Core Service Report

Home Health Care

Consumer Category:
With / At Risk of Health Conditions

Primary Consumer Group:
Persons with Physically Disabling Conditions

February 2007

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COMPANION REPORTS

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

ACKNOWLEDGEMENTS

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SNAPSHOT

AIRS Code Level I: Health Care (L)
AIRS Code Level II: Specialized Treatment (LT)
Core Service: Home Health Care (LT-280)

Investment Committee: Health & Caring For All and Senior Success
Cluster: Rehabilitation/Specialized Treatment and Basic Subsistence/Supportive Services

AIRS Definition: Programs that make necessary medical services available in the homes of people who are aged, ill, or convalescing.

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

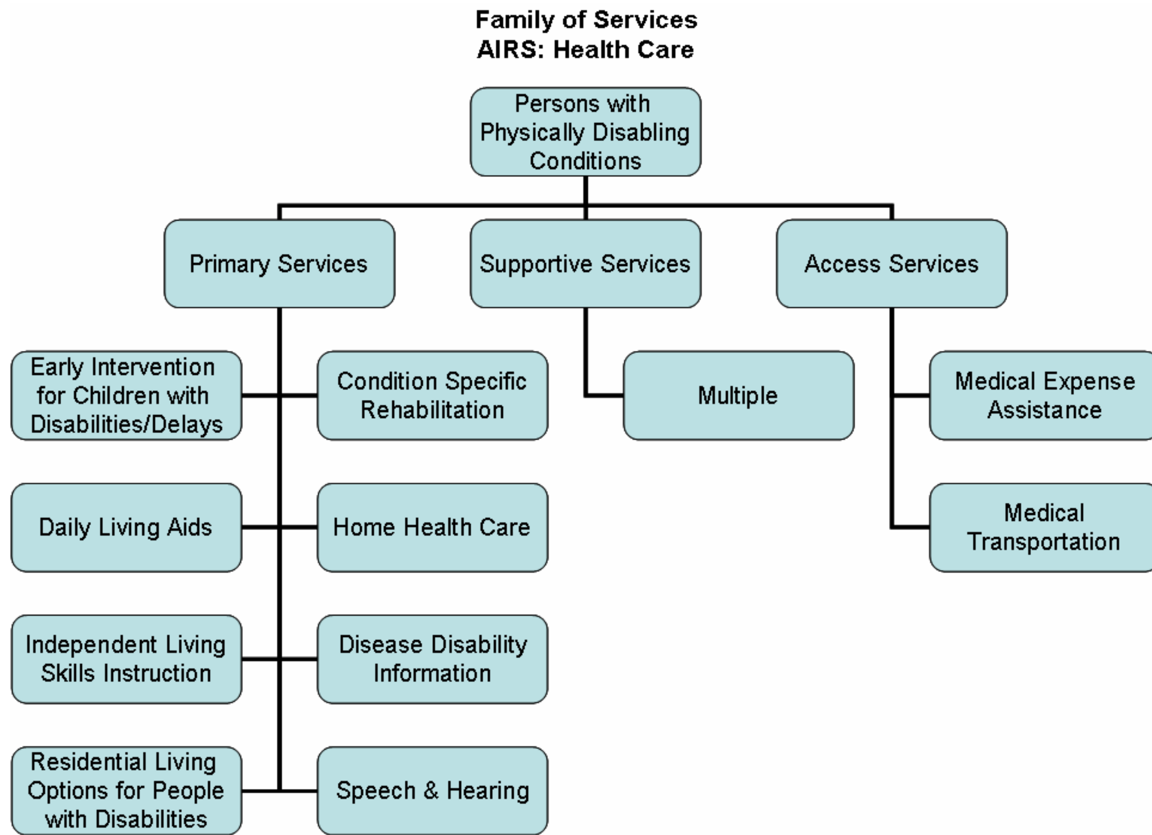
There are also three core services related to in home services: home health care, in-home assistance, and residential living options for people with disabilities. To avoid as much duplication as possible across reports, the content of the core service reports were organized as follows with all of them being part of the broad package of home and community-based services:

- **Home Health Care** is for people of all ages who need temporary (weeks or months) in-home care from medical professionals for rehabilitation from a hospital stay, recovery from illness, injury or surgery or for a terminal medical condition.

- **In-Home Assistance** is for older adults (60+) who need long-term (many months or years) care in home custodial services by paraprofessionals for chronic medical conditions, chronic severe pain, permanent disabilities, dementia, ongoing need for help with activities of daily living, or need for supervision. While the narrative of this report covers an entire package of services to support community-based long term care needs of homebound older adults, this report only includes “homemaker,” “personal care,” and “chore” in the funding and consumer data. There are separate reports for medical transportation, home-delivered meals, daily living aids, independent living skills, and adult day care.

- **Residential Living Options** for People with Disabilities discusses both in-home and institutional care for adults who are disabled and under 60 years.

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



Core Service Environment

Home and community-based services—ranging from skilled nursing and physical therapy to help with daily activities such as bathing and dressing—are vital to many people with chronic illness or disability. By 1995, these services had become the fastest growing component of health care spending in the United States, according to the Visiting Nurse Service of New York. Demand for home care was increasing due to consumer preference, the aging of Americans, the increasing number of families with limited time available to provide informal care, pressure to reduce hospital and nursing home stays and technological advances that made it possible to manage more complex conditions at home. At the same time, financial and political forces were pushing for cuts in spending growth and limits on the government's fiscal responsibility. Proposed changes in Medicare and Medicaid—the public programs that pay for most home and community-based services—would alter delivery systems, payment mechanisms, provider incentives and service patterns. Managed care organizations were becoming more active in chronic illness and supportive services. (Robert Wood Johnson Foundation [RWJF], 2004)

There is considerable debate among experts concerning the issues and challenges facing America's home health care system, especially as it will be impacted by the aging of the population (Applebaum, Straker, Mehdizadeh, Warshaw & Gothelf, 2002). Researchers disagree about the number of elderly who will require care, what aging means, and the implications for policy at federal and state levels. Despite these disagreements, most agree that the current system requires modifications if it is to meet the increasingly complex needs of consumers in a rapidly changing society.

Policies related to Medicare and Medicaid have tremendous impact on providers' capacity to offer services and consumers' benefits from services. There have been a number of changes in these policies that have—and will—affect home health care services.

Home health is a mandatory Medicaid benefit for eligible persons. Medicaid's home health care benefit primarily covers skilled nursing services and physical and other therapies. Medicare provides for the majority of *skilled* home care, but a much smaller share of unskilled services when compared to Medicaid (Kassner, 2006).

The Deficit Reduction Act of 2005 offers reforms in both Medicare and Medicaid that could, according to Congress, save the federal government $26.5 billion in Medicaid expenditures over a ten-year period. Under this legislation, states are allowed to charge premiums and higher co-payments for services including prescription drug coverage, physicians' services, and hospitalization (to encourage personal responsibility); scale back benefits or eliminate coverage for services currently guaranteed by federal law; and end coverage for people who do not pay premiums after 60 days (Pear, 2005).

Core Service Consumers

For the purpose of this core service report, the target population is people of all ages who need medically necessary skilled nursing care to help with rehabilitation from a hospital stay; recovery from illness, injury or surgery; or for a terminal medical condition.

In February 2004, the National Center for Health Statistics (NIHS) published findings from the "National Home and Hospice Care 2000" study. Data was collected on approximately 1.3+ million persons receiving home health care in the U.S. Of that total, 29.5 percent were under 65 years of age, while the majority (70.5 percent) was over 65 years old.

Since 1992, the number of persons receiving all home health care services increased until 1996, when the number began to decline. The decline is more than likely the impact from the Balanced Budget Act of 1997, which focused on the key factors of service delivery and the means of compensating providers.

In 2000, an estimated 5,042 individuals were home health care patients in Cuyahoga County, or 0.36 percent of the total population. The number of persons receiving home health care is expected to decrease to 4,737 by 2015 because of population shifts.

Core Service Delivery

The definition of home health care for this report is: programs that make necessary medical services available in the homes of people of all ages who are aged, ill, or convalescing, i.e., medical/skilled

services. In addition to physician and skilled nursing care, it can include physical and occupational therapy, speech-language therapy, and social services. It is distinguished from in-home assistance services that are either ancillary custodial services provided with skilled care or a package of services that is part of the long-term care system.

Home health care involves a formal program of care and treatment performed in a person's home, is prescribed by a physician, and is prescribed in lieu of treatment in a hospital or skilled nursing facility, or results in a shorter hospital or skilled nursing facility stay. The home health care program must be organized, administered, and supervised by a hospital or qualified licensed personnel under the medical direction of a physician (www.brevard.edu/FO/definitions.asp).

Custodial care is always a part of a skilled care plan for home care. The patient receives skilled care from a nurse or therapist and custodial care from an aide who helps with bathing, dressing, ambulating, toileting, incontinence, medicating, and possibly feeding. Medicare pays for both types of services (Day, n.d.).

According to United Way – First Call for Help (FCFH) database and the Long Term Care Ombudsman (February 2005), there are 62 providers of home health care operating in 63 sites located in Cuyahoga County. Thirty-six are nonprofit providers, 18 are for-profit, and 8 are governmental agencies. United Way funds one nonprofit agency and has one location in the Cleveland area. Based only on FCFH call data, those requesting home health care in the county increased from 254 per year in 2000 to 287 by year 2004, which represented about a 13 percent increase. FCFH call data indicated that between 2000-2004 there were a total of 1,285 requests for help, with 98.5 percent of the requests met.

Medicare is the largest single payer of home health care services at 31.6 percent in 2002; in the same year, Medicaid accounted for 13.3 percent; state and local governments 15.8 percent; and private insurance 18.6 percent.

In February 2004, the Centers for Medicare and Medicaid Services projected that Medicare home health care spending will increase 7.3 percent from 2002 to 2013 and account for 32 percent of the total spending. Private spending in the same period was projected to comprise 37 percent of the total (Basic Statistics About Home Care, updated 2004). While spending is expected to increase on Medicare, especially with the aging of the baby boomers, some restructuring of the Medicare system is expected as many note that current levels are "unsustainable."

The FY 2007 budget proposes trimming Medicaid spending by $14 billion over five years, with the biggest changes coming from capping government providers, eliminating administration and transportation expenses for school-based services, establishing stricter reimbursement policies for rehabilitation services, phasing down a provider tax, and recouping administrative costs assumed in the TANF program.

As of May 11, 2006, over $2.4 million in revenues for home health care has been identified countywide. More than fifty percent of the revenues are from contracts or grants from government organizations and 26 percent from federated organizations. United Way of Greater Cleveland's funds account for 17 percent of the total.

What Works; What Doesn't

Medicare managed care has generally not paid enough to cover the high costs of the seriously ill; thus most managed care programs cannot capitalize on their potential to provide good care (Lynn & Adamson, 2003).

> Other countries have begun to base medical coverage decisions, in part, on how many years of life a treatment is expected to produce. However, raising the subject of conditioning access to life-extending treatment on anything (costs, effects on life span, or effects upon quality of life) in the United States may provoke controversy. An easier course is to cut back on other services that are hard to track or whose benefit is not so apparent.

The national challenge is to establish a method by which the cost of care of those with fatal chronic illnesses is matched with concerns of the chronically ill elderly and their families, even if it means that costly treatments are sometimes not readily available to some chronically ill elderly (Lynn & Adamson, 2003).

Some home health agencies are certified by Medicare and/or Medicaid. Both programs can certify home health agencies for meeting agency participation conditions.

In addition to the Ohio Department of Health, the Community Health Accreditation Program (CHAP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are two organizations that have been authorized by the Centers for Medicare & Medicaid Services (formerly HCFA) to certify home health care agencies. There were 333 Medicare certified agencies in Ohio in 1999 (Applebaum & Mehdizadeh, 2001 in Scripps Gerontology Center, 2003).

Gap Analysis

An estimated 5,042 persons need home health care in Cuyahoga County. In FY 2004, 6,896 persons received home health care in Cuyahoga County. This results in a surplus of 1,854. See Researcher's Note in Gap Analysis section of this report.

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

In the broadest sense, home health care has a long history that began in the 1880s and includes home health agencies, home care aide organizations, and hospice programs. The service is provided to patients returning to their homes after short-term hospital care, or long-term institutional care (Simon-Rusinowitz, Bochniak, Mahoney, & Hecht, 2000 in Kapp).

> Home and community-based services—ranging from skilled nursing and physical therapy to help with daily activities such as bathing and dressing—are vital to many people with chronic illness or disability. By 1995, these services had become the fastest growing component of health care spending in the United States, according to the Visiting Nurse Service of New York. Demand for home care was increasing due to consumer preference, the aging of Americans, the increasing number of families with limited time available to provide informal care, pressure to reduce hospital and nursing home stays and technological advances that made it possible to manage more complex conditions at home. At the same time, financial and political forces were pushing for cuts in spending growth and limits on the government's fiscal responsibility. Proposed changes in Medicare and Medicaid—the public programs that pay for most home and community-based services—would alter delivery systems, payment mechanisms, provider incentives and service patterns. Managed care organizations were becoming more active in chronic illness and supportive services. (RWJF, 2004)

There is considerable debate among experts concerning the issues and challenges facing America's home health care system, especially as it will be impacted by the aging of the population (Applebaum, Straker, Mehdizadeh, Warshaw & Gothelf, 2002). Researchers disagree about the number of elderly who will require care, what aging means, and the implications for policy at federal and state levels. For some researchers, there is the perception that disabilities among older persons will increase and drive up the need for more home and nursing care. The implication is that the absolute numbers of persons needing care will continue to increase, prompting a shortage of resources (Even, Ghosal, & Kunkel, 1998) (Applebaum et al., 1997; 2002).

Others believe that the baby-boomer-driven demand for long-term supportive services is not likely to increase substantially until 2020—roughly 20 years or more from now—if at all (Redfoot & Pandya, 2002). Knickman and Snell (2002) are optimistic about future demand, citing the National Long-Term Care study's finding that the disability rate for all elderly Americans is dropping despite population growth. In short, they believe that the assumption that increased numbers and longevity deterministically relates to higher rates of disability, increased usage of institutional or non-institutional long-term supportive services, and the need for more staff is clearly wrong.

> To the contrary, longevity gains over the past decade and a half have been accompanied by declining disability rates and declining use of nursing home services. Whether one anticipates major demand for long-term supportive services or relatively modest increases depends to a large degree on one's

> assumptions about whether or not these trends will continue. As past experience indicates, accurate projections of future demand for long-term supportive services cannot be derived by simply projecting current utilization patterns onto future cohorts. Demography is not destiny. (Friedland and Summer, 1999)

Despite these disagreements, most agree that the current system requires modifications if it is to meet the increasingly complex needs of consumers in a rapidly changing society.

PUBLIC POLICY ISSUES

Policies related to Medicare (a wholly federal program) and Medicaid (which is affected by both federal and state regulation) have tremendous impact on providers' capacity to offer services and consumers' benefits from services. There have been a number of changes in these policies that have—and will—affect home health care services.

With the passage of the Medicare Bill in 1965, the current structure of health care and means of delivering health services were put in place and have defined American public health care policy for the past four decades. Initially, Medicare policy established that the hospital would be the primary site of care and that the compensation structure would be a cost-based, retrospective reimbursement system (Murer, 2000). The next development in health care came in 1982 with the passing of the prospective payment system (PPS) and the introduction of diagnosis-related groups (DRGs). DRG-based payment essentially leveled compensation for services rendered across the U.S. to patients in acute care hospital settings.

> The greatest significance of this period was the change from a reimbursement system (retrospective) to a payment system (prospective) with little accepted variance from one facility to another or one region to another. (Murer, 2000)
>
> Home health care is an important and popular service for Medicare beneficiaries. In the early 1990s, the use of post-acute services (e.g., home health care and nursing homes) grew. Medicare expenditures for home health increased 350 percent between 1990 and 1996, and expenditures for skilled nursing facilities increased 400 percent. The number of Medicare providers of these services increased more than 50 percent. Policymakers believed that much of the increasing expenditures resulted from the relatively open-ended reimbursement system. (RWJF, 2004)

In 1997, with cost pressures mounting and dire predictions of bankruptcy of the health care system, Congress passed the Balanced Budget Act of 1997 (BBA). The BBA focused on the key factors of service delivery and the means of compensating providers. It was a key vehicle in Congress' desire to create a better means of providing Medicare services and to control cost (Murer, 2000).

> The BBA mandated major changes in the way Medicare home health is reimbursed, by requiring the implementation of a prospective payment system for services and the use of an interim payment system to limit costs while the prospective payment system was being developed. The interim

> payment system constrained agency reimbursement through reducing the limits on payments per service and, in addition, adding an aggregate per-beneficiary cost limitation. It was phased in from October 1997 through fiscal year 1998; fiscal year 1999 was the first year in which the interim payment system was fully implemented. Many analysts were concerned that this system would jeopardize access to home care, especially for beneficiaries most in need of care. (RWJF, 2004)

In response to the concerns about the possible negative effects of BBA on home care, through its home care research initiative, the Robert Wood Johnson Foundation (RWJF) engaged in a number of studies to determine the impact of the BBA on home health care services. Researchers compared data from before the BBA (fiscal years 1996 and 1997) with those for the period in which the interim payment system was in effect (fiscal years 1998 [phase in] and 1999 [full implementation]). Some of the major post-BBA findings were:

- Use of Medicare home health services fell dramatically after the BBA.
- There was a shift in the mix of visit types toward providing more skilled care.
- Home health episodes shortened after the BBA. (An episode is defined as beginning or ending when there is a 60-day period for which no Medicare home health service was billed).
- For all beneficiaries, the average drop in frequency of use of home health services was 21 percent. Among home health users, there were significantly greater-than-average decreases in the number of visits for females (42 percent) and for those age 85 and older (45 percent), compared with a 41 percent average decrease. Beneficiaries under age 65 had a significantly smaller-than-average decrease of 33 percent. Those age 85 and older and nonwhites had a 41 percent decrease in their payments, with an average decrease of 37 percent.
- Larger-than-average decreases in visits and payments per use were found for cardiac disrythmias, cerebrovascular disease and hypertensive disease. Smaller-than-average decreases in the number of visits and payments were found for those with diagnoses of cancer and skin ulcers.
- There was a significant increase in the percentage of home health users having a skilled nursing facility admission during the 120 days after their admission to home health.
- There were significant differences in the percentage of home health users visiting an emergency room.
- Mortality among home health users increased significantly post-BBA.
- The rate of being hospitalized for the same body system diagnoses post-BBA decreased.
- The interim payment system did not lower the quality of home health care. Patients' functional status was as likely to improve and more likely to stabilize during the interim payment system. Health status and symptoms were not affected.
- Satisfaction with home health care, in general, did not decrease during the interim payment system.

- Disabled beneficiaries' satisfaction with home health care did not decrease on most measures.
- There was no cost shifting to Medicaid found.
- There was very little cost shifting from home health care to other Medicare post-acute care.

In summary, according to the principal investigator Nelda McCall:

> The evidence suggests that the effect of the BBA has been to move the Medicare home health benefit away from the provision of long-term personal care services and return it to a benefit focused on nursing care and rehabilitation. This was one of the intentions of the BBA, and it seems to have been accomplished successfully. In addition, the home health interim payment system does not appear to have adversely affected Medicare beneficiaries. Nor did it result in cost shifts to Medicaid, or to any substantial extent, to other post-acute services. Despite dramatic service use reductions, few effects were found. (RWJF, 2004)

The Deficit Reduction Act of 2005 offered reforms in both Medicare and Medicaid that could save the federal government $26.5 billion in Medicaid expenditures over a ten-year period. Under this legislation, states are allowed to charge premiums and higher co-payments for services including prescription drug coverage, physicians' services, and hospitalization (to encourage personal responsibility). It scales back benefits or eliminates coverage for services currently guaranteed by federal law; and ends coverage for people who do not pay premiums after 60 days (Pear, 2005).

In response to the Deficit Reduction Act, in 2005, Ohio passed a Medicaid budget that significantly limited projected increases in Medicaid spending mainly by reducing benefits, eligibility, and reimbursements. The Health Policy Institute of Ohio published a thorough analysis of the budget. Per its findings, the budget eliminates coverage for parents with incomes between 90 and 100 percent of poverty (100 percent of poverty in 2007 is $20,000 for a family of four). The Ohio Department of Job and Family Services (ODJFS) estimates that 27,000 patients will lose coverage through this policy action. The total amount of money for the adult dental benefit is reduced by nearly 50 percent. ODJFS must restructure its adult dental benefit into a smaller package of covered services, which will affect around 800,000 adults. The Ohio reduction cut spending for the Disability Medical Assistance (DMA) program by $80 million, reducing it from $140 million to $60 million over the two years.

Changes in the state Medicaid budget will also affect providers, who in many cases will need to pass on the effects to patients. For example, except for children's hospitals and pharmacies, hospitals' payment rates will be frozen at the SFY 2005 level. Children's hospitals will get a rate increase while pharmacies will receive a rate cut. Hospitals will experience two other actions that will reduce their payments from Medicaid. First, ODJFS is in the process of recalibrating the payment rates for all hospital services. Second, ODJFS is changing its policy for paying cost sharing payments for people on Medicaid and Medicare (these individuals are termed "dual-eligibles" and the cost sharing is called "crossover payments"). This change will make sure that Medicaid pays no more than the maximum amount it would pay if the consumer did not have Medicare coverage. The hospital or nursing home will have to seek the rest of the owed money from Medicare. The budget bill also requires ODJFS to increase the use of consumer cost sharing. The rules for cost sharing are

currently in the clearance review process and open for public comment. The intention is that cost sharing will cause consumers to be more careful in their use of health services (and reduce use of services) (Hayes, 2005).

Specifics of funding policy will be discussed in Section IV of the report.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

For the purpose of this core service report, the target population is people of all ages who need medically necessary skilled nursing care to help with rehabilitation from a hospital stay; recovery from illness, injury or surgery; or for a terminal medical condition.

DEMOGRAPHIC CHARACTERISTICS

In February 2004, the National Center for Health Statistics (NIHS) published findings from the 2000 National Home and Hospice Care Study. The data was collected on approximately 1.3+ million (1,355,300) persons receiving home health care in the U.S. Of that total, 29.5 percent (400,100) persons) were under 65 years of age, while the majority (70.5 percent or 955,200 persons) were over 65 years old. The survey defines home health care as service provided to individuals and families in their places of residence for the purpose of promoting, maintaining, or restoring health or for maximizing the level of independence while minimizing the effects of disability and illness, including terminal illness.

Of those receiving home health care services, 1,017,900 (75 percent) were receiving medical/skilled nursing services, which is consistent with the service definition for this core service report. Some of the specific findings regarding demographics for this group are as follows:

- Gender
  - Males: 374,300 (37 percent)
  - Females: 643,600 (63 percent)
- Race
  - White: 793,300 (78 percent)
  - Black: 126,500 (12 percent)
  - Unknown: 72,000 (7 percent)
- Age
  - Under 18 years: 50,500 (5 percent)
  - 18-44 years: 89,100 (9 percent)
  - 45-64 years: 170,800 (17 percent)
  - 65-74 years: 174,800 (17 percent)
  - 75-84 years: 325,100 (32 percent)
  - 85+ years: 207,500 (20 percent)

Slightly more than one-third (37 percent, 501,000) of all home health care patients (1,355,300) were receiving other therapeutic services including dietary and/or nutritional therapy, enterostomal therapy, IV therapy, occupational therapy, physical therapy, respiratory therapy, speech therapy and/or audiology, and other high-tech care. Twelve percent (160,000) also received psychosocial services. Of all home health care patients (1,355,300), the following are reported conditions:

- Visually impaired: 334,900 (25 percent)
- Hearing impaired: 267,000 (20 percent)

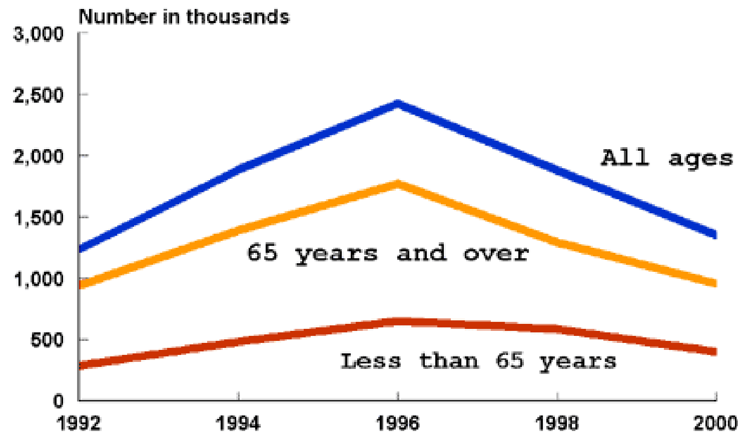
- Incontinence: 188,800 (14 percent)
- Has indwelling urinary catheter or urostomy: 148,400 (11 percent)
- Diagnosis and ICD-9-CM Code:
  - Infectious and parasitic disease: 9,300 (0.7 percent)
  - Neoplasms: 69,600 (5.1 percent)
  - Endocrine, nutritional, and metabolic diseases and immunity disorders: 128,800 (9.5 percent)
  - Diseases of the blood and blood-forming organs: 33,100 (2.5 percent)
  - Mental disorders: 51,200 (3.8 percent)
  - Diseases of the nervous system and sense organs: 83,300 (6.1 percent)
  - Diseases of the circulatory system: 320,000 (23.6 percent)
  - Diseases of the respiratory system: 92,200 (6.8 percent)
  - Diseases of the digestive system: 36,300 (2.7 percent)
  - Diseases of the genitourinary system: 39,100 (2.9 percent)
  - Diseases of the skin and subcutaneous tissue: 58,800 (4.3 percent)
  - Diseases of the musculoskeletal system and connective tissue: 132,500 (9.8 percent)
  - Symptoms, signs and ill-defined conditions: 82,200 (6.1 percent)
  - Injury and poisoning: 138,900 (10.3 percent)

By way of comparison, Medicare data from 1999 shows the principal diagnosis for home health care utilization as follows:

- Diseases of the circulatory system: 31.4 percent
- Injury and poisoning: 15.9 percent
- Diseases of the musculoskeletal system and connective tissue: 14.1 percent
- Diseases of the respiratory system: 11.6 percent (Basic Statistics about Home Health Care, updated 2004).

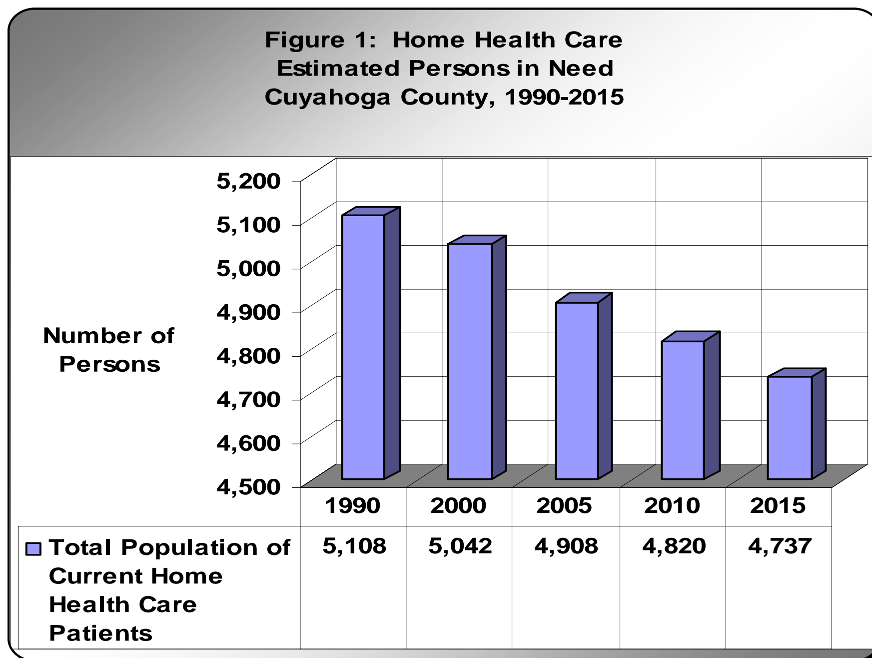
Medicare patients receiving home health care begin receiving services upon discharge from the hospital, but in 2000, a study performed by the U.S. Department of Health and Human Services, Office of the Inspector General found that 38 percent of the users came directly from the community with no hospital or nursing home stay within 15 days of receiving services.

Since 1992, the number of persons receiving all home health care services increased until 1996, when the number began to decline. The decline is more than likely the impact from the Balanced Budget Act of 1997 that was discussed previously. (See following figure.)



Estimated Persons in Need

In 2000, 5,042 individuals were estimated to be home health care patients in Cuyahoga County, or 0.36 percent of the total population. The number of persons receiving home health care is expected to decrease to 4,737 by 2015 because of population shifts. (See Figure 1.)



Sources:

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

** National Home and Hospice Care Survey, 2000. "Current Home Health Care Patients," February 2004; (1,017,900 skilled medical care patients divided by U.S. population in 2000 (281,421,906) equals 0.36 percent of total population. Assumes same percentage across periods.

This estimate of persons in need of home health care 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 United Way funded agencies and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

In FY 2004, United Way funded 6,782 persons for home health care. (See Attachment 3.) In 2004, the Cuyahoga County's Department of Senior and Adult Services' Home Care Skilled & Support Services (DSAS) funded 48 actual annual consumers, and Ryan White Title I served 66.

Per the 2000 U.S. Census, while 47 percent of the county's total population was male and 53 percent female, consumers funded by United Way served 36 percent males and 64 percent females, and Ryan White served 73 percent males and 24 percent females. DSAS data was unavailable.

Racially, according to the 2000 U.S. Census, 67 percent of the county's population was Caucasian, 28 percent African American, and 2 percent Asian. Three percent of the county's population was Hispanic. The data from providers funded by United Way is inconclusive as 88 percent is unknown. Ryan White Title I providers served 36 percent Caucasian and 49 percent African American, with 14 percent of the data unknown. DSAS data was unavailable.

Household income was unreported for all funders.

Geographically, 31 percent of the total county population resided in Cleveland and the remaining 69 percent in the suburbs. (See Attachment 4.) Providers funded by United Way served 42 percent in the City of Cleveland and 58 percent in the suburbs.

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The definition of home health care for this report is: programs that make necessary medical services available in the homes of people of all ages who are aged, ill, or convalescing, i.e., medical/skilled services. In addition to physician and skilled nursing care, it can include physical and occupational therapy, speech-language therapy, and social services. It is distinguished from in-home assistance services that are either ancillary custodial services provided with skilled care or a package of services that is part of the long-term care system.

BACKGROUND ON CORE SERVICE

Home care service or home and community-based service are the broader terms that include both "high technology" skilled care and "high touch" personal care services, often in partnership with informal caregivers (Congressional Budget Office, 1999 in Mehdizadeh & Murdoch, 2003). Informal care is provided by spouses, family and community members who are familiar with personal tolerances, preferences, and responses to sickness and disabilities. Formal care givers bring general and expert knowledge about health and risk that can enhance the effectiveness of home care (Harvath, et al, 1995 in Young, 2003). Technological advances also have introduced medical treatments, previously performed only by professionals in hospital settings, to the community and homes (Ward-Griffin & McKeever, 2000). Among people receiving long-term care in the community, most (80 percent) received care from family or friends and fewer than 11 percent received all of their care from a paid home care worker (The Institute for Research on Women & Gender, 2002).

From the consumer point of view, skilled home health care and custodial in-home assistance are closely related and often difficult, if not impossible, to separate. Once a patient reaches the community, these services are not separated but rather are part of a bundle of coordinated services. However, as noted above, this core service report views home health care as service for people of all ages who need temporary in-home skilled care from medical professionals for weeks or months for rehabilitation from a hospital stay; recovery from illness, injury or surgery; or for a terminal medical condition. This is different from in-home assistance for older adults or adults with disabilities needing long-term care from paraprofessionals in home-custodial services for many months or years for chronic medical conditions, chronic severe pain, permanent disabilities, dementia, ongoing need for help with daily living activities, or need for supervision. Much of the research literature does not clearly make this distinction and labels both types of in-home services interchangeably.

Home health care is a formal program of care and treatment performed in the home of a person, is prescribed by a physician, and is prescribed in lieu of treatment in a hospital or skilled nursing facility, or results in a shorter hospital or skilled nursing facility stay. The home health care program must be organized, administered, and supervised by a hospital or qualified licensed personnel under the medical direction of a physician (Brevard College, n.d.).

> Custodial care (in-home assistance) and skilled care (home health care) are terms used by the medical community and health care plans such as health insurance plans, Medicare, Medicaid and the Veteran's Administration. They

are used primarily to differentiate care provided by medical specialists as opposed to care provided by aides, volunteers, family or friends. The use of these terms and their application is important in determining whether a health care plan will pay for services or not. Generally, skilled services are paid for by a health care plan and custodial services, not in conjunction with skilled care, are not covered. However, custodial services are almost always a part of a skilled service plan of care and by being included, custodial services are paid by the health care plan as well. (Day, n.d.)

Skilled care is the provision of services and supplies that can be given only by or under the supervision of skilled or licensed medical personnel. Skilled care is medically necessary when provided to improve the quality of health care of patients or to maintain or slow the decompensation of a patient's condition, including palliative treatment. Skilled care is prescribed for settings that have the capability to deliver such services safely and effectively. (Day, n.d.)

Custodial care (in-home assistance) is the provision of services and supplies that can be given safely and reasonably by individuals who are neither skilled nor licensed medical personnel. The medical necessity and desired results of skilled care must be clearly documented by a written treatment plan approved by a physician. A patient may have skilled and custodial needs at the same time. In these circumstances, only those services and supplies provided in connection with the skilled care are to be considered as such. The treatment plan must include:

- The applied therapies;
- The frequency of the treatment which is consistent with the therapeutic goals;
- The potential for a patient's restoration within a predictable period of time, if applicable;
- The time frame in which the prescribing physician will review the case for the purpose of evaluating a patient's status and before reassessing the medical necessity of ongoing treatment; or
- The maintenance, palliative relief, or the slowing of decompensation in a patient's status, if applicable. (Day, n.d.)

Researchers and advisers who are not part of the medical community often confuse custodial care and skilled care with specific care activities. For example, help with the activities of daily living is a care activity thought to be by definition custodial care. Whereas the monitoring of vital signs, ordering medical tests, diagnosing medical problems, administering of intravenous injections, prescribing and dispensing medicine, drawing blood, giving shots, dressing wounds, providing therapy and counseling are all activities normally associated with skilled care. But many non-medical advisers and researchers don't know that skilled and custodial refer to the people who deliver the care not the actual care given. (Day, n.d.)

> A skilled care provider can also provide services normally thought to be provided by custodial caregivers. Such things as help with activities of daily living and so-called instrumental activities of daily living are often furnished by skilled providers in the course of their treatment. Or a skilled care plan may call for services that can be delivered by a custodial caregiver but it would still be under the skilled plan of care for that individual. On the other hand, those who deliver custodial services may from time to time perform those activities supposedly reserved for skilled providers. Such things as taking blood pressure, administering medicines, giving shots or changing wounds might be provided under certain circumstances by a custodial provider. (Day, n.d.)

Custodial care is always a part of a skilled care plan for home care. The patient receives skilled care from a nurse or therapist and custodial care from an aide for help with bathing, dressing, ambulating, toileting, incontinence, medicating and possibly feeding. Medicare pays for both types of services. (Day, n.d.)

> Some larger traditional home health agencies are integrating non-medical services into their care delivery. This means Medicare and Medicaid are not paying the bill for this portion of a home health agency's business. Also many large integrated facilities providers (combined nursing homes, assisted living and independent retirement arrangements) are offering more non-medical or personal home health care. (Day, n.d)

In Ohio there were 333 home health agencies in 2003. The largest proportion (47.1 percent) is proprietary home care agencies followed by hospital-based organizations at 27.0 percent. (See Table 1.)

Table 1: Ohio's Medicare/Medicaid Certified Home Health Agencies

Type of Agency	% of Agencies
Proprietary Home Care	47.1%
Hospital Based	27.0%
Nursing Home Based	3.6%
Private Nonprofit	10.5%
Public/County	7.2%
Visiting Nurse Associations	4.6%
Total (n=333)	**100.0%**

Source: Scripps Gerontology Center, 2003

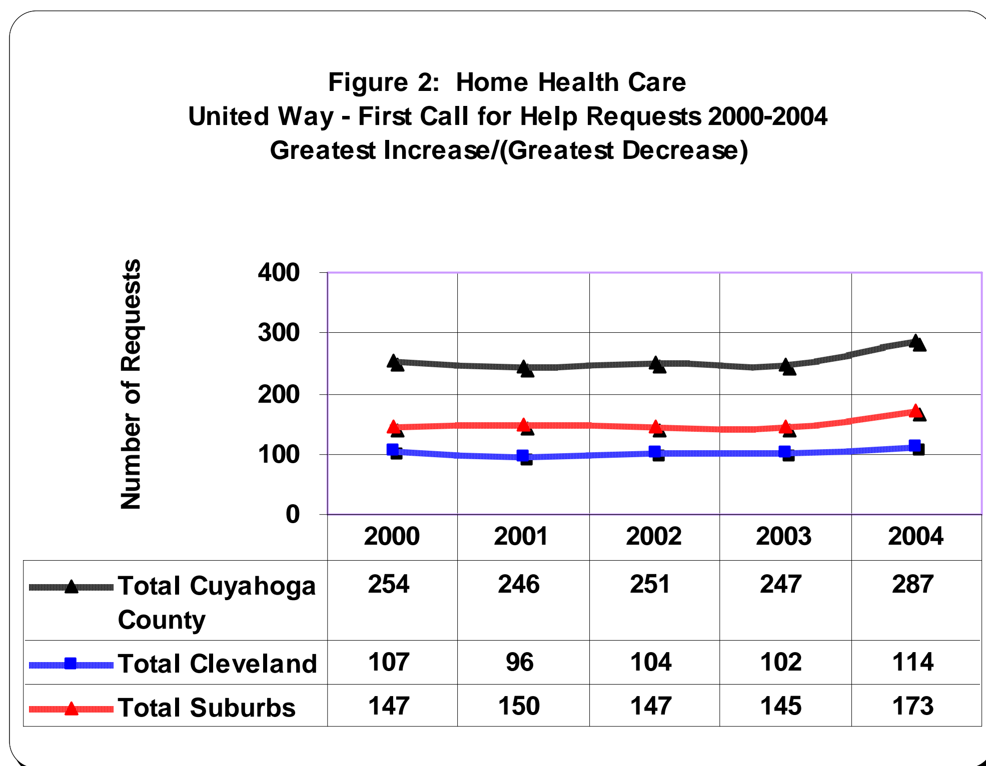
Some of these agencies specialize in supportive services and others in providing services at the high tech-end of the service spectrum. About 45 percent of home health agencies offer skilled nursing services, about 12 percent offer hospice, and just under 10 percent provide infusion therapies. Approximately 4 of 10 provide transportation and two-thirds offer companion service. Service offerings vary by agency type. The affiliated agencies are more likely to deliver nursing and infusion therapy compared to the other organizational types. Sixty percent of affiliated agencies offer nursing service, compared to 45 percent in the public payment group, and about one-third of the private-pay category. Hospice service was not significantly different across agency types. The

affiliated agencies were significantly more likely to provide infusion therapy, but even in this group of agencies less than 12 percent reported providing the service (Straker & Applebaum, 1999). As of July 2005, Medicare listed 76 certified home health agencies in Cuyahoga County.

United Way – First Call for Help Call Data & Long Term Care Ombudsman

According to United Way – First Call for Help (FCFH) database and the Long Term Care Ombudsman (February 2005), there are 62 providers of home health care operating in 63 sites located in Cuyahoga County. Twenty-one sites are located in the City of Cleveland and 42 in the surrounding suburbs. Thirty-six are nonprofit providers, eighteen are for-profit and eight are governmental agencies. United Way funded one nonprofit agency and has one location in the Cleveland area. (See Attachments 5 and 6.)

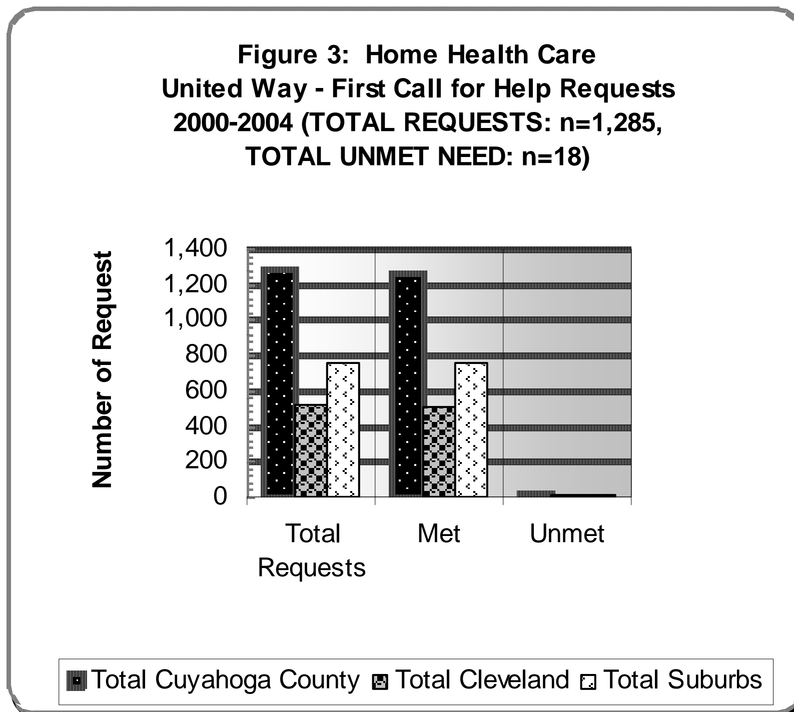
Based only on FCFH call data, those requesting home health care in the county increased from 254 per year in 2000 to 287 by year 2004, which represented about a 13 percent increase. There were similar increases for the City of Cleveland and the suburbs. At 17.6 percent, the largest increase was in the suburbs, compared to a 10 percent increase in Cleveland over the same period. In 2004, 39.7 percent of the county's requests for home health care originated in the City of Cleveland. This proportion has remained fairly constant over the past four years, with the exception of 2003, when a large number (48.5 percent) of the 247 requests originated in Cleveland. (See Figure 2 and Attachment 7.)



	2000	2001	2002	2003	2004
Total Cuyahoga County	254	246	251	247	287
Total Cleveland	107	96	104	102	114
Total Suburbs	147	150	147	145	173

United Way - First Call for Help data indicated that between 2000-2004 there was a total of 1,285 requests for help, with 98.5 percent of the requests being met. Only 18 (1.5 percent) of the requests were not met. Over the five-year period, a majority of the requests originated in the suburbs: 59.2 percent compared to 40.8 percent for the City of Cleveland. Home health requests increased in

Cleveland by 6.5 percent and by 15 percent in the suburbs over the five-year period. For both areas, the largest increase occurred in 2004, perhaps signaling future increases. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders
The major sources of government funding for home health care are:

- Medicare
- Medicaid
- Ryan White Title I
- Veterans Administration

The following are the sources and percentages of funding for home health care services in 2002: Medicare (31.6 percent), Medicaid (13.3 percent), state and local governments (15.8 percent), private insurance (18.6 percent), out-of-pocket (18.0 percent), and other (3.0 percent) (Basic Statistics about Home Care, updated 2004).

Medicare
Medicare is a health insurance program for people 65 years of age and over, some disabled people under 65 years of age, and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant) administered by the Centers for Medicare and Medicaid Services. Medicare reimbursement can be provided for home health care either through fee-for-service Medicare or a Medicare health maintenance organization (HMO). Medicare is the principle payer to home health agencies for their services. In 2000, Medicare paid an estimated 85 to 90 percent of the total cost of home health agency services (Day, n.d.).

> Home health services through Medicare are available under Parts A and B. In order to qualify for Medicare home care, a person must have a skilled need, must be homebound and there must be a plan of care ordered by a physician. Prior to 1997, Medicare typically paid for home care for as long as it was needed. Prior to 1997, annual Medicare costs were almost double the amount several years prior. In order to save money Medicare has since gone to a prospective payment system where, according to the plan of care, a certain amount of money is allocated to resolve the skilled need for the patient. Monies are typically provided for a period of up to 60 days. If the patient recovers sooner, money can be redistributed to other patients who are not responding as well. At the point where the patient does not respond or improve, no more Medicare money is forthcoming. After Medicare cuts off, a person continuing to need long-term care services must find sources other than Medicare. (Day, n.d.)
>
> Home health agencies deliver a variety of skilled services. In addition, the plan of care always includes custodial services to help the care-recipient remain in the home. These would include an aide for an hour or two a day to help with bathing, dressing and transferring. If there is time remaining other personal services may be offered as well. These personal services are also covered by Medicare. (Day, n.d.)
>
> Recently Medicare has redefined what it means by "homebound" to allow recipients to leave the home on a limited basis. Between 2003 and 2006 Medicare has been testing a program where selected home health agencies can provide adult day health care instead of home health services. If successful, the program will offer a new dimension in Medicare home care. In addition, under the new definition, Medicare will also allow and pay for home visits from doctors who specialize in homebound elderly patients. Limited office visits are also allowed under the new definition. Finally, in the past few years Medicare is paying for home tele-health visits through a home tele-health, computer work station. Tele-health is being used with some success to provide home care in rural areas where it would be difficult to arrange the personal visit from a home health care agency. (Day, n.d.)

Although Medicare will authorize up to 60 days of home care at a time, according to the Centers for Medicare and Medicaid Services (CMS) the average length of stay for Medicare home care services is 41.5 days. Often a person continues to need supervision or care after Medicare stops paying; but the payment for that must come from a source other than Medicare (Day, n.d.).

Medicare will also pay for home care services (in-home assistance) on a limited basis to help a homebound person who is recovering from an injury or medical condition. Medicare provides a home health agency about 60 days worth of payment to help with the recovery. If the recipient fails to respond, deteriorates, or is not improving in any way, Medicare will no longer cover the cost of care (Day, n.d.).

Medicare pays for 100 percent of medically necessary home care expenses, but will not pay for help with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) when they are the only types of services needed. Medicare also pays 80 percent of the Medicare-approved cost of durable medical equipment. Thirty-three percent of Ohio's Medicare beneficiaries received home health care in 2001 (U.S. General Accounting Office, May 2002). In 1998, 69 percent of Ohioans with Medicare coverage also had Medigap coverage (HIAA, 2002). Premiums for a 65-year-old ranged from $53 per month for basic supplemental coverage to $569 a month for comprehensive coverage, depending upon the insurance carrier (OSHIIP, 2002 in Scripps Gerontology Center, 2003).

Medicare is the largest single payer of home health care services. Medicare will provide health care to an estimated 43.7 million Americans in FY 2007, including 7 million people with disabilities. The budget provides $449.2 billion in outlays for Medicare in FY 2007, up from $389.4 billion in FY 2006. However, the budget also includes changes that would reduce Medicare spending by $2.488 billion in FY 2007, and $35.9 billion over five years ($105 billion over ten years). Among other proposals, the budget proposes charging wealthy senior citizens higher monthly premiums, raising them from $88.50 to between $100 and $155.

In February 2004, the Centers for Medicare and Medicaid Services projected that Medicare home health care spending would increase 7.3 percent from 2002 to 2013 and account for 32 percent of the total spending. Private spending in the same period was projected to comprise 37 percent of the total (Basic Statistics About Home Care, updated 2004).

County-level funding information is not available, but state-level reimbursement for home health care has increased significantly from $333 million in FY 2003, to $369 million in FY 2004, to $389 million in FY 2005.

Medicaid

Medicaid is the medical assistance provided in Title XIX of the Social Security Act. It is a federal/state administered program for the medically indigent. Reimbursements for home health care can be obtained through fee-for-service Medicaid or the Medicaid HMO. The federal government establishes general guidelines for the program although Medicaid eligibility requirements are established by each state.

Home health care is a mandatory Medicaid benefit for eligible persons. However, Medicare provides the majority of *skilled* home care (skilled nursing services and physical and other therapies), but a much smaller share of unskilled services when compared to Medicaid (Kassner, 2006).

Medicaid beneficiaries whose family incomes are 100 to 150 percent of the federal poverty level can also be charged 10 percent of any Medicaid-funded service. (In FY 2007, the federal poverty level at 100% and 150% is $9,800/$14,700 for a single individual and $13,200/$19,800 for a two-person family.) For those with higher incomes, 20 percent of service costs may be required, though total co-payments for the family cannot exceed 5 percent of the family income (Pear, 2005).

The federal government provides states with matching funds to finance the Medicaid program, a share determined by a formula that compares the state's average per capita income level to the national income average. These federal medical assistance percentages varied from 50 percent to

77 percent in 2004. In Ohio, the federal government pays approximately 40 percent (Moniz & Gorin, 2003; CMMS, 2005d).

As mandated by law, the Ohio Medicaid program provides services such as inpatient hospital, outpatient hospital, prescription drugs, durable medical equipment, physicians, laboratory and x-ray, nursing facility, home health, and Early Periodic Screening and Diagnostic Treatment (EPSDT) services. These services are mandatory services that all state Medicaid programs must provide to eligible consumers. In addition, the state of Ohio has opted to cover pharmacy, dental, private duty nursing, physical therapy, occupational therapy, speech and hearing, psychology, podiatry, community behavioral health care services, and others. Also, federal law requires these state plan services to be available statewide. Consumers of Medicaid have the freedom to choose from among qualified eligible providers. Medicaid may offer additional services to persons with disabilities who are enrolled in a home- and community-based waiver. Ohio covers waiver services such as emergency response systems, home-delivered meals, supplementary equipment/adaptive devices, home modification, out-of-home respite, adult day care, supported employment, and homemaker/personal care services (Johnson et al., 2001).

Medicaid has specific requirements for how services are to be provided to recipients; however, states can apply for waivers which allow them to modify service provision. Instead of providing care in a nursing home or hospital, individuals being served with a home care wavier can receive services in home or a community-based setting provided that the costs of home care would not exceed costs in an institution. A central goal of these Medicaid waiver programs is to help consumers avoid institutionalization. Currently, Ohio has several waivers that are administered by the Ohio Department of Job and Family Services, the Ohio Department of Mental Retardation and Developmental Disabilities, or the Ohio Department of Aging. The following table lists the names of these waivers and the agency that administers them.

Name of Waiver	Agency that Administers the Waiver Program
Individual Options Waiver	Ohio Department of Mental Retardation and Developmental Disabilities
Level One Waiver	Ohio Department of Mental Retardation and Developmental Disabilities
Ohio Home Care Waiver	Ohio Department of Job and Family Services
PASSPORT Waiver	Ohio Department of Aging
Transitions Waiver	Ohio Department of Job and Family Services

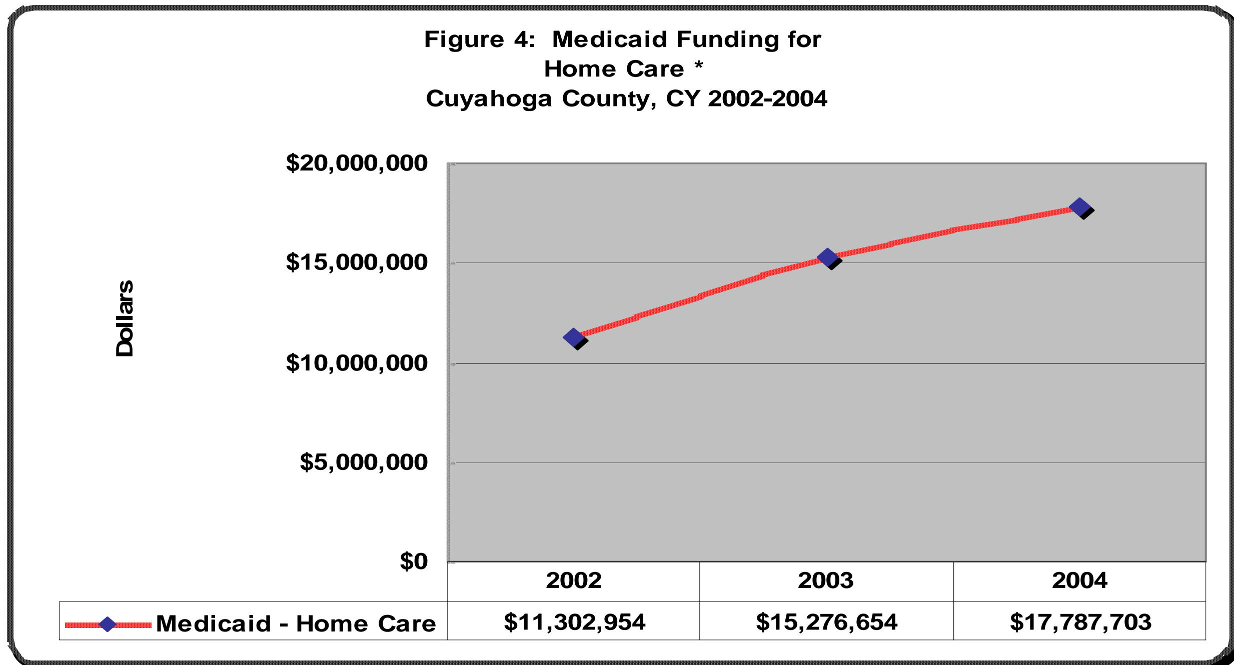
Source: Ohio Legal Rights Services. (n.d.). Medicaid Waiver Programs in Ohio. Retrieved December 4, 2006 from http://olrs.ohio.gov/asp/olrs_WaiversTables.asp

These Medicaid waiver programs significantly affect home health care services since the policies affect reimbursement for Medicaid patients receiving home health care.

In FY 2007, Medicaid will provide health care to an estimated 52.9 million low-income individuals, children, and people with disabilities. The budget provides $199.4 billion in outlays for FY 2007, up from $192.3 billion in FY 2006. However, the budget also proposes trimming Medicaid spending by $14 billion over five years, with the biggest changes coming from capping government providers ($3.8 billion), eliminating administration and transportation expenses for school-based services ($3.6 billion), establishing stricter reimbursement policies for rehabilitation services ($2.3 billion), phasing down a provider tax ($2.1 billion), and recouping administrative costs assumed in the TANF

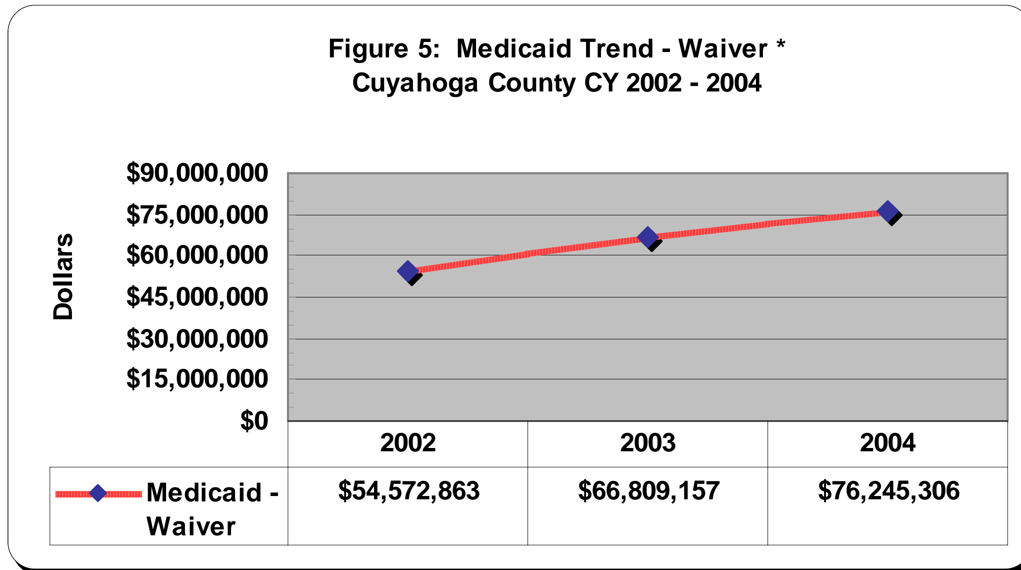
program ($1.7 billion).

In Cuyahoga County, Medicaid funding for home care has increased from $11.3 million in 2002 to $17.8 million in 2004. This includes funding for other core services in addition to home health care that did not align exactly with Medicaid categories of service. (See Figure 4.) While Medicaid spending is expected to continue increasing, cost containment measures such as reductions in eligibility, services, and reimbursement levels are anticipated.



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

In Cuyahoga County, Medicaid funding for waivers (which includes home health care, in-home assistance, adult day care, and home delivered meals) has increased from $54.6 million in 2002 to $76.2 million in 2004. (See Figure 5.)

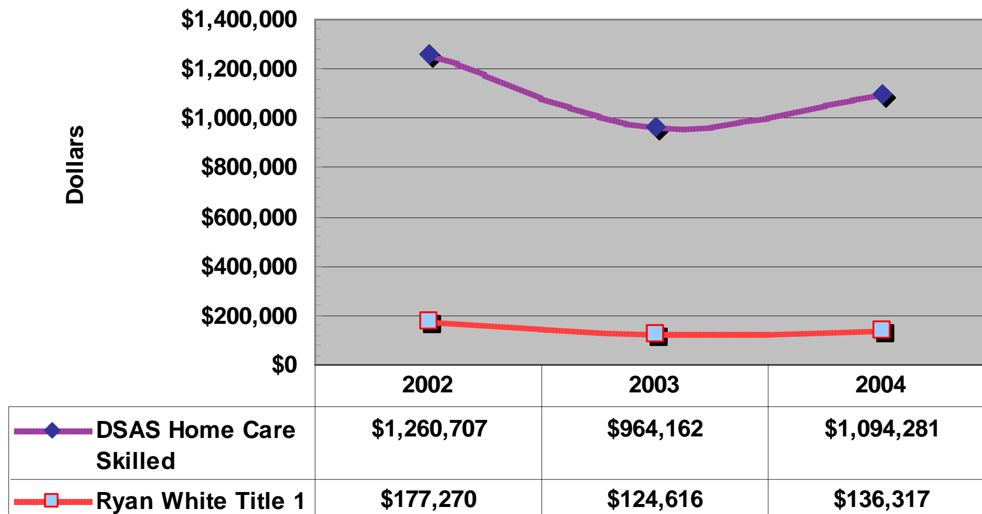


* Includes the following core services: Adult Day Care, Case/Care Management, Home Delivered Meals, Home Health Care, In-Home Assistance, and Residential Living Options for People with Disabilities.

Title I of the Ryan White CARE Act
Authorized under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, and administered by the 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, including hospice. 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.

Veteran's Administration
The Veteran's Administration (VA) will also pay for home care for qualifying veterans on a basis similar to Medicare; however, it is probably paid more liberally without a definite cutoff of services. Under VA rules, as with Medicare, there must be a medical need for care in the home. VA home care must be approved by a medical staff at the local veteran's hospital (Day, n.d.). Amount of funding for home health care from the VA was not available at the time this report was written.

Trends of Identified Government Funders in Cuyahoga County
Skilled home health care operated by the Cuyahoga County Department of Senior and Adult Services (DSAS) has decreased from $1.26 million in 2002 to $1.1 million in 2004. Likewise, Ryan White Title I funds have decreased from $177,270 to $136,317 over the same period. (See Figure 6.)



	2002	2003	2004
DSAS Home Care Skilled	$1,260,707	$964,162	$1,094,281
Ryan White Title 1	$177,270	$124,616	$136,317

Source: Cuyahoga County Department of Senior and Adult Services and Ryan White Title I

IDENTIFIED REVENUES

As of May 11, 2006, over $2.4 million in revenues for home health care has been identified countywide. This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland. (See Table 2.)

More than fifty percent of the revenues are from contracts or grants from government organizations and 26 percent from federated organizations. United Way of Greater Cleveland's funds account for 17 percent of the total.

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

Funder	Period	A Identifiable Total Dollars Countywide		B Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			**0.00%**	**135,877**	**0.58%**
Abington Foundation, The	2003	75,000			
Mt. Sinai Health Care Foundation, The	2003	63,651			
Other Private Foundations - Not Elsewhere Classified				99,820	
Eaton Charitable Fund	2003	10,000			
Total - Foundations & Trusts		**148,651**	**6.09%**	**99,820**	**0.43%**
Jewish Community Federation	2004	643,000			
Total - Federated Fundraising Organizations		**643,000**	**26.36%**	**0**	**0.00%**
Department of Veterans' Affairs				23,000	
Other Federal Funders - Not Elsewhere Classified				53,000	
Subtotal Federal Government		***0***	***0.00%***	***76,000***	***0.33%***
Department of Job and Family Services				178,308	
Subtotal State of Ohio		***0***	***0.00%***	***178,308***	***0.76%***
Department of Senior and Adult Services	2004	1,094,281			
HIV Services Planning Council Ryan White Title I	2004	136,317			
Subtotal Cuyahoga County Funding Sources		***1,230,598***	***50.44%***	***0***	***0.00%***
Medicaid *				1,231,433	
Medicare				19,288,909	
Other Private Insurer				1,200,065	
Subtotal Third Party Payee/Direct Bill		***0***	***0.00%***	***21,720,407***	***93.06%***
Total - Contracts/grants from government organizations		**1,230,598**	**50.44%**	**21,974,715**	**94.15%**
Private Pay/Fee for Service				12,122	
Total - Program Service Fees		**0**	**0.00%**	**12,122**	**0.05%**
Total - Investment Income			**0.00%**	**86,073**	**0.37%**
Total - All Other Revenue			**0.00%**	**614,747**	**2.63%**
Subtotal Non - UWGrCle Support		**2,022,249**	**82.89%**	**22,923,354**	**98.21%**
Total - UWGrCle investment committee allocation		**417,512**	**17.11%**	**417,512**	**1.79%**
Subtotal UWGrCle Support - 4001, 4701 & 4703		**417,512**	**17.11%**	**417,512**	**1.79%**
Total Support/Revenue		**2,439,761**	**100%**	**23,340,866**	**100%**

* Medicaid dollars have not been entered under countywide total for this core service because not all Medicaid services are a one-to-one match with United Way core services. Medicaid Service - Home Care ($17,787,703 in 2004) - Falls into AIRS 1 Health Care and has been entered as an aggregate total for that AIRS Level. Home Care includes the following core services: Daily Living Aids and Home Health Care. 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 ($76,245,306 in 2004) - 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

Since about 90 percent of all home health agency care is paid for by Medicare or Medicaid, the cost of care is not necessarily relevant for this study. But some families do pay for this service out of their own pockets. Costs will vary from area to area. A nurse, therapist, or social worker may cost $70.00 to $100.00 an hour. An aide to assist with activities of daily living may cost $10.00 to $25.00 an hour (Day, n.d.).

In the United States, registered nurses employed in the home health care field receive, on average, $22.00 to $30.00 per visit. Payment/reimbursement of other skilled services vary according to the specific discipline (Wikipedia.com, 2006).

V. WHAT WORKS; WHAT DOESN'T

What Works

The evolution of home health care is a good example of how significantly public policy changes influence service delivery. Changed eligibility requirements and changed methods of reimbursement have affected how many people receive service, who delivers the service, and total expenditures. As more information and research is obtained, other public policy decisions will be made that will cause the home health care industry to continue evolving and changing. Depending on which assumptions are supported, projections of future demand range widely and will contribute to policymakers' difficulty in making decisions affecting long-term supportive services to older persons with disabilities. What is certain is that more consumer control, autonomy, and a quest for dignity among older seniors will lead to changes in public policy.

Medicare-managed care has generally not paid enough to cover the high costs of the seriously ill; thus most managed care programs cannot capitalize on their potential to provide good care. Attracting members who are already very sick would be financially disastrous. There are some incentives that could help align Medicare coverage more closely with needed care (Lynn & Adamson, 2003):

- Medicare payment could require specific performance criteria for key elements of care such as continuity, symptom relief, and advance-care planning.
- In addition to the current adjustments for age, gender, region, and diagnosis, payment for Medicare's managed care benefit could be higher for those who are more seriously ill.
- Hospitals could be paid much less for second admissions for the same serious chronic condition in a patient who had no advance-care planning during the first hospitalization (Lynn & Adamson, 2003).

Making difficult decisions regarding allocation of resources is an issue that many experts believe will be a necessity as the burden of Medicare and Medicaid increases dramatically over the next several decades.

> Other countries have begun to base medical coverage decisions, in part, on how many years of life a treatment is expected to produce. However, raising the subject of conditioning access to life-extending treatment on anything (costs, effects on life span, or effects upon quality of life) in the United States may provoke controversy. An easier course is to cut back on other services that are hard to track or whose benefit is not so apparent.

The national challenge is to establish a method by which the cost of care of those with fatal chronic illnesses is matched with concerns of the chronically ill elderly and their families, even if it means that costly treatments are sometimes not readily available to some chronically ill elderly (Lynn & Adamson, 2003).

What Doesn't Work

It is suggested that the problem is not so much the number of older people in this country as it is that America's health care system is still learning how to think about and respond to how living changes toward the end of life. Shaped largely in the two decades after World War II, the U.S. health care system is designed mainly to prevent illness and to engineer dramatic rescues from injury or

illness—mostly with surgery and medication. This concept works well for younger, basically healthy people. Indeed, its success has contributed to the dramatic improvements in American life expectancy (Lynn & Adamson, 2003).

However, the system has been slow to adapt to the new challenge of chronic illness in old age. Commonplace experience, buttressed by studies of current care arrangements for the chronically ill elderly, suggests that these patients must navigate a fragmented care system that offers them a patchwork of uncoordinated services that does not meet their needs. The increasing number of families confirms the point that health care arrangements for persons with chronic illness often do not work smoothly, reliably, or well (Lynn & Adamson, 2003). There are countless examples of inadequate, limited, and costly care for older Americans experiencing a chronic disability (Applebaum et al., 2002). It is suggested that at the interface between chronic and acute care– estimates range between 10 and 40 million—may represent the industry's most difficult challenge (Lynn & Adamson, 2003).

Our current health care delivery system is organized by setting: nursing home, hospital, home, and doctor's office. This determines how insurance pays bills, providers meet patients, and regulations are applied. Each care provider generally works in only one setting. Patients needing chronic care change settings often and may do so for several years; however, they have an overriding need for continuity of care, both across settings and across the changing challenges of worsening illness (Lynn & Adamson, 2003).

It must also be recognized that while consumer choice is a guiding principle of many health and human services, choosing home health care over other forms of care regardless of level of need, financial situation, and ability of individuals' informal network to provide support does not work. Although many older adults want to stay living at home for as long as possible ("age in place"), this may not be possible or appropriate. Care can be very expensive, and some people may be better served in facilities offering 24/7 levels of care (Bradford, n.d.).

IMPACT ON COMMUNITY

None have been identified.

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Some home health agencies are certified by Medicare and/or Medicaid. Both programs can certify home health agencies as meeting agency participation conditions. These agencies are inspected regularly to ensure that all standards are met. In addition, staff members who provide the services hold licenses corresponding to their respective profession. Conditions for participation address patients' rights; release of patients' identifiable Outcome and Assessment Information Set (OASIS) data; compliance with federal, state, and local laws; acceptance of patients; plan of care and medical supervision; reporting OASIS information; maintaining clinical records; and staffing of qualified personnel.

Under Medicare, certification is based on agency policies, practices, the care provision process, and staff qualifications, licensure, and training. "Each agency is required to evaluate their policies and administrative practices, annually, as well as review a sample of ongoing and closed client cases for adherence to clinical practice standards (42 CFR 484)" (Straker & Applebaum, 1999, p. 2).

Certification activities consist of onsite visits and auditing of compliance with regulations such as criminal background checks and training of employees (Scripps Gerontology Center, 2003).

The Home Health Quality Initiative provides information about agencies offering home health services. The home health quality measures used consider patients' physical and mental health and ability to perform basic daily activities. The information collected is called the Outcome and Assessment Information Set (OASIS). The outcome measures used by OASIS are as follows:

- Improvement in ambulation/locomotion;
- Improvement in transferring;
- Improvement in toileting;
- Improvement in pain interfering with activity;
- Improvement in bathing;
- Improvement in management of oral medications;
- Improvement in upper body dressing;
- Stabilization in bathing;
- Acute care hospitalization;
- Any emergent care provided; and
- Improvement in confusion frequency (Medicare, Home Health Compare, 2005).

There are also checklists available to assist consumers in their selection of a home health care agency. The Administration on Aging has a 20-question guide and the Centers for Medicare and Medicaid Services has a 12-question checklist.

Home health agencies that participate in the Medicare and Medicaid programs have certification and quality review requirements established and enforced by federal and state regulatory units. There are also current efforts underway to identify and track the outcomes of certified home health care via the use of a standardized reporting mechanism on client conditions (OASIS). Although the methods and resources allocated to monitoring the quality of care are routinely criticized, these efforts do exist and are being expanded and improved. Agencies are also under state licensure in 39 states. Eleven states, including Ohio, do not license or regulate home health agencies in any manner.

Certification requirements typically center on the structure of the agency (policies, practices, and staff) and the processes for providing care. Agencies certified for Medicare reimbursement must adhere to established standards for patient rights, qualifications and licensure of agency personnel, service provision, and training of personnel. Each agency is required to evaluate their policies and administrative practices annually, as well as reviewing a sample of ongoing and closed client cases for adherence to clinical practice standards (42 CFR 484).

Ohio

In states (such as Ohio) that do not require licensing or certification for operations, home health agencies are not required to adhere to standards such as training, availability of back-up materials, having written plans of care, respecting patient confidentiality, giving notice of service termination, and checking for criminal records. It is unclear whether they actually do so. Because of the growth of the home health industry and the tremendous increase in out-of-pocket expenditures allocated to such care, considerable interest has been raised about home health providers that are not subject to any regulatory control (Straker & Applebaum, 1999).

In Ohio, home health agencies can be certified for Medicare and Medicaid. At the state level, the Community Health Care Facilities and Services Board of the Ohio Department of Health are responsible for assuring compliance with Medicare certification requirements of home health agencies.

In addition to the Ohio Department of Health, the Community Health Accreditation Program (CHAP) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are two organizations that have been authorized by the Centers for Medicare & Medicaid Services (formerly HCFA) to certify home health care agencies. In 1999, there were 333 Medicare certified agencies in Ohio (Applebaum & Mehdizadeh, 2001 in Scripps Gerontology Center, 2003).

It is argued that independent oversight in investigation of patients' complaints will lead to Ohio's care providers delivering better quality of care. Better public scrutiny is one of several recommendations made in a report from the National Academy of Sciences Institute of Medicine. In the past two years it has worked with 149 of Ohio's 1,000 nursing homes, 151 of the state's 425 Medicare-certified home health care agencies, and most of the state's hospitals. A private oversight firm reviewed a third of the 303 complaints it received last year from the 1.7 million Ohio seniors on Medicare. However, evaluation firms have been criticized for not publishing the results of their investigations (citing doctor-client privilege) and also for not being a significant factor in impacting the way providers do business. It has been suggested that they may yet prove useful as Medicare moves toward tying payments to the quality of services rendered by physicians, nurses, hospitals, nursing homes, drug plans, and other providers (Jaffe, 2006).

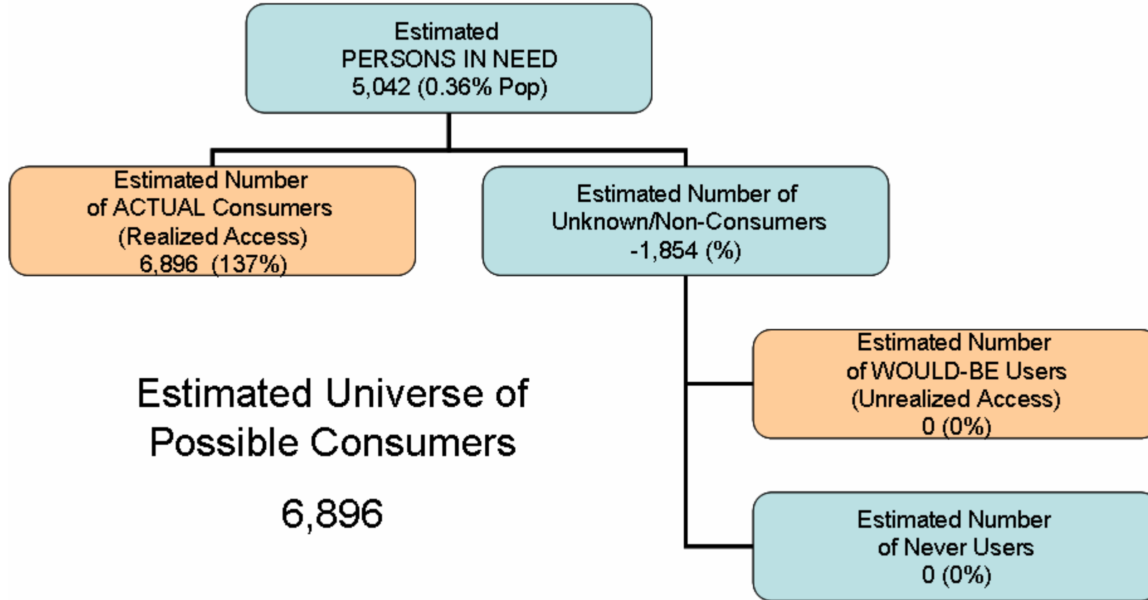
VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Home Health Care:

- An estimated 5,042 persons need home health care. This is based on an application of the percentage of current patients of all ages (0.36 percent of total U.S population) who received skilled home health care services as reported in the 2000 National Home and Hospice Care Survey (2004) to the total Cuyahoga County population.[1]
- In FY 2004, 6,896 persons received home health care in Cuyahoga County. This includes consumers funded by United Way (6,782), DSAS (48), and Ryan White Title I (66). It must be noted that this is an under-statement of those funded for home health care in the county because it does not include data from many other providers.
- This results in a surplus of 1,854 (5,042 – 6,896 = -1,854). (See Figure 7.)

Researcher's Note:
The researchers talked directly to the staff of the National Home and Hospice Care Survey to verify the national figure of home health care patients noted above prior to applying it to Cuyahoga County data. Intuitively on both a national and local level the figure appears low. In addition, an extensive search to identify another way of estimating need for home health care services was completed. The National Home and Hospice Care Survey was the only relevant study identified. As was noted in the previous footnote, discharge data was considered as an alternative, but not used because of duplication.

[1] The NHHCS notes that 1.335 million people were current patients of home health care--a patient on the home health agency's roster as of the night before the survey. This is 0.36 percent of the total U.S population of 281,421,906. An alternative figure for persons in need that was considered and not used was discharges. Discharges are patients formally discharged from care by the home health agency during a designated month randomly selected for each agency prior to data collection. Both live and dead discharges are included. A patient can be counted more than once if the patient was discharged more than once during the reference period; therefore, discharges represent episodes of care rather than patients. There were 7.179 million discharges in the 2000 survey. Thus, in 2000 the U.S. population was 281,421,906 and the total number of discharges in home health care was 7,179,000 or 2.55 percent of the total population. In Cuyahoga County, 2.55 percent of the total population would be 34,063. Given that discharges reflect episodes instead of unduplicated clients, the current patient figure was used to estimate persons in need and not those discharged.



Service Site Index
There is no service site index available because we did not have sufficient information from the Long Term Care Ombudsman to determine the service areas of home health care agencies. Experience has also indicated that many home health agencies serve the entire county, so there would not be variability across zip codes.

Service Capacity
The following are observations from focus groups conducted for United Way's core service planning (2005):

> *With more diagnoses, as you grow older, you tend to end up with more diseases—blood pressure issues, diabetes, circulatory issues … that creates a lot of medication that these people are taking. We are seeing people come to the door with 11-17 different medications they are taking … and have to cover the cost of.*

There are a number of providers that offer services to Russian individuals. Other ethnic communities are underrepresented because they do not know about the services, they struggle with language barriers, or they have family members who would rather provide for them.

> *Some of the different ethnic groups would like to take care of their own family members. They do not want strange people, so to speak, to come into their home. It's part of their culture to take care of their own family in their own community.*

Not enough has been done to reach the Asian and Hispanic communities in Cleveland. Outreach to those communities can be difficult because they would rather deal with agencies with representatives who speak their language. There are marketing plans going forward to target these communities.

> *We had two Chinese consumers who recently withdrew from the program because they felt they could not communicate with their health care provider and they were hoping that we could provide a Cantonese-Chinese dialect worker! You know when you get that specific it's very hard to provide services.*

Cuts in Medicaid and Medicare were the major concern of the group. They understood that the number of clients they serve is going to continue growing while at the same time the Medicaid and Medicare benefits may shrink. They also anticipate cuts on federal, state and local levels in other funding sources.

> *...this is the most difficult time for aging funding in 30 years because every level faces cuts.*

New drugs that allow people to live longer with illnesses like Alzheimer's disease and other forms of long-term dementia is also a trend the group observes. These drugs are supposed to arrest or slow down the development of an illness in its early stage. The group understands the advantages of these drugs, but they also know that these drugs will prolong a very long illness. With cuts to funding sources, it is very difficult for agencies to provide services for an increasing number of patients with long-term illnesses.

> *...we are seeing people earlier and they stay more functional longer, so if you add the baby boomers to that population, it's going to be a very huge problem.*

VII. SUMMARY

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

- Home and community-based services—ranging from skilled nursing and physical therapy to help with daily activities such as bathing and dressing—are vital to many people with chronic illness or disability.
- By 1995, these services had become the fastest growing component of health care spending in the United States, according to the Visiting Nurse Service of New York.
- Demand for home care was increasing due to consumer preference, the aging of Americans, the increasing number of families with limited time available to provide informal care, pressure to reduce hospital and nursing home stays and technological advances that made it possible to manage more complex conditions at home.
- At the same time, financial and political forces are pushing for cuts in spending growth and limits on the government's fiscal responsibility.
- There is considerable debate among experts concerning the issues and challenges facing America's home health care system, especially as it will be impacted by the aging of the population. Despite these disagreements, most agree that the current system requires modifications if it is to meet the increasingly complex needs of consumers in a rapidly changing society.
- Medicare is the largest single payer of home health care services, at 31.6 percent in 2002. In the same year, Medicaid accounted for 13.3 percent, state and local governments 15.8 percent, and private insurance 18.6 percent.
- The FY 2007 budget proposes trimming Medicaid spending by $14 billion over five years.
- As of May 11, 2006, over $2.4 million in revenues for home health care has been identified countywide.
- Medicare-managed care has generally not paid enough to cover the high costs of the seriously ill; thus most managed care programs cannot capitalize on their potential to provide good care.
- The national challenge is to establish a method by which the cost of care of those with fatal chronic illnesses is matched with concerns of the chronically ill elderly and their families, even if it means that costly treatments are sometimes not readily available to some chronically ill elderly.
- It is suggested that the problem is not so much the number of older people in this country as it is that America's health care system is still learning how to think about and respond to how living changes toward the end of life.
- There are 62 providers of home health care operating in 63 sites located in Cuyahoga County.
- An estimated 5,042 persons need home health care in Cuyahoga County. In FY 2004, 6,896 persons received home health care in Cuyahoga County. This results in a surplus of 1,854. See Researcher's Note in Gap Analysis section of this report.

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ATTACHMENTS

Attachment 1: Researcher List

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

Attachment 2: Technical Notes

Technical Notes:
Methodology, Caveats, Limitations of Data

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

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

Unit of Analysis

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

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

United Way - First Call for Help Data

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

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

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

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

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

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

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

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

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

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

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

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

Funding Information for Core Services

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

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

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

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

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

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

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

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

Medicaid Funding

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

<u>Entered as Aggregate Total Under Appropriate AIRS Level</u>

- 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.

<u>Entered as Aggregate Total Under Third Party Payee/Direct Bill</u>

- 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.

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Attachment 3: Actual Consumer Demographics

Core Service: Home Health Care LT-280					
		Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ***		
	Total Population (%)*	Total Population of Current Home Health Care Patients (%)**	UW Program Report Data Cuy Cnty Only (79%)	DSAS Home Care Skilled & Support (%)	Ryan White Title I (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	2004
TOTAL	1,393,978	5,042	6,782	48	66
Percent		0.36%			
GENDER					
Male	47.2%	N/A	36.2%	0.0%	72.7%
Female	52.8%	N/A	63.6%	0.0%	24.2%
Unknown Data****			0.2%	0.0%	3.0%
Missing Data******			0.0%	100.0%	0.0%
RACE*****					
White alone	67.1%	N/A	8.1%	0.0%	36.4%
Black or African American alone/combination	27.9%	N/A	3.3%	0.0%	48.5%
Asian alone/combination	2.1%	N/A	0.1%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	N/A	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	N/A	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	N/A	0.3%	0.0%	1.5%
Unknown Data****			88.1%	0.0%	13.6%
Missing Data******			0.0%	100.0%	0.0%
HISPANIC***	3.3%	N/A	0.3%	0.0%	12.1%
AGE					
0-4	6.5%	N/A	5.3%	0.0%	98.5%
5-9	7.3%	N/A	0.1%	0.0%	
10-14	7.1%	N/A	0.2%	0.0%	
15-19	6.4%	N/A	0.9%	0.0%	
20-34	19.1%	N/A	8.1%	0.0%	
35-54	29.3%	N/A	13.7%	0.0%	
55-64	8.7%	N/A	9.2%	0.0%	
65-74	7.8%	N/A	14.9%	0.0%	1.5%
75+	7.8%	N/A	47.4%	0.0%	0.0%
Unknown Data****			0.0%	0.0%	0.0%
Missing Data******			0.0%	100.0%	0.0%
INCOME*******					
Average Household Size	2.4	N/A			
$0-$9,999	11.3%	N/A	0.0%	0.0%	0.0%
$10,000-$14,999	6.9%	N/A	0.0%	0.0%	0.0%
$15,000-$19,999	6.7%	N/A	0.0%	0.0%	0.0%
$20,000-$29,999	13.6%	N/A	0.0%	0.0%	0.0%
$30,000 and above	61.5%	N/A	0.0%	0.0%	0.0%
Unknown Data****			100.0%	0.0%	100.0%
Missing Data******			0.0%	100.0%	0.0%
Totals	100.0%	N/A	100.0%	100.0%	100.0%

Attachment 3: Actual Consumer Zip Codes (continued)

* US Census SF1 (P1); SF4 (PCT144)
** National Home and Hospice Care Survey, 2000. "Current Home Health Care Patients," February 2004; (1,017,900 skilled medical care patients divided by U.S. population in 2000 (281,421,906) equals 0.36 percent of total population. Assumes same percentage across periods.
*** United Way Program Report Data FY 2004; Note: Consumers could be funded by more than one funding source; thus the columns are not 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.
*****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.
******Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
******* The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." This method isolates and minimizes the non-minority population ("White alone").
********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 Health Care LT-280						
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ***		
	City/Town (% Cleveland)	Total Population (%)*	Total Population of Current Home Health Care Patients (%)**	UW Program Report Data (%)	DSAS Home Care Skilled & Support (%)	Ryan White Title I (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	2004
TOTAL		1,393,978	5,042	6,782	48	66
Percent			0.36%			
44017	Berea	1.4%	N/A	0.4%	0.0%	0.0%
44022	Bentleyville	1.3%	N/A	0.7%	0.0%	0.0%
44040	Gates Mills/Mayfield Village	0.2%	N/A	0.1%	0.0%	0.0%
44070	North Olmsted	2.4%	N/A	1.9%	0.0%	0.0%
44101	Cleveland (100%)	0.0%	N/A	0.0%	0.0%	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	N/A	6.7%	0.0%	0.0%
44103	Cleveland (100%)	1.8%	N/A	2.5%	0.0%	0.0%
44104	Cleveland (100%)	2.1%	N/A	3.1%	0.0%	0.0%
44105	Cleveland/NewburghHts/GarfieldHts	3.9%	N/A	4.7%	0.0%	0.0%
44106	Cleveland/Cleveland Hts (60%)	2.3%	N/A	2.5%	0.0%	0.0%
44107	Lakewood/Cleveland	4.1%	N/A	4.9%	0.0%	0.0%
44108	Cleveland/Bratenahl (90%)	2.6%	N/A	2.7%	0.0%	0.0%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	N/A	6.4%	0.0%	0.0%
44110	Cleveland/East Cleveland (98%)	1.9%	N/A	1.5%	0.0%	0.0%
44111	Cleveland (100%)	3.1%	N/A	3.8%	0.0%	0.0%
44112	East Cleveland/Cleveland	2.4%	N/A	1.8%	0.0%	0.0%
44113	Cleveland (100%)	1.4%	N/A	2.5%	0.0%	0.0%
44114	Cleveland (100%)	0.3%	N/A	0.5%	0.0%	0.0%
44115	Cleveland (100%)	0.6%	N/A	0.9%	0.0%	0.0%
44116	Rocky River	1.5%	N/A	2.6%	0.0%	0.0%
44117	Euclid/Cleveland	0.9%	N/A	0.6%	0.0%	0.0%
44118	ClevelandHts/UniversityHts/ShakerH	3.2%	N/A	2.0%	0.0%	0.0%
44119	Cleveland/Euclid (50%)	1.0%	N/A	0.4%	0.0%	0.0%
44120	Shaker Hts/Cleveland	3.4%	N/A	3.8%	0.0%	0.0%
44121	University Hts/South Euclid	2.5%	N/A	1.4%	0.0%	0.0%
44122	Beachwood/Highland	2.5%	N/A	1.9%	0.0%	0.0%
44123	Euclid	1.3%	N/A	0.5%	0.0%	0.0%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	N/A	2.2%	0.0%	0.0%
44125	Valley View/Garfield Hts	2.1%	N/A	2.4%	0.0%	0.0%
44126	Fairview Park/Cleveland	1.2%	N/A	1.3%	0.0%	0.0%
44127	Cleveland (100%)	0.6%	N/A	1.1%	0.0%	0.0%
44128	Warrensville Hts/Cleveland	2.4%	N/A	3.0%	0.0%	0.0%
44129	Brooklyn/Parma/Cleveland	2.1%	N/A	1.7%	0.0%	0.0%
44130	Parma/Cleveland	3.8%	N/A	2.5%	0.0%	0.0%
44131	Independence/Seven	1.5%	N/A	1.4%	0.0%	0.0%
44132	Euclid	1.1%	N/A	0.9%	0.0%	0.0%
44133	North Royalton	2.1%	N/A	0.8%	0.0%	0.0%
44134	Parma/Cleveland	2.9%	N/A	2.4%	0.0%	0.0%
44135	Cleveland/Linndale (90%)	2.0%	N/A	2.5%	0.0%	0.0%
44136	Strongsville	3.1%	N/A	0.8%	0.0%	0.0%
44137	Maple Hts/Cleveland	1.9%	N/A	1.8%	0.0%	0.0%
44138	Olmsted Twp/Olmsted Falls	1.3%	N/A	0.8%	0.0%	0.0%
44139	Bentleyville/Glenwillow/Solon	1.6%	N/A	0.5%	0.0%	0.0%
44140	Bay Village	1.2%	N/A	1.2%	0.0%	0.0%
44141	Brecksville	1.0%	N/A	0.6%	0.0%	0.0%
44142	Brookpark/Cleveland	1.5%	N/A	0.8%	0.0%	0.0%
44143	Highland Hts/Richmond Heights	1.7%	N/A	1.2%	0.0%	0.0%
44144	Brooklyn/Cleveland	1.6%	N/A	2.1%	0.0%	0.0%
44145	Westlake	2.3%	N/A	3.7%	0.0%	0.0%
44146	Walton Hills/Oakwood/Bedford	2.3%	N/A	2.1%	0.0%	0.0%
44147	Broadview Hts	1.1%	N/A	0.6%	0.0%	0.0%
44149	Strongsville			0.4%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes*****				0.3%	0.0%	0.0%
Missing****				0.0%	100.0%	100.0%
Unknown *****				26.6%	0.0%	0.0%
Total Cuyahoga County*****		**100.5%**	**N/A**	**100.0%**	**0.0%**	**0.0%**
Total Known Cleveland		**30.5%**	**N/A**	**41.8%**	**0.0%**	**0.0%**
Total Known Suburbs		**69.5%**	**N/A**	**57.9%**	**0.0%**	**0.0%**
Unknown & Missing				**26.6%**	**100.0%**	**100.0%**

Attachment 4: Actual Consumer Zip Codes (continued)

* US Census SF1 (P1)
** National Home and Hospice Care Survey, 2000. "Current Home Health Care Patients," February 2004; (1,017,900 skilled medical care patients divided by U.S. population in 2000 (281,421,906) equals 0.36 percent of total population. Assumes same percentage across periods.
*** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
****** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zip codes because some zip codes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005 & Long Term Care Ombudsman Database		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	62	1
Number of Providers by Type		
Nonprofit	36	1
For-profit	18	-
Government	8	-
Other	-	-
Total Number of Sites	63	1
Number of Service Sites per Provider		
1	61	1
2 – 5	1	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code *		
Total Cuyahoga County	63	1
Total Cleveland	21	1
Total Suburbs	42	0

* Detailed information by zip code was unavailable for this core service because United Way – First Call for Help 2005 database contained only 17 home health care providers and the Long-Term Care Ombudsman was able to provide a list of home health care providers only. The number of sites and service areas of providers was unknown.

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005 and Long Term Care Ombudsman Options Database	
Agency	**Services**
A-1 Healthcare Inc	
Almost Family Medlink	
Arcadia Health Services, Inc.	
Benjamin Rose	At Home Care for Elderly (3rd Party Payor/Sliding Scale), Mental Health Services, At Home Care for Elderly (Direct Full - Pay)
Caring Alternative	
City of Euclid	Senior Center - Home Personal Care
City of Lakewood Department of Human Services Division of Aging	Home Health Care
Cleveland Clinic Home Care Services	
Concordia Care	All - Inclusive Care In The Community for Frail Elderly
Custom Healthcare Professional	
Cuyahoga County Department of Senior & Adult Services	Home Support Services
Cuyahoga Nurses Registry	
Genuine Home Health Care	
Gibson Gals Nurses Registry	
Guardian Health Services	
Hanson Services Inc	
Harbinger Hospice	
Heartland Home Care	
Heritage Home Health Care	
Home Care Network	
Home Care Relief Inc.	
Home Instead Senior Care	
Homelink Home Care	
Hospice of the Western Reserve	
Hospital Home Health Service	
Infinity Health Services	
Integrity Home Care	
Jewish Community Care At Home	
Judson At University Circle	Home Care
Kaiser Permanente of Ohio	Home Health Care
LTC Nursing Services	
Malachi House	
Manor Care Health Service	
Maureen's Helping Hands Inc	
Maxim Healthcare Service	
Maxim Healthcare Services	
Medlink of Ohio	
Mega-Medical Services & Staffing	
Menorah Park Center for Senior Living	Home Health Services
Missouri Lemyra Inc	
Montefiore	Home Health Care

Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005 and Long Term Care Ombudsman Options Database	
Agency	**Services**
Northcoast Health Care DBA Intrepid	
Options For Senior America	
Outreach Home Health Service	
Parkgate Home	
Parma Community General Hospital	Home Health Care
Personal Touch Home Care of Ohio	
Personalized Care	
Priority Staffing	
Reserve Home Health Care	
Senior Outreach Services	Personal Care Services, Nurse Home Visits
Southwest General Health Center	Home Health Care
St. John West Shore Hospital	Home Health Care
Suburban West Nurses Registry	
Sunrise Home Health Care	
The Caring People, Inc	
United States Department of Veterans Affairs	Home Health Care
Universal Nursing Service	
University Hospital Home Care Services	
Visiting Nurse Association Healthcare Partners of Ohio	**In Home Medical Visitation/Care/Consultation, Obstetrical Services, Pediatric Care, Older Adult Care, Private Nursing/Home Health Care Services, Special Care/Pre-Hospice Program, Home Care Aide Services**
Visiting Physicians Association	Visiting Physicians
Western Reserve Area Agency on Aging	Information, Assessment and Home Care Services
Willcare Home Health Care	

Bold represents agency funded by United Way for this service.

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

LT-280 Home Health Care								
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
44146	Walton Hills/Oakwood/Bedford	1	6	6	2	9	800%	5
44123	Euclid	1	0	4	2	5	400%	2
44143	Highland Hts/Richmond Heights	4	6	3	5	12	200%	6
44121	University Hts/South Euclid	2	7	8	4	6	200%	5
44145	Westlake	2	0	3	1	6	200%	2
44124	Pepper Pike/Mayfield Hts./Lyndhurst	3	7	6	10	8	167%	7
44129	Brooklyn/Parma/Cleveland	2	5	4	7	5	150%	5
44114	Cleveland	2	2	3	5	5	150%	3
44120	Shaker Hts/Cleveland	8	7	16	13	20	150%	13
44105	Cleveland/Newburgh Hts/Garfield Hts	7	16	7	21	15	114%	13
44142	Brookpark/Cleveland	3	2	3	3	6	100%	3
44111	Cleveland	4	11	10	5	8	100%	8
44108	Cleveland/Bratenahl	10	16	14	14	17	70%	14
44118	ClevelandHts/UniversityHts/ShakerHts	6	12	3	10	10	67%	8
44110	Cleveland/East Cleveland	8	3	6	8	13	63%	8
44112	East Cleveland/Cleveland	9	9	16	14	14	56%	12
44119	Cleveland/Euclid	3	1	2	0	4	33%	2
44134	Parma/Cleveland	5	9	5	7	6	20%	6
44136	Strongsville	4	3	2	0	0	(100%)	2
44133	North Royalton	5	1	4	4	1	(80%)	3
44139	Bentleyville/Glenwillow/Solon	4	1	0	1	1	(75%)	1
44022	Bentleyville	3	0	0	1	1	(67%)	1
44116	Rocky River	3	2	4	7	1	(67%)	3
44107	Lakewood/Cleveland	8	7	1	4	3	(63%)	5
44137	Maple Hts/Cleveland	7	5	4	4	3	(57%)	5
44135	Cleveland/Linndale	9	7	8	4	4	(56%)	6
44103	Cleveland	10	3	8	9	5	(50%)	7
44113	Cleveland	6	3	3	3	3	(50%)	4
44117	Euclid/Cleveland	2	3	2	3	1	(50%)	2
44125	Valley View/Garfield Hts	4	3	8	2	2	(50%)	4
44126	Fairview Park/Cleveland	5	1	1	3	3	(40%)	3

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

LT-280 Home Health Care								
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**
44102	Cleveland/Brooklyn	11	10	8	9	7	(36%)	9
44140	Bay Village	3	0	0	1	2	(33%)	1
44109	Cleveland/Brooklyn Hts	12	7	10	4	8	(33%)	8
44128	Warrensville Hts/Cleveland	17	13	12	13	12	(29%)	13
44127	Cleveland	4	2	4	1	3	(25%)	3
**** Total Cuyahoga County**		**254**	**246**	**251**	**247**	**287**	**13%**	**257**
**** Total Cleveland**		**107**	**96**	**104**	**102**	**114**	**7%**	**105**
**** Total Suburbs**		**147**	**150**	**147**	**145**	**173**	**18%**	**152**
* 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 Home Health Care Requests 2000-2004: Unmet Need

LT-280 Home Health Care					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS 00-04			%
		Requests	Met	Unmet	Unmet
44134	Parma/Cleveland	32	30	2	6%
44113	Cleveland	18	17	1	6%
44109	Cleveland/Brooklyn Hts	41	39	2	5%
44104	Cleveland	45	43	2	4%
44129	Brooklyn/Parma/Cleveland	23	22	1	4%
44107	Lakewood/Cleveland	23	22	1	4%
44121	University Hts/South Euclid	27	26	1	4%
44105	Cleveland/Newburgh Hts/Garfield Hts	66	64	2	3%
44128	Warrensville Hts/Cleveland	67	65	2	3%
44106	Cleveland/Cleveland Hts	40	39	1	3%
44102	Cleveland/Brooklyn	45	44	1	2%
44120	Shaker Hts/Cleveland	64	63	1	2%
44108	Cleveland/Bratenahl	71	70	1	1%
***Total Cuyahoga County**		**1,285**	**1,267**	**18**	**1%**
***Total Cleveland**		**523**	**513**	**10**	**2%**
***Total Suburbs**		**762**	**754**	**8**	**1%**

FCFH DATA NOTES

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

Unmet = service request for which there was no referral.

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

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

United Way of
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