Core Service Report

Home-Delivered Meals

Consumer Category:
Age

Primary Consumer Group:
Seniors and Other Adults Remaining Independent

February 2007

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COMPANION REPORTS

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

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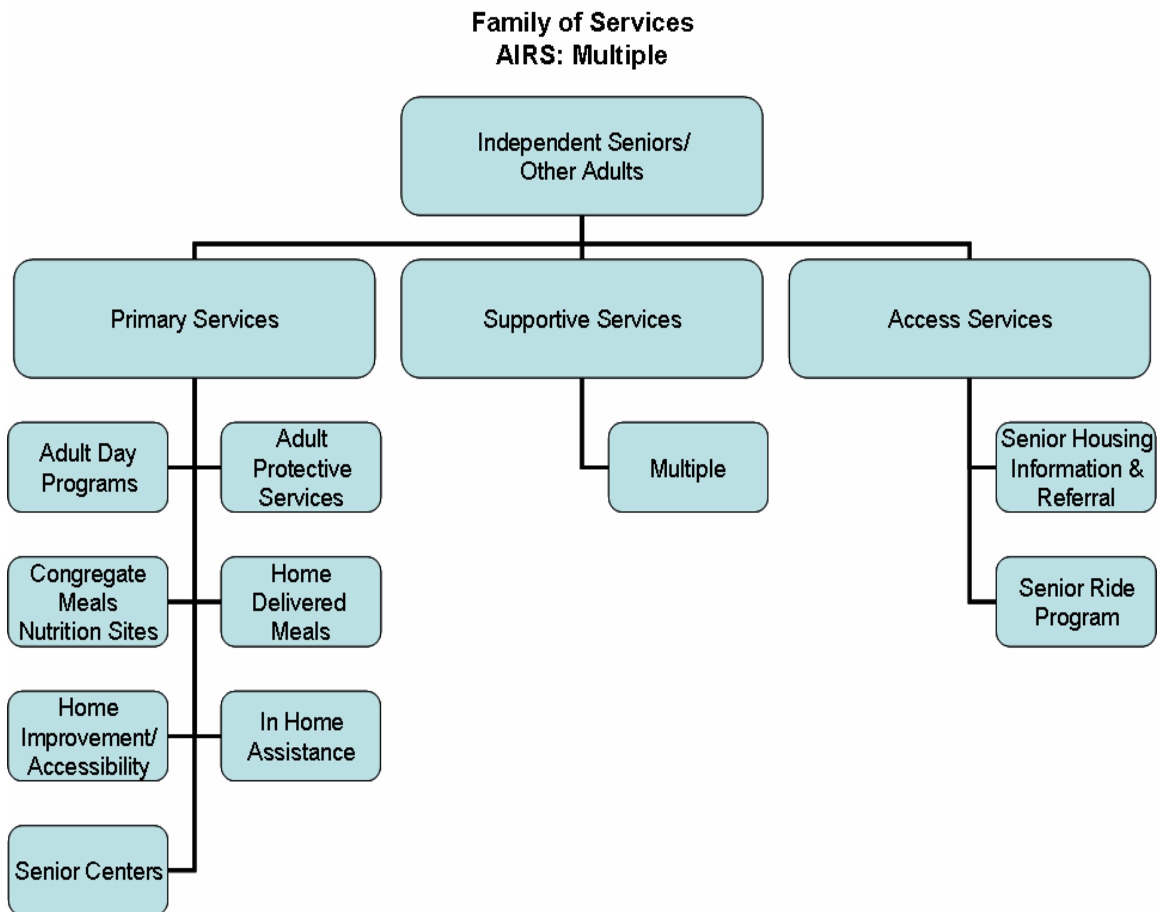
SNAPSHOT

AIRS Code Level I: Basic Subsistence (B)
AIRS Code Level II: Food (BD)
Core Service: Home-Delivered Meals (BD-500.350)

Investment Committee: Senior Success
Cluster: Basic Subsistence/Supportive Services

AIRS Definition: Programs that prepare and deliver regular meals to older adults and people with disabilities who are unable to shop and/or prepare the food for themselves, or travel to a site where a meal is being served.

Home-Delivered Meals is part of a family of services for older adults. The service targets independently functioning older adults and other adults and is one of seven services targeting this consumer group. In addition, there are two services that are necessary to access other services. (See figure below.)



Core Service Environment

According to a national public opinion survey conducted by the Association of Aging and Retired Persons (AARP) (2003), an overwhelming majority of older adults want to stay in their own homes as long as possible. Home-delivered meal programs have been proven to contribute to allowing older adults to avoid early and unnecessary institutionalization and are a critical component of the home and community-based long-term care service system (Mathematica Policy Research, 1996).

Key public policy issues affecting home-delivered meals programs are the funding and policy decisions that reinforce trends away from institutionalization and toward more home- and community-based service options. This is an effort to contain cost, often referred to as the "rebalancing" of long-term care.

The focus on consumer choice and home- and community-based services is recognized at the federal level. One key example is the Choices for Independence Pilot Project (Choices) proposed by the U.S. Administration on Aging for the Reauthorization of the Older American Act. Choices aims to strengthen the nation's capacity to promote the dignity and independence of older people, meet the challenges associated with the aging of the baby boom generation, and strengthen the Act's role in promoting consumer choice, control, and independence in long-term care.

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

Growing reliance on, and clear consumer preference for, community-based services will increase the demand for home-delivered meals. However, funding for home-delivered meals is not keeping pace with demand. Stagnant or decreasing funding of home-delivered meals programs in the face of rising demand will be a major public policy issue.

Core Service Consumers

The target population addressed in this core service report is persons 60 years and older who have moderate or severe disabilities; however, younger adults with disabilities can also be consumers of home delivered meals. A moderate disability is defined as requiring help in at least one of the following daily living activities: eating, transferring in or out of bed or a chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental daily living activities: walking, shopping, meal preparation, housekeeping, or using transportation. A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment.

Home-delivered meals programs target vulnerable populations; the majority lives alone, is poor or near poor, is over 75 years old and/or has difficulty with activities of daily living (ADL) such as eating, dressing or walking. Additionally, the program targets the socially isolated; about one half reported they would like to do more with respect to social activities, twice the rate for the general older population. Additionally, the participating population was found to have the following characteristics:

- Between 80 and 90 percent have incomes below 200 percent of the poverty level—twice the rate for the overall elderly population.
- More than twice as many live alone compared with the overall elderly population.
- More than twice as many have physical impairments compared with overall elderly population (Administration on Aging, 2004) and approximately two-thirds of participants are at an unhealthy weight (most are overweight).
- Seventy-five percent are at high nutritional risk; 25 percent are at moderate risk, and 25 percent reported they do not always have enough money or food stamps to buy food
- Sixty-two percent receive one half or more of their daily food intake from their home-delivered meals.
- Recipients are more impaired and frail than the overall 60+ population (Administration on Aging, 2003).

When home delivered meal and congregate meal participants are compared, the following themes are apparent (Mathematica Policy Research, 1996):

- The demographic profile of congregate and home delivered meal participants is similar except that there are more home delivered meal participants in the 85+ age cohort and fewer in the 60-74 year cohort.
- Except for high blood cholesterol levels, the prevalence of each chronic condition is higher for home-delivered than congregate participants, for some conditions by twice as much.
- Title III home-delivered meal program participants are considerably more functionally impaired than congregate participants.
- Title III congregate participants as a group are very mobile and physically active, and they are considerably more mobile and physically active than Title III home-delivered meal participants.
- Most Title III meal program participants report having enough food to eat. Relatively small but meaningful proportions of congregate and home-delivered participants, however, report one or more circumstances of food insecurity during the past month.

In 2000, 71,786 individuals 60 and older had moderate disabilities in Cuyahoga County. This number is projected to increase to 74,731 by 2020 with the aging of the babyboomers.

Core Service Delivery
The definition of the core service for this report is: services or activities designed to prepare and deliver one or more meal a day to an individual's residence in order to prevent institutionalization, malnutrition, and feelings of isolation.

Home-delivered meals may be delivered hot, cold, frozen, dried, canned, or as supplemental foods. Breakfast, lunch, dinner, or a combination of two or three meals may be provided five days per week, and also can be provided on the weekends. Meals served under the program must provide at least one-third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, as well as the Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 53 home-delivered meal providers operating out of 63 sites, 36 of which are nonprofit and 17 are government. In FY 2004 (July 2003 to June 2004), United Way funded 1 of these providers.

FCFH call data shows a decrease in the number of requests for information for home-delivered meals programs in the county: from 1,504 in 2000 to 1,395 in 2004 (7 percent). Over the same five-year period, FCFH had 7,320 requests for information about home-delivered meals programs. Of these requests, they were able to make referrals to 94 percent of callers.

A large portion of government funding for meals programs comes from Title III funds provided through the Older Americans Act (OAA). The home-delivered meals program is the third largest part of the Administration on Aging's (AoA) budget. This program's appropriation has declined from $183 million in FY 2005, to $182 million in FY 2006, and is expected to decrease by $181 million in FY 2007 (U.S. Department of Health and Human Services, 2006).

PASSPORT, Ohio's Medicaid waiver for home- and community-based services for people age 60 and over, is the second largest government funder of home-delivered meals. Actual funding from the state's general revenue fund for all PASSPORT services in FY 2003 was $55 million. In FY 2007, it has more than doubled to $121 (Legislative Services Commission, 2006). In Cuyahoga County between 2002 and 2004, PASSPORT funding increased 12 percent. Funding from the Older Americans Act was mixed from 2002 to 2004, with an overall increase of about 1 percent during this time.

As of May 11, 2006, slightly more than $4.48 million in revenues for home-delivered meals programs has been reported countywide. Almost 96 percent of the revenues are from contracts or grants from government organizations. United Way of Greater Cleveland's funds account for less than 3 percent the total from Investment Committee allocations and designations.

What Works; What Doesn't

Home-delivered meals programs contribute to good health and well-being of older adults by providing appropriate nutrition. Home-delivered meal programs have been proven to contribute to allowing older adults to avoid early and unnecessary institutionalization and are a critical component of the home and community-based long-term care service system (Mathematica Policy Research, 1996).

Below is a list of what makes the program relevant to current and changing populations and what can increase efficiencies and improve quality:

- Meals should appeal to the cultural preferences of clients; include community input when developing meals; offer a variety of meals from different ethnic groups, and provide authentic ethnic cuisine.
- Providers should offer cultural food items as side dishes, desserts, or snacks, if not the entrée on a regular basis (National Resource Center on Nutrition, Physical Activity, and Aging, 2004).
- Providers should employ staff and volunteers who reflect the diversity of the community served.

Lack of coordination and collaboration is consistently noted as a major barrier to providing effective services to older adults.

Some specific facts on community impact of home-delivered meal programs include the following: for every $1 invested in nutrition programs, $3.25 is saved in health care costs; the cost of treating a malnourished hospital client is four times greater than the cost of treating a

well-nourished client; and seniors in poor nutritional status are more likely to need home care or be institutionalized (Olsen, n.d.).

Gap Analysis
The estimated universe of possible consumers is 14,357, including both realized (3,859) and unrealized (10,498) 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 dare 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

A healthy diet is essential for older adults, but evidence from numerous sources indicates that a significant number of the elderly fail to get the amounts and types of foods they need for optimum nutrition. The aging process produces physiological changes that can dramatically affect nutritional status due to declines in smell and taste perception and ability to digest foods. Disability, weakness, and fatigue may limit ability to grocery shop and to cook. Economic changes may contribute to poor nutrition due to financial pressures that require older adults with severely restricted budgets to make difficult choices about necessities. Finally, social and psychological issues can have serious problems leading to compromised nutrition status. Older adults may lack social support due to the death of a spouse, limited family contact, retirement, disability, and other factors. These major life events often lead to a loss of social connectedness that can decrease life satisfaction and increase depressive symptoms, which in turn have been shown to significantly compromise health and well-being. All these factors can contribute to the fact that a significant number of older men and women consume less food than necessary to meet energy and nutrient requirements, and are at moderate to high nutritional risk, which significantly compromises their ability to live independently (AgeWorks, n.d.).

To address the nutrition needs of older adults, the federal government created the Federal Elderly Nutrition Program in 1972 as part of the Older Americans Act. The purpose of the Elderly Nutrition Program, including home-delivered meals programs, is to “improve the dietary intakes of participants and to offer participants opportunities to form new friendships and to create informal support networks” (Administration on Aging, 2004). The underlying purpose is to make community-based services available to support older adults in maintaining their independence.

Most older adults live, and want to remain living, in the community. According to “Older Americans 2004: Key Indicators of Well-Being,” nationally, the majority of older Americans live in traditional community settings (93 percent), while only 2.5 percent live in community housing with services, and 4.4 percent live in long-term care facilities. In addition, according to a national public opinion survey conducted by the Association of Aging and Retired Persons (AARP) (2003), an overwhelming majority of older adults want to stay in their own homes as long as possible. Home-delivered meals programs contribute to good health and well-being of older adults by providing appropriate nutrition. Home-delivered meal programs have been proven to contribute to allowing older adults to avoid early and unnecessary institutionalization and are a critical component of the home and community-based long-term care service system (Mathematica Policy Research, 1996).

There are several key social and demographic trends affecting the consumers of home-delivered meals. These include:

- *Older adults are living healthier, less disabled, and longer lives*.
  With improved socio-economic conditions and advances in health care, national studies have found that older adults are healthier, less disabled, and are living longer. This trend is expected to continue and perhaps improve even further. Life expectancy for all Americans has reached an all-time high at 77.6 years in 2003 with the gap between male and female life expectancy closing to 5.3 years. This is continuing a trend toward

narrowing since the peak gap of 7.8 years in 1979. Although disparities remain among races, ethnicities, and gender, record-high life expectancies were found for white males (75.4 years) and black males (69.2 males), as well as for white females (80.5 years) and black females (76.1 years) (National Center for Disease Control, 2005).

- *Disability rates among older persons have declined substantially*.
  The rate of disability in the adult population has been declining consistently by 1.5 percent per year since the early 1980s, according to researchers at Duke University (Johnson et al., 2001). The National Long-term Care Survey found that the number of older persons with a chronic disability has remained essentially unchanged at 7 million since 1989, although the older population has risen substantially, resulting in 2.3 million fewer older persons with disabilities than would have been predicted based on 1982 rates. Continued declines in disability are expected. Additionally, even though the prevalence of some chronic conditions has been increasing, the debilitating effects of many of those conditions have been reduced. Based on such findings, researchers have concluded that both treatment and prevention of potentially disabling chronic conditions contribute significantly to decreasing disability rates (Redfoot & Pandya, 2002). Less disability can mean that seniors will stay more active and function more independently. However, when viewing these advances in health and longevity it is important to note that much variability in health status emerges later in life not as a result of chance; access to medical care, behavioral patterns including nutrition, educational background, and working conditions all influence the quality of one's later years. Higher rates of disability and chronic diseases remain for disadvantaged populations (The Institute for Research on Women and Gender, 2002).

- *The older adult population is exploding.*
  Growth in the older adult population will also be a major factor in the future direction of home-delivered meal programs, especially in light of federal appropriations for the Elderly Nutrition Program not keeping pace with this population increase. In 1900, 4 percent of the United States population was 65 or older; at the beginning of 2000, 13 percent of the population was in that age group. The projection is that in fewer than thirty years 20 percent of the population will be 65 or older (Martin, Molea, Hedges, Johnson, and Teaford, 2002). The increase in the number of individuals 85 and older, who are often especially frail, will have a profound effect on home-delivered meal programs.

- *Older adults as a cohort are more diverse*.
  As society ages, older adults are becoming more diverse. In 2000, 16 percent of persons 65 and over identified themselves as being from one of the four minority populations (Native American/Alaska Native, Asian/Pacific Islander, African American, Hispanic). By mid-century over one-third (36 percent) of all older Americans are projected to come from these groups. Older people of color not only have higher rates of chronic diseases such as diabetes, hypertension, and cancer, they also have elevated substance abuse rates and shorter life expectancies (The Institute for Research on Women and Gender, 2002). There are social and psychological correlates to observed health and mental health problems among ethnic elders. Older age among many is characterized by higher rates of poverty, greater likelihood of living alone, lower availability of good health insurance, and fewer private pensions, resulting in greater dependency on government support (The Institute for Research on Women and Gender, 2002). Home-delivered meals program providers will need to accommodate the increasing diversity of older adults.

Older adults have higher incomes, though disparities by race and gender remain.

The proportion of destitute people among those aged 65 and older dramatically declined from roughly 30 percent in 1959 to just over 10 percent today. However, it is important to note that many are still at risk of impoverishment in a downturn. Almost two thirds of elderly households have incomes below $20,000 a year. While median income for white Americans 65 and older is $16,954, median income for African Americans is $9,649. Net wealth, or the accumulation of assets over a lifetime, varies even more than incomes. About 60 percent of the age 65 and older population own their own homes. One-half of the population aged 65 and older has less than $9,500 in financial assets. By comparison, 20 percent of the population aged 65 or older has net worth in excess of $355,000 with only 40 percent invested in their homes. These differences, of course, carry vast implications for the quality of extended lives. For myriad reasons, divorced, widowed, and never married women age 75 or older are at far greater risk of impoverishment than are men. African American men, too, are particularly vulnerable to the burdens that can come with aging. They are poorer and far more likely than their white counterparts to suffer debilitating chronic health conditions and disabilities in older age (The Institute for Research on Women and Gender, 2002). Home-delivered meal programs will need to reach out and accommodate these at-risk populations.

Trends in Types and Duration of Medical Treatment

Hospital stays are becoming shorter, and outpatient treatment is becoming more the standard of care, resulting in more individuals being in a compromised health status and often unable to provide appropriate nutrition for themselves (Koffman, Raphael, & Weiner, 2004). Home delivered meals are often part of a package of post-hospitalization services.

PUBLIC POLICY ISSUES

Key public policy issues affecting home-delivered meals programs are the funding and policy decisions that reinforce trends away from institutionalization and toward more home and community-based service options.

FEDERAL

Older Americans Act (OAA)

A large portion of government funding for meals programs comes from Title III funds provided through the Older Americans Act (OAA). The OAA was signed into law in 1965 amid growing concern about older individuals' access to health care and their general well-being. The OAA established the federal Administration on Aging (AoA) and charged the agency with advocating on behalf of Americans 60 or older (now estimated at 46 million individuals) and implementing a range of assistance programs aimed at older persons, especially those at risk of losing their independence. AoA has identified that at-risk group as older individuals who are:

- Age 85 or older:
- Living alone without access to a caregiver:
- Low income:
- Members of minority groups:
- Persons with disabilities: or
- Victims of abuse, neglect, or exploitation (AoA 2002a in Koffman, Raphael, & Weiner, 2004).

Federal funds are distributed to states on the basis of the state's share of the U.S. population age 60 and above (Koffman, Raphael, & Weiner, 2004). The AoA funds social and health services to an estimated 7 million older persons and their caregivers each year (AoA 2002c) through the network of state units on aging, more than 650 local area agencies on aging, and more than 225 tribes and Native American organizations. AoA awards funds under Title III of the OAA to the 57 state units on aging to plan, develop, and coordinate systems of in-home- and community-based services, under which home-delivered meal programs fall.

The National Council on Aging has made appropriations for services funded through OAA a top priority in its policy platform for 2007-2008.

> The OAA funds critical programs and services to keep seniors healthy and independent, including: nutrition, senior centers, home and community services, family caregiver support, protection against abuse and neglect, older worker training and employment, transportation, and health promotion/disease prevention. OAA programs save tax dollars by reducing premature nursing home placement, averting malnutrition and controlling chronic health conditions.
>
> Congress accomplished the number one priority from the 2005 White House Conference on Aging--reauthorization of the OAA. With that step completed, NCOA's key goal turns now to boosting OAA appropriations. OAA appropriations have been essentially frozen at $1.8 billion since FY 2003, meaning purchasing power has been seriously eroded, both by inflation and by the growing numbers of seniors in need. $1.8 billion can not go as far today as it did in 2003. NCOA urges Congress to increase OAA appropriations by 10 percent in FY 2008 and again in FY 2009, and to continue 10 percent increases through FY 2014, which would double the 2007 amount. (National Council on Aging, 2007)

The Older Americans Act Title III funds in 2003 were worth approximately 57 cents compared to 1980 Title III funds worth one dollar. In Ohio, senior community services funding has been reduced by 25 percent since 2001 (Ohio Association of Area Agencies on Aging, 2005).

Specific funding information is provided in Section IV.

Choices for Independence — Home- and Community-Based Services

The focus on consumer choice and home- and community-based services is recognized at the federal level, especially by the Administration on Aging and the aging services network. One key example is demonstrated by the Choices for Independence Pilot Project (Choices) proposed by the U.S. Administration on Aging for the Reauthorization of the Older American's Act. Choices aims to strengthen the nation's capacity to promote the dignity and independence of older people, meet the challenges associated with the aging of the baby boom generation, and strengthen the Act's role in promoting consumer choice, control, and independence in long-term care. Choices has the following core components:

- Empower individuals—both those in immediate need and those who have the ability to plan ahead for their long-term care—to make informed decisions about their support options.

- Provide states and communities with greater flexibility under the Older Americans Act to help moderate- and low-income individuals remain in their homes and delay premature entry into nursing homes by providing funding that targets individuals—not service categories, as with the current titles under the act.
- Strengthen the role of the Older Americans Act in translating research into practice by promoting the use of evidence-based health promotion and disease prevention programs at the community level through local aging services provider organizations such as senior centers, nutrition programs, senior housing projects, and faith-based groups.

STATE

Ohio Access for People with Disabilities

Ohio has also modified policies to accommodate consumer choice and home- and community-based care. "Ohio Access for People with Disabilities," a plan prepared by seven state departments and presented to Governor Robert Taft in 2001, suggests a policy shift in addressing the long-term care needs of Ohio's frail elderly and disabled. As states, along with the federal government, are key funders of public health plans, this state-level support is essential. Expected outcomes of this new vision include enhanced consumer: 1) independence, 2) personal dignity and responsibility, 3) access to community services and decreased reliance on institutional care settings, 4) quality of life, 5) health and safety, and 6) the most efficient use of limited funds. The role of informal care networks includes family, friends, and neighbors, who are noted to provide 80 percent of all long-term care, is emphasized. The plan supports an approach that will drive the development of home- and community-based care choices in support of health, wellness, and prevention of unnecessary, premature institutionalization where home and community-based options should be the norm rather than the exception. Additionally, the following goals have been established:

- Elders and persons with disabilities live with dignity in settings they prefer.
- Elders and persons with disabilities receive safe, high-quality long-term care, services, and supports wherever they live.
- Relatives, neighbors, and friends who care for and support elders and persons with disabilities receive the information and services needed to plan for their future and support their caregiver role.

Medicaid Waivers

Ohio's increasing support for Medicaid home- and community-based waivers shows the state's commitment to provide services in settings people prefer. A Medicaid home- and community-based waiver allows a state to provide services beyond its state plan to a limited number of people who meet certain conditions. The waiver program has been growing significantly in all states, including Ohio. States have the flexibility to design each waiver program and select the mix of services that best meets the needs of the individuals they wish to serve. Medicaid waiver programs are offered through the Ohio Department of Job and Family Services (ODJFS), the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD), and the Ohio Department of Aging. Waivers provide community services to income eligible individuals who would otherwise be institutionalized. Currently, Ohio has several waivers that offer home-delivered meals: Individual Options waiver, Ohio Home Care waiver, PASSPORT waiver, and Transitions waiver. Expansion of Medicaid waivers, such as PASSPORT or other options for long term care such as OPTIONS for Elders in Cuyahoga County are important since they are often some of the largest funders of home-delivered meals.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

Based on the Administration on Aging's definition, the target home-delivered meals consumers are older adults with the greatest social and/or economic need, with particular attention to low-income minorities. More specifically for this report, the target population is persons 60 years and older who have moderate or severe disabilities; however, younger adults with disabilities can also be consumers of home delivered meals.[1]

A moderate disability is defined as requiring help in at least one of the following daily living activities: eating, transferring in or out of bed or a chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental daily living activities: walking, shopping, meal preparation, housekeeping, or using transportation.

A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment.

DEMOGRAPHIC CHARACTERISTICS

National
Several national studies have yielded important information about the nutritional health of older adults. Some key findings from the 2004 National Health and Nutrition Examination survey follow:

- *Most older Americans' diets required improvement*.
  A majority of older people reported diets that needed improvement (67 percent) or were poor (14 percent).

- *Older people living in poverty had even poorer nutrition.*
  These individuals were less likely to report a good diet (9 percent) than older people living above the poverty level (21 percent). Older adults in the lowest income group were less likely to consume three meals per day than were older adults in the higher income group (67 percent vs. 80 percent). Older adults in the lowest-income group were significantly less likely than older adults in the other two income groups to consume breakfast.

- *About 1/3 of older Americans are at a healthy weight*.
  Twenty-nine percent of individuals 65 and older were at a healthy weight. More women (31 percent) were at a healthy weight than men (26 percent).

- *Older adults were, on average, overweight*.
  Older adults had a mean body mass index (BMI) of 26.7 (normal is 18.5 to 24.9). Older adults in the low income groups had a significantly greater mean BMI than older adults in the higher-income group (27.3 vs. 26.5).

[1] Low income individuals tend to age more quickly than their middle-class counterparts, and often use resources at an earlier life stage.

- *The prevalence of obesity among older adults increased dramatically*.
  In the 1960-62 NHANES, 18 percent of people age 65-75 were obese; 55 percent were overweight. By 1999-2002, 36 percent were obese; 73 percent were overweight.

- *Prevalence of underweight among people age 65 and over was low*.
  In 1999-2002, two percent of older men and women were underweight. However, older women age 65 and over were three times as likely as their male counterparts to be underweight.

Other national and state studies of the Federal Nutrition Program have yielded important information about the demographic characteristics of home-delivered meal participants. For example, in 2003, the Administration on Aging funded *Pilot Study: First National Survey of Older Americans Act Title III Service Recipients* which showed that home-delivered meals programs target vulnerable populations, the majority of which live alone, are poor or near poor, are over 75 years old and/or have difficulty with activities of daily living (ADL) such as eating, dressing or walking. Additionally, the program targets the socially isolated; about one half of whom reported they would like to do more with respect to social activities, twice the rate for the general older population.

The study also found that home delivered meals are provided to individuals who need them most:

- Seventy-three percent were at high nutritional risk; 25 percent were at moderate risk.
- Sixty-two percent received one half or more of their daily food intake from their home delivered meal.
- Twenty-five percent reported they did not always have enough money or food stamps to buy food.
- Targeted to recipients who are more impaired and frail than the overall 60+ population, suggesting that these Older Americans Act services contribute to maintaining individuals in their homes.

Comparison of Congregate and Home Delivered Meal Participants

A study conducted by Mathematic Policy Research (1996), the most recent available, compared congregate and home delivered meal programs on a number of variables, including demographic characteristics, health status, functional status, mobility and leisure time physical activity, and food and dietary behaviors.

Demographic Characteristics: The demographic profile of congregate and home delivered meal participants is similar.

> The study found that the average Title III congregate meal program participant is 76 years old compared to the average home-delivered participant at age 78. Fourteen percent of congregate participants and 26 percent of home-delivered participants are 85 or older. Most congregate and home-delivered meal program participants are female, with the ratio of female to male participants exceeding 2 to 1. More than one-half of Title III meal program participants (57 percent of congregate participants and 60 percent of home-delivered meal participants) live alone. Twenty-eight percent of congregate participants and 16 percent of home-

delivered participants reside in rural areas (places with fewer than 2,500 inhabitants).

(See Table 1.)

Table 1: Selected Demographic Characteristics of Title III Congregate and Home Delivered Meal Participants

Characteristic	Title III Congregate Meal Participants	Title III Home-Delivered Meal Participants	Overall U.S Elderly (60+) Population
AGE			
Less than 60	1%	2%	--
60-74	43%	30%	67%
75-84	42%	42%	25%
85 and older	14%	26%	8%
Average Age (Years)	76	78	72
Female	69%	70%	58%
Live Alone	57%	60%	25%
Rural[a]	28%	16%	25%
MINORITY STATUS			
Non-Hispanic blacks	12%	18%	8%
Hispanics	12%	5%	4%
All minorities	27%	25%	14%
INCOME STATUS			
Below 100% of the DHHS poverty guidelines	34%	48%	15%
Below 200% of the DHHS poverty guidelines	79%	90%	38%
Low-Income Minority [b]	15%	16%	4%
Unweighted Sample Size	**1,040**	**818**	**40,116,501**

SOURCE: Elderly Nutrition Program Evaluation, participant survey, weighted tabulations, Mathematica Policy Research, 1996.

Health Status: Except for high blood cholesterol levels, the prevalence of each chronic condition is higher for home-delivered than congregate participants, for some conditions by twice as much. According to the study by Mathematica Policy Research (1996):

> The average number of self-reported diagnosed chronic health conditions is 2.4 for congregate participants, compared with 3.0 for home-delivered participants. Forty-one percent of congregate participants have three or more chronic conditions; 59 percent of home-delivered participants have three or more diagnosed chronic conditions. The most common health problems, reported by about one-fifth to more than one-half of Title III participants, include arthritis, hypertension, heart disease, lung or breathing problems, elevated blood cholesterol levels, and diabetes. Eleven to 20 percent of Title III congregate and home-delivered participants also reported a history of stroke or cancer. Eighteen percent of congregate participants and 30 percent of home-delivered participants reported that they recently lost or gained 10 pounds involuntarily. Recent and severe involuntary changes in body weight have been shown to be associated with an increased risk of poor nutritional status and adverse health problems (Nutrition Screening Initiative 1991).

Overall, the health characteristics of Title III congregate and home-delivered meal participants differ in a number of important ways. Compared with congregate participants, home-delivered participants are nearly twice as likely to report being in "poor" or "fair" health and are more likely to report multiple chronic health problems. Home-delivered meal program participants are nearly twice as likely to have had a hospital or nursing home stay during the past year and are nearly three times as likely to have had multiple hospital stays. They are more likely than congregate participants to be taking multiple prescription drugs and over-the-counter medications. Among home-delivered meal participants, proportionately more are underweight by BMI standards and proportionately fewer are overweight. However, congregate and home-delivered participants report a similar overall number of diagnosed chronic health conditions, and congregate participants report a health profile that also places them at risk for nutrition-related problems. Indeed, at least half of congregate participants and home-delivered meal participants have nutrition-related chronic diseases. For example, significant minorities of both groups--one-fifth of congregate and nearly one-third of home-delivered meal participants--may be underweight, and the prevalence of obesity, which imposes risk for complications of chronic disease, may be high in both groups.

Compared with the overall elderly population, both congregate and home-delivered meal program participants generally fare worse on most of the health dimensions examined for which we have comparable data. Home-delivered participants are considerably less healthy relative to the overall elderly population. For example, 48 percent of all elderly (age 65 and older) have arthritis, compared with 51 percent and 64 percent of congregate and home-delivered participants, respectively. Thirty-eight percent of all elderly people (age 65 and older) have hypertension, compared with about 50 percent each of congregate and home-delivered meal program participants. Sixty-three percent of home-delivered participants and 33 percent of congregate participants rate their current health as "fair or poor," compared with 29 percent of the overall elderly population.

Functional Status: According to Mathematica Policy Research (1996), a substantial proportion of Title III home-delivered meal program participants are severely functionally impaired and need daily help performing one or more activities critical for them to remain in their homes or the community and to avoid unnecessary and costly institutionalization.

Title III home-delivered meal program participants are considerably more functionally impaired than congregate participants. After examining each ADL category separately, we found that home-delivered meal program participants are approximately 7 to 18 times more likely than congregate participants to be impaired in ADLs (activities of daily living). For example, 37 percent of home-delivered participants are unable to walk or have much difficulty walking without assistance, compared with five percent of congregate participants. Home-delivered participants are three to six times more likely than congregate participants to be impaired in IADLs

> (instrumental activities of daily living). Sixty-four percent of home-delivered meal program participants are unable to shop or have much difficulty shopping for groceries without assistance, compared with 13 percent of congregate participants; 41 percent of home-delivered participants are unable to prepare or have much difficulty preparing meals without assistance, compared with 7 percent of congregate participants. Home-delivered meal participants, on average, are impaired in 2 ADLs and 2 IADLs, compared with 0.2 and 0.4 for congregate participants, respectively. Overall, home-delivered meal participants, on average, are unable to perform or have much difficulty performing four ADLs and IADLs, compared with less than one for congregate participants.

Mobility and Leisure Time Physical Activity: Title III congregate participants as a group are very mobile and physically active, and they are considerably more mobile and physically active than Title III home-delivered meal participants according to Mathematica Policy Research (1996).

> Ninety-one percent of congregate participants report getting out of their homes at least once per week; 73 percent report getting out of the house five or more times per week. In contrast, 46 percent of home-delivered participants report getting out of the house at least once per week, and only 15 percent get away from their home five or more times per week. About 70 percent of Title III congregate participants report that they participated in leisure time activities during the past month. These activities include walking, other forms of exercise, gardening, or other physical activities. Congregate participants report, on average, 21 leisure time physical activities during the past month (the median number is 13). In contrast, less than half (42 percent) of home-delivered meal program participants report any leisure time physical activities during the past month. Home-delivered meal participants report an average of 10 leisure time physical activities during the past month (the median is zero).

Food and Dietary Behaviors: According to Mathematica Policy Research (1996), most Title III congregate and home-delivered meal participants report consuming about three meals a day, including daily breakfast.

> About half of congregate participants and nearly two-thirds of home-delivered meal participants usually eat alone when they consume meals at home. The vast majority (95 percent) of congregate participants and the majority (67 percent) of home-delivered participants can prepare hot meals if they absolutely have to. Yet, fully one-third of home-delivered meal participants are unable to prepare hot meals for themselves. A minority (15 percent) of congregate participants report their current appetite as "poor" or "fair," compared with 36 percent of home-delivered meal program participants. More than 20 percent of congregate participants and 31 percent of home-delivered meal program participants are on special diets, most commonly to lower blood cholesterol levels. About half of those on special diets are on two or more special diets concurrently. About one-third of Title III meal program participants have an illness or condition that has changed the kind or amount of food eaten. About 40 percent of congregate and home-delivered participants report

taking vitamin supplements daily; half of these persons report consuming two or more supplements daily.

Most Title III meal program participants report having enough food to eat. Relatively small but meaningful proportions of congregate and home-delivered participants, however, report one or more circumstances of food insecurity during the past month (Mathematica Policy Research, 1996).

> Ten percent of congregate participants and 16 percent of home-delivered meal program participants mentioned experiencing one or more of these instances of food insecurity during the past month. Note that while the percentages appear relatively modest, they mean that, within the 30 days preceding the interview, approximately 237,000 congregate participants and 127,000 home-delivered participants experienced food insecurity. Food insecurity is somewhat higher for home-delivered meal participants than for congregate participants (16 percent versus 10 percent).

Additionally, the Title III participating population was found to have the following characteristics:

- Between 80 and 90 percent of participants have incomes below 200 percent of the poverty level, twice the rate for the overall elderly population.
- More than twice as many participants live alone compared with the overall elderly population.
- Approximately two-thirds of participants are at an unhealthy weight (most are overweight).
- More than twice as many participants have physical impairments compared with overall elderly population (Administration on Aging, 2000).
- Seventy-five percent are at high nutritional risk; twenty-five percent are at moderate risk.
- Sixty-two percent receive one half or more of their daily food intake from their home-delivered meals.
- Twenty-five percent report they do not always have enough money or food stamps to buy food.
- Recipients are more impaired and frail than the overall 60+ population (Administration on Aging, 2003).

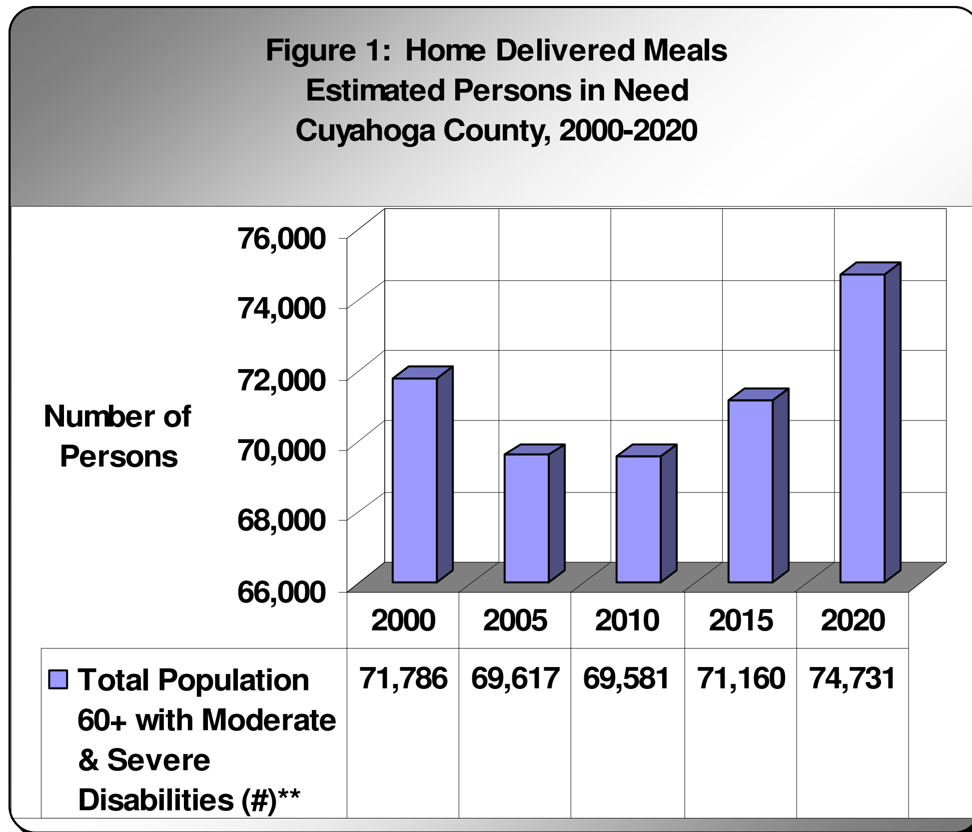
Ohio

The Ohio home-delivered meals program reflects similar trends. Some of the results of an Ohio Department of Aging study on home-delivered meal participants (Martin, Hedges, & Johnson, 2000) are as follows:

- Thirty-five percent lived alone.
- Eighty percent of clients had incomes equal to or less than 150 percent of the poverty level.
- Thirty-four percent of the PASSPORT and 4 percent of the OAA home-delivered meals participants needed assistance with three daily living activities.
- Sixty-one percent were at high nutritional risk.
- Sixty-nine percent were female, 31 were male.
- Average age was 79.

Estimated Persons in Need

In 2000, 71,786 individuals were estimated to be in need of home-delivered meals. (See Figure 1.) This estimate was determined by the number of individuals 60 and older with moderate or severe disabilities. This number is projected to increase to 74,731 by 2020 with the aging of the babyboomers. However, as will be addressed in Section IV, there is a considerable gap in service availability, and demand for home-delivered meals is expected to increase as trends in consumer preference and cost containment measures for long-term care further expand funding and availability of home- and community-based services for older adults.



Source:
** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).

It is recognized that this is a conservative estimate of persons in need of home-delivered meals because persons under 60 years also need meals. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the number of consumers actually served. It includes the actual number of consumers reported by 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 funded home-delivered meals programs that served 1,133 persons. (See Attachment 3.) In CY 2004, the Western Reserve Area Agency on Aging funded programs that served 2,503 actual annual consumers. PASSPORT funded home-delivered meals programs that served 1,356 clients. (Note: these numbers represent clients, not actual number of meals served).

Older women were more represented in reported information about home-delivered meals relative to the makeup of the population. Per the 2000 US Census, while 40 percent of the county's total 60+ population is male and 60 percent female, reporting entities primarily served females, ranging from 69 percent for United Way clients to 68 percent for WRAAA clients to 77 percent for PASSPORT clients.

Relative to the makeup of the population, African-Americans were more represented in reported information on home-delivered meals. In 2000, according to the U.S. Census, 77 percent of the county's total 60+ population was Caucasian, 21 percent African American, and 1 percent Asian. Home-delivered meal participants funded by United Way were 53 percent African-American, WRAAA-funded clients were 29 percent African-American, and PASSPORT-funded clients were 51 percent African-American.

For both United Way and WRAAA, race was unknown for more than a quarter of clients. Hispanics were not highly represented, with only 0.4 percent of United Way, 1.8 percent of WRAAA, and 0 .6 percent of PASSPORT clients compared to 1 percent of the 60+ cohort.

One hundred percent of United Way home-delivered meal program clients had incomes below $14,999, and 70 percent had incomes below $9,999. Income information for the remainder of clients was unreported.

Geographically, 24 percent of individuals 60 and older live in the City of Cleveland, and 76 percent live in the suburbs. Of the United Way home-delivered meals participants reporting address, 79 percent lived in the city of Cleveland, with the remainder living in the suburbs (4.5 percent with 16 percent unknown). OAA funding through WRAAA served 57 percent in the city of Cleveland, 43 in the suburbs. PASSPORT funded clients lived 41 percent in the city of Cleveland, 59 percent in the suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

Following the uniform definition of services from the Social Services Block Grant, home-delivered meals are those services or activities designed to prepare and deliver one or more meals a day to an individual's residence in order to prevent institutionalization, malnutrition, and feelings of isolation. Component services or activities may include the cost of personnel, equipment, and food; assessment of nutritional and dietary needs; nutritional education and counseling; socialization services; and information and referral (Administration for Families and Children, n.d.).

BACKGROUND ON CORE SERVICE

Sometimes called "Meals on Wheels," home-delivered meals programs are partly designed as nutrition programs that deliver meals to homebound older adults who are unable to prepare food for themselves. Equally as important, home-delivered meal programs also offer isolated older adults social interaction with the individuals who deliver the meals and monitor their health and well-being.

The home-delivered meals program is one of the six services that comprise the Federal Elderly Nutrition Program (FENP), which is authorized under Title III of the Older Americans Act (OAA) and is administered through the area agencies on aging. The largest amount of funding for home-delivered meals comes from the Older American's Act (OAA); in Ohio, 70 percent of funding for home-delivered meals comes from this source (Ohio Department of Aging, 2000). The purpose of the Elderly Nutrition Program, including home-delivered meals is to "improve the dietary intake of participants and to offer participants opportunities to form new friendships and to create informal support networks" (Administration on Aging, 2003). The underlying purpose is to make community-based services available to support older adults in maintaining their independence.

FENP sets eligibility for the program at 60 years of age, although some other populations, such as spouses of any age, are also permitted to receive meals. Though there is no set income eligibility, services focus on older people with the greatest economic or social need, with special attention given to low-income minorities and rural residents (Administration on Aging, 2003).

Home-delivered meals may be delivered hot, cold, frozen, dried, canned, or as supplemental foods. Breakfast, lunch, dinner, or a combination of two or three meals may be provided five days per week, and also can be provided on the weekends. Meals served under the program must provide at least one third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, as well as the Dietary Guidelines for Americans, issued by the Secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. In practice, the Elderly Nutrition Program's 3 million elderly participants are receiving an estimated 40 to 50 percent of required nutrients from meals provided by the program (Administration on Aging, 2003). Because of the rise in diabetes and hypertension, agencies that provide meals to older adults expect to see a rise in clients requesting meals that are part of restricted, low sodium, low cholesterol diets. Providing these meals is more expensive and agencies will find it challenging to meet the increased demand.

Volunteers are essential to home-delivered meals programs. In Ohio, the use of volunteers is widespread. Almost seven of ten providers use volunteers alone or combinations of volunteer and paid staff to deliver meals. Volunteers deliver meals for almost one in ten providers. Rural providers are more likely to use paid staff to deliver meals. Most providers use retired senior volunteers. One in five has experience with corporate and/or student volunteer programs. About one in ten either does not use volunteers or has not been successful in recruiting volunteers. One provider captured its experience with volunteers in this way: “The pool of volunteers is dwindling due to availability of part-time jobs and increased need for volunteers in the general community” (Ohio Department of Aging, 2000).

Home-delivered meals can provide a significant support for caregivers of older adults who are trying to maintain their independence and remain in their own homes. Family members (who are most often not compensated for the care they provide) provide the majority of long-term care. About 80 percent of care provided to older persons in their homes is given informally by family and friends. The typical working caregiver spends an average of 22 hours a week on caregiving duties (Scripps Gerontology Center, 2003). Home-delivered meals remove some burden from caregivers, allowing them to continue providing support and meet their obligations to themselves and their own families.

Nationally, the number of meals provided and the demand for home-delivered meals has increased significantly over the years. In fiscal year 1988, there were 94.7 million home-delivered meals served compared to 130 million in fiscal year 1998, a 27.2 percent increase (National Policy & Resource Center on Nutrition & Aging, Meal Services, 2002). Ohio has seen a similar increase. Per a 2000 report by the Ohio Department of Aging, there has been a 30 percent increase in home-delivered meals (Ohio Department of Aging, 2000). PASSPORT home-delivered meals accounted for the bulk of this, with a 136 percent increase. OAA-funded meals also increased at a rate of 9 percent. Demand is expected to increase due to health care cost containment and rapid hospital discharge, as well as the increasing senior population and trends in policies that support home- and community-based care options.

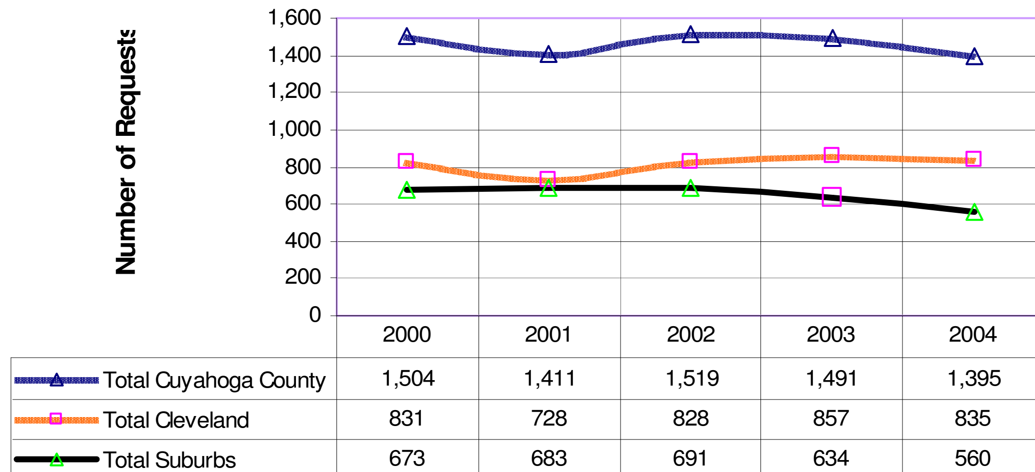
Given the current flat funding, meeting the need for home-delivered meals is unlikely. The Elderly Nutrition Program Evaluation, Nutrition Project Survey reported that a substantial number (41 percent) of home-delivered meals programs have a waiting list. In an unweighted sample, the mean number on the waiting list was 85 and the median was 35. The differences in these numbers can be explained by the inclusion of a few large programs with long waiting lists; but even the median is about 30 percent of the programs’ average daily number of home-delivered meal recipients (Administration on Aging, 2003).

United Way – First Call for Help Data

Based on United Way - First Call for Help’s (FCFH) database (February 2005), there are 53 home-delivered meal providers operating out of 63 sites, 36 of which are nonprofit and 17 are government. In FY 2004 (July 2003 to June 2004), United Way funded 1 of these providers. (See Attachments 5 and 6.)

United Way - First Call for Help call data shows on overall slight decrease (7 percent) in the number of requests for information for home-delivered meals programs from 1,504 requests in 2000 to 1,395 requests in 2004. Most calls came from the City of Cleveland. (See Figure 2.)

Figure 2: Home Delivered Meals
First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)



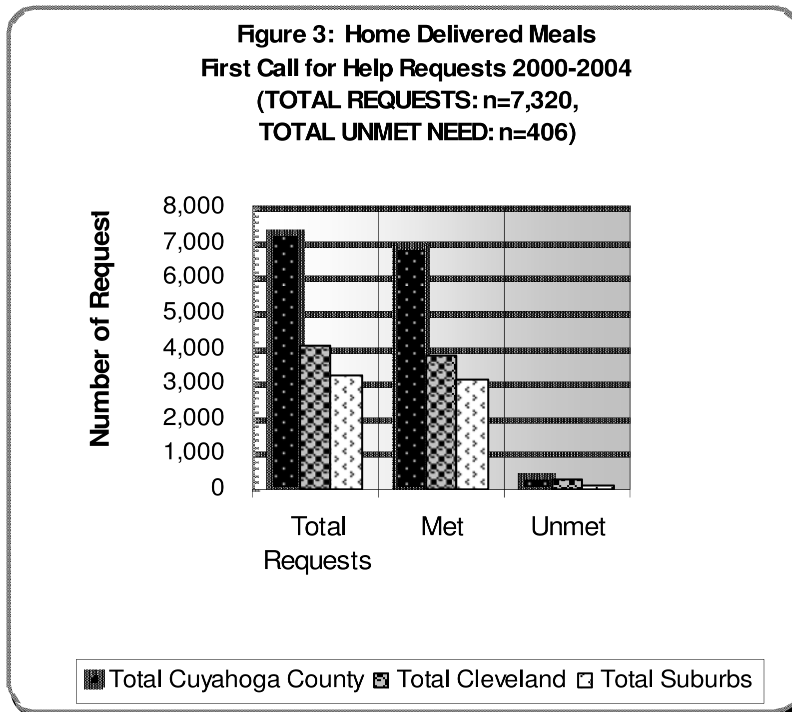
	2000	2001	2002	2003	2004
Total Cuyahoga County	1,504	1,411	1,519	1,491	1,395
Total Cleveland	831	728	828	857	835
Total Suburbs	673	683	691	634	560

The highest average number of calls per year from 2000-2004 came from the following Cuyahoga County zip codes:

- 44108: Cleveland/Bratenahl (117 calls average);
- 44105: Cleveland/Newburgh Hts/Garfield Hts (88 calls average);
- 44128: Warrensville Hts/Cleveland (73 calls average);
- 44109: Cleveland/Brooklyn Hts (72 calls average);
- 44120: Shaker Hts/Cleveland (69 calls average);
- 44110: Cleveland/East Cleveland (66 calls average);
- 44104: Cleveland (59 calls average);
- 44111: East Cleveland/Cleveland (58 calls average);
- 44111: Cleveland (57 calls average); and
- 44103: Cleveland (55 calls average).

(See Attachment 7.)

Of the 7,320 requests for home-delivered meal programs from 2000-2004, United Way - United Way - First Call for Help was able to provide an appropriate referral for 94 percent; 406 callers had an unmet need, meaning that there was no agency to refer to. Cleveland's unmet need was 7 percent and the suburbs' 3 percent. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders
The major sources of government funding for home delivered meals are:

- Older Americans Act (OAA);
- Ryan White CARE Act - Title I;
- PASSPORT (Medicaid Waiver); and
- Cuyahoga County Health and Human Services Levies (OPTIONS for Elders through Department of Senior and Adult Services).

These sources are further described below.

FEDERAL

Older Americans Act (OAA)
As described in Section II of this report, the Administration on Aging awards formula grants under Title III of the Older Americans Act (OAA) to the 57 state units on aging to plan, develop, and coordinate systems of in-home and community-based services under which home-delivered meal programs fall. The AoA's FY 2005 budget totaled approximately $1.397 billion. In FY 2006, the budget decreased to $1.366 billion. The home-delivered meals program is the third largest part of the AoA's budget. This program's appropriation has declined from $183 million in FY 2005, to $182 million in FY 2006, and is expected to decrease by $181 million in FY 2007 (U.S. Department of Health and Human Services, 2006). In Ohio, Senior Community Services funding, which funds home-delivered meals, has been reduced by 25 percent since 2001 (Ohio Association of Area Agencies on Aging, 2005).

Ryan White CARE Act - Title I

Authorized under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and administered by the U.S. Department of Health and Human Services Health Resources and Services Administration, Ryan White Title I funds provide emergency assistance to eligible metropolitan areas (EMAs) that are most severely affected by the HIV/AIDS epidemic. Formula grants are based on number of living cases of AIDS, and discretionary grants are available. To be eligible, an area must have reported at least 2,000 AIDS cases during the previous five years and have a population of at least 500,000. Ryan White Title I funds can be used for many different kinds of outpatient and ambulatory health services. Although not specifically meant to provide meals, Ryan White Title I funds offer individualized nutritional counseling that is essential to HIV/AIDS clients who often have weight loss and nutritional problems. Local Title I HIV health services planning councils make allocation decisions. In FY 2006 $301 million was allocated nationally from Title I. In 2006, Cleveland received $3.349 million: $1.793 million in formula grants and $1.314 in supplemental funding with another $214,208 for Minority AIDS Initiative funding.

STATE

PASSPORT (Medicaid Waiver)

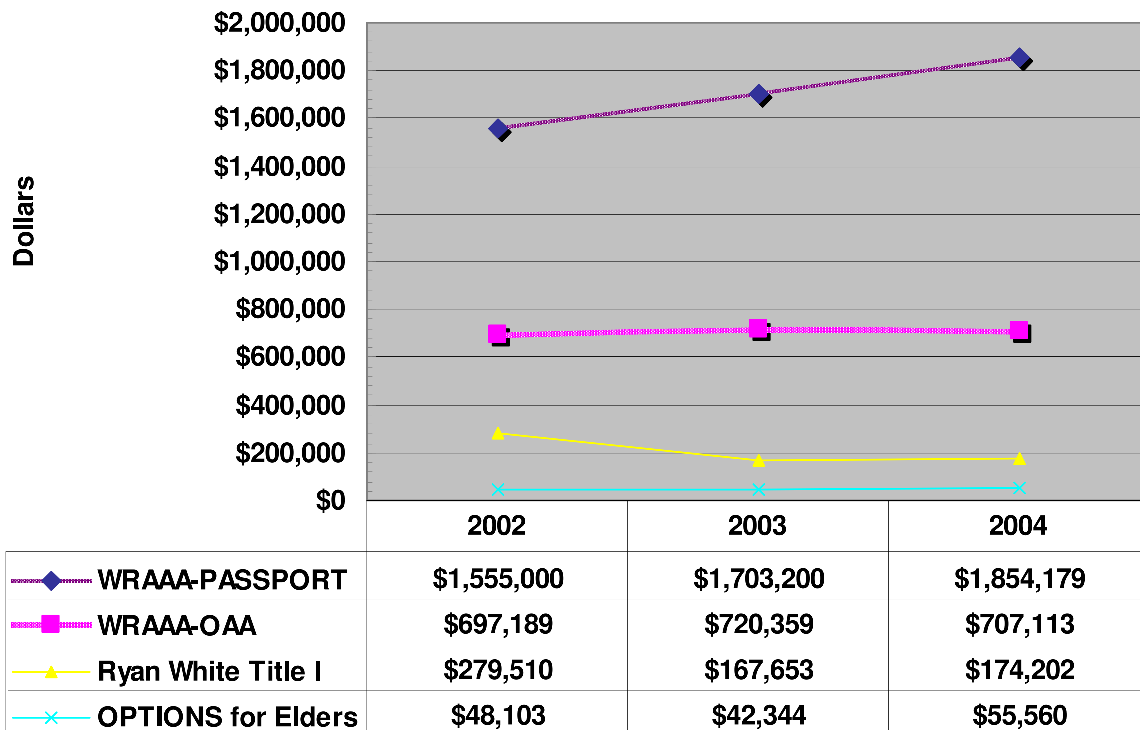
PASSPORT, Ohio's Medicaid waiver for home- and community-based services for people age 60 and over, is the second largest government funder of home-delivered meals—and the most rapidly growing. The goals of the program are to direct people needing long-term care to the appropriate setting and provide necessary home care to prevent the institutionalization of people who can remain in the community. Actual funding from the state's general revenue fund for PASSPORT in FY 2003 was $55 million. In FY 2007, it has more than doubled to $121 (Legislative Services Commission, 2006). High consumer demand for the PASSPORT program—as evidenced by waiting lists, continued planned expansion, and other cost containments proposed for Medicaid—suggest that the demand for home-delivered meals will continue to grow.

LOCAL

Cuyahoga County Health and Human Services Levies (OPTIONS for Elders through Department of Senior and Adult Services)

The Cuyahoga County Department of Senior and Adult Services (DSAS) administers the OPTIONS home support program that provides in-home care to older Cuyahoga County residents who, because of income and/or assets, are not eligible for PASSPORT or other Medicaid waiver programs. Home-delivered meals are part of this program's service. Funding for this program comes from the Cuyahoga County commissioners through the county's Health and Human Services levies. There are currently two Cuyahoga County health and human services (HHS) levies—one at 2.9 mils set to expire in 2011 (passed in November 2006 as Issue 19), and the other at 4.9 mils set to expire in 2008. The levy provides a flexible source of funds for the county. The amount of money generated through these levies has been increasing: in 2002 $119.3 million was available; in 2006, $168.4 million was expected to be available. The replacement levy of November 2006 will generate an additional $27.3 million annually.

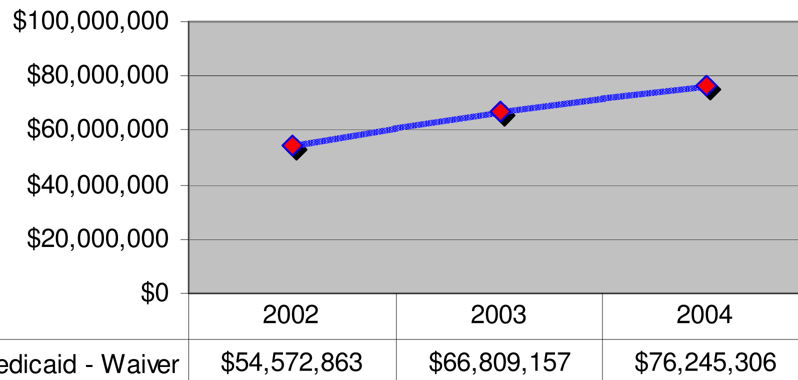
Trends of Identified Government Funders in Cuyahoga County
At the local level, home-delivered meals funding has been mixed from various sources. Between 2002 and 2004, PASSPORT funding increased 12 percent. Funding from the Older Americans Act was mixed from 2002-2004, with an overall increase of about 1 percent during this time. Ryan White Title I funds decreased substantially by 38 percent, and OPTIONS increased by 13 percent. (See Figure 4.) The Medicaid waiver funding increased from $55 million to $76 million over the same period. (See Figure 5.)



	2002	2003	2004
WRAAA-PASSPORT	$1,555,000	$1,703,200	$1,854,179
WRAAA-OAA	$697,189	$720,359	$707,113
Ryan White Title I	$279,510	$167,653	$174,202
OPTIONS for Elders	$48,103	$42,344	$55,560

Source: Respective Funding Sources

Figure 5: Medicaid Trend - Waiver *
Cuyahoga County CY 2002 - 2004



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

IDENTIFIED REVENUES

As of May 11, 2006, slightly more than $4.48 million in revenues for home-delivered meals programs has been reported countywide. (See Table 2.) This includes information from foundations; federated fundraising organizations; regional, county, and municipal government; and United Way of Greater Cleveland.

Almost 96 percent of the revenues are from contracts or grants from government organizations. Western Reserve Area Agency on Aging (WRAAA) is by far the primary funder (accounting for 91 percent of government funding) through three main funding streams: PASSPORT (Ohio's home-based Medicaid waiver) at $1.85 million, Older Americans Act at $707,000, and through cost of meal reimbursements at $1.5 million. United Way of Greater Cleveland's funds account for less than 3 percent the total from Investment Committee allocations and designations.

Table 2: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Home-delivered Meals, 2003/2004.

		A		B	
Funder	Period	Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Other Private Foundations - Not Elsewhere Classified				2,264	
Total - Foundations & Trusts		**0**	**0.00%**	**2,264**	**0.23%**
Jewish Community Federation	2004	64,000			
Total - Federated Fundraising Organizations		**64,000**	**1.43%**	**0**	**0.00%**
Other Federal Funders - Not Elsewhere Classified				396,522	
Subtotal Federal Government		***0***	***0.00%***	***396,522***	***40.01%***
WRAAA-PASSPORT	2004	1,854,179			
Subtotal State of Ohio		***1,854,179***	***41.39%***	***0***	***0.00%***
Western Reserve Area Agency on Aging (WRAAA)				445,000	
WRAAA-OAA-Title III C-2	CY2004	707,113			
WRAAA-Cost of Meals	CY2004	1,500,206			
Subtotal Regional Funding Sources		***2,207,319***	***49.27%***	***445,000***	***44.90%***
Cuyahoga Metropolitan Housing Authority (CMHA)				3,897	
HIV Services Planning Council Ryan White Title I	2004	174,202			
Other Cuyahoga County Funders - Not Elsewhere Classified				12,000	
OPTIONS for Elders	2004	55,560			
Subtotal Cuyahoga County Funding Sources		***229,762***	***5.13%***	***15,897***	***1.60%***
All Other Funding - Not Elsewhere Classified				6,475	
Subtotal Other Govt Funding Sources		***0***	***0.00%***	***6,475***	***0.65%***
Total - Contracts/grants from government organizations		**4,291,260**	**95.78%**	**863,894**	**87.16%**
Subtotal Non - UWGrCle Support		**4,355,260**	**97%**	**866,158**	**87.39%**
Total - UWGrCle investment committee allocation		**125,000**	**2.79%**	**125,000**	**12.61%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**125,000**	**2.79%**	**125,000**	**12.61%**
Total Support/Revenue		**4,480,260**	**100%**	**991,158**	**100%**

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

REIMBURSEMENT/COST

Per an evaluation conducted in 1993-1995 (the most recent available) for the Administration on Aging, the average cost of a home-delivered meal was $5.31, including donated labor and supplies. Paid labor was about 37 percent of the meal cost. Most paid staff members worked at the meal sites and were involved in preparing or serving the meals. Transporting meals to homes in the home-delivered meal program cost an average of 34 cents, or 17 percent of paid labor costs paid. Food costs--ingredients or payments made to vendors for already prepared meals--were approximately $1.75 in both home delivered and congregate meal programs. (Mathematica Policy Research, 1996) (See Table 3.)

Table 3: Comparison of Congregate and Home Delivered Meal Costs

Cost Component	Title III Congregate Meals	Title III Home-Delivered Meals
Total Labor Costs	**$2.22**	**$2.43**
Paid Labor	1.79	1.96
Site	1.18	1.04
Central kitchen	.11	.13
Central administration	.47	.42
Transportation to site	.04	.03
Transportation to homes	NA	.34
Volunteer Labor	.43	.47
Site	.42	.10
Central kitchen	*	*
Central administration	.01	.01
Transportation to site	*	*
Transportation to homes	NA	.36
Total Nonlabor Costs	**2.95**	**2.88**
Foods/Vendor	1.74	1.72
Supplies	.13	.11
Rent	.14	.13
Insurance/Utilities	.30	.30
Equipment	.26	.30
Other Costs	.11	.06
Donated Food/Space	.28	.26
Total Paid Costs	**4.46**	**4.57**
Total Costs (Paid and Nonpaid)	**5.17**	**5.31**
Unweighted Sample Size	**170**	**156**

Source: Elderly Nutrition Program Evaluation, cost data collection instruments, weighted tabulations. Mathematic Policy Research, 1996

Nutrition projects relied heavily on volunteer labor and donations to obtain additional resources to provide meals to their clients, and the full cost estimates cited above include the value of these resources. When only direct monetary costs are considered, the average costs were $4.57 for home-delivered meals. Volunteer labor accounted for much of the differences. Most projects employed volunteers in the kitchen to help with food preparation and as deliverers of meals to individual homes. In-kind contributions mostly involved space donated or leased at very low prices for use by the nutrition projects. (Mathematica Policy Research, 1996)

The state of Ohio reports that the average meal cost is $5.45 (Ohio Department of Aging, 2000). WRAAA reimburses providers at two different rates for PASSPORT and for meals funded through the Older Americans Act (OAA). For OAA-funded home-delivered meals, the WRAAA's reimbursement rate varies per provider, but the median is $1.08, which is paid directly to the caterer. As a policy of the Administration on Aging, home-delivered meal participants are strongly encouraged to contribute voluntarily to the cost of their meals, but providers are prohibited from requiring cost sharing for nutrition services (Administration on Aging, n.d.).

PASSPORT-funded home-delivered meals are reimbursed at the full cost of the meal. This includes the direct and indirect costs necessary to provide the meal. The federal Administration on Aging (AoA), which administers all Older American's Act programs, has ruled that in cases where home-delivered meals are provided to participants of means-tested programs (including Medicaid waiver programs such as PASSPORT) the reimbursement rate to the Older American's Act program must cover the full cost of the meal. The full cost of the meal includes direct and indirect costs. It should be noted that waiver agencies that fund the service may not require a participant to pay or donate toward the cost of a home-delivered meal when that meal is paid for in full by the waiver (Wisconsin Department of Health and Human Services, 2004). As of 2000, the PASSPORT waiver rate for one home-delivered meal is $6.32 (Ohio Department of Job and Family Services, 2004).

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

Home-delivered meals programs enable older adults to remain living independently in their homes by a) improving their nutritional status, thereby contributing to a variety of other positive health outcomes such as decreased functional disability, b) providing a limited but important increase in social contact, and c) connecting older adults with other resources. Additionally, home-delivered meal programs help remove some of the responsibilities placed on caregivers so they can continue supporting older adults in maintaining independence without "burning out."

Below is a list of programs and suggested techniques for service design, management, and delivery of home-delivered meals programs that are designed to be relevant to current and changing populations, increase efficiencies, and improve quality:

- Meals should appeal to the cultural preferences of clients, especially with the increases in older minority populations and the substantial health disparities that exist. Providing culturally appropriate, nutritious, high-quality, tasty meals can be an effective outreach effort to bring in the target population, improve customer satisfaction, promote health, and reduce health disparities. Some of the strategies suggested include:
  - Include community input when developing meals.
  - Employ staff and volunteers who reflect the diversity of the community served.
  - Provide authentic ethnic cuisine.
  - Offer a variety of meals from different ethnic groups.
  - Offer cultural food items as side dishes, desserts, or snacks, if not the entrée on a regular basis (National Resource Center on Nutrition, Physical Activity, and Aging, 2004).

- Providers should view themselves as part of a community-based long-term care system that provides cross-referrals and coordination of service delivery at all levels within the aging network, and should recognize that for many older adults they are often an entry-point for this network and a first-line resource for accessing other services.

- Older adults should be given the opportunity to contribute financially for their meal.

- To ensure their participation, engage baby boomers in discussions about future directions of present day service programs for the elderly (White House Conference on Aging, 2005).

What Doesn't Work

Lack of coordination and collaboration is consistently noted to be a major barrier to providing effective services to older adults. Focus group participants for United Way's core service planning (2005) also noted issues with exchange of information and data. Currently, there is no centralized location of information that all agencies can share to discover data about where to access services for their clients. As one participant noted, "*I wish there was a central point where everyone can post or go to just exchange information about things that are going on within their particular program*." It is difficult for service providers to navigate existing sources of

information and determine which program should be selected. Service providers tend to utilize programs they are familiar with: "…*the programs you know, you end up using them more…*" The program selection is based on the service providers' awareness and penetration in the service community.

IMPACT ON COMMUNITY

Programs help older adults have better nutritional status and community connections, which improves their health and well-being and thereby enables them to remain in their own homes longer. By supporting older adults to remain in their homes, fewer may need high-cost, taxpayer-financed hospitalizations or care in such places as long-term care facilities or nursing homes. Some specific facts on community impact of home-delivered meal programs include the following:

- For every $1 invested in nutrition programs, $3.25 is saved in health care costs.
- Cost of treating a malnourished hospital client is four times greater than the cost of treating a well-nourished client.
- Seniors in poor nutritional status are more likely to need home care or be institutionalized (Olsen, n.d.).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Currently, home-delivered meals programs do not have accreditation or certification for their operations, although there are very specific eligibility criteria for funding from some sources, such as PASSPORT and Title III of the Older American's Act. Providers are required to serve meals that provide one third of the recommended dietary allowances established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences as well as the Dietary Guidelines for Americans issued by the Secretaries of the U.S. Department of Health and Human Services and the U. S. Department of Agriculture. WRAAA-funded providers must follow a menu, created by WRAAA, which meets all nutritional requirements. In addition, the U.S. Administration on Aging started the Performance Outcome Measures Project (POMP) for state and community programs, including home-delivered meals programs. A number of surveys are used in relation to home-delivered meals to obtain information on the quality of service, the extent to which receiving meals helps maintain or improve clients' well-being, and outcomes of participation. Data is also collected on social and emotional well-being and demographic information (Administration on Aging, Performance Outcomes Measures Project, n.d.). Finally, there are government regulations related to food preparation that must be followed.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Home Delivered Meals:

- An estimated 71,786 persons need home-delivered meals, which is the number of Cuyahoga County individuals 60 and older with moderate to severe disabilities.

- Based on available information about actual consumers, approximately 3,859 persons over 60 have realized access to home-delivered meals, which is the number of individuals reported as served by OAA and PASSPORT funding through the WRAAA. This assumes that there is duplication across the numbers reported by United Way and OAA funds (but not PASSPORT funds).

- This leaves a net estimate of 67,927 persons who are either receiving services from unaccounted-for sources or are not receiving home-delivered meals at all. (71,786 – 3,859 = 67,927)

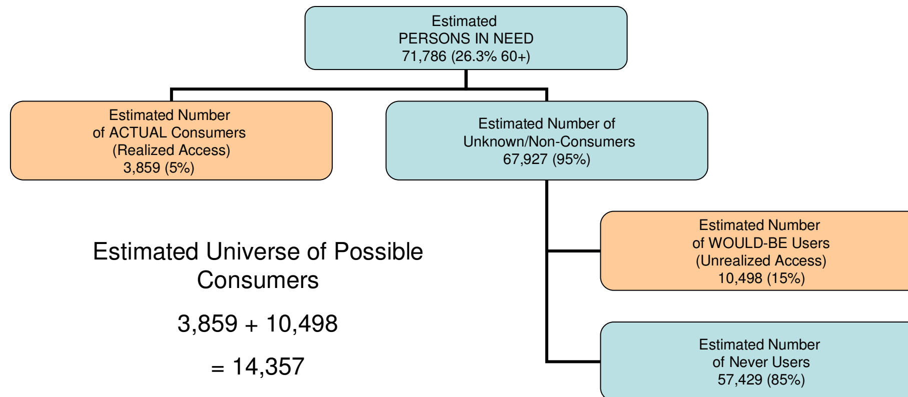
- A 1996 evaluation of the Older American's Act Elderly Nutrition Program (through which home-delivered meal programs are funded) found that 41 percent of providers have a waiting list, suggesting a significant unmet need for these services (Mathematica Policy Institute, 1996).

- It is estimated that 80 percent of those in need (57,429) are covered by the informal caregiving system of families, friends, and neighbors and the remaining 20 percent by the formal caregiving system (14,357), the estimated universe of possible consumers (Mehdizadeh et al., n.d.). (71,786 x 80% = 57,429) and (71,786 x 20% = 14,357)

- The result is 10,498 persons with unrealized access, i.e., the number of would-be consumers who would use the service if they knew about it and it were accessible and affordable. (14,357 – 3,859 = 10,498)

- The estimated universe of possible consumers is 14,357, including both realized (3,859) and unrealized (10,498) access. (See Figure 6.)

Figure 6: Consumer Estimates
Home Delivered Meals



Service Site Index
Countywide, according to United Way - First Call for Help (February 2005), there are 63 service sites for home-delivered meal programs. This is a ratio of 228 possible consumers (estimated 14,357 total) to one service site countywide. Service providers report to United Way - First Call for Help which zip codes are included in their respective service areas. The Service Site Index in Attachment 9 lists the number of sites located in each zip code, and the number of service sites that report serving a particular zip code. Dividing the estimated number of possible consumers in each zip code by the number of service sites that could serve that zip code provides a ratio of consumers to service sites for each zip code. This is a measure of potential service accessibility by possible universe of service consumers per zip code area. Note that this measure does not include the capacity of providers to offer the service, for example, the number of home delivered meals that can be provided on a daily basis. It is only capturing whether there is a possibility of being a client. The lower the ratio, the greater is the chance of receiving a meal.

The ratios on the Service Site Index range from a high of 94:1 in zip code 44130 (Parma/Cleveland) to a low of 4:1 in zip code 44115 (Cleveland). In addition to 44130, 2 other zip codes have ratios of 80 consumers or greater to one service site:

- 44134 (Parma/Cleveland - 90:1); and
- 44124 (Pepper Pike/MayfieldHts/Lyndhurst - 82:1).

(See Attachment 10 for map.)

Service Capacity

Gaps in Special Populations Not Served
The United Way core service key informants (2005) identified groups of individuals that currently need but are not receiving services:

- Individuals with low incomes:
- Older adults ages 85 to 100:
- Older adults taking care of grandchildren or adult children with a mental or physical disability;
- Older adults within the Asian community who are suffering from cancer;
- Family members desiring respite services while they are the primary caregivers of individuals suffering from chronic diseases and dementia.
- Minorities who may need service, but are suspicious of it.

Key informants also indicated that senior centers have difficulty attracting older adults who are from Asian, Eastern European (Slavic), and Hispanic populations. Many of the older adults from these ethnic groups do not speak English, making it very difficult to market senior centers to them. Literacy is another issue. For instance, one participant found a number of Hispanic older adults who are illiterate in their own language. Some obstacles among the minority communities lacking these services include language barriers, cultural diversity, and the lack of understanding of the services that are available. It is difficult to reach individuals in the Asian and Hispanic communities because of their close family ties and language barriers. Some key informants felt that the insufficient supply of services to the Asian and Hispanic communities is due to the lack of funds and volunteers, specifically those who are bilingual.

Another service gap was identified for younger participants. The focus group noted that there is an aged 55-59 population that is also in need of services. However, this population may not be able to obtain services from their agency because they do not meet federal eligibility requirements, which mandates that clients be 60 years old (in most cases). The agency then has to refer these clients to other agencies that could serve them.

Finally, focus group participants noted that there may be a significant population that requires services, but does not currently seek services because they do not wish to ask agencies for help or be dependent on outside agencies or individuals for assistance.

> *It is really a real step for them to ask anybody outside of their family circle or neighbors to do anything for them and so for those ten people that call us there's probably ten thousand who are sitting there gritting there teeth and saying, "Well, I just have to do without."*

Additionally, many individuals do not know how to access the services. There may be a number of people who never "get on the radar" of the agencies. Outreach to these populations is essential.

Gaps in Communities Served
The key informants were asked which specific communities in Cleveland have an insufficient supply of services. They indicated that this tends to be in some of the first-tier suburban areas as well as Cleveland's inner city, where there is the greatest concentration of risk factors such as poor economic conditions and low education status. However, despite the greater need for services, there are fewer providers in the City of Cleveland. One key informant specifically

identified the Collinwood area as needing a meals program since the closing of Collinwood Community Services Center. Focus group participants also expressed concerns about older adults moving out of Cuyahoga County into surrounding counties that may not have the infrastructure to serve them as they age.

Gaps in Types of Meals Served

There is an increasing service gap in types of meals that the home-delivered meal provider network is able to provide. Older adults are increasingly in need of more specialized diets. Focus group participants noted the difficulty of providing highly specialized therapeutic diets through the established network. These diets are often so specialized that they need to come out of a controlled environment such as a hospital or other healthcare facility.

VII. SUMMARY

In summary, there are several major findings from the research on home-delivered meal programs:

- According to a national public opinion survey conducted by the Association of Aging and Retired Persons (AARP) (2003), an overwhelming majority of older adults want to stay in their own homes as long as possible. Home-delivered meal programs have been proven to contribute to allowing older adults avoid early and unnecessary institutionalization and are a critical component of the home and community-based long-term care service system (Mathematica Policy Research, 1996).
- Key public policy issues affecting home-delivered meals programs are the funding and policy decisions that reinforce movement away from institutionalization and toward more home- and community-based service options.
- Stagnant or decreasing funding of home-delivered meals programs in the face of rising demand will be a major public policy issue.
- In Cuyahoga County, PASSPORT funding increased 12 percent between 2002 and 2004. Funding from the Older Americans Act was mixed from 2002-2004, with an overall increase of about 1 percent during this time. Ryan White CARE Act Title I funds decreased substantially by 38 percent, and OPTIONS increased by 13 percent. Medicaid waiver funding increased from $55 million to $76 million over the same period.
- As of May 11, 2006, slightly more than $4.48 million in revenues for home-delivered meals programs has been identified countywide.
- Elements that make a program relevant to current and changing populations, increase efficiencies, and improve quality include: employment of staff and volunteers who reflect the diversity of the community served; meals that appeal to the cultural preferences of clients, especially with the increases in older minority populations and the substantial health disparities that exist.
- Home-delivered meal programs help remove some of the responsibilities placed on caregivers so they can continue supporting older adults in maintaining independence without “burning out.”
- Lack of coordination and collaboration is consistently noted to be a major barrier to providing effective services to older adults.
- The estimated universe of possible consumers is 14,357, including both realized (3,859) and unrealized (10,498) access.
- Countywide, there are 63 service sites for home-delivered meal programs. This is a ratio of 228 possible consumers (estimated 14,357 total) to one service site countywide.

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

Attachment 3: Actual Consumer Demographics

Core Service: Home Delivered Meals BD-500.350								
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ***				
	Total Population (%)*	Total Population 60+ (%)**	Population 60+ with Moderate or Severe Disabilities	UW Program Report Data Cuy Cnty Only 100% (%)	PASSPORT (%)	WRAAA (%)	Ryan White Title I (%)	OPTIONS for Elders (%)
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	2004	CY2004	2004	2004
TOTAL	**1,393,978**	**273,378**	**71,786**	**1,133**	**1,356**	**2,503**	**84**	**Missing**
Percent		**19.6%**	**26.3%**					
GENDER								
Male	47.2%	40.4%	N/A	29.5%	23.0%	31.4%	73.8%	N/A
Female	52.8%	59.6%	N/A	69.3%	77.0%	67.9%	25.0%	N/A
Unknown Data****			-	1.2%	0.0%	0.7%	1.2%	N/A
Missing Data*****			-	0.0%	0.0%	0.0%	0.0%	100.0%
RACE****								
White alone	67.1%	77.4%	N/A	20.3%	46.6%	38.6%	36.9%	N/A
Black or African American alone/combination	27.9%	20.7%	N/A	53.4%	51.0%	29.2%	48.8%	N/A
Asian alone/combination	2.1%	1.1%	N/A	0.0%	0.0%	0.1%	0.0%	N/A
American Indian and Alaska Native alone/combination	0.7%	0.4%	N/A	0.2%	0.0%	0.0%	0.0%	N/A
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	N/A	0.0%	0.0%	0.1%	0.0%	N/A
Some other race alone/combination	2.1%	0.6%	N/A	0.2%	1.1%	0.0%	1.2%	N/A
Two or more races		0.8%	N/A	0.0%	0.0%	0.0%	0.0%	N/A
Unknown Data****			-	25.9%	0.7%	30.2%	13.1%	N/A
Missing Data*****			-	0.0%	0.6%	1.8%	0.0%	100.0%
HISPANIC*****	3.3%	1.1%	N/A	0.4%	0.6%	1.8%	11.9%	N/A
AGE								
0-4	6.5%			0.0%	0.0%	0.0%		N/A
5-9	7.3%			0.0%	0.0%	0.0%		N/A
10-14	7.1%			0.0%	0.0%	0.0%		N/A
15-19	6.4%			0.0%	0.0%	0.0%	98.8%	N/A
20-34	19.1%			0.0%	0.0%	0.0%		N/A
35-54	29.3%			0.0%	0.0%	0.0%		N/A
55-64	8.7%	N/A	N/A	8.2%	37.0%	31.7%		N/A
65-74	7.8%	N/A	N/A	34.7%		0.0%	1.2%	N/A
75+	7.8%	N/A	N/A	55.9%	63.0%	66.6%		N/A
Unknown Data****				1.2%	0.0%	1.7%	0.0%	N/A
Missing Data*****				0.0%	0.0%	0.0%	0.0%	100.0%
INCOME******								
Average Household Size	**2.4**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
$0-$9,999	11.3%	N/A	N/A	69.5%	0.0%	0.0%	0.0%	N/A
$10,000-$14,999	6.9%	N/A	N/A	30.5%	0.0%	0.0%	0.0%	N/A
$15,000-$19,999	6.7%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	N/A
$20,000-$29,999	13.6%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	N/A
$30,000 and above	61.5%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	N/A
Unknown Data****			-	0.0%	0.0%	0.0%	0.0%	N/A
Missing Data*****			-	0.0%	100.0%	100.0%	100.0%	100.0%
Totals	**100.0%**	**N/A**	**N/A**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000, SF1(P1); SF3 (P52); SF4 (PCT144)
*** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).
****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 multipled by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category which may result in more conservative estimates for children and the "old old" which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Home Delivered Meals BD-500.350									
			Estimated Persons in Need		Actual Number/Percent of Consumers by Funding Source ****				
	City/Town (% Cleveland)	Total Population (%)*	Total Population 60+ (%)**	Population 60+ with Moderate or Severe Disabilities	UW Program Report Data (%)	WRAAA Cuy Cty Only (%)	PASSPORT Cuy Cty Only (%)	Ryan White Title I (%)	OPTIONS for Elders (%)
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	2004	2004	2004	2004
TOTAL		1,393,978	273,378	71,786	1,133	2,503	1,356	1,356	Missing
Percent			19.6%	26.3%					
44017	Berea	1.4%	1.3%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44022	Bentleyville	1.3%	1.3%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	0.3%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44070	North Olmsted	2.4%	2.5%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.6%	0.0%	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	2.3%	N/A	0.0%	10.2%	0.0%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	1.5%	N/A	9.6%	6.7%	5.1%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	1.4%	N/A	5.8%	3.9%	4.3%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	3.1%	N/A	0.2%	1.9%	3.5%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.3%	N/A	19.0%	7.5%	13.1%	0.0%	0.0%
44107	Lakewood/Cleveland	4.1%	3.1%	N/A	0.0%	7.3%	3.2%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	2.5%	N/A	17.1%	4.1%	7.1%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	2.3%	N/A	0.1%	6.7%	0.1%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	1.5%	N/A	6.2%	1.5%	5.2%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	2.5%	N/A	5.5%	4.4%	0.0%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	2.1%	N/A	0.3%	5.0%	6.9%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	0.8%	N/A	2.5%	3.3%	0.4%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	0.3%	N/A	4.6%	1.1%	1.0%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	0.2%	N/A	2.7%	1.6%	1.0%	0.0%	0.0%
44116	Rocky River	1.5%	2.2%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	1.4%	N/A	0.0%	0.0%	1.0%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	2.6%	N/A	0.2%	2.4%	6.4%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	1.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	3.1%	N/A	0.2%	3.7%	4.3%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	2.2%	N/A	0.0%	1.2%	4.0%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	3.7%	N/A	0.0%	0.1%	0.7%	0.0%	0.0%
44123	Euclid	1.3%	1.4%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	4.5%	N/A	0.0%	0.8%	4.9%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	2.5%	N/A	0.0%	2.1%	0.0%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	1.5%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	0.4%	N/A	0.1%	0.9%	0.3%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	2.8%	N/A	0.0%	3.7%	1.0%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	2.4%	N/A	0.0%	0.7%	0.0%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	5.2%	N/A	0.0%	6.3%	0.0%	0.0%	0.0%
44131	Independence/Seven	1.5%	2.2%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44132	Euclid	1.1%	1.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44133	North Royalton	2.1%	1.7%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	3.7%	N/A	0.0%	1.4%	0.0%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.0%	2.0%	N/A	5.5%	3.4%	0.0%	0.0%	0.0%
44136	Strongsville	3.1%	2.5%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	1.9%	N/A	0.0%	4.3%	0.1%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.2%	N/A	0.0%	0.0%	0.1%	0.0%	0.0%
44140	Bay Village	1.2%	1.1%	N/A	0.0%	0.0%	0.1%	0.0%	0.0%
44141	Brecksville	1.0%	1.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	1.8%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	2.0%	N/A	0.0%	0.0%	3.1%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	1.9%	N/A	0.0%	2.3%	0.0%	0.0%	0.0%
44145	Westlake	2.3%	2.6%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.6%	N/A	3.9%	1.5%	23.2%	0.0%	0.0%
44147	Broadview Hts	1.1%	1.1%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes******					16.1%	0.0%	0.0%	0.0%	0.0%
	Missing*****				0.0%	0.0%	0.0%	100.0%	100.0%
	Unknown ******				0.0%	0.0%	0.0%	0.0%	0.0%
	Total Cuyahoga County	**100.0%**	**100.0%**	N/A	**100.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**
	Total Known Cleveland	**30.5%**	**24.2%**	N/A	**79.4%**	**57.0%**	**41.1%**	**0.0%**	**0.0%**
	Total Known Suburbs	**69.5%**	**75.8%**	N/A	**4.5%**	**43.0%**	**58.9%**	**0.0%**	**0.0%**
	Unknown & Missing				**0.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**

* U.S. Census 2000, SF1 (P1)

** U.S. Census 2000, SF1 (P1)

*** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).

**** 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.

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS – 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	53	1
Number of Providers by Type		
Non-profit	36	1
For-profit	-	-
Government	17	-
Other	-	-
Total Number of Sites	63	5
Number of Service Sites per Provider		
1	48	-
2 – 5	5	1
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	1	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	1	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	2	-
44103 – Cleveland	2	-
44104 – Cleveland	2	1
44105 – Newburgh Hts/Garfield Hts	1	-
44106 – Cleveland Hts/Cleveland	1	-
44107 – Cleveland/Lakewood	2	-
44108 – Cleveland/East Cleveland	1	-
44109 – Cleveland/Brooklyn Hts	1	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	2	-
44112 – Cleveland/East Cleveland	1	-
44113 – Cleveland	3	1
44114 – Cleveland	1	-
44115 – Cleveland	2	-
44116 – Rocky River	1	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	1	-
44119 – Cleveland/Euclid	1	-
44120 – Cleveland/Shaker Hts	3	1
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	3	-
44123 – Euclid	2	-
44124 – Pepper Pike/Mayfield Village	3	-
44125 – Valley View/Garfield Hts	3	-
44126 – Cleveland/Fairview Park	1	-
44127 – Cleveland	1	-
44128 – Cleveland/Warrensville Hts	2	-
44129 – Cleveland/Brooklyn/Parma	-	-

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

PROFILE OF CORE SERVICE PROVIDERS – 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44130 – Cleveland/Parma	1	-
44131 – Seven Hills/Brooklyn Hts	3	-
44132 – Euclid	-	-
44133 – North Royalton	2	-
44134 – Parma/Cleveland	1	-
44135 – Cleveland/Linndale	2	1
44136 – Strongsville	1	-
44137 – Maple Hts/Cleveland	1	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	1	-
44140 – Bay Village	1	-
44141 – Brecksville	1	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	2	-
44145 – Westlake	1	-
44146 – Walton Hills/Oakwood/Bedford	2	1
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-
Total Cuyahoga County	63	5
Total Cleveland	22	3
Total Suburbs	41	2

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
AIDS Taskforce of Greater Cleveland	Nutrition Support & Transportation
Aldersgate United Methodist Church	Home-Delivered Meals
Altenheim	Home-delivered Meals
City of Bay Village Department of Community Services	Home-delivered Meals
Bellaire-Puritas Meals on Wheels	Home-delivered Meals
Brecksville-Broadview Heights Meals on Wheels	Home-delivered Meals
City of Brooklyn Senior Center	Home-delivered Meals (Long-Term) and (Short-Term)
Village of Brooklyn Heights	Home-delivered Meals
Catholic Charities Services of Cuyahoga County	Home-delivered Meals: St. Martin De Porres, Broadway Golden Hours, West Rose-Mt. Carmel
Cuyahoga County Department of Senior & Adult Services	Home Care Assistance / Coordination - Elderly
City of East Cleveland Helen S. Brown Senior Citizen Center	Meals - Home-delivered and Congregate
East End Neighborhood House	Senior Center - Meals - Congregate and Home-delivered
City of Euclid	Senior Center - Home-delivered Meals
Euclid Meals on Wheels	Home-delivered Meals
City of Garfield Heights	Senior Center - Home-delivered Meals
Golden Age Centers of Greater Cleveland	**Home-delivered Meals - Main Site and Cluster Sites**
Goodrich-Gannett Neighborhood Center	Senior Center - Food / Nutrition
Harvard Community Services Center	Home-delivered Meals
Hillcrest Meals on Wheels	Home-delivered Meals - Highland Hts./Lyndhurst/S. Euclid/Mayfield Village & Hts./Richmond Hts.
City of Independence	Home-delivered Meals
Jewish Family Service Association of Cleveland	Eldercare - Home-delivered Meals
City of Lakewood Department of Human Services	Home-delivered Meals
Lakewood Meals on Wheels	Home-delivered Meals
City of Maple Heights	Senior Center - Home-delivered Meals
Meals on Wheels of Cleveland Heights	Home-delivered Meals
Meals on Wheels of Collinwood	Home-delivered Meals
Meals on Wheels of Garfield Heights	Home-delivered Meals
Merrick House	Meals: Home-delivered and Congregate
Murtis H. Taylor Multi-Service Center	Home-delivered Meals
Muslim Council for the Concerns of The Elderly	Home-delivered Meals - Halal - 2 Saturdays/Month/Halal - Weekly
City of North Olmsted Department of Human Resources	Home-delivered Meals
Village of North Randall	Home-delivered Meals
City of North Royalton	Home-delivered Meals
Orange Meals on Wheels	Home-delivered Meals
City of Parma Service Department	Senior Center - Home-delivered Meals
City of Parma Heights	Senior Center - Home-delivered Meals

Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	**Services**
Royal Redeemer Lutheran Church	Home-delivered Meals
The Salvation Army	Social Services/Hot Meal/Home-delivered Meals - Seniors
Schnurmann House	Home-delivered Meals - Seniors
Senior Citizen Resources	Home-delivered Meals
Senior Outreach Services	Home-delivered Meals
City of Seven Hills	Home-delivered Meals
Shaker Heights Meals on Wheels	Home-delivered Meals
Solon Meals on Wheels	Home-delivered Meals
Southeast Clergy Meals on Wheels	Home-delivered Meals
Southwest Meals on Wheels	Home-delivered Meals
University Settlement	Home-delivered Meals
Village of Valley View	Home-delivered Meals
Vocational Guidance Services	Senior Center - Home-delivered Meals
West Park Meals on Wheels	Home-delivered Meals
West Shore Meals on Wheels	Home-delivered Meals
West Side Community House	Home-delivered Meals
Western Reserve Area Agency on Aging	Information, Assessment and Home Care Services

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Home-delivered Meals Requests – 2000-2004: Greatest Increase/Greatest Decrease

BD-500.350 Home-delivered Meals United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44126	Fairview Park/Cleveland	4	7	12	2	10	150%	7
44107	Lakewood/Cleveland	13	24	20	20	24	85%	20
44115	Cleveland	12	9	24	18	18	50%	16
44105	Cleveland/Newburgh Hts/Garfield Hts	75	92	87	85	103	37%	88
44127	Cleveland	14	11	12	10	19	36%	13
44139	Bentleyville/Glenwillow/Solon	3	5	1	11	4	33%	5
44110	Cleveland/East Cleveland	56	48	48	105	73	30%	66
44109	Cleveland/Brooklyn Hts	66	65	77	66	85	29%	72
44117	Euclid/Cleveland	15	19	26	19	19	27%	20
44135	Cleveland/Linndale	39	25	53	35	49	26%	40
44017	Berea	8	9	12	15	10	25%	11
44070	North Olmsted	9	10	5	6	11	22%	8
44118	ClevelandHts/UniversityHts/ShakerHts	24	27	17	21	29	21%	24
44146	Walton Hills/Oakwood/Bedford	25	40	28	43	29	16%	33
44131	Independence/Seven Hills/Brooklyn Hts	7	16	11	6	8	14%	10
44137	Maple Hts/Cleveland	14	10	28	23	16	14%	18
44113	Cleveland	28	17	40	25	31	11%	28
44132	Euclid	10	5	7	9	11	10%	8
44133	North Royalton	10	6	5	9	11	10%	8
44121	University Hts/South Euclid	24	38	24	19	26	8%	26
44140	Bay Village	1	4	2	3	0	(100%)	2
44116	Rocky River	18	8	14	5	3	(83%)	10
44022	Bentleyville	5	1	1	10	1	(80%)	4
44136	Strongsville	16	8	11	5	6	(63%)	9
44123	Euclid	17	8	15	10	7	(59%)	11
44134	Parma/Cleveland	26	17	15	15	11	(58%)	17
44125	Valley View/Garfield Hts	37	20	22	18	17	(54%)	23
44129	Brooklyn/Parma/Cleveland	15	7	11	12	7	(53%)	10
44114	Cleveland	17	8	6	3	8	(53%)	8
44143	Highland Hts/Richmond Heights	24	31	23	23	13	(46%)	23
44145	Westlake	7	2	5	2	4	(43%)	4
44144	Brooklyn/Cleveland	41	46	30	27	27	(34%)	34
44108	Cleveland/Bratenahl	130	113	121	125	95	(27%)	117
44104	Cleveland	77	56	55	50	57	(26%)	59

Attachment 7: United Way - First Call for Help Home-delivered Meals Requests – 2000-2004: Greatest Increase/Greatest Decrease (continued)

BD-500.350 Home-delivered Meals United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					**%Change***	**Avg. #**
		2000	**2001**	**2002**	**2003**	**2004**	**00&04**	**Calls 00-04**
44120	Shaker Hts/Cleveland	82	61	78	65	61	(26%)	69
44147	Broadview Hts	4	5	6	1	3	(25%)	4
44124	Pepper Pike/Mayfield Hts./Lyndhurst	28	38	30	17	22	(21%)	27
44103	Cleveland	59	50	65	55	48	(19%)	55
44128	Warrensville Hts/Cleveland	69	76	77	87	58	(16%)	73
44142	Brookpark/Cleveland	7	16	8	15	6	(14%)	10
44112	East Cleveland/Cleveland	62	47	66	61	54	(13%)	58
44111	Cleveland	54	43	65	75	48	(11%)	57
44138	Olmsted Twp/Olmsted Falls	9	11	12	15	8	(11%)	11
44119	Cleveland/Euclid	13	19	11	15	12	(8%)	14
	****Total Cuyahoga County**	**1,504**	**1,411**	**1,519**	**1,491**	**1,395**	**(7%)**	1464
	****Total Cleveland**	**831**	**728**	**828**	**857**	**835**	**0%**	816
	****Total Suburbs**	**673**	**683**	**691**	**634**	**560**	**(17%)**	648

* Extremely high percentages are due to low numbers.

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

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

BD-500.350 Home-delivered Meals					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	**Met**	**Unmet**	**Unmet**
44127	Cleveland	66	50	16	24%
44115	Cleveland	81	62	19	23%
44141	Brecksville	6	5	1	17%
44129	Brooklyn/Parma/Cleveland	52	44	8	15%
44102	Cleveland/Brooklyn	413	352	61	15%
44114	Cleveland	42	37	5	12%
44103	Cleveland	277	248	29	10%
44133	North Royalton	41	37	4	10%
44119	Cleveland/Euclid	70	64	6	9%
44105	Cleveland/Newburgh Hts/Garfield Hts	442	405	37	8%
44104	Cleveland	295	271	24	8%
44113	Cleveland	141	130	11	8%
44109	Cleveland/Brooklyn Hts	359	334	25	7%
	*** Total Cuyahoga County**	**7,320**	**6,914**	**406**	**6%**
	*** Total Cleveland**	**4,079**	**3,785**	**294**	**7%**
	*** Total Suburbs**	**3,241**	**3,129**	**112**	**3%**

FCFH DATA NOTES

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

Unmet = service request for which there was no referral.

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

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

Attachment 9: Service Site Index

Core Service: Home Delivered Meals BD-500.350									
Service Site Index									
Zip	Number of Sites*****	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#)*	Total Population 60+ (#)**	Estimated Persons in Need - Total Population 60+ with Moderate or Severe Disabilities (#)***	Estimated Universe of Possible Consumers per Geographical Area****	Number of Service SITES Serving Geographical Area (Per Agencies Reported Intended Service Area to First Call for Help)*****	Potential Service ACCESSIBILITY by Service Consumers per Geographical Area Ratio of CONSUMERS to Service SITES
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/2005	
TOTAL	63			1,393,978	273,378	71,786	14,357	63	228:1
Percent					19.6%	26.3%	20.0%		
44117	-	**Euclid/Cleveland**	**African Am 53.1%**	**12,078**	**3,744**	**983**	**197**	**7**	**28:1**
44105	**1**	**Cleveland/NewburghHts/GarfieldHts (75%)**	**African Am 61.9%**	**54,834**	**8,540**	**2,243**	**448**	**11**	**41:1**
44106	**1**	**Cleveland/Cleveland Hts (60%)**	**African Am 62.2%**	**32,417**	**6,224**	**1,634**	**327**	**9**	**36:1**
44110	-	**Cleveland/East Cleveland (98%)**	**African Am 74.7%**	**26,536**	**4,126**	**1,083**	**217**	**7**	**31:1**
44120	**3**	**Shaker Hts/Cleveland**	**African Am 76.7%**	**47,349**	**8,406**	**2,207**	**441**	**9**	**49:1**
44103	**2**	**Cleveland (100%)**	**African Am 80.2%**	**25,348**	**4,174**	**1,096**	**219**	**9**	**24:1**
44108	**1**	**Cleveland/Bratenahl (90%)**	**African Am 94.9%**	**36,456**	**6,939**	**1,822**	**364**	**10**	**36:1**
44112	**1**	**East Cleveland/Cleveland**	**African Am 95.2%**	**33,222**	**5,702**	**1,497**	**299**	**8**	**37:1**
44128	**2**	**Warrensville Hts/Cleveland**	**African Am 95.8%**	**33,612**	**7,641**	**2,006**	**401**	**13**	**31:1**
44104	**2**	**Cleveland (100%)**	**African Am 97.5%**	**28,904**	**3,734**	**981**	**196**	**10**	**20:1**
44115	**2**	**Cleveland (100%)**	**African Am 98.4%**	**8,186**	**489**	**128**	**26**	**7**	**4:1**
44114	**1**	**Cleveland (100%)**	**Asian 20.3%**	**3,891**	**877**	**230**	**46**	**7**	**7:1**
44109	**1**	**Cleveland/Brooklyn Hts (98%)**	**Hispanic 20.3%**	**45,783**	**6,409**	**1,683**	**337**	**7**	**48:1**
44102	**2**	**Cleveland/Brooklyn (95%)**	**Hispanic 20.4%**	**52,108**	**6,361**	**1,670**	**334**	**9**	**37:1**
44113	**3**	**Cleveland (100%)**	**Hispanic 23.5%**	**19,466**	**2,282**	**599**	**120**	**8**	**15:1**
44017	1	Berea		19,005	3,544	931	186	5	37:1
44022	-	Bentleyville		17,720	3,665	962	192	7	27:1
44040	-	Gates Mills/Mayfield Village		2,883	740	194	39	6	6:1
44070	1	North Olmsted		34,081	6,734	1,768	354	5	71:1
44101	-	Cleveland (100%)		-	-	0	-	1	N/A
44107	2	Lakewood/Cleveland		56,710	8,645	2,270	454	6	76:1
44111	2	Cleveland (100%)		42,967	6,767	1,777	355	10	36:1
44116	1	Rocky River		21,122	6,135	1,611	322	5	64:1
44118	1	ClevelandHts/UniversityHts/ShakerHts		45,279	7,014	1,842	368	9	41:1
44119	1	Cleveland/Euclid (50%)		13,493	3,041	799	160	7	23:1
44121	-	University Hts/South Euclid		35,185	6,118	1,607	321	8	40:1
44122	3	Beachwood/Highland Hills/ShakerHts		34,883	10,212	2,682	536	10	54:1
44123	2	Euclid		18,363	3,780	993	199	6	33:1
44124	3	Pepper Pike/MayfieldHts/Lyndhurst		40,334	12,459	3,272	654	8	82:1
44125	3	Valley View/Garfield Hts		29,876	6,831	1,794	359	8	45:1
44126	1	Fairview Park/Cleveland		17,196	4,014	1,054	211	5	42:1
44127	1	Cleveland (100%)		8,403	1,151	302	60	5	12:1
44129	-	Brooklyn/Parma/Cleveland		29,658	6,581	1,728	346	7	49:1
44130	1	Parma/Cleveland		53,615	14,364	3,772	754	8	94:1
44131	3	Independence/Seven Hills/BrooklynHts		20,666	6,063	1,592	318	8	40:1
44132	-	Euclid		15,322	2,963	778	156	6	26:1
44133	2	North Royalton		28,685	4,544	1,193	239	6	40:1
44134	1	Parma/Cleveland		40,396	10,242	2,689	538	6	90:1
44135	2	Cleveland/Linndale (90%)		28,561	5,366	1,409	282	9	31:1
44136	1	Strongsville		43,858	6,943	1,823	365	5	73:1
44137	1	Maple Hts/Cleveland		26,107	5,204	1,367	273	6	46:1
44138	-	Olmsted Twp/Olmsted Falls		18,046	3,681	967	193	5	39:1
44139	1	Bentleyville/Glenwillow/Solon		22,231	3,223	846	169	7	24:1
44140	1	Bay Village		16,076	3,075	807	161	5	32:1
44141	1	Brecksville		13,676	3,146	826	165	5	33:1
44142	-	Brookpark/Cleveland		21,132	4,811	1,263	253	5	51:1
44143	-	Highland Hts/Richmond Heights		23,730	5,483	1,440	288	9	32:1
44144	2	Brooklyn/Cleveland		21,805	5,203	1,366	273	8	34:1
44145	1	Westlake		31,972	7,122	1,870	374	5	75:1
44146	2	Walton Hills/Oakwood/Bedford		31,648	7,018	1,843	369	7	53:1
44147	-	Broadview Hts		15,954	3,059	803	161	5	32:1

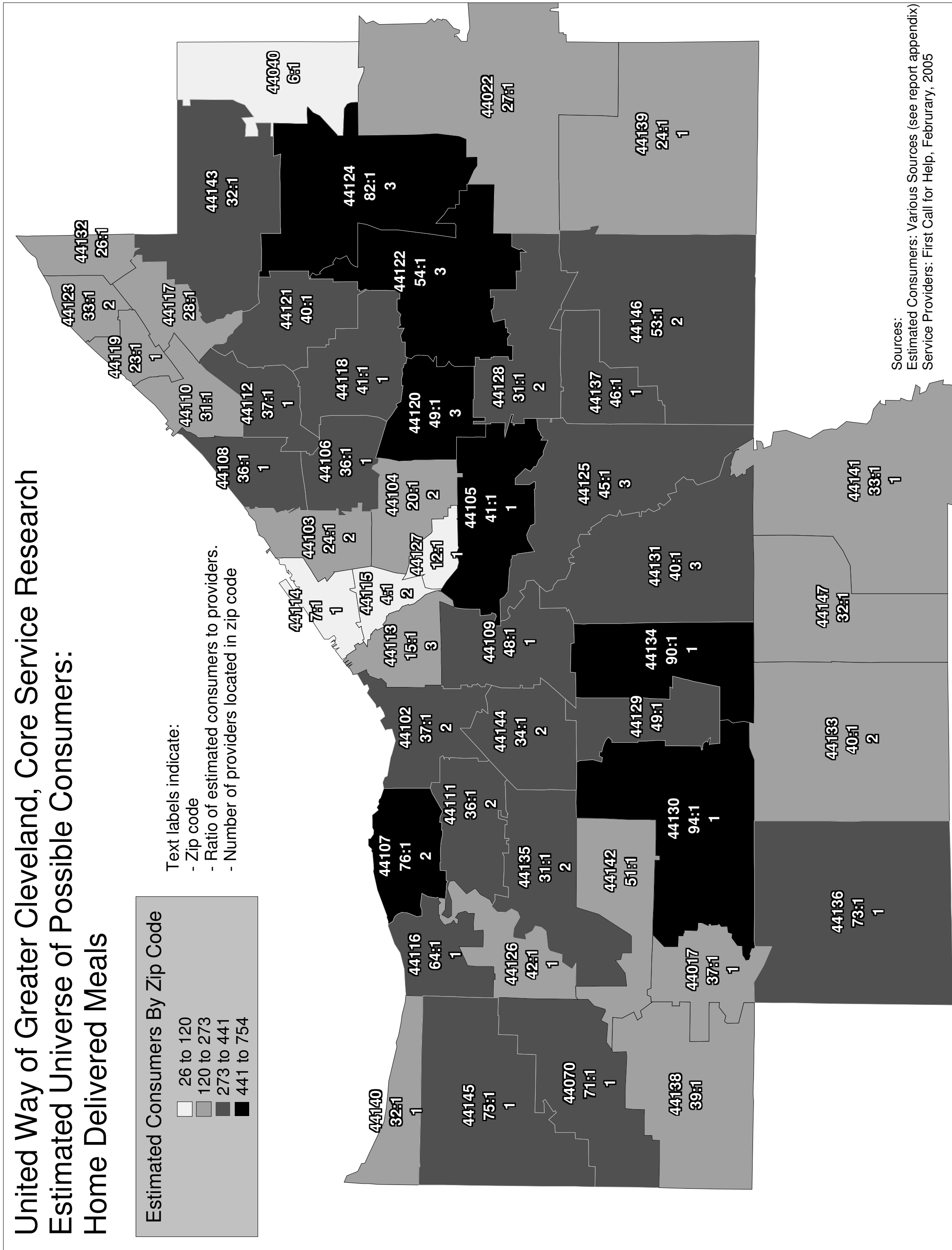
* U.S. Census 2000, SF1 (P1)

** U.S. Census 2000, SF1 (P1)

*** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).

**** A 1996 evaluation of the Older American's Act Elderly Nutrition Program (through which home-delivered meal programs are funded) found that 41 percent of providers have a waiting list, suggesting a significant unmet need for these services (Mathematica Policy Institute, 1996). It is estimated that 80 percent of those in need (57,429) are covered by the informal caregiving system of families, friends, and neighbors and the remaining 20 percent by the formal caregiving system (14,357), the estimated universe of possible consumers (Mehdizadeh et al., n.d.). (71,786 x 80% = 57,429) and (71,786 x 20% = 14,357)

Attachment 10: Map



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