programs, policies,

and educational efforts should be based upon the best available scientific evidence. ... Quest for equity and social justice is based on the recognition that although public health organizations have a responsibility for everyone, rich and poor, insured and uninsured, urban and rural, they have a special responsibility for the underserved and for those in greatest need ... Interdependence demands that we develop community approaches for dealing with interrelated health problems and broaden our network of partners. (Marks, 2003)

Office of Disease Prevention and Health Promotion (ODPHP)

Congress established the Office of Health Information and Health Promotion, which later became the Office of Disease Prevention and Health Promotion (ODPHP), to address the lack of improvement in illness, disability, and premature death despite the vast increase in health care expenditures and the greatly improved access to care for most Americans. The mission of ODPHP is to provide leadership, coordination, and policy development for public health prevention activities by establishing and promoting national health objectives and dietary guidelines for Americans. ODPHP is within the Office of Public Health and Science (OPHS), a division within the Office of the Secretary.

Its authorizing legislation (Title XVII, Section 1701 of the Public Health Service Act) gives ODPHP authority to establish national health objectives and to establish a National Health Information Center. Special legislation (Public Law 101-445) establishes the role of the secretaries of HHS and USDA in publishing the *Dietary Guidelines for Americans* every 5 years.

ODPHP focuses national attention on disease prevention and health promotion issues and keeps Americans informed of ways to reduce their risk of disease and increase years of healthy life. ODPHP provides leadership, coordination, and policy development for disease prevention and health promotion programs by 1) providing a cohesive framework for the prevention activities of the department; 2) serving as the focal point within HHS for nutrition policy development and coordination; 3) developing and promoting innovative approaches to communicating health information; and, 4) supporting health professions education, conducting policy research, and disseminating information specific to disease prevention and health promotion.

One of the most cited statistics is the imbalance of investments in medical treatment compared with prevention activities. Modifiable behaviors such as tobacco use, poor nutrition, and physical inactivity account for approximately 40 percent of annual deaths. According to a 2002 article in *Health Affairs*, ninety-five percent of the trillion dollars the United States spends on health goes to direct medical care services, while just 5 percent goes to prevention. Other evidence includes legislative history of the Title XVII of the Public Health Act, select scientific articles establishing the importance of disease prevention and health promotion, and training activities. *Dietary Guidelines for Americans*, *Healthy People*, *HealthierUS*, *Steps to a HealthierUS*, and the National Health Information Center address the existing problem.

The Office on Women's Health (OWH)

The Office on Women's Health (OWH) was established in 1991 within the U.S. Department of Health and Human Services. OWH coordinates the efforts of all the HHS agencies and offices involved in women's health. OWH works to improve the health and well-being of women and girls in the United States through its innovative programs, by educating health professionals, and motivating behavior change in consumers through the dissemination of health information.

Other Policy Issues

Tobacco Use

A principal public policy issue related to disease is the decreasing and/or elimination of tobacco use, which causes a variety of diseases—heart and cancer being the two primary ones. A variety of efforts by advocacy groups at the national, state, and local levels have been engaged in the effort to stop/prevent tobacco use, especially among children and teens. States were provided with resources through the Master Tobacco Settlement to initiate tobacco use prevention and smoking cessation programs, but the results have been mixed as states have utilized the resources to plug budget deficits or to fund other programs for which they lacked resources. In this respect, Ohio is like many other states. Local efforts to create “clean indoor air” ordinances have been met with considerable opposition by the bar and restaurant lobby that fears the loss of business from such legislation, although there is considerable economic research to the contrary. In spite of this, government has embraced, and many companies have adopted, clean indoor air policies and encourage and support smoking cessation programs for their employees. While some view the issue of tobacco use as an infringement on personal rights, the primary issue is health because tobacco is the number one cause of heart disease, cancer, asthma, and can be related to some kidney disease and infant mortality.

In November 2006, the voters of Ohio passed an initiative to prohibit smoking of tobacco products in public places and places of employment and to ensure that there be a uniform statewide minimum standard to protect workers and the public from the health hazards associated with exposure to secondhand smoke from tobacco.

Obesity

While obesity is recognized as a major health problem, little can be done in the legislative policy arena to reduce an individual’s food intake, thus leaving the task to others in the community and public health arena to inform and educate consumers about nutrition, eating habits, lifestyle changes, and where to go for help. Public pressure can have an impact in terms of the food preparation practices of restaurants and information about the nutritional value of the food. Schools are becoming more conscious about what is served in their cafeterias and are making changes as a result.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

For this core service report, the target population is defined as health information consumers.

DEMOGRAPHIC CHARACTERISTICS

Status of Health among Americans

- Tobacco use is the single largest cause of preventable premature mortality in the United States (Guide to Community Preventive Services, 2004).
- Most Americans are sedentary: only 25 percent of adults and 27 percent of adolescents get moderate exercise regularly (Guide to Community Preventive Services, 2004)
- One in 4 American children today is obese and at risk of related health problems (Guide to Community Preventive Services, 2004).
- According to the American Association for Health Education (2003), despite great improvements in the overall health of the nation, racial and ethnic minority groups—including African Americans, Alaska Natives, Native Americans, Asian Americans, Hispanic Americans, and Pacific Islanders—are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:
 - **Cardiovascular Disease.** Heart disease and stroke are the leading causes of death for all racial and ethnic groups in the United States. Rates of death from heart diseases were 29 percent higher among African American adults than among white adults, and death rates from stroke were 40 percent higher.
 - **Diabetes.** Prevalence of diabetes is 70 percent higher among African Americans and about 100 percent higher among Hispanics than whites of similar age. In Native Americans/Alaskan Natives, prevalence of diabetes is more than twice that of the total population.
 - **HIV/AIDS.** Although African Americans and Hispanics represented only 25 percent of the U.S. population, they accounted for roughly 55 percent of adult AIDS cases and 82 percent of pediatric AIDS cases reported through 1999.
 - **Breast Cancer.** African American women are more likely to die of breast cancer than are women of any other racial or ethnic group.
 - **Immunizations.** Rates of immunizations are lowest among minorities.
 - **Infant Mortality.** African American, Native American, and Puerto Rican infants have higher death rates than white infants.

Other statistics from the Centers for Disease Control and Prevention (CDC) are alarming because obesity correlates to a variety of chronic illnesses.

- *Overweight* and *obesity* are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. The terms also identify ranges of weight that have been shown to increase the likelihood of certain diseases and other health problems.
- For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the “body mass index” (BMI). BMI is used because, for most people, it correlates with their amount of body fat. An adult who has a BMI between 25

and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese.

- For children and teens, BMI ranges above a normal weight have different labels (at risk of overweight and overweight). Additionally, BMI ranges for children and teens are defined so that they take into account normal differences in body fat between boys and girls and differences in body fat at various ages.
- Today, about 16 percent of all children and teens in the United States are overweight. Perhaps even more alarming than the prevalence of childhood obesity is the rapidly rising trend. Today, more than twice as many children—and almost three times as many teens—are overweight as in 1980. Even our nation’s preschoolers are affected. Among children ages 2 to 5, the prevalence of overweight has increased from 7 percent to more than 10 percent, or by more than 40 percent since 1994.
- Obesity also has risen dramatically in U.S. adults. Today 65 percent of all people age 20 and older are overweight or obese. Since 1991, the prevalence of obesity among adults has increased by more than 75 percent.
- Throughout the United States, overweight and obesity have increased in people of all ethnic groups, all ages, and both genders. This is not an isolated threat to health, nor one limited to a particular population group. The obesity epidemic threatens everyone, but not everyone is equally at risk. For example, among children and adolescents, obesity is more common in African Americans and Hispanics. According to a national study, from 1986 to 1998 overweight prevalence rose by more than 120 percent among African-American and Hispanic children, compared with more than 50 percent among whites. Among adults, overweight and obesity are highest among African-American (77.2 percent) and Mexican-American (71.7 percent) females, and American-Indian (76.6 percent) and Mexican-American (73.1 percent) males (AHA & RWJF, 2005).
- Obese or overweight people also have a lower life expectancy (AHA & RWJF, 2005). Obese people who live to age 65 have much larger annual Medicare expenses than people of normal weight (Finkelstein, 2005).

Chronic Health Conditions

A *chronic health condition* is a general term that encompasses both chronic diseases and impairments (Harris Interactive, 2003). They tend to be influenced by behavioral risk factors, requiring a shift away from the traditional medical model that focuses on pathogens and disease processes. The U.S. National Center for Health Statistics defines a chronic condition as one that lasts 3 months or more. In ancient Greece, the “father of medicine” Hippocrates distinguished diseases that were acute (abrupt, sharp and brief) from chronic ones. The term *subacute* was coined to designate the middle-ground between acute and chronic illnesses (medterms.com, n.d.).

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

- Four particular conditions—asthma, depression, diabetes, and congestive heart failure—affect nearly half of all Americans with chronic conditions. Asthma, depression, and diabetes each affect about 5.4 percent of the population. This translates into an estimated 75,275 persons in Cuyahoga County for each disease. An additional 1.8 percent of the population suffers from congestive heart failure, an estimated 25,091 persons in Cuyahoga County.

- Of the 125 million persons with long-term illnesses, 44 percent have co-morbid conditions to manage; i.e., they are experiencing more than one chronic condition. This translates into an estimated 276,008 in Cuyahoga County.
- Some of these conditions are nonfatal chronic illnesses (e.g. arthritis and hearing or vision problems); some are serious, eventually fatal, chronic conditions (e.g. cancers, organ system failures, including those affecting the heart, liver, kidney, or respiratory system, dementia, and strokes); others are considered frailty, i.e., the fragility of multiple body systems as their customary reserves diminish with age and disease (Lynn and Adamson, 2003).
- The uninsured and underinsured report poorer quality of life, fewer visits to doctors, less adequate knowledge of how to care for their illness, poorer relationships with their doctors, and less benefit from modern standards of care (The Robert Wood Johnson Foundation, 2001).
- One-third of the chronically ill in America simply are not receiving the information and services needed to manage their illness successfully (The Robert Wood Johnson Foundation, 2001).

The chronic disease entities described in this report are arthritis, cancer, cardiovascular (heart) diseases, chronic obstructive pulmonary disease, diabetes, epilepsy, hemophilia, kidney disease, muscular diseases, sickle cell anemia, and strokes. For this analysis, prevalence and incidence numbers will be used to describe the persons affected by a condition, illness or disease.¹ (See Attachment 3 for a detailed description of each of these.)

Consumers of Disease/Disability Information

Consumers of disease/disability information can include persons who are or suspect they are at risk for, have symptoms of, or are diagnosed with a disease or illness (primarily a chronic illness). Disease knows no specific race, ethnic group, gender, or age. However, the prevalence of many of these diseases is greater among minority populations, as was noted previously. This may be due to lack of access, insurance, education, and lifestyle. Furthermore, there has been an increase in the number of patients who are uninsured, underinsured, and unemployed (without a COBRA).

Two key trends are directly affecting consumers of health care information according to The Robert Wood Johnson Foundation (2001):

- The increasingly more popular cost containment strategy of consumer-driven health care plans where responsibility for making choices about care, including treatment options is shifted to consumers. (These plans are often characterized by high deductibles but cover wellness visits, cafeteria style benefits, and increased cost sharing and tiered provider networks.)
- The emergence of the self-management model of health care for chronic conditions that focuses on patients' needs and concerns where the physician and patient are partners in

¹ "Prevalence" quantifies the proportion of individuals in a population who have a disease during a specific time period. "Incidence" refers to the number of new cases of disease that develop in a population of individuals at risk during a specific time period. While both prevalence and incidence rates have similar denominators (that is, the population at risk) and include new cases in their numerator, prevalence rates also contain existing cases in the numerator. Some of the diagnoses are referred to as (1) conditions, and (2) illnesses or diseases. Conditions, illnesses, and diseases can be acute, temporary, progressive, and/or chronic.

care (as opposed to the medical model where the doctor tells patients what to do and patient complies). Since chronic conditions wax and wane over time, and often have no definitive treatment plans, patients often need to make daily decisions regarding their self-care. Self-management for chronic conditions is a centerpiece for long-term care and requires greater access to information. Therefore, an empowered health care consumer needs to have easy access to accurate information that is culturally competent and respects patient centered concerns.

Two recent studies differ significantly in the reported number of consumers seeking information:

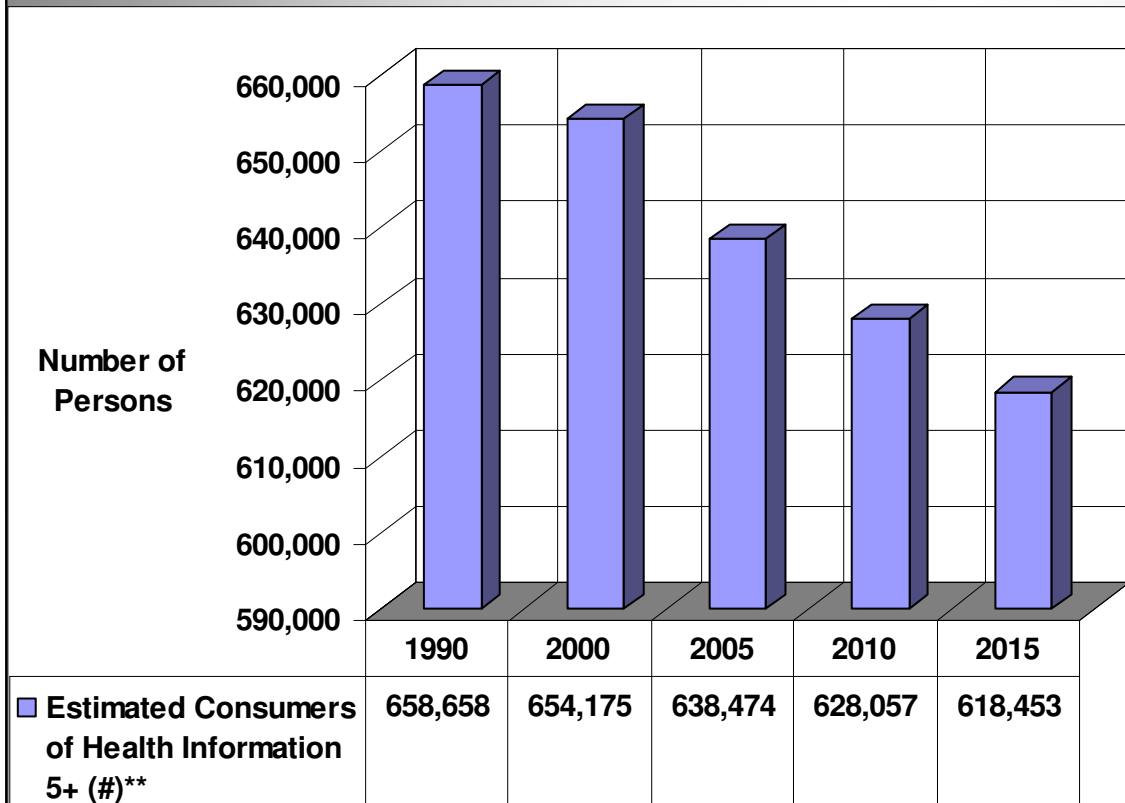
- Per a 2001 report by the Center for Studying Health System Change (an organization funded principally by the Robert Wood Johnson Foundation and affiliated with Mathematica Policy Research, Inc.), 38 percent of adults sought health information from a source other than their doctor in the previous year. Among individuals with chronic conditions, 44 percent were reported to seek health information.
- According to a 2005 RAND Corporation report, more than 60 percent of American consumers have searched for information to help them make treatment decisions in the last 12 months, with about one-third saying the information they found affected their treatment choices or their choice of a health care facility.
- Per the Health System Change report, consumers who neither saw a doctor nor sought health information tend to have less education and lower incomes, are disproportionately uninsured, male, and members of racial or ethnic minority groups. Education level is the key variable in explaining who is more likely to seek health information. People with a college degree are twice as likely to seek health information as those without a high school diploma. Women are more likely to seek information than men, older people less likely than young, and people with low incomes are less likely than higher income people.

A susceptibility profile may be possible for some diseases, which will enable organizations that provide prevention and disease management information to more precisely target those at risk in a community. Some of these characteristics vary by disease. For example, women report higher levels of hypertension than men (52 percent versus 47 percent), asthma (9 percent versus 7 percent), chronic bronchitis (7 percent versus 5 percent), and arthritic symptoms (39 percent versus 31 percent) than men. Men report higher levels of heart disease (37 percent versus 27 percent), cancer (25 percent versus 18 percent), diabetes (18 percent versus 14 percent), and emphysema (7 percent versus 4 percent) (National Health Interview Survey, 2005).

Estimated Persons in Need

In 2000, an estimated 654,175 individuals 5 and older in Cuyahoga County were health information consumers. This includes 38 percent of the 18 and older population and 100 percent of persons 5 to 18 years. The number of estimated consumers is projected to decrease to 618,453 by 2015 because of shifts in the population. (See Figure 1.)

**Figure 1: Disease/Disability Information
Estimated Persons in Need
Cuyahoga County, 1990-2015**



Sources:

* US Census: 1990, SF1(P1); 2000, SF3 (P8); 2005-2015, Ohio Department of Development, (July, 2003).

** Estimated population 5+ who are consumers of health information, 38 percent. (Source: Issue Brief, Center for Studying Health System Change, March 2003: Details a 2001 survey of US households that found only 38 percent of adults sought health information from a source other than their doctor.); Assume 100% children/youth 5-17. Assumes same percentage of 50.2% total population across all periods.

While this estimate of persons in need of disease/disability information may be low as it excludes information that physicians may provide, 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 numbers of consumers actually served. It includes the actual number of consumers reported by agencies funded by United Way and by



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

In FY 2004, United Way (UW) funded 149,392 Cuyahoga County residents for the disease/disability information core service. (See Attachment 4.) The Western Reserve Area Agency on Aging served 218 persons and the Cuyahoga County Board of Health served 21,990.

In Cuyahoga County, 47 percent of the county's total 5+ population are male and 53 percent female. Consumers funded by United Way were 23 percent male and 65 percent female, with the remaining 12 percent unknown. The Western Reserve Area Agency on Aging (WRAAA) reported similar percentages, with 29 percent male and 71 percent female. The Cuyahoga County Board of Health (CCBOH) was not able to provide demographic data.

In 2000, according to the U.S. Census, 68 percent of the county's total 5+ population were Caucasian, 28 percent African American, and 2 percent Asian. Consumers of disease/disability information funded by United Way were 42 percent Caucasian, 22 percent African American, and less than 1 percent Asian. WRAAA consumers were 91 percent Caucasian and 9 percent African American.

Three percent of the county's 5+ population were Hispanic and 2 percent of United Way funded consumers.

No income information was available from United Way providers or the other funders.

In 2000, thirty percent of the population 5+ who are estimated consumers of disease/disability information in Cuyahoga County resided in Cleveland and the remaining 70 percent in the suburbs. (See Attachment 5.) Eleven percent of consumers funded by UW resided in Cleveland and 19 percent in the suburbs, with the remainder unknown. Data was not available for the other funders.

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of the core service for this report is: programs that provide information about the etiology, symptoms, preventive measures, screening/diagnostic procedures, and/or methods of treatment or management for specific illnesses or disabling conditions; and/or that disseminate information about the latest research with regard to a particular illness or condition.

BACKGROUND ON CORE SERVICE

Levels of Health Promotion

There are two levels of health promotion: the individual level and the community or public health level. Information dissemination at the community level is frequently the purview of public health organizations such as governmental public health departments, while disease-focused organizations are most likely to operate at the individual level (Rimer & Glanz, 2003).

Contemporary health promotion at the community level involves more than simply educating individuals about healthy practices. It includes efforts to change the organizational behavior as well as the physical and social environment of communities. It is also about developing and advocating policies, such as economic incentives, that support health. Health promotion programs seeking to address health problems across this spectrum employ a range of strategies and operate on multiple levels (Rimer & Glanz, 2003).

The individual level is the most basic one in health promotion practice, so planners must be able to explain and influence individuals' behavior. Many health practitioners spend most of their work time in one-on-one activities such as counseling or patient education, and individuals are often the primary target audience for health education materials. Because individual behavior is the fundamental unit of group behavior, individual-level behavior change theories often comprise broader-level models of group, organizational, community, and national behavior. Individuals participate in groups, manage organizations, elect and appoint leaders, and legislate policy. Thus, achieving policy and institutional change requires influencing individuals (Rimer & Glanz, 2003).

Initiatives that serve communities and populations, not just individuals, are at the heart of public health approaches to preventing and controlling disease. Community-level models explore how social systems function and change and how to mobilize community members and organizations. They offer strategies that work in a variety of settings, such as health care institutions, schools, worksites, community groups, and government agencies. Embodying an ecological perspective, community-level models address individual, group, institutional, and community issues. Communities are often understood in geographical terms, but they can be defined by other criteria too. For instance, there are communities of shared interests (e.g., the artists' community) or collective identity (e.g., the African American community). When planning community-level interventions, it is critical to learn about the community's unique characteristics. This is particularly true when addressing health issues in ethnically or culturally diverse communities. Comprehensive health promotion programs often use advocacy techniques to help support individual behavior change with organizational and regulatory change. In recent

years, innovative tools and methods for evaluation and measurement have been developed to capture the successes of community-level health promotion efforts (Rimer & Glanz, 2003).

Interventions that evolve from a comprehensive planning process, build on prior research, and use health behavior theories are more likely to be effective. By investigating what factors influence the target population's behavior, including their social and physical environments, practitioners gain the raw materials they need to meet the needs of that population. Theory helps practitioners interpret the findings of their research, making the leap from facts on a page to understanding the dynamic interactions between behavior and environmental context. Systematic approaches to tailoring, targeting, implementing, and evaluating programs provide practitioners with a framework for translating this insight into actions that improve health outcomes (Rimer & Glanz, 2003).

Because reducing risk of disease does not eliminate risk of disease, early detection of some chronic conditions has the potential to alter the natural history of disease. For cancer, cardiovascular disease and diabetes, screening for risk or early manifestations of disease can reduce incidence and mortality through recommendations for altered lifestyles, pharmacological interventions, treatment of precursor lesions, or earlier treatment of the disease itself. . . . Although the importance of prevention and early detection generally is understood, inadequacies in the structure and organization of health care delivery, along with competing societal influences, detract from the adequate delivery of and reimbursement for preventive services. As a result, the delivery of preventive care emphasizes the use of opportunities for prevention during acute and chronic illness encounters. (Eyre et al., 2004).

Health Literacy

Health promotion, early assessment, and prevention in the context of the diseases and disabilities described in this report need to consider the consumer's health literacy, methodologies to enable behavior change, methods of imparting information, the timing of information communication, and even collaborations with care providers.

Health literacy: Literacy and health literacy are skills that consumers must have to successfully navigate the health care system ... Health literacy is the degree to which people have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions ... Patients with inadequate health literacy did not read medication dosing instructions, appointment slips, and directions for an X-ray procedure accurately ... A study among patients with Type-2 diabetes found that those with inadequate functional health literacy were less likely to have good glycemic control and more likely to have poor control than those with adequate health literacy ... Knowledge of patients' literacy levels can help to inform program design, improve health outcomes, and avoid unnecessary hospitalizations ... Many techniques are available to simplify information conveyed to patients ... repeating instructions, putting the most important information first, using examples of personal experience to illustrate, and ... stories rather than abstract data are effective. As a rule, individuals with poor literacy skills rely on their listening skills to learn ... Other interventions include offering

medical instructions on audio or video tape and providing visual rather than written cues and suggesting behaviors and actions that the patient should take ... It is worth noting that even individuals who read at the college level have been found to prefer medical information that is written at a seventh grade level. (Dubow, 2004)

Models of Behavior Change

There are a number of models of behavior change that should be considered in developing disease communication programs for consumers. They are (1) the Health Belief Model, (2) AIDS Risk Reduction Model, (3) Stages of Change, and (4) Theory of Reasoned Action (Family Health International, (2002). The principles and ideas of these models provide frameworks and examples for improving the effectiveness of disease information/communication programs. For example, the Stages of Change model identifies five components in the process of behavior change, namely, *pre-contemplation*, *contemplation*, *preparation for action*, *action*, and *maintenance*. In *pre-contemplation*, an individual has a problem and the process of consciousness-raising must first occur before the individual can recognize it. The process of information dissemination can be useful during *contemplation*, which occurs when the individual recognizes the problem and considers what to do. *Preparation for action* occurs when there is a plan to do something about the problem; the process of information dissemination is specific about where and what to do. *Action* is beginning the use of new behavior consistently, and *maintenance* is the use of that behavior for longer periods of time.

Lorig and Holman identify similar approaches to patient education and identify two other important issues—the effect of change and the importance of focusing on patient perceived problems.

... [A]lthough seldom acknowledged, healthful behavior change often has emotional sequeli. Changing behavior may itself bring about feelings of loss, anxiety, fear, frustration and even depression ... Self-management programs must be based on patients' perceived problems rather than what health professionals think patients should know and do. For example, traditional arthritis education programs focus on preventing disability and disability management. While the major concern of arthritis patients is pain ... This does not mean that information about managing disability is not taught. Rather, it is taught in the context of pain management. (Lorig and Holman, 2000)

Methods of Information Dissemination

Each disease/illness affects an individual (and family) differently; may strike at different times in the life cycle; and may include numerous specific types of the disease, with different symptom pictures and affected parts of the body.

The provision of information about diseases in educational and information programs is useful when the consumer is able to (1) hear and comprehend the information, (2) mobilize inner and external resources to take action, (3) follow through on the action and receive treatment, and (4) maintain the healthy behavior that may be appropriate to the disease and the individual's situation.

The provision of information to a consumer can occur (1) prior to symptom development as preventive education, (2) with the occurrence of symptoms as diagnostic education and/or for

decision-making about treatment, and (3) post diagnosis and acute treatment for chronic disease management. The method of information provision, reception, and utilization of information is related to the consumer's socio-economic status, educational achievement, age, culture, and health literacy. Health information needs to be presented differently to various populations in culturally competent ways and according to disease.

The framing of information should be consumer focused. Information should be presented to patients based on what health professionals think patients should know and are concerned about. For example, traditional arthritis information programs focus on preventing disability and disability management; however, pain is the patients' major concern.

A disease that has many different types increases the scope of information that a provider needs to have in order to inform, educate, and assist consumers with general and specific information about a disease. For example, there are more than 100 different types of cancer.

Methods of imparting information can be active (as in outreach), passive, or both, and include print, audio, visual, and verbal. In any event, the information to be communicated must be at the literacy level of the consumer and use means that the consumer will be most likely to use effectively. In the case of each of the specific diseases and types, the information should be based on the most current information available. "Health information seeking is defined as the search for and receipt of messages that help to reduce uncertainty regarding health status and construct and social and personal (cognitive) sense of health" (Cotton et al., 2004).

The use of the Internet in seeking health information is another method of information dissemination. Cotton and Gupta's findings from a study on the use of the Internet...

...suggest that there are particular factors that discriminate between individuals who seek online vs. offline health information. These factors are ones that have traditionally been associated with the digital divide ... Inequalities associated with education and income result in a lower likelihood on Internet utilization in general and health information seeking more specifically. If ... using the Internet for health information seeking can help to disseminate health information to marginalized groups and to empower health care consumers more generally, determining ways to increase Internet usage among less educated and lower income groups may be one way to decrease inequalities associated with health care provision and decision making. (Cotton et al., 2004)

Finally, Woolf et al. suggests that promoting informed choice is a viable model for dispensing knowledge for making medical decisions. Although focused on providing information from primary care sources and not community based health organizations, there is some merit to the idea of decision counselors.

Decision counselors offer certain qualities that clinicians may lack: a talent for assembling the best educational resources for patients without the interference of competing agendas and specialty bias, and the expertise to guide patients in recognizing and applying personal preferences. (Woolf et al., 2005)

While certainly a more intensive and interactive approach than the provision of a piece of print material, the feasibility of such an approach may be useful, especially given the abundance of evidence-based data and programs that may be generated by national disease-specific organizations.

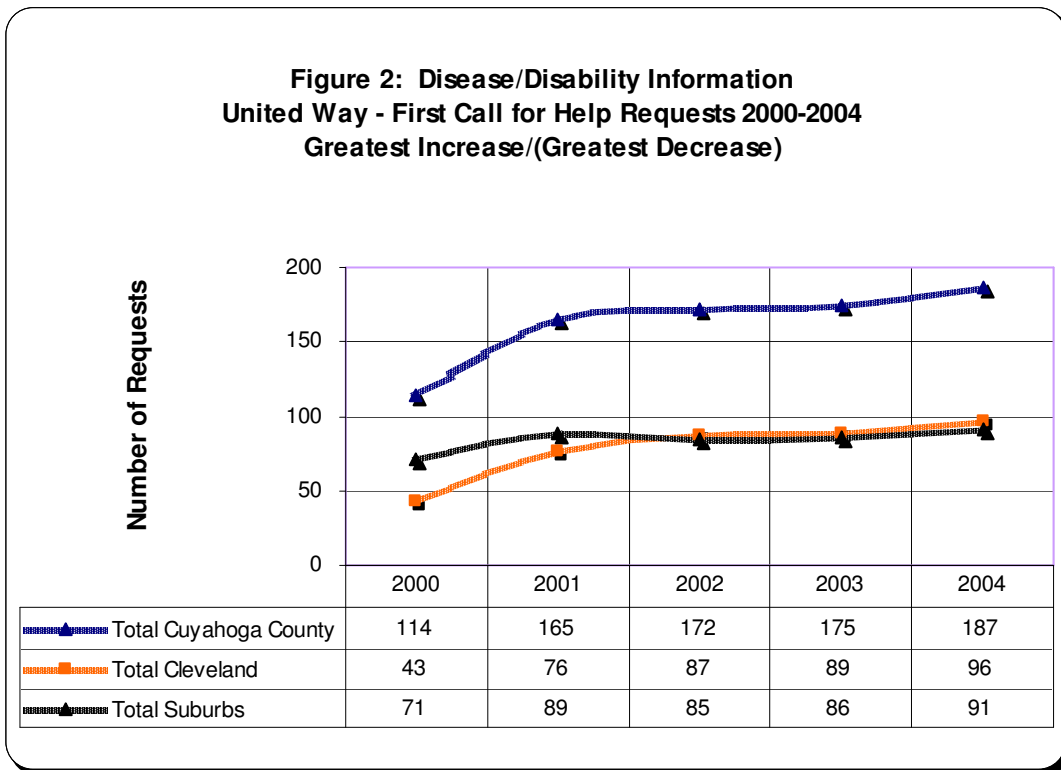
United Way – First Call for Help Call Data

Based on United Way - First Call for Help's (FCFH) database (2004), there are 66 disease/disability information providers operating from 72 different sites, 5 of which are government run and 61 are nonprofit. Disease/disability information providers are located at 33 sites in Cleveland and 39 in the suburbs. (See Attachments 6 and 7.)

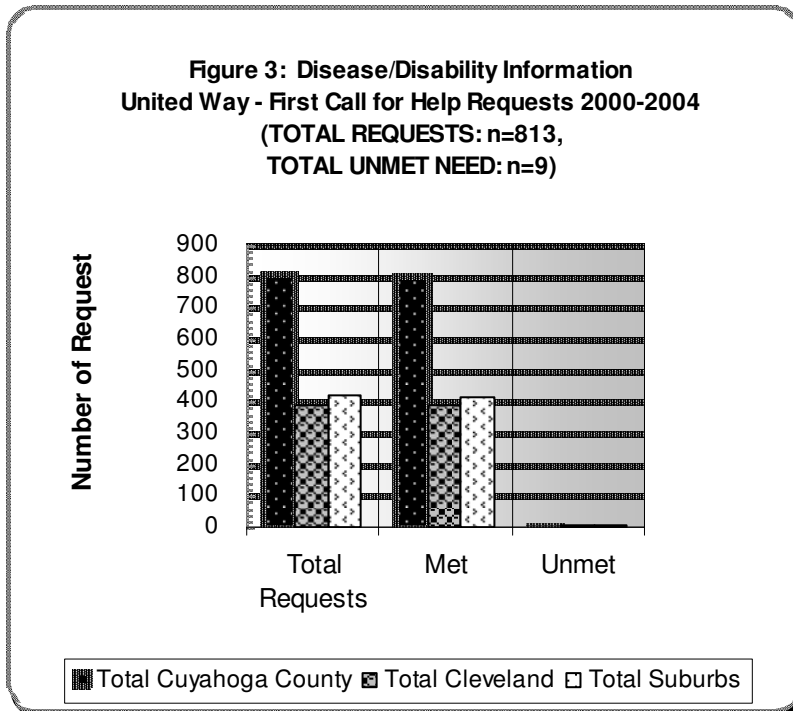
United Way – First Call for Help call data shows a slight increase in the number of total requests for disease/disability information in the county: from 114 in 2000 to 187 in 2004 (64 percent increase). Calls from the City of Cleveland increased 123 percent, from 43 to 96, and calls from the suburbs increased by 28 percent, from 71 to 91, for the same time period. (See Figure 2.) Calls came from 86 percent of Cuyahoga County zip codes with the following experiencing the highest average number of calls from 2000-2004:

- 44105 (Cleveland/Newburgh Hts/Garfield Hts - 9)
- 44102 (Cleveland/Brooklyn - 9)
- 44107 (Lakewood/Cleveland - 8)
- 44108 (Cleveland/Bratenahl - 7)

No other zip code had an average number of calls greater than 5. (See Attachment 8.)



Over the same five-year period, United Way – First Call for Help had 813 requests for disease/disability information. Of these requests, referrals were made to 99 percent of callers; however, some Cuyahoga County callers (9) had an unmet need, meaning there was no agency to which to refer the caller. Four of the calls came from the City of Cleveland and five came from the suburbs. No zip code experienced more than one unmet call for the five-year period. (See Figure 3 and Attachment 9.)



FUNDING OF CORE SERVICES

Major Government Funders

The major sources of government funding for Disease/Disability Information programs are:

- Preventive Health and Health Services Block Grant (PHHSBG)
- 2005 Omnibus Appropriations Bill
- Title III-D of Older Americans Act

NATIONAL

Preventive Health and Health Services Block Grant (PHHS)

States invest their PHHS Block Grant dollars in a variety of public health areas. PHHS Block Grant dollars are used to support existing programs, implement new programs, and respond to unexpected emergencies.

The PHHS Block Grant appropriations have been decreasing regularly since the all-time high of \$158 million in 1995 to \$99 million in FY 2006. In FY 2005, the appropriation was \$131 million. Substantial portions of the funding were related to chronic diseases and health education.

In Ohio in FY 2005, \$5.5 million was available from the PHHS Block Grant. Of this, the following was spent on chronic illness related programs:

- Arthritis, Osteoporosis, and Chronic Back Conditions: \$111,417
- Health Communication: \$137,534
- Heart Disease and Stroke: \$2,747,236
- Immunization and Infectious Diseases: \$37,108
- Respiratory Diseases: \$90,570

2005 Omnibus Appropriations Bill

The 2005 Omnibus Appropriations Bill gives several prevention efforts increased funding, including obesity, diabetes, and other chronic-disease prevention programs at the Centers for Disease Control and Prevention (CDC), as well as some demonstration projects in various states. The funding is perhaps in response to stark health statistics that undeniably mark the growing financial impact of treating conditions that behavioral interventions can help prevent. Although the 2005 appropriations bill didn't necessarily create new programs, many prevention efforts received funding increases. In particular, the CDC saw a spike in prevention funding. Chronic-disease prevention appropriations to the CDC increased by approximately \$55 million over funding for 2004. Specifically:

- Diabetes-prevention activities received an increase of \$4 million, tobacco-prevention activities grew by \$15 million, and prevention centers gained \$5 million.
- The CDC childhood obesity prevention program, VERB, earned approximately \$60 million in funding. VERB is a national, multicultural marketing campaign to fight childhood obesity and related health problems. It encourages kids to become physically active every day through paid advertising, partnerships with community agencies, and special events.
- The STEPS to a Healthier U.S. Program gained \$6 million. Through the program, the CDC helps states, cities, and tribal entities launch chronic disease prevention efforts that reduce the burdens of diabetes, obesity, and asthma; and address three related risk factors—physical inactivity, poor nutrition, and tobacco use (Holloway, 2005).

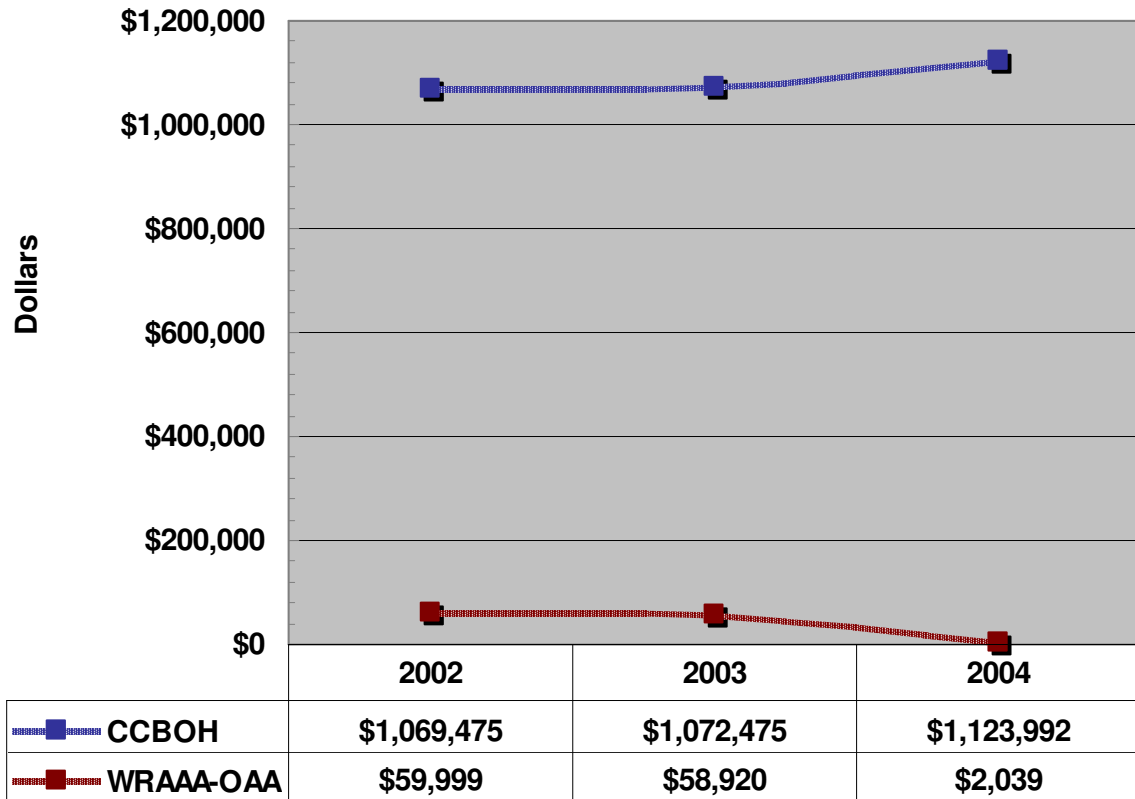
Title III-D of the Older Americans Act

As discussed in Section II, Title III-D of the Older Americans Act (OAA) funds are administered by local area agencies on aging for disease prevention and health promotion. In Cuyahoga County this is the Western Reserve Area Agency on Aging. In 2005, Ohio received a total of about \$46 million for all OAA funds, which leveraged an additional \$71 million in state and local funds. The total level of III-D funds for the state was not available at the time this report was written

Trends of Identified Government Funders in Cuyahoga County

As shown in Figure 4, government funding from the County Board of Health has maintained while the Western Reserve Area Agency on the Aging has decreased. Overall, this is a part of governmental budget cutting that is trickling down from the federal to state and local governments.

Figure 4: Identified Government Funding for Disease Disability Information Cuyahoga County, CY 2002-2004



Source: Cuyahoga County Board of Health and Western Reserve Area Agency on Aging Older American’s Act

Other Funders

In addition to federal funding sources, there are a number of national foundations that have specialized focus on health promotion. Three of the major foundations are: The Henry J. Kaiser Family Foundation ; The W.K. Kellogg Foundation ; and The Robert Wood Johnson Foundation

The Henry J. Kaiser Family Foundation

The foundation is a nonprofit, private operating foundation that focuses on the major health care issues facing the nation. The foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. KFF develops and runs its own research and communications programs, often in partnership with outside organizations. The foundation contracts with a wide range of outside individuals and organizations through its programs. Through its policy research and communications programs, the foundation works to provide reliable information in a health system in which the issues are increasingly complex and the nation faces difficult challenges and choices. The foundation is not associated with Kaiser Permanente or Kaiser Industries. Two of the foundation’s current focus areas are on public policy and media, and public education (Kaiser Foundation, 2006).

W.K. Kellogg Foundation

The foundation has supported health promotion programs since the early 1970s. Traditionally, the foundation focused many of its resources on primary prevention projects to reduce high-risk behavior, with an emphasis on health education within schools, worksites, hospitals, community agencies, and universities. In 1987, the foundation shifted its focus away from these isolated projects to support efforts that integrate health promotion activities within community-based health services to serve those most in need. (Greenburg, 1990)

Currently, health programming at the Kellogg Foundation focuses explicitly on improving individual and community health, and improving access to, and the quality of, health care. Its current goal is to promote health among vulnerable individuals and communities through programming that empowers individuals, mobilizes communities, engages institutions, improves health care quality and access, and informs public and marketplace policy. Grant making takes into account the social and economic determinants of health within a person’s community, the quality of health institutions within that community, and the policies that determine how health services are organized, provided, and financed. Grant making also targets communities, health care systems, and public health as centers of change (Kellogg Foundation, 2006).

The Robert Wood Johnson Foundation

The foundation seeks to strengthen the public health system to make it better prepared to promote health and protect all Americans from a wide range of threats—from bioterrorism to emerging infectious diseases to health problems such as obesity, tobacco use, and asthma. The foundation’s approach is to help state and local public health leaders build critical skills, particularly in information management, communications and advocacy; develop new tools for leaders to use in measuring and improving performance; and advocate for sustained attention to public health needs (Robert Wood Johnson Foundation webpage, 2006).

IDENTIFIED REVENUES

As of May 11, 2006, over \$4.4 million in revenues for disease/disability information has been identified countywide. This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland. (See Table 1.)

Over twenty-five percent of the revenues are from contracts or grants from government organizations. United Way of Great Cleveland is the primary funder; it contributed 2.3 million (52.4 percent) of the total identified revenues.

Table 1: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Disease/Disability Information, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			0.00%	726,213	10.52%
Britton Fund	2004	10,000			
Bruening Foundation, Eva L. and Joseph M.	2003	25,000			
Cleveland Foundation, The	2004	281,391		66,625	
Mandel Foundation	2003	1,000			
McGregor Foundation, The	2004	57,923			
Mt. Sinai Health Care Foundation, The	2003	285,000			
Murphy Foundation, The John P	2004	1,000			
Nord Family Foundation, The	2003	17,500			
Reuter Foundation, The	2004	20,000			
Saint Luke's Foundation	2004	30,265			
Sisters of Charity Foundation of Cleveland	2004	40,000			
Other Private Foundations - Not Elsewhere Classified				724,746	
The Sherwick Fund (of The Cleveland Foundation)	2004	38,000			
Cleveland Electric Illuminating Co. Foundation	2004	22,150			
Eaton Charitable Fund	2003	18,500			
Key Foundation	2003	48,305		6,000	
Sherwin-Williams Foundation, The	2004	3,500			
Other Corporate Foundations - Not Elsewhere Classified				20,000	
Forest City Enterprises	2003	72,333			
Total - Foundations & Trusts		971,867	22.04%	817,371	11.84%
Total - Special Events - Growth			0.00%	1,717,422	24.89%
Combined Federal Campaign				10,887	
Jewish Community Federation				20,500	
Total - Federated Fundraising Organizations		0	0.00%	31,387	0.45%
United Way of Summit County				24,749	
Other United Ways - Not Elsewhere Classified				12,000	
Total - Other United Ways		0	0.00%	36,749	0.53%
Department of Job and Family Services				194,697	
Subtotal State of Ohio		0	0.00%	194,697	2.82%
WRAAA - OAA - III-D	CY2004	2,039			
Subtotal Regional Funding Sources		2,039	0.05%	0	0.00%
Cuyahoga County Board of Health	2004	1,123,992			
Subtotal Cuyahoga County Funding Sources		1,123,992	25.49%	0	0.00%
Community Development Block Grant				23,605	
Subtotal City of Cleveland Funding Sources		0	0.00%	23,605	0.34%
All Other Funding - Not Elsewhere Classified				75,436	
Subtotal Other Govt Funding Sources		0	0.00%	75,436	1.09%
Total - Contracts/grants from government organizations		1,126,031	25.54%	293,738	4.26%
Total - Membership dues under \$150			0.00%	99,695	1.44%
Total - Investment Income			0.00%	432,549	6.27%
Total - All Other Revenue			0.00%	434,550	6.30%
Subtotal Non - UWGrCle Support		2,097,898	47.58%	4,589,674	66.51%
Total - UWGrCle designations applied to program		276,308	6.27%	276,308	4.00%
Total - UWGrCle investment committee allocation		2,033,689	46.12%	2,033,689	29.47%
John K. Mott Youth Fund Distribution Grant		1,500		1,500	
Total - Special UWGrCle grants applied to programs		1,500	0.03%	1,500	0.02%
Subtotal UWGrCle Support - 4001, 4701 & 4703		2,311,497	52.42%	2,311,497	33.49%
Total Support/Revenue		4,409,395	100%	6,901,171	100%

REIMBURSEMENT/COST

Not relevant because of breadth of the subject matter and modes of delivery.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

The value of health information is based on the assumption that having knowledge will enable and empower consumers to make choices and take action on their health care concerns and needs. Changes in the health care system, and the need for greater consumer involvement in the process, necessitate the need for greater communication approaches by health care organizations.

Some best practices in this service area are assertive community treatment teams, community health workers, dual diagnosis integrated treatment teams, multi-family psychological education, supportive employment, illness management and recovery, cognitive behavior therapy, multi-system therapy, teaching family model, treatment foster care, and dialectic behavior therapy. These are local programs designed to reach underserved populations and to provide adequate services.

Per *Guides to Community Preventive Services* (2004), the following prevention strategies have been found to be effective (based on “strong” or “sufficient” evidence):

- Methods for tobacco use prevention and control for which there is strong or sufficient evidence:
 - Strategies to reduce exposure to environmental tobacco smoke (smoking bans and restrictions)
 - Strategies to reduce tobacco use initiation by children, adolescents, and young adults (increasing the unit price for tobacco products; mass media education (campaigns) when combined with other interventions)
 - Strategies to increase tobacco cessation (increasing the unit price for tobacco products; mass media education campaigns when combined with other interventions)
 - Strategies to increase tobacco cessation appropriate for health care systems (provider reminder systems to individuals; those plus provider education, reducing patient out-of-pocket costs for effective treatments for tobacco use and dependence, patient telephone support quit lines when combined with other interventions.
- Methods for promoting physical activity for which there is strong or sufficient evidence:
 - Informational approaches (community-wide campaigns; “point-of-decision” prompts)
 - Behavioral and social approaches (individually-adapted behavior change, school-based physical education, non-family social support)
 - Environmental and policy approaches (creation and/or enhanced access to places for physical activity.)
- Diabetics who tightly control their blood sugar levels can cut their risk of heart attacks and strokes in half.
- Health promotion is another critical factor in optimizing outcomes for older adults by delaying the onset of diseases, managing chronic illnesses, maximizing function, and alleviating symptoms. Even in late life, health promotion matters.
- Efforts to integrate and standardize information systems across settings and providers will improve access to timely and relevant information, promoting optimal care.

A long-awaited federally funded study shows that diabetics who tightly control their blood sugar levels can cut their risk of heart attacks and strokes in half. The findings, from nearly 1,400 diabetics who have been followed for more than a decade, provide the first direct evidence that the risk of the most serious complications of this disease that affects millions of Americans can be minimized by aggressive treatment. “There are nearly 21 million Americans who have diabetes, and the number is rising because of the increasing number of elderly and obese people. This shows that it is really important both for physicians and patients to really focus on this,” said Judith E. Fradkin of the National Institute of Diabetes and Digestive and Kidney Diseases, which funded the study. “It requires eternal vigilance, and it’s hard. But this is pretty definitive evidence of the value of making that effort” (Stein, 2005).

Health promotion is a critical factor in optimizing outcomes for older adults by delaying the onset of diseases, managing chronic illnesses, maximizing function, and alleviating symptoms. Even in late life, health promotion matters. Improving outcomes for frail older adults starts with primary prevention to improve general health, delay the onset of disability, and increase productivity and well-being (Young, 2003).

Within Cleveland, the Visiting Nursing Association (VNA) administers a leading practice that uses technology to promote health, educate about medication abuse, and help older people perform self-assessments of their health. Also, informants mentioned that there are physicians who have gone into the homes of older adults to administer medical care.

Advances in telecommunications and assistive devices have the potential to enhance information flow and promote independence for older adults. Efforts to integrate and standardize information systems across settings and providers will improve access to timely and relevant information, thereby promoting optimal care. Telemedicine has particular relevance for resource-poor rural communities as a means for educational outreach to health care providers and informal caregivers, to facilitate communication between health care providers and out of town adult children, to provide access to specialists, and to improve the capacity for consultation (Goins, Kategile, & Dudley, 2001 in Young, 2003).

What Doesn’t Work

There are a number of barriers to consumers’ utilization of disease-focused information: (1) language and culture that may hinder access to information for some, (2) the digital divide between young and old, poor and middle-income persons, computer literate and computer shy, (3) consumer denial and fear of disease, and (4) physical and economic access to health care.

Current approaches to health promotion and prevention of cardiovascular disease, cancer, and diabetes do not approach the potential of the existing state of knowledge. A concerted effort to increase application of public health and clinical interventions of known efficacy to reduce prevalence of tobacco use, poor diet, and insufficient physical activity—the major risk factors for these diseases—and to increase utilization of screening tests for their early detection could substantially reduce the human and economic costs of these diseases (Eyre et al., 2004).

The prevalence of some diseases in some geographic areas may be related to racial disparities in health. While there are some efforts underway to study these disparities, there seems to be little coordination of effort.



Health promotion efforts about diseases and disabilities in communities showing evidence of racial disparities need to be carefully constructed around cultural as well as evidence-based programs. Collaboration with organizations located in these communities may provide opportunities to improve disease/disability health education.

IMPACT ON COMMUNITY

There are many cost benefit studies that have been done on specific types of health education programs and work-place health promotion efforts. Expenditures for health care in the United States continue to rise and were estimated to reach \$1.66 trillion in 2003, according to U.S. Department of Health and Human Service's 2003 publication "Prevention Makes Common 'Cents.'" Much of the cost can be attributed to the diagnosis and treatment of chronic diseases and conditions such as diabetes, obesity, cardiovascular disease, and asthma. A recent review of health promotion and disease management programs found a significant return on investment for these programs, with benefit-to-cost ratios ranging from \$1.49 to \$4.91 (median of \$3.14) in benefits for every dollar spent on the program (U.S. Department of Health and Human Services, 2003).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Currently, there are no standards for disease/disability health educators. Professionals functioning in health promotion capacities come from a variety of educational backgrounds—nursing, social work, psychology, and public health.

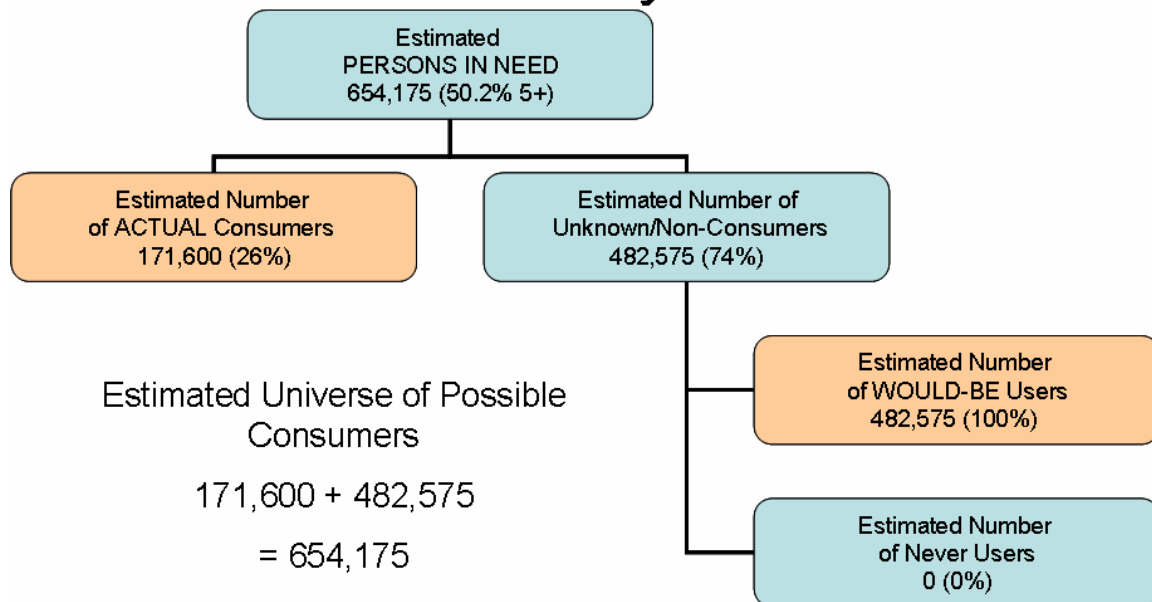
Some disease-specific health promotion programs have been developed by national health organizations and are based on research findings and effective evidence-based programs.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Disease/Disability Information:

- A conservative estimate of 654,175 persons need disease/disability information. This includes 100 percent of children and youth five through 17 years and 38 percent of adults 18 years and older, the percentage of adults who sought health information from a source other than their doctor, according to a 2001 survey of U.S. households.
- Based on available information about actual consumers, approximately 171,600 persons have realized access to disease/disability information. This is the sum of persons who were funded through United Way (149,392), WRAAA (218), and the Cuyahoga County Department of Health (21,990). The assumption is that there is no duplication across these sources.
- This leaves a net estimate of 482,575 who are either receiving services from unaccounted-for sources or are not receiving disease/disability information. (654,175 – 171,600 = 482,575)
- This leaves an estimated universe of 654,175 possible consumers, including realized (171,600) and unrealized (482,575) access. (See Figure 5.)

Figure 5 - Consumer Estimate: Disease/Disability Information



Service Site Index

Because of the nature and diversity of this service, no service site index was completed.

Service Capacity

Two underserved populations are African-Americans that live on the west side of Cleveland and Cleveland's Hispanic population according to United Way focus group participants (2005). They also believe that Cleveland lacks health care professionals of color. For example, there are only three or four certified diabetes educators who are African-American in Cleveland. Currently, consumers may have difficulty accessing some health promotion programs due to transportation, language, and time constraints.

VII. SUMMARY

The following are the major findings from the research on this service:

- The new paradigm is a self-management model of health care for chronic conditions; prevention; promotion of healthy life style; and education about high-risk behaviors.
- The major public policy agenda related to health in the U.S. is articulated in the “Healthy People 2010 & Steps to a Healthier U.S.: Leading Prevention.” The vision is of a community where diseases are prevented when possible, controlled when necessary, and treated when appropriate.
- Racial and Ethnic Approaches to Community Health (REACH) is a federal initiative with a goal of eliminating racial and ethnic disparities in health by the year 2010.
- A principal public policy issue related to disease is the decreasing and/or elimination of tobacco use, which causes a variety of diseases—heart and cancer being the two primary ones.
- The Preventive Health and Health Services Block Grant appropriations have been decreasing regularly since the all-time high of \$158 million in 1995 to \$99 million in FY 2006. In FY 2005, the appropriation was \$131 million. Substantial portions of the funding were related to chronic diseases and health education.
- In Cuyahoga County, government funding for disease/disability information decreased slightly from \$1,129,474 in 2002 to \$1,126,031 in 2004. Funding from the Cuyahoga County Board of Health increased while Western Reserve Area Agency on Aging decreased.
- As of May 11, 2006, over \$4.4 million in revenues for disease/disability information has been identified countywide.
- There are a number of methods for encouraging tobacco use prevention and control and promoting physical activity for which there is strong or sufficient evidence. In addition it has been found that diabetics who tightly control their blood sugar levels can cut their risk of heart attacks and strokes in half; that efforts to integrate and standardize information systems across settings and providers can improve access to timely and relevant information, thereby promoting optimal care.
- Improving outcomes for frail older adults starts with primary prevention to improve general health, delay the onset of disability, and increase productivity and well-being (Young, 2003).
- Efforts to integrate and standardize information systems across settings and providers will improve access to timely and relevant information, thereby promoting optimal care.
- The prevalence of some diseases in some geographic areas may be related to racial disparities in health. While there are some efforts underway to study these disparities, there seems to be little coordination of effort.
- The estimated universe of possible consumers is 654,175, including realized (171,600) and unrealized (482,575) access.

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ATTACHMENTS

Attachment 1: Researcher List

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Attachment 2: Technical Notes

Technical Notes: Methodology, Caveats, Limitations of Data

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

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

Unit of Analysis

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

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

United Way - First Call for Help Data

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

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

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

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

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

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

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

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

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

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

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

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

Funding Information for Core Services

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

Foundation Funding

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

Federated Funding Sources

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

Government Funding

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

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

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases where Medicaid is a significant source of revenue, the data was entered as an

aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

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

Medicaid Funding

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

Entered as Aggregate Total Under Appropriate AIRS Level

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

Entered as Aggregate Total Under Third Party Payee/Direct Bill

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

United Way of Greater Cleveland Funding

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees

and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

United Way Agency Revenues

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

Consumer and Financial Data: Caveats

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

All Core Services

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

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

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

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

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

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

Gap Analysis Methodology & Limitations

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

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

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

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

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

Service Site Index

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

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

Specific Service Issues

Senior Services

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

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

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

References

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Attachment 3: Chronic Diseases – Incidence and Prevalence

Arthritis: 42.7 million adults in the U.S. have doctor diagnosed arthritis (just over 1 in 5 adults). The percentage of adults with arthritis ranges from 18 percent in Hawaii to 37 percent in West Virginia. The state median was 27 percent in 2003. Arthritis affects all race and ethnic groups: 34.3 million white adults, 4.4 million black adults, 2.6 million Hispanic adults, and 1.3 million adults of other races have arthritis. The risk of arthritis increases with age and is more common among women than men.

In Ohio in 2003, there were 2,538,000 adults with arthritis, or about 30 percent of the adult population. Thirteen percent of the 18-44 year olds, 41 percent of the 45-64 year olds, and 55 percent of the 65+ year olds had arthritis. Thirty-four percent of women and 25 percent of men were afflicted, while 30 percent of whites, 26 percent of blacks, and 26 percent of Hispanics had arthritis. Arthritis is not a single disease; there are more than 100 different types, the most common being osteoarthritis, rheumatoid, and gout (Centers for Disease Control and Prevention (2004).

Cancers: Cancer remains the most serious threat to the health and longevity of Ohio residents under age 75 and is the second leading cause of death among Ohioans ... The annual cancer incidence rate (2001) in Ohio is 464 cases per 100,000 residents and is 2 percent less than the rate at the national level for 2000 (473 per 100,000). The leading sites of cancer incidence include: lung and bronchus, breast, prostate and colon and rectum. The majority of cancers of the lung and bronchus and the colon and rectum were diagnosed at later stages, which is associated with lower probability of survival ... The annual cancer mortality rate in Ohio for 2001 was 207 per 100,000 residents, and is nearly 4 percent higher than the rate at the national level. The leading sites of cancer mortality include: lung and bronchus, colon and rectum, breast and prostate. Ohio ranks 12th in the country among males in the overall cancer mortality rate and ninth among females” (Ohio Department of Health, 2004).

About 88 percent of total cancer cases occurred among whites, 9.1 percent among blacks and less than 1 percent among persons of additional races. However, the annual age-adjusted incidence rate per 100,000 is highest among blacks (436.6 per 100,000) compared to whites (460.8 per 100,000) and additional races (430.3 per 100,000). About 89 percent of total cancer deaths occurred among whites, 10.7 percent among blacks and less than 1 percent among additional races. The average annual age-adjusted mortality rate for blacks, however, is 30 percent higher than the mortality rate for whites (270.3 vs. 209.1 per 100,000 respectively. (Ohio Department of Health and The Ohio State University, 2005)

Table A: Cancer Incidence and Mortality: Average Annual Number of Invasive Cancer Cases and Age-Adjusted rates per 100,000 by Gender for Cuyahoga County, 1997-2001.

	Male		Female		Total	
	# Cases	Rate	# Cases	Rate	# Cases	Rate
Incidence	3,839	580.2	4,015	441.8	7,854	493.5
Mortality	1,818	279.6	1797	183.8	3,614	220.0

Source: Cancer Incidence and Mortality Among Ohio Residents, 1997-2001. Ohio Cancer Incidence Surveillance System, Ohio Department of Health and the Ohio State University, Columbus, OH, March 2005.

Cardiovascular disease (CVD) is the nation’s leading killer among both men and women, and affects all racial and ethnic groups. The disease is the leading cause of death among Americans in middle age, killing more than 160,000 people between the ages of 35 and 64 each year in the United States. In Ohio, CVD is the number one cause of death and the primary cause of premature mortality for both men and women, assuming average life expectancy of 76.7 years. Cardiovascular Disease includes Coronary Heart Disease and Cardiovascular Disease (Stroke) ... Ohio ranks 19th highest for age-adjusted mortality rate for total cardiovascular disease, 8th highest for coronary heart disease, and 34th highest for stroke ... Morbidity and mortality from CVD are related to a number of modifiable risk factors, including unhealthy behaviors (cigarette smoking, sedentary lifestyle, and poor dietary habits) and adverse health conditions (high blood pressure, elevated blood cholesterol, diabetes and obesity). Many experts view cardiovascular disease as largely preventable ... Reducing the prevalence of modifiable risk factors is an important way to reduce cardiovascular disease morbidity and mortality in Ohio. (Chan et al., 2001)

Table A2: Average Age-Adjusted Cardiovascular Disease (CVD), Coronary Heart Disease (CHD), and Stroke Mortality Rates per 100,000 population for the U.S., Ohio and Cuyahoga Co., 1998

Cardiovascular Disease	National Mortality Rate	Ohio Mortality Rate	Cuyahoga County Mortality Rate
CVD		398.9	396.1 to 421.9
CHD	208	238.8	262.0 to 329.4
Stroke	60	66.9	68.8 to 74.9

Source: Chan et al., July 2001

Table A3: Mortality Rates Variation by Gender and Race, Cardiovascular Disease (CVD), Coronary Heart Disease (CHD), and Stroke Mortality Rates per 100,000 population for Ohio in 1998.

Cardiovascular Disease	State Mortality Rate	White Males	Black Males	White Females	Black Females
CVD	398.9	450	546.9	312.5	402.9
CHD	238.8	278.7	313.9	175.1	213.9
Stroke	66.9	66.4	89.9	63.1	83.8

Source: Chan et al., July 2001

Chronic obstructive pulmonary disease (COPD) includes emphysema and chronic bronchitis and is characterized by the permanent destruction of lung tissue resulting in airflow blockage. Approximately 80 to 90 percent of COPD cases are caused by smoking. In 2001, COPD killed 123,974 Americans making it the fourth leading cause of death. COPD is the only leading cause of death on the rise and is expected to be the third leading cause of death by 2020 as the number of older people, who are most susceptible to COPD from past smoking behavior, continues to increase ... From 1997 to 2000, the average age-adjusted COPD death rate (in the U.S.) was 44 deaths per 100,000 population ... the average COPD death rate among whites was 46 deaths per 100,000 compared to 32 deaths per 100,000 for African Americans.

For this same period, the death rate for COPD in Ohio was 48.5 deaths per 100,000, 50.3 for whites and 36.2 for African Americans. At 35 COPD deaths per 100,000, the average age-adjusted COPD death rate in Cuyahoga County was well below the regional, state, and national averages. The COPD death rate for African Americans was 30 deaths per 100,000, compared to 38 deaths per 100,000 whites (UWS & FCP, 2003).

Just as COPD is more a disease of adults, asthma is more a chronic disease of children, but it affects adults too. Asthma is a complex syndrome of reversible airway obstruction, airway inflammation, and bronchial hyperirritability that occurs following exposure to stimuli such as allergens, viral respiratory infections, vigorous exercise, cold air, cigarette smoke, and air pollutants (American Academy of Pediatrics 1994) (Damberg and Kamberg, 2000).

Current prevalence estimates for the state of Ohio indicate that 10.3 percent of adults have been told by a doctor that they have asthma (872,153 adults) ... The National Health Interview Survey (2002) reports a prevalence rate for children aged 0-17 of 13 percent ... affecting 6.3 million children. Nearly one in 13 school-aged children have asthma, and the rate is rising more rapidly in preschool-aged children than in any other age group ... Asthma is the number one cause of school absenteeism due to chronic illness resulting in approximately 14 million missed school days and an estimated \$957 million loss from caretakers time off work. (American Lung Association, 2005)

Diabetes: There are two types of diabetes: Type 1 usually begins in childhood, occurs because the body does not produce enough insulin, and requires the use of insulin injections to manage the disease process.

Type 2 usually occurs in adults over age 45 but is becoming more common in younger persons. It occurs because the body cannot use its own insulin properly. It can be controlled by diet, exercise and medication, and is more common among African-Americans, American Indians, Hispanics and Asian Americans. Diabetes can damage the kidneys, eyes, nervous system, heart and blood vessels and increase the risk of heart attacks, stroke and chronic kidney disease (National Kidney Foundation, 2005). The prevalence of total diabetes in the United States for all ages in 2002 was 18.2 million people (or 6.3 percent of the population). There are about 13 million people who have been diagnosed and an additional 5.2 million people who are undiagnosed. About 210,000 people under that age of 20 have diabetes (or about 0.26 percent of all people in this age group). Approximately one in every 400 to 500 children and adolescents has Type 1 diabetes. About 18 million people age 20 years or older (or 8.7 percent of all people in this age group) have diabetes. About 8.6 million people 60 years or older (or 18.3 percent of all people in this group) have diabetes. Diabetes was the sixth leading cause of death listed on U.S. death certificates in 2000. (American Diabetes Association, 2002)

In Ohio, there were 716,000 persons diagnosed with diabetes in 2004. This represents a 23 percent increase in the number of persons with the disease since 2000. The largest growth was in the 18 to 44 year old age group (37 percent) and the 75+ age group (36 percent) (Centers for Disease Control and Prevention, 2004).

Epilepsy: is a chronic neurological condition characterized by recurrent seizures that are caused by abnormal cerebral nerve cell activity. Epilepsy is classified as idiopathic or symptomatic. Idiopathic epilepsy has no known cause, and the person has no other signs of neurological disease or mental deficiency. Symptomatic epilepsy results from a known condition, such as stroke, head injury, poisoning, Lennox-Gastaut syndrome, and cerebral palsy. More than 2 million people in the U.S. ... suffer from epilepsy; more than 300,000 people with epilepsy are under the age of 14, and more than 500,000 are over the age of 65 (Neurology Channel, 2005). Each year, about 181,000 people in the U.S. are diagnosed with epilepsy; the very young and older adults are the most likely to be affected. People of lower socio-economic status, residents of urban areas, and minority populations tend to bear a disproportionate burden. . . . Because of restrictions from certain activities, public prejudice, and public fear of people who have seizures, 20 to 30 percent of people with epilepsy are underemployed (National Center for Chronic Disease Prevention, 2004) Over 90,000 people in Ohio have epilepsy. . . . One-third of people with epilepsy are children. Epilepsy can result in developmental delays and brain damage in children. Kids with epilepsy have higher rates of grade repetition and drop out. Forty-four percent of people with epilepsy don't complete high school. One third of people with epilepsy are elderly. Ten percent of nursing home residents receive anti-seizure medication. Seizures in the elderly are caused by stroke, heart disease, brain tumors and Alzheimer's. (Epilepsy Foundation of Central Ohio, n.d.)

Hemophilia: is a genetic disorder—usually inherited—of the mechanism of blood clotting. Depending on the degree of the disorder present in an individual, excess bleeding may occur only after specific, predictable events (such as surgery, dental procedures, or injury) or occur spontaneously, with no known initiating event. . . . In hemophilia, certain clotting factors are either decreased in quantity, absent, or improperly formed.

There are three types:

Hemophilia A is the most common type of bleeding disorder and involves decreased activity of factor VIII. There are three levels of factor VIII deficiency: severe, moderate, and mild ... Individuals with hemophilia B have symptoms very similar to those of hemophilia A, but the deficient factor is factor IX. This type of hemophilia is also known as Christmas disease. Hemophilia C is very rare and much more mild than hemophilia A or B; it involves factor XI. Hemophilia A affects between one in 5,000 to one in 10,000 males in most populations. One recent study estimated the prevalence of hemophilia was 13.4 cases per 100,000 U.S. males (10.5 hemophilia A and 2.9 hemophilia B). By race/ethnicity, the prevalence was 13.2 cases/100,000 among white, 11.0 among African American, and 11.5 among Hispanic males. The vast majority of people with either hemophilia A or B are male. (HealthAtoZ, 2002)

About 20,000 people in the U.S. have hemophilia. The prevalence rate is approximately 1 in 13,600. About 400 babies are born annually with hemophilia (WrongDiagnosis. 2003). Because of its large Amish population and their high prevalence of hemophilia B, Ohio has the largest number of persons with hemophilia B in the country. Although less well known than hemophilia, von Willebrand disease is actually the most common inherited bleeding disorder—estimated to affect up to 1 percent of the population. It affects both women and men equally, but women exhibit more symptoms (Ohio Department of Health, n.d.b).

Kidney Disease: Ten to 20 million people in the United States have kidney disease but don't know it, according to researchers at the National Institutes of Diabetes and Digestive and Kidney Diseases and the National Institutes of Health. . . . Over the past decade the number of people with kidney failure doubled and the number starting dialysis or having a first kidney transplant increased by 50 percent so that more than 400,000 Americans are now being treated for kidney failure at a cost of \$25 billion annually. People with chronic kidney disease are at high risk for premature death, heart attacks and strokes as well as hypertension, anemia, bone disease and malnutrition. (Longley, 2004)

The number of Americans with kidney failure is growing by 6 percent a year, with the U.S. leading the world in the number of new cases per million. In 1997, more than 79,000 Americans developed end-stage renal disease (ESRD), or total kidney failure, bringing the total number of Americans treated for ESRD to more than 360,000. People with total kidney failure require dialysis treatments or a kidney transplant to stay alive (The Medical Reporter, 1999). During the calendar year 2001, the *prevalence* of ESRD was 392,023 U.S. residents under treatment.

Incidence (2001) was 93,327 U.S. residents who were new beneficiaries of treatment (United States Renal Data System, 2003).

The prevalence count of kidney failure in Ohio on December 31, 2002 shows 17,568 patients, or a rate of 1,530 per one million. The incidence count (newly diagnosed patients) in 2002 totaled 4,281, or an incidence rate of 360 per million (U.S. Renal Data System, 2005).

Muscular Diseases (Health Insite, 2005). There are a number of muscular diseases including chronic fatigue syndrome, fibromyalgia, muscular dystrophy, and motor neuron disease.

- *Chronic fatigue syndrome* (CFS) is an illness characterized by extreme exhaustion. Other common symptoms include aching muscles, joint pains, headache, sore throat, and flu-like sensations. The cause is unknown and recovery can take years. In some cases, people don't recover and suffer relapses throughout their lives.
- Estimates of the prevalence of CFS range from 4 to 200 per 100,000 people, and it is estimated that up to 500,000 people in the United States have CFS. There have been varying reports on the incidence of CFS in women, and estimates range from 60–85 percent of CFS cases diagnosed in women.⁵ Additionally, there appears to be a higher incidence in the African American population, with the least incidence seen among Asians and Caucasians (American Dental Association, 2006).
- *Fibromyalgia syndrome* is a condition where pain occurs in muscles and surrounding structures without any obvious tissue damage. The pain is usually widespread and people often experience fatigue. Fibromyalgia affects mostly women, between the ages of 35 to 60 years, from all nationalities and culture groups. It can also affect children. The symptoms of fibromyalgia can go up and down. Many people find the symptoms are worst first thing in the morning and last thing at night. The symptoms can be mild, moderate, or severe. There may be extended periods of time—perhaps even years—when symptoms disappear. Other people have pain every day, or there may be variations between these two extremes. The cause or causes of fibromyalgia are not known. There is no cure but treatment can help some symptoms. The symptoms of fibromyalgia can vary widely from mild to severe. The most common symptoms include any of the following: fatigue and exhaustion; pain—which may present in a variety of ways (such as aching, burning, throbbing, or stabbing). The pain may be generalized or in one area; sleep disturbance; headaches; slowed mental processing; stiffness, usually worse in the morning; anxiety; and depression. It is estimated that approximately 1 in 73 or 1.36 percent or 3.7 million people in the U.S. have fibromyalgia (WrongDiagnosis, 2003).
- *Muscular dystrophy* refers to a group of neuromuscular disorders that cause progressive and selective degeneration and weakness of voluntary muscles. There are approximately 60 separate diseases that can be classed as neuromuscular disorders, all of which involve the progressive and irreversible wasting of muscle tissue. Neuromuscular diseases are divided into three main groups:

- Dystrophies are characterized by muscle wasting from within the muscles themselves. A person affected by a muscular dystrophy disorder has a mutation within their genetic makeup that prevents the maintenance and repair of muscle tissue.
- Atrophies are characterized by muscle wasting caused by a disorder of the nerve system of the spinal cord, which influences our ability to use muscles effectively.
- Neuropathies are characterized by muscle wasting caused by a disorder of the nerve system within the peripheral parts of the body, which also influences our ability to use muscles.

People affected by atrophy or neuropathy disorders are unable to use their muscles due to problems associated with their nervous system rather than a problem within the muscles themselves.

Each of the 60 odd muscular dystrophy diseases has a separate cause. For instance, Duchenne MD is caused by a genetic defect that results in the body's failure to produce the dystrophin protein. Friedreich's ataxia is caused by the degeneration of nerve tissue in the spinal cord and nerves that extend to the peripheral areas such as the arms and legs.

There is no cure for any of the 60 neuromuscular disorders. Medical research continues in the hope of finding a cure. However, the discovery of a cure for one disorder may not necessarily have immediate application in curing another disorder.

Muscular dystrophy affects approximately 1 in 651,450 or 417 people in the U.S. It is considered a "rare disease" (WrongDiagnosis, 2003).

- *Motor neuron disease* (MND) often begins with weakness of the muscles of the hands or feet. It eventually leads to generalized paralysis. People with motor neuron disease need help with daily activities and have a life expectancy of three to five years after their diagnosis.

The physical effects of motor neuron disease (MND) can include weakness or muscle wasting, often first noticed in the hands or feet; difficulty swallowing or slurred speech; muscle twitching; cramps; emotional instability or depression; and fatigue/pain.

The causes of MND are unknown, but worldwide research includes studies on viruses, toxins, genetic factors and immune factors; nerve growth factors and chemicals that control nerve cells and allow them to communicate with each other; and growth, repair, and aging of motor neurons.

Approximately 1 in 49,566 or 0.00 percent or 5,487 people in the U.S. have MND (WrongDiagnosis, 2003).

Sickle Cell Disease is an inherited blood disorder that affects red blood cells ... blood cells that contain mostly hemoglobin S, an abnormal hemoglobin. Sometimes these red blood cells become sickle shaped (crescent shaped) and have difficulty passing through small blood vessels. When sickle-shaped cells block small blood vessels, less blood can reach that part of the body. Tissue that does not receive a normal blood flow eventually becomes damaged. There is currently no universal cure for sickle cell disease. There are several types of sickle cell disease

... Sickle cell trait is an inherited condition in which both hemoglobin A and S are in the red blood cells, always more A than S. Sickle cell trait is not a type of sickle cell disease. People with sickle cell trait are generally healthy. (Sickle Cell Disease Association of America, 2005)

Seventy-two thousand people in the U.S. have sickle cell anemia. In addition there are 2 million carriers in the U.S.; 1 in 12 African Americans are carriers. The incidence of sickle cell anemia is 1 per 500 African American births; 1 per 1,000-1,400 Hispanic-American births, and the incidence rate is 1 in 34,000 or 0.0 percent or 8,000 people in the U.S. (WrongDiagnosis. 2003).

Stroke, or cerebrovascular disease, is a loss of brain function caused by a lack of blood circulation to areas of the brain. Stroke is the third leading cause of death after heart disease and cancer and is a leading cause of long-term disability. In 2000, stroke killed more than 167,000 people, accounting for about 1 of every 14 deaths. Stroke death rates are substantially higher for African Americans than for whites. The primary risk factors for stroke are the same as those for heart disease including hypertension, high blood cholesterol, cigarette smoking and being overweight. From 1997 to 2000, the average age-adjusted stroke death rate was 63 deaths per 100,000 population. Racial disparities existed in stroke mortality rates between Whites and African Americans. From 1997 to 2000, the average stroke death rate among Whites was 61 deaths per 100,000, compared to 84 deaths per 100,000 African Americans. Stroke death rates have been decreasing about 2 percent each year in all racial categories ... The average age-adjusted stroke death rate from 1997 to 2001 for all Northeast Ohioans was 58 per 100,000 population ... Cuyahoga County—at 57 stroke deaths per 100,000 population, the average age-adjusted stroke death rate in Cuyahoga County was similar to the regional rate, but roughly 10 percent lower than the state and national averages. The stroke death rate for African Americans was 62 deaths per 100,000 population, compared to 56 deaths per 100,000 whites. From 1997 to 2001, the stroke death rate decreased more than 3 percent per year among all races and whites and by almost 2 percent per year among African Americans. (United Way Services and Federation for Community Planning [UWS & FCP], 2000)

Attachment 4: Actual Consumer Demographics

Service: Disease/Disability Information LH-270.170						
	Total Population (%) [*]	Total Population 5+ (%) ^{**}	Estimated Consumers of Health Information 5+ (%) ^{***}	Actual Number/Percent of Consumers by Funding Source ^{****}		
				UW Program Report Data Cuy Cnty Only 91.9% (%)	WRAAA (%)	Cuyahoga County Board of Health (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	CY2004	2004
5-18 years		256,467	256,467			
18+ years		1,046,599	397,708			
TOTAL	1,393,978	1,303,066	654,175	149,392	218	21,990
Percent		93.5%	50.2%			
GENDER						
Male	47.2%	47.0%	N/A	22.9%	28.9%	0.0%
Female	52.8%	53.0%	N/A	65.2%	71.1%	0.0%
Unknown Data ^{*****}				11.9%	0.0%	0.0%
Missing Data ^{*****}				0.0%	0.0%	100.0%
RACE ^{*****}						
White alone	67.1%	67.8%	N/A	42.4%	90.8%	0.0%
Black or African American alone/combo	27.9%	27.4%	N/A	21.7%	8.7%	0.0%
Asian alone/combo	2.1%	2.1%	N/A	0.3%	0.0%	0.0%
American Indian and Alaska Native alone/combo	0.7%	0.7%	N/A	0.0%	0.5%	0.0%
Native Hawaiian and Other Pacific Islander alone/combo	0.1%	0.1%	N/A	0.0%	0.0%	0.0%
Some other race alone/combo	2.1%	2.0%	N/A	0.1%	0.0%	0.0%
Unknown Data ^{*****}				35.4%	0.0%	0.0%
Missing Data ^{*****}				0.0%	0.0%	100.0%
HISPANIC ^{*****}	3.3%	3.2%	N/A	1.9%	0.0%	0.0%
AGE						
0-4	6.5%			0.8%	0.0%	0.0%
5-9	7.3%	7.8%	N/A	3.2%	0.0%	0.0%
10-14	7.1%	7.6%	N/A	2.3%	0.0%	0.0%
15-19	6.4%	6.8%	N/A	4.4%	0.0%	0.0%
20-34	19.1%	20.4%	N/A	25.2%	0.0%	0.0%
35-54	29.3%	31.4%	N/A	26.9%	0.0%	0.0%
55-64	8.7%	9.3%	N/A	16.3%	0.0%	0.0%
65-74	7.8%	8.3%	N/A	6.5%	0.0%	0.0%
75+	7.8%	8.4%	N/A	12.4%	60.1%	0.0%
Unknown Data ^{*****}				0.0%	0.0%	0.0%
Missing Data ^{*****}				0.0%	39.9%	100.0%
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	0.0%	0.0%	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	0.0%	0.0%	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	0.0%	0.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	0.0%	0.0%	0.0%
\$30,000 and above	61.5%	N/A	N/A	0.0%	0.0%	0.0%
Unknown Data ^{*****}				0.0%	0.0%	0.0%
Missing Data ^{*****}				100.0%	100.0%	100.0%
Totals	100.0%	N/A	N/A	100.0%	100.0%	100.0%

Attachment 4: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
** U.S. Census 2000 SF3 (P8), SF3 (PCT 26); SF4 (PCT 69)
*** Estimated population 18+ who are consumers of health information, 38 percent. (Source: Issue Brief, Center for Studying Health System Change, March 2003: Details a 2001 survey of US households that found only 38 percent of adults sought health information from a source other than their doctor.); Assume 100 percent children/youth 5-17.
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
***** The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category which may result in more conservative estimates for children and the "old old" which may actually have larger proportions of persons in the lower income categories.

Attachment 5: Actual Consumer Zip Codes

Core Service: Disease/Disability Information LH270.170							
Period	City/Town (% Cleveland)	Total Population (%) [*] 1/1/2000-12/31/2000	Total Population 5+ (%) ^{**} 1/1/2000-12/31/2000	Estimated Consumers of Health Information 5+ (%) ^{***} 1/1/2000-12/31/2000	Actual Number/Percent of Consumers by Funding Source ^{****}		
					UW Program Report Data (%) 7/1/2003-6/30/2004	WRAAA (%) CY2004	Cuyahoga County Board of Health (%) 2004
5-18 years			256,467	256,467			
18+ years			1,046,599	397,708			
TOTAL		1,393,978	1,303,066	654,175	149,392	218	21,990
Percent			100.0%	50.2%			
44017	Berea	1.4%	1.4%	NA	0.3%	0.0%	0.0%
44022	Bentleyville	1.3%	0.8%	NA	0.6%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.2%	NA	0.1%	0.0%	0.0%
44070	North Olmsted	2.4%	2.5%	NA	0.7%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	NA	0.4%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	3.7%	NA	0.6%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	1.8%	NA	0.9%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	2.0%	NA	0.7%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	3.9%	NA	0.6%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.3%	NA	1.2%	0.0%	0.0%
44107	Lakewood/Cleveland	4.0%	4.1%	NA	0.7%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	2.6%	NA	1.5%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (96%)	3.3%	3.2%	NA	0.7%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	1.9%	NA	0.9%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	3.0%	NA	0.5%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.3%	NA	1.1%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	1.4%	NA	0.6%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.3%	NA	0.5%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.5%	NA	0.8%	0.0%	0.0%
44116	Rocky River	1.5%	1.5%	NA	0.5%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	0.9%	NA	0.7%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	3.3%	NA	1.0%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	1.0%	NA	0.6%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.3%	NA	1.0%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.5%	NA	0.9%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	2.6%	NA	0.9%	0.0%	0.0%
44123	Euclid	1.3%	1.3%	NA	0.4%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	3.0%	NA	0.7%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.2%	NA	0.3%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.2%	NA	0.2%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.6%	NA	0.1%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.4%	NA	1.1%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.1%	NA	0.4%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	3.9%	NA	1.1%	0.0%	0.0%
44131	Independence/Seven	1.5%	1.5%	NA	0.5%	0.0%	0.0%
44132	Euclid	1.1%	1.1%	NA	0.8%	0.0%	0.0%
44133	North Royalton	2.0%	2.1%	NA	0.2%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	2.9%	NA	0.4%	0.0%	0.0%
44135	Cleveland/Linddale (90%)	2.0%	2.0%	NA	0.3%	0.0%	0.0%
44136	Strongsville	3.1%	3.2%	NA	0.5%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	NA	0.6%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	NA	0.2%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	NA	0.4%	0.0%	0.0%
44140	Bay Village	1.1%	1.2%	NA	0.3%	0.0%	0.0%
44141	Brecksville	1.0%	1.0%	NA	0.3%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.5%	NA	0.3%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	1.7%	NA	0.5%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.6%	NA	0.3%	0.0%	0.0%
44145	Westlake	2.3%	2.3%	NA	0.5%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.3%	NA	0.5%	0.0%	0.0%
44147	Broadview Hts	1.1%	1.1%	NA	0.3%	0.0%	0.0%
44149	Strongsville				0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes*****					69.8%	0.0%	0.0%
Missing*****					0.0%	100.0%	100.0%
Unknown*****					8.9%	0.0%	0.0%
Total Cuyahoga County*****		100.0%	100.0%	NA	100.0%	0.0%	0.0%
Total Known Cleveland		30.5%	30.2%	NA	11.0%	0.0%	0.0%
Total Known Suburbs		69.5%	69.8%	NA	19.3%	0.0%	0.0%
Unknown & Missing					8.9%	100.0%	100.0%

Attachment 5: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000 SF3 (P8)
*** Estimated population 18+ who are consumers of health information, 38 percent. (Source: Issue Brief, Center for Studying Health System Change, March 2003: Details a 2001 survey of US households that found only 38 percent of adults sought health information from a source other than their doctor.); Assume 100 percent children/youth 5-17.
**** 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 6: 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	66	9
Number of Providers by Type		
Nonprofit	61	9
For-profit	-	-
Government	5	-
Other	-	-
Total Number of Sites	72	9
Number of Service Sites per Provider		
1	63	9
2 – 5	3	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea		
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	-	-
44103 – Cleveland	-	-
44104 – Cleveland	-	-
44105 – Newburgh Hts/Garfield Hts	1	-
44106 – Cleveland Hts/Cleveland	10	4
44107 – Cleveland/Lakewood	2	-
44108 – Cleveland/East Cleveland	2	-
44109 – Cleveland/Brooklyn Hts	2	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	1	-
44112 – Cleveland/East Cleveland	2	-
44113 – Cleveland	5	1
44114 – Cleveland	3	-
44115 – Cleveland	7	1
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	2	-
44119 – Cleveland/Euclid	1	-
44120 – Cleveland/Shaker Hts	1	-
44121 – University Hts/South Euclid	1	-
44122 – Orange/Warrensville Hts	5	2
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	2	-
44125 – Valley View/Garfield Hts	2	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	1	-
44128 – Cleveland/Warrensville Hts	1	-
44129 – Cleveland/Brooklyn/Parma	3	-
44130 – Cleveland/Parma	4	-
44131 – Seven Hills/Brooklyn Hts	7	1

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	1	-
44140 – Bay Village	1	-
44141 – Brecksville	2	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	2	-
44146 – Walton Hills/Oakwood/Bedford	-	-
44147 – Broadview Hts	1	-
44149 – Strongsville	-	-
	-	-
Total Cuyahoga County	72	9
Total Cleveland	33	6
Total Suburbs	39	3

Attachment 7: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
4Real Ministries	Sexually Transmitted Disease (STD) Helpline
AIDS Taskforce of Greater Cleveland	Health / Disease Information and Referral - HIV/AIDS
ALS Association - Northeast Ohio Chapter	Nursing Consultation and ALS Disease Information, Lending Library
Alzheimer's Association Cleveland Area Chapter	Educational Programs, Services for Diagnosed Individuals, Publications and Resource Library
American Cancer Society - Cuyahoga Area Office	Cancer Information and Education, Prostate Cancer Education & Support, Educational Programs for Cancer Patients and Families
American Diabetes Association	Educational Services and Membership
American Heart Association - Cleveland Metro Division	Health Information and Education
American Liver Foundation	Health Information and Research Funds - Liver Diseases
American Lung Association of Ohio	Asthma Awareness, Asthma Management, Community Education
American Red Cross Greater Cleveland Chapter	Health Education - HIV/Aids, Health Education - Child Abuse/Childhood Illness Prevention
American Sickle Cell Anemia Association	Health Information - Sickle Cell Disease
Arthritis Foundation - Northeastern Ohio Chapter	Educational Materials
Autism Society of Greater Cleveland	Information & Education Autism Spectrum Disorder
Brain Injury Association of Ohio	Information and Referral - Brain Injuries
Center for Mental Retardation	Health Education and Information – MR/DD
City of Cleveland Department of Public Health	Education/Information-Communicable Diseases, Public Health - Inspection and Remediation-Lead
Cleveland Clinic Foundation	Education/Information - Cancer Resource Center
Cleveland Hearing and Speech Center	Outreach - Deaf/Hard of Hearing Infants and Toddlers
Community Re-Entry	Support Services - Ex-Offenders
Crohn's and Colitis Foundation of America	Health Information and Support - Crohn's and Colitis
Cuyahoga County District Board of Health	Epidemiology Div. - Communicable Disease Preven. and Control
Cuyahoga Special Education Service Center	Family Services
Cystic Fibrosis Foundation - Rainbow Chapter	Health Information - Cystic Fibrosis
Diabetes Association of Greater Cleveland	Diabetes Risk Assessment, Information, Education and Referral
Empowerment Center of Greater Cleveland	Asthma Education and Management
Environmental Health Watch	Assistance/Information - Health and Environmental Hazards
Epilepsy Association	Advocacy, Information and Referral Services
Euclid Hospital	Health Education/Information - Fibromyalgia
Fragile X Alliance of Ohio	Health Information and Education - Fragile X Syndrome

Attachment 7: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Free Clinic of Greater Cleveland	HIV/Aids Screening
Greater Cleveland Dental Society	Dental Society
Greater Cleveland Health Education and Service Council	Blood Pressure Screening Referrals & Health Information
Hillcrest Hospital	Health Education/Information - Arthritis
HUMADAOP	HIV Testing and Counseling, HIV/AIDS Education Services
Huron Hospital	Health Education - Congestive Heart Failure
Juvenile Diabetes Research Foundation Northeast Ohio Chapter	Diabetes and Public Health Education
Kidney Foundation of Ohio	Community Education, Patient Assistance
City of Lakewood Department of Human Services	Lead Poisoning Prevention
Lakewood Hospital	Education/Information - Diabetes
Learning Disabilities Association of Cuyahoga County Education and Training Center	Parent Education, Library - Learning Disabilities
Leukemia and Lymphoma Society	Health Information
Lupus Foundation of America Greater Cleveland Chapter	Health Information and Education - Lupus
March of Dimes Birth Defects Foundation	Resource and Referral Service
Marymount Hospital	Cardiac Rehabilitation
MetroHealth Medical Center	Community Family Planning Services/Reproductive Health
Minority Women With Breast Cancer Uniting	Outreach and Education Regarding Breast Cancer
Multiple Sclerosis Association of America	Public Education and Awareness
Muscular Disease Society of Northeastern Ohio	Health Care Coordination - Muscular Disease
Muscular Dystrophy Association National Headquarters	Information, Education and Advocacy
National Alliance for The Mentally Ill - Metro Cleveland	Education for The General Population, Mental Health Resource Library, Community Forums on Mental Health
National Association for the Advancement of Colored People - Cleveland Branch	Aids/HIV Awareness
National Multiple Sclerosis Society - Ohio Buckeye Chapter - Northeast Ohio Office	Educational Programs
North East Ohio Health Services	Mental Illness Treatment
Northeast Ohio Hydrocephalus Support Group	Hydrocephalus Support and Education Group
Northern Ohio Breast Cancer Coalition Fund	Information/Support/Advocacy - Breast Cancer
Northern Ohio Hemophilia Foundation	Information and Referral - Hemophilia, Orientation and Education for Newly Diagnosed Families
Parma Community General Hospital	Diabetes Education Programs and Classes, Stroke and Arthritis Information Meetings
Prevent Blindness Ohio - Northeast Ohio Chapter	Information - Visual Impairments
Southwest General Health Center	Health Support Group and Education for Diabetes
St. John West Shore Hospital	Education for Diabetes

Attachment 7: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
St. Vincent Charity Hospital	Osteoporosis Detection and Treatment
Twin Hope	Support and Information - Bereavement / Multiple Births
Twin to Twin Transfusion Syndrome Foundation	Information, Education, Support--Twin/Twin Transfusion Syn.
United Cerebral Palsy Association of Greater Cleveland	Information on Cerebral Palsy
United States Department of Veterans Affairs	Education/Information
University Hospitals of Cleveland	Education/Information - Asthma, Education/Information - Cancer

Bold represents agencies funded by United Way for this service.

Attachment 8: United Way - First Call for Help Disease/Disability Information Requests – 2000-2004: Greatest Increase/Greatest Decrease

LH-270.170 Disease/Disability Information								
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		
44108	Cleveland/Bratenahl	1	7	12	4	13	1200%	7
44111	Cleveland	2	3	9	4	8	300%	5
44142	Brookpark/Cleveland	1	5	0	1	3	200%	2
44106	Cleveland/Cleveland Hts	3	4	2	6	9	200%	5
44136	Strongsville	1	2	1	0	3	200%	1
44102	Cleveland/Brooklyn	5	13	8	8	12	140%	9
44105	Cleveland/Newburgh Hts/Garfield Hts	5	6	10	15	11	120%	9
44132	Euclid	2	4	1	1	4	100%	2
44137	Maple Hts/Cleveland	1	3	2	2	2	100%	2
44146	Walton Hills/Oakwood/Bedford	2	2	5	6	4	100%	4
44118	ClevelandHts/UniversityHts/ShakerHts	4	6	5	5	7	75%	5
44107	Lakewood/Cleveland	6	7	8	8	10	67%	8
44125	Valley View/Garfield Hts	3	5	2	1	5	67%	3
44143	Highland Hts/Richmond Heights	2	3	1	1	0	(100%)	1
44128	Warrensville Hts/Cleveland	6	2	5	5	0	(100%)	4
44145	Westlake	1	1	0	3	0	(100%)	1
44134	Parma/Cleveland	4	4	3	4	1	(75%)	3
44144	Brooklyn/Cleveland	3	2	4	4	1	(67%)	3

**Total Cuyahoga County	114	165	172	175	187	64%	163
**Total Cleveland	43	76	87	89	96	123%	78
**Total Suburbs	71	89	85	86	91	28%	84

* Extremely high percentages are due to low numbers.

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

**Attachment 9: United Way - First Call for Help Disease/Disability Information
2000-2004: Unmet Need**

LH-270.170 Disease/Disability Information					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44131	Independence/Seven Hills/Brooklyn Hts	3	2	1	33%
44122	Beachwood/Highland Hills/Shaker Hts.	18	17	1	6%
44135	Cleveland/Linddale	23	22	1	4%
44106	Cleveland/Cleveland Hts	24	23	1	4%
44118	ClevelandHts/UniversityHts/ShakerHts	27	26	1	4%
44115	Cleveland	36	35	1	3%
44107	Lakewood/Cleveland	39	38	1	3%
44112	East Cleveland/Cleveland	44	43	1	2%
44105	Cleveland/Newburgh Hts/Garfield Hts	47	46	1	2%
*Total Cuyahoga County		813	804	9	1%
*Total Cleveland		391	387	4	1%
*Total Suburbs		422	417	5	1%
FCFH DATA NOTES					
<p>Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)</p> <p>Unmet = service request for which there was no referral.</p> <p>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.</p> <p>* 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.</p>					



**United Way of
Greater Cleveland**

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