

Core Service Report

In-Home Assistance

Consumer Category:
Age

Primary Consumer Group:
**Seniors and Other Adults
Remaining Independent**



February 2007

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COMPANION REPORTS

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

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SNAPSHOT

AIRS Code Level I: Individual & Family Life (P)

AIRS Code Level II: Individual & Family Support Services and Family Support Services (PH)

Core Service: In-Home Assistance (PH-330)

Investment Committee: Health & Caring for All and Senior Success

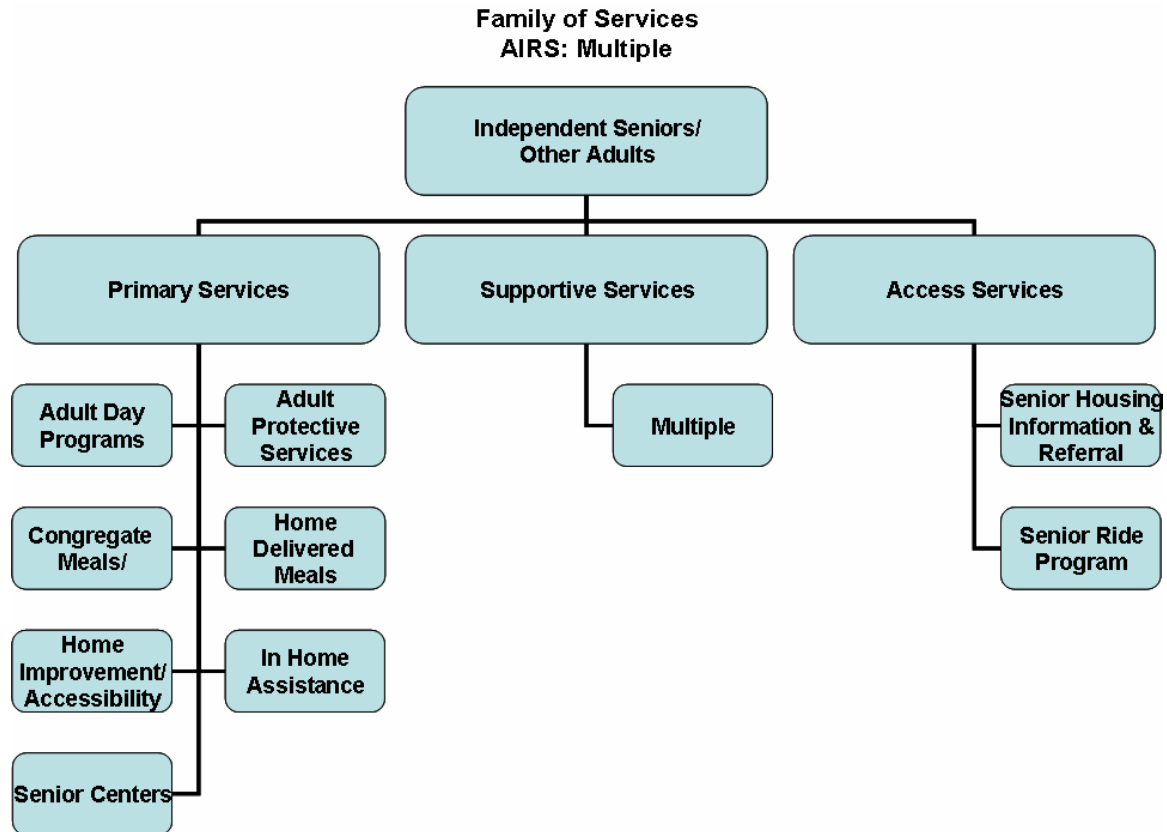
Cluster: Rehabilitation/Specialized Treatment and Basic Subsistence/Supportive Services

AIRS Definition: Programs that provide assistance in performing routine household, yard, and personal care activities for older adults, people with disabilities, eligible needy person, families whose normal routines have been disrupted by an emergency, or others who need or want these services. The objective of in-home assistance is to help the recipient sustain independent living in a clean, safe, and healthful home environment.

Special Note: There are 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.

In-Home Assistance is one of seven core services in a family of services for independent seniors and other adults. In addition, Senior Housing Information & Referral and the Senior Ride Program help consumers access those services. (See figure below.)



Core Service Environment

An increasing older population, reduced length of stay in hospitals resulting from prospective Medicare payment changes, more consumer interest in receiving care at home, and the expansion of federal, state and private insurance coverage for home health services have given home care services an important position in the health service delivery system. Home care services include both “high technology” skilled care and “high touch” personal care services. In-home assistance is “high touch” personal care service; in most cases it does not require nursing skills or doctor supervision. In-home assistance of older adults contributes to their good health and well-being, enabling them to remain living in their own homes and connected to their families and communities.

The current philosophical underpinning of public policies for in-home assistance at the national level is de-institutionalization, independent living, and a shift of policy decisions and responsibilities away from the federal government to the states. At the state and local levels, policies center around costs, community based care, and consumer choice. The role of planning, diet, and exercise is a major emerging theme for the prevention of premature aging and death.

In 1981, Congress enacted legislation that allowed states to request a waiver from the federal government to use Medicaid funds to serve individuals with chronic disability in non-institutional settings. Currently every state in the nation has at least one waiver program (Mehdizadeh & Applebaum, 2005).

In 1996, the Ohio Department of Human Services revised its home health services under the Ohio Home Care Program. The purpose of this program is to provide home care services to Medicaid-eligible consumers who are in need of such services due to their functional abilities and/or medical condition (Johnson et al., 2001).

In September 2005, Congress passed the bill to reauthorize the Older Americans Act (H.R. 6197) which was originally signed into law in 1965 amid growing concern over older individuals' access to health care and their general well-being. The bill includes language from the Positive Aging Act, with a new focus on the mental health needs of older adults, increased authorization of appropriations for programs to support family caregivers, and language to support home- and community-based long-term care for older adults.

Core Service Consumers

The target population addressed in this core service report is persons 60 years and older with moderate or severe disabilities.

Ohio currently has one of the largest aging populations in the nation, with 173,000 individuals age 60 and older with a severe disability that requires long-term in-home assistance. Ohio's population aged 60 and over is currently declining and will continue to do so until 2010. This population will grow rapidly after 2010 as the "baby boomers" begin to reach age 65 (Johnson et al., 2001).

Ohio's PASSPORT program has become a major component of the state's approach to delivering long-term care. Four in five participants are women; about three in four are Caucasian; four in five are unmarried; and eight in ten live in their own homes. The typical PASSPORT consumer is most likely to be an unmarried Caucasian woman. The average age of participants is 76, with 35 percent over the age of 80. Recent trends suggest that there has been a slight increase in the proportion of PASSPORT consumers in the youngest age groups. In June 2004, 27 percent of PASSPORT consumers were between the ages of 60 and 69, compared to 23 percent in both 1994 and 1999. Population projections indicate that this increase is commensurate with an increase in the number of Ohioans between the ages of 60 and 69 (Mehdizadeh & Applebaum, 2005).

In 2000, nearly 25,000 individuals over age 60 in Cuyahoga County had a severe disability, and 47,075 had a moderate disability. Almost 14 percent of the population over age 60 live in poverty, and 25 percent belong to a racial or ethnic minority group. Nearly 7 in 10 individuals age 60+ in the county have 12 or fewer years of education (Mehdizadeh et al., n.d.).

In 2000, there were 71,786 persons 60 years and older with severe or moderate disabilities in Cuyahoga County. This number is projected to decrease through 2010 and then begin to increase as the baby boomers come of age. By 2020, it is projected that 74,731 persons 60+ will have a severe or moderate disability.

Core Service Delivery

The definition of the core service for this report is: either ancillary custodial service provided with skilled care along with home health care, or a package of services that is part of the community-based long-term care system. It is distinguished from home health care, which is short-term medical skilled care provided in the homes of persons of all ages.

In-home assistance services allow older persons with limitations to recuperate from illness and live independently in their home. Service providers aid the healing process and help prevent discomforts such as going hungry, losing weight, dehydration, and injuries due to falls and burns. Personal assistance services refer to assistance as “tasks ... that individuals would normally do for themselves if they did not have a disability” (Litvak, Zukas, & Heumann, 1987) such as:

- Personal care/activities of daily living, including bathing, dressing, eating, mobility, toileting, and transfer;
- Instrumental activities of daily living, including meal preparation, menu planning, laundry, housekeeping, shopping, money management, and transportation;
- Communication, such as reader services for the blind and interpreter services for the deaf; and
- Paramedical services, including, but not limited to, medication administration, catheterization, injections, and ventilator care (Scala & Mayberry, 1997).

In-home assistance might also involve home modifications, assistive devices and technologies, case management, and other services (Doty, Kasper, & Litvak, 1996). The persons who provide this assistance may be called personal assistants, attendants, aides, home care workers, or consumer-directed care attendants (Scala & Mayberry, 1997).

Based on United Way-First Call for Help’s (FCFH) database (2004), there are 61 providers of in-home assistance service operating from 83 different sites, 29 of which are nonprofit and 32 are government. In FY 2004 (July 2003 to June 2004), United Way funded 1 of these providers. The number of those requesting in-home assistance help in the county declined from a high of 26 in 2000 to 22 by 2004, which represented a 15 percent decline. Of the 2,591 requests, FCFH was able to respond to 93 percent of the calls.

There are three primary sources of government supports for in-home assistance services: Medicare, Medicaid, and local county levies. Medicare pays for limited home health care service when an enrollee requires skilled nursing care at home. Medicaid is the primary funder of both institutional and community-based long-term care, including in-home assistance as defined in this core service report.

Many home- and community-based services are provided through local tax levies voted on in local elections and must be renewed every 3-5 years. Older adult services in Cuyahoga County are paid for through the Health and Human Services levy.

In Cuyahoga County, the OPTIONS for Elders Program increased from \$576,109 in 2002 to \$1,969,221 in 2004. Older American’s Act funding has decreased from \$529,595 in 2002 to \$419,751 in 2004.

As of May 11, 2006, nearly \$49.9 million in revenues for in-home assistance has been identified countywide. Close to 100 percent of the revenues are from contracts or grants from government

organizations and United Way of Greater Cleveland's funds account for 0.04 percent of the total.

The OPTIONS for Elders program uses a sliding fee scale. The total package of services cannot be more than \$700 per month. Both the sliding fee scale grid and the monthly ceiling are updated as needed (Cuyahoga County Department of Senior and Adult Services, n.d.).

What Works; What Doesn't

Family caregivers are an important aspect to consider with in-home assistance since they provide such a large percentage of support. Stress and burn-out can be minimized with quality care provided by others or in combination with the family caregiver.

Solutions that improve communication and support between formal systems and families have the potential to influence the quality of life and care for individuals and their caregivers (Young, 2003).

Consumers have identified a number of factors that contribute to quality home care: the opportunity to maintain independence, autonomy, and choice; a good consumer/worker relationship; flexibility of care plan and worker tasks; and reliability, honesty, and competence of workers. (Woodruff & Applebaum, 1996; Kane, Kane, Illston, & Eustis, 1994; Eustis, Kane & Fischer, 1993).

Systematic reviews and meta-analyses of research on the efficacy of community-based programs have identified positive outcomes in consumer and family satisfaction with services, but have not substantiated global improvements in health or functional status for participants, nor cost savings for care (Weissert & Hedrick, 1994; Zarit, Gaugler, & Jarrott, 1999).

Fragmentation of the home health care system has major issues that suggest that the system does not always work as effectively as it should.

The total economic value of long-term care to older people in Ohio was estimated at almost \$10 billion. When this total was broken down by type of care, the value of institutional care was about \$3.8 billion, the value of community-based formal services was \$1.1 billion, and the value of care provided by family, friends, and neighbors was nearly \$4.9 billion (Mehdizadeh & Murdoch, 2003).

Gap Analysis

The estimated universe of possible consumers is 17,947 included realized (6,579) and unrealized (11,368) access.

I. FOREWORD

INTRODUCTION

United Way of Greater Cleveland (UW), in partnership with the Cuyahoga County Board of Commissioners, has initiated a large scale core service planning process to generate data and engage in community-wide dialogue about the community's safety net of core service and consumer needs in the Greater Cleveland area. In addition, UW envisions this process as an opportunity to better understand its role in the community and its long term capacity to improve the lives of Greater Clevelanders.

The primary goal of the Cuyahoga County core service research is to identify consumer needs and assess whether there are service gaps/duplications on a community-wide level. The findings from this research will guide future funding decisions at UW, and they will also be used to stimulate dialogue with other funders and groups in the community. United Way intends to continue to fund a broad array of "safety net" services that are important to the Greater Cleveland area. But it is hoped that the research findings will inform how UW dollars may be dispersed to have the greatest impact on current realities, needs, and priorities in the Greater Cleveland community.

METHODOLOGY

United Way contracted with MCS Consulting Service, LLC, to conduct the core service research, which focuses on both the consumers served and services provided. (See Attachment 1 for list of members of the research team.) The research team has obtained information about each core service from multiple data sources. At the end of the research process there will be substantial information available for some services and less for others, which will provide a clearer picture of what information *is* available and where there are *significant gaps*.

The questions addressed are:

- Including public policies, what are the environmental influences that are impacting both service consumers and the capacity for service delivery?
- Who are the service consumers? What are the factors that lead to a need for services? How many consumers are there? How many have there been in the past several years and what factors influenced the historic trend line? What are the projected numbers for the future? What is their demographic profile? Where do they reside? How many are receiving services funded by government and/or United Way?
- What is the philosophy that drives service delivery? Has it changed? What does the service consist of? Who provides the service?
- What are the funding sources? What are the annual revenues from government sources, federated fund raising organizations, foundations, and United Way of Greater Cleveland? What are the historic government funding trends and what is projected for the future? What is the reimbursement amount?
- What works and what doesn't work in service delivery?
- Are there service gaps, duplication, under-utilization?

The primary information sources used for this report are:

- Results of 20 focus groups with 159 direct service staff of United Way member agencies and non-members, and key informant interviews with 93 experts in the respective service areas (February 2005). Participants were asked about consumer populations that are increasing and those with unmet needs; they provided insight about specific service gaps and duplication, as well as services they perceive to be outdated or under-utilized.
- United Way Program Report data for FY 2004 (July 2003 to June 2004). Each year United Way member agencies submit information to their respective investment committees on each funded core service they provide. Among other things, this information includes a demographic profile of the consumers served, the zip codes where the consumers reside, and all revenue sources that support the service. The research team has aggregated this information for each core service.
- United Way - First Call for Help call data (2000 to 2004) - United Way - First Call for Help provides a 24/7 information and referral service through its 211 telephone line. The research team analyzed data from its large database, which includes the names of service providers for most core services, the activities they provide and the zip codes in which they and those they serve are located, the number of calls received, and whether the need was met or unmet. Unmet needs are those for which there was no resource to reference.
- Literature reviews on service trends and issues as well as best practices (i.e., what works/ what doesn't work in service delivery), including impact on the individual/family and on the community.
- Searches for information on public policies that are currently impacting consumers or service delivery.
- U.S. Census and American Community Survey data for various time periods.
- Data from funders on actual consumer populations and funding levels.

(See Attachment 2 for technical notes on the research methodology as well as limitations of the data.)

II. THE CORE SERVICE ENVIRONMENT

CORE SERVICE ENVIRONMENT

An increasing older population, reduced length of stay in hospitals resulting from prospective Medicare payment changes, more consumer interest in receiving care at home, and the expansion of federal, state and private insurance coverage for home health services have given home care services an important position in the health service delivery system. Home care services include both “high technology” skilled care and “high touch” personal care services. In-home assistance as defined in this core service report is “high touch” personal care service; in most cases it does not require nursing skills or doctor supervision. In-home assistance of older adults contributes greatly to their good health and well-being, enabling them to remain living in their own homes and connected to their families and communities.

Most individuals 60 years and older have assistance needs similar to the general population; however, the chronically ill and frail elderly have specialized needs that, if not met, increase visits to the emergency room, the possibility of being placed in a nursing home, or premature death. Home health care and in-home assistance are closely related services and often difficult, if not impossible, to separate. Once the patient reaches the community, these are not separate services, but rather are provided in a bundle of other coordinated services. Similarly, it is difficult to isolate the individual effects of these actions.

Functional status varies considerably among older adults, with most remaining independent in daily functions while continuing to work and be active participants in their respective communities throughout their lives. However, increasingly after age 85 (and for some at earlier ages), a portion of frail elderly who are severely disabled will need assistance with activities of daily living. Older adults comprise the largest group of care recipients in the United States while they also represent the greatest number of caregivers (either partners or adult children) for other elders (Spillman & Pezzin, 2000). Viewed in this light, caregiving can represent an intertwining of two frailty trajectories (Cartwright, Archbold, Stewart, & Limandri, 1994). Racial, developmental, biological, psychosocial, and functional diversity must also be anticipated and appreciated as health care services are explored for older adults (Young, 2003).

The growing need for home care is among the most urgent issues of our maturing society. Contrary to popular misconception, however, the primary source of care for those who are ill in this country (of all ages) remains family and friends. And contrary to popular lore, Americans do not abandon older people to nursing homes in massive numbers or even rely primarily on paid professionals for care. Relatively few people who need long-term care — only 4.3 percent of the aged population — live in a nursing facility on any given day. Among people receiving long-term care in the community, fewer than 11 percent receive all of their needed care from a paid home care worker. (The Institute for Research on Women and Gender, 2002)

One participant in a focus group conducted for United Way (2005) noted that *“the historic deinstitutionalization movement has already had a tremendous impact on the disabled population. A major implication of these policy decisions is a shift to expect families to provide more services.”*

Family members, who are not compensated for their contributions, provide the majority of long-term care. A nationwide survey indicated that the prevalence of informal caregiving is 31.7 percent for Asian households, 29.4 percent for blacks, 26.8 percent for Hispanics and 24 percent for whites (Family Caregiving in the U.S., 1997 in Young, 2003). Numerous studies indicated that informal caregivers provide up to eighty percent of in-home care for the older disabled over age sixty (Young, 2003). Policy makers fear what is referred to as the “woodwork effect”; that is, the more services provided by the formal care system, the less likely the disabled will be to receive home care from family and the community, thus unreasonably pushing up the demand and cost of health care (Knickman & Snell, 2002; Merlis, 2000; Tilly, Wiener, & Cuellar, 2000; Young, 2003).

A number of studies explored utilization and preferences for home health care among various ethnic groups (Jenkins, 2001; McCormick et al., 2002; Morrow-Howell, Chadiha, Proctor, Hourd-Bryant, & Dore, 1996; Mui & Burnette, 1994). African Americans were less inclined to use the formal care system than whites. Whether this is merely due to cultural differences in service use or not is a question. Whites generally showed a stronger inclination toward formal services than other ethnic groups, including Hispanic, African American, and Asian American older adults. A Stanford University study (The Institute for Research on Women and Gender, 2002) asked whether the lower utilization among minorities is due to differences of cultural values and family preferences or biases and prejudices within the system that impede access.

Predictions about the future need for in-home assistance based purely on past trends can lead to inaccurate conclusions if they fail to take into account the factors driving social change and the unique characteristics of each successive cohort of older persons. Projecting past utilization patterns for long-term supportive services onto future population profiles of older persons is likely to exaggerate potential demand for services and their costs. For example, the doubling of Ohio’s elderly population over the next twenty years may not necessarily lead to a doubling of the need for services.

The experiences of the cohorts of persons who reached old age in the 1970s and early 1980s proved to be an inadequate basis upon which to project current demand for widowed women who came of age during the Great Depression and World War II years and had relatively few economic and family resources to draw upon in their later years. At that time, high rates of disability, widowhood, and childlessness combined with low rates of wealth accumulation created a demand for publicly subsidized long-term supportive services. (Redfoot & Pandya, 2002)

While predicting the future is an uncertain art, the characteristics of the cohorts who will enter late old age during the next two decades suggest that demand for long-term supportive services—especially in institutional settings—will grow very slightly, if at all, during that time. Favorable demographic and socioeconomic characteristics of the cohorts entering late life (such as improved literacy and economics) and medical improvements should result in moderate demand. Indeed, if disability rates continue to decline at the current pace, the number of

disabled older persons could be fewer at the end of 2010 than it is now (Redfoot & Pandya, 2002).

Nevertheless, projections for the future health status of the aging population are mixed. 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 dropped from 26.2 percent in 1982 to 19.7 percent in 1999, resulting in a net of 100,000 fewer disabled elderly, despite population growth. Others have expressed caution that this decline reflects instrumental improvements with no real decline in activities of daily living (ADL) disability, which implies that while there are fewer needing help, their needs are more intense (Spillman & Pezzin, 2000 in Young, 2003).

Increased life expectancy, decreased rates of disability, and the increasing number of persons with dementia and other forms of chronic illness will impact the utilization of in-home assistance services. The life expectancy for whites at 78.3 was up slightly from 2003, while the increase for blacks was larger with an increase from 72.7 to 73.3. However black males still have a life expectancy of less than seventy years. The National Center for Health (reported in the *Plain Dealer* April 20, 2006), quoting from the "National Vital Statistics Report in 2005," found that whites live an average of 5.4 more years than blacks. Black men have the shortest life expectancy at 68.8 years, and live 6.9 years less than black women, who live an average of 75.6 years. For black males' shorter life expectancy, high mortality rates between the ages of 16 and 32 is a factor to be considered, along with accidents and injuries that lead to premature disabilities later in life.

It is speculated that modern medicine—high tech clinical tests and procedures—play a relatively major role in increasing life expectancy. It is also argued that the biggest mortality rate change during the 20th century was decreases in the mortality rates during the childhood years, since decreases in mortality later in life become progressively smaller. Austad (2005) reasons that if high-tech medicine does play a significant role, it would probably be most obvious among the elderly in a more than seven-year improvement in life expectancy. Increased attention to public health measures such as clean water, air, workplace improvements, and improved housing may be significant factors in improving life expectancy. Austad states that the changes are also probably due to some combination of improved nutrition, uncontaminated food, and the widespread availability of vaccinations during the childhood years (Austad, 2005).

Recently, aging research found that by age 85 as many as 50 percent of older persons will become demented or suffer with Alzheimer's disease (Hy & Keller, 2000). As the over 85 population grows at an increasing rate, the emotional, social, and economic costs of neurological aging, such as dementia and Alzheimer's, may become major challenges to health care providers and families providing informal care (Austad, 2005). Other studies have suggested that the increases in diabetes and obesity could be equally challenging as the population ages.

Dementia and frailty patients can often live for a decade with increasing symptoms and increasing disability. Thus, the care system must be structured to accommodate very long durations of progressive illness and to adapt to changing family situations, slow decline in the patient's capabilities, and either a sudden or lingering death (Lynn & Adamson, 2003).

One of the participants in a focus group conducted for United Way (2005) made a similar comment based on her experience:

New drugs that are allowing people to live longer with illnesses like Alzheimer's Disease and other forms of long-term dementia. These drugs are supposed to arrest the development of the illness or slow it down at an early stage. While there are definitely advantages from these drugs, they also 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.

PUBLIC POLICY ISSUES

The current philosophical underpinning of public policies for in-home assistance at the national and state level is providing care to individuals in a setting they prefer, and a shift of policy decisions and responsibilities away from the federal government to the states.

NATIONAL

Consumer Directed Care

As described in a study by the National Council on Disability:

The term "consumer-directed care" has its roots in the independent living movement and is most commonly used in reference to home- and community-based long-term care and support services. Consumer direction of services grows out of a philosophical orientation that emphasizes the ability of people with disabilities to assess their own needs and make choices about what services would best meet those needs. It also reflects a view that consumers can and should have options to choose the personnel or provider entities that deliver their services, manage the delivery of services, and monitor the quality of services...

The past 30 years have seen a revolution in the way disability is addressed in American society... America's system of health care has traditionally maintained an institutional bias and typically insisted that services and care be directed by health care professionals, with few options for consumer direction or control. Recently, health policy shifts and practice changes have explored consumer-directed health care. For example, federal and state governments and advocates have combined over the past ten years to explore the use of consumer-directed home and community-based health care, long-term personal assistance services, and telemedicine and telerehabilitation. (National Council on Disability, 2004)

Consumer-directed care emphasizes the provision of services in a setting the consumer prefers, which is most often the home. For this reason, the policy of consumer-directed care strongly affects in-home assistance programs. The commitment on the part of the federal government to explore consumer-directed care resulted in the establishment of the National Institute on Consumer-Directed Long-Term Services. The Institute is funded by the Administration on Aging and the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services; it represents a partnership between the National Council on the

Aging, Inc. and the World Institute on Disability. There have also been a number of recent initiatives by the Robert Wood Johnson Foundation in the area of consumer direction (Scala & Mayberry, 1997).

Medicaid and Shift to Home- and Community Based Care

Medicaid's home- and community-based care waiver programs are an important component of consumer-based care that allows individuals to receive care in setting they prefer. In 1981, Congress enacted legislation allowing states to request a waiver from the federal government to use Medicaid funds for individuals with chronic disability in non-institutional settings. Prior to this legislation, Medicaid long-term care funds could only be used for nursing home care. To be eligible for Medicaid-funded services under the home- and community-based waiver, an individual had to meet the nursing home admission criteria as established by each state. Because there were nursing home residents who could be in non-institutional settings, the popularity of the waiver programs around the United States has increased substantially in the past two decades. Currently every state in the nation has at least one waiver program and, in fact, there are nearly 300 waivers in operation that serve individuals with disabilities of all ages. Nationally, more than 800,000 participants are being served through an array of waiver programs. The \$19 billion spent on home care waiver programs in 2003 represented nearly 22 percent of all Medicaid long-term care expenditures (Mehdizadeh & Applebaum, 2005). Ohio's Medicaid waiver programs are explained later in this section.

Olmstead Decision

In June 1999, the U.S. Supreme Court ruled that it was a violation of the Americans with Disabilities Act (ADA) for states to provide services in institutions when disabled individuals could be served more appropriately in community-based settings (Olmstead vs. L.C., 119 S. Ct. 2176, 1999). This landmark ruling called for the integration of services within local communities and had a major impact on the services available to older Americans. However, the ruling does not create an entitlement or call for a fundamental alteration of public programs; it applies only if the provision of community services represents a reasonable accommodation (Koffman, Raphael, & Weiner, 2004). A report published by the National Center on Disability notes, "The Olmstead Supreme Court decision has provoked a wave of institution-to-community planning among states that are responsible for ensuring that Medicaid recipients are provided health care in the most integrated setting appropriate, typically the individual's home and community" (National Center on Disability, 2004).

Older Americans Act (OAA)

In addition to the waiver programs, other funding sources such as the Older American's Act (OAA) support in-home assistance services. OAA (P.L. 89-73) was signed into law in 1965 amid growing concern over older individuals' access to health care and their general well-being. The OAA established the Administration on Aging (AoA) and charged the agency with advocating on behalf of Americans 60 and over and implementing a range of assistance programs aimed at older persons, especially those at risk of losing their independence. That at-risk group has been identified as older individuals 85+ who are living alone without access to a caregiver; low income; members of minority groups; persons with disabilities; and victims of abuse, neglect, or exploitation (AoA 2002a in Koffman, Raphael, & Weiner, 2004). Federal funds are distributed to states on the basis of the state's share of the U.S. population age 60 and above (Koffman, Raphael, & Weiner, 2004).

AoA awards funds under Title III of the OAA to the 57 state units on aging to plan, develop, and coordinate systems of in-home and community-based services. These programs include

supportive services, congregate and home-delivered meals, in-home services for frail elderly, and disease prevention and health promotion services. Transportation is one of the supportive services that can be funded under Title III-B and is the second largest service element (after congregate and home-delivered meals) funded under Title III (Koffman, Raphael, & Weiner, 2004).

In September 2005, Congress passed the bill to reauthorize the Older Americans Act (H.R. 6197). The bill includes language from the Positive Aging Act, with a new focus on the mental health needs of older adults, increased authorization of appropriations for programs to support family caregivers, and language to support home- and community-based long-term care for older adults.

STATE

Ohio's Medicaid Waivers

Ohio has five Medicaid waivers offered through three state agencies: the Ohio Home Care waiver and the Transitions waiver are administered by the Ohio Department of Job and Family Services (ODJFS) and are for people with severe disabilities and medically unstable conditions who require care in a hospital or nursing home; the PASSPORT waiver, which is administered by the Ohio Department of Aging and is for people age 60 or over who require care in a nursing home; and the Individual Options (IO) waiver and Level One waiver, which is administered by the Ohio Department of Mental Retardation and Developmental Disabilities for people who require care in a facility for people with mental retardation and/or developmental disabilities. Ohio's waiver services include emergency response systems, home-delivered meals, supplementary equipment/adaptive devices, home modification, out-of-home respite, adult day care, supported employment, nursing care, and homemaker/personal care services (ODJFS, 2006.)

The Ohio General Assembly, in passing a budget bill for the 2006-2007 biennium, authorized the creation of the Medicaid-funded Assisted Living waiver. Any Medicaid waiver program required approval from the federal Centers for Medicare and Medicaid Services (CMS). Recognizing this fact, the legislation that created the Assisted Living program authorized funding beginning July 1, 2006. During the first year of implementation (SFY 2007), the program is authorized to enroll up to 1,800 eligible Ohioans. To be eligible, participants must be financially eligible for Medicaid and an area agency on aging must determine a need for "nursing facility level of care," the same as the PASSPORT program requirements. Further, the budget bill excludes or limits participation of two groups: nursing facility residents desiring to relocate to assisted living and existing Medicaid waiver consumers (i.e. PASSPORT, Ohio Home Care, or Choices participants) who are withdrawing from the program and would otherwise be forced to enter a nursing facility permanently. Consumers, once determined eligible, can select from any eligible assisted living provider (Lawrence, 2005).

LOCAL

Local Taxes for Older Adult Issues

Many counties in Ohio have passed tax levies to support older persons' services or facilities. In Franklin, Hamilton, and Delaware counties, these levy funds are specifically targeted for in-home services to older persons (Benson, 2000). In Montgomery County, the ComCare program provides PASSPORT-type services to older individuals who need at least a protective level of care but not immediate nursing home placement (and who, therefore, are ineligible for



PASSPORT). It is one of many programs supported by a county human services levy (Kapp, 2000). The Cuyahoga County Health and Human Services levy supports the Cuyahoga OPTIONS Program for Elders, which is also for those who need a protective level of care. Specific funding information regarding this levy is included in Section IV.

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

For the purpose of this core service report, the target population for in-home assistance is persons 60 years and older with moderate or severe disabilities.

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

DEMOGRAPHIC CHARACTERISTICS

Ohio

Ohio currently has one of the largest aging populations in the nation, with 173,000 individuals age 60 and older experiencing a severe disability that requires long-term in-home assistance. Ohio's elder population aged 60 and over is currently declining and will continue to do so until 2010. This population will grow rapidly after 2010 as the "baby boomers" begin to reach age 65. This is because from the beginning of the Great Depression to the end of World War II, fewer babies were born in the United States than either before or after this fifteen year period (Johnson et al., 2001).

This "baby dearth" means that between 2010 and 2020, the number of Ohioans aged 75-90 will actually decline as well—the population most in need of long-term care in either nursing homes or residential care facilities. Because of increased longevity and declining disability, the number of Ohioans aged 85 and older will continue to grow without experiencing this fifteen year dip. One reason for this trend is that the rate of disability in the adult population has been declining consistently by 1.5 percent per year since the early 1980s, according to researchers at Duke University (Johnson et al., 2001).

More older people in the state are receiving long-term support in their own homes through Ohio's PASSPORT program and with their own out-of-pocket expenditures. The number of older people living in residential care facilities, particularly assisted living residences, has also grown (Mehdizadeh & Applebaum, 2003).

At the same time, occupancy rates of nursing facilities in the state have dropped, as have the sheer number of residents served on a daily basis. Despite an increase of 50,000 Ohioans over age 85 in the past decade, the average number of nursing home residents has dropped by almost 5,700, and the number of Medicaid-supported residents has dropped by more than 2,700 (Mehdizadeh & Applebaum, 2003). Interestingly, for every one person in a nursing home in 2001, there were two equally

impaired people who lived in the community (Mehdizadeh, Kunkel, & Ritchey, 2001 in Scripps Gerontology Center, 2003).

Ohio's PASSPORT program has become a major component of the state's approach to delivering long-term care. About 63,500 Ohio residents age 60 and older were receiving Medicaid funded long-term care in June 2004. Of those long-term care recipients, 22,500 received services in their homes through PASSPORT, compared to 41,000 whose services were provided in nursing facilities. Thus, in 2004, 35 percent of all Medicaid long-term care clients over age 60 were home care participants. By comparison, in 1994 only 12 percent of Medicaid long-term care recipients were PASSPORT participants. At that time there were 52,500 Medicaid nursing home residents over age 60 and 7,161 PASSPORT participants (Mehdizadeh & Applebaum, 2005).

Four in five PASSPORT participants are women; about three in four are Caucasian; four in five are unmarried; and eight in ten live in their own homes. The typical PASSPORT consumer is most likely to be an unmarried Caucasian woman. Participants' average age is 76, with 35 percent over the age of 80. Recent trends suggest that there has been a slight increase in the proportion of PASSPORT consumers in the youngest age groups. In June 2004, 27 percent of PASSPORT consumers were between the ages of 60 and 69, compared to 23 percent in both 1994 and 1999. Population projections indicate that this increase is commensurate with an increase in the number of Ohioans between the ages of 60 and 69 (Mehdizadeh & Applebaum, 2005).

PASSPORT consumers are considered disabled based on the extent to which they can perform activities of daily living (ADLs) such as bathing, dressing and grooming. More than six in ten participants are impaired in three or more ADLs. Participants are most likely to be impaired in bathing (97 percent), transferring from their bed to a chair (75 percent), and dressing (62 percent). One in five participants is incontinent and needs supervision to perform tasks of daily living. PASSPORT consumers have considerable impairment in their ability to perform instrumental activities of daily living (IADLs) such as meal preparation, shopping, and transportation. Participants, on average, are impaired in six of these IADLs (Mehdizadeh & Applebaum, 2005).

PASSPORT participants experience considerable functional and health limitations and require hands-on assistance from both formal and informal care providers. The majority of PASSPORT participants have a primary caregiver, although almost 40 percent of the caregivers report their own health as fair or poor. PASSPORT participants most often leave the program because of death, or placement in a nursing home or hospice. Participants who left for these reasons had been in the program for an average of 2.5 years (Mehdizadeh & Applebaum, 2005).

Sixty-eight percent of PASSPORT consumers report an active primary caregiver. In the vast majority of cases (89 percent) these caregivers are

relatives. More than one-half of the caregivers (52 percent) live with the PASSPORT participant. Seven in ten caregivers are women. Almost four in ten assess their physical health as fair or poor, and a little over one in four label their emotional health as fair or poor. A little over one-half of the caregivers (56 percent) report full- or part-time employment. When asked to rate their ability to provide assistance in the future, about one-fifth reported that they would be less able to continue caregiving (Mehdizadeh & Applebaum, 2005).

Each year between 25 and 30 percent of PASSPORT consumers leave the program. The most common reasons were death (40 percent) or admission to a nursing home (34 percent). An additional 8 percent were admitted to hospice care or required long-term hospitalization. In some cases the participant no longer met the financial (7.1 percent) or functional eligibility (1 percent) for the program. Some individuals withdrew because they could not agree on a plan of care with the PASSPORT agency (5 percent). Finally, about 4 percent move out of the state. A review of the length of stay data for persons withdrawing show that those who died or were admitted to nursing homes had been PASSPORT participants for almost 2.5 years prior to exiting the program (Mehdizadeh & Applebaum, 2005).

Cuyahoga County

In 2000 in Cuyahoga County, nearly 25,000 individuals over age 60 had a severe disability and 47,075 had a moderate disability. A lack of health coverage could be a factor in swelling the ranks of persons with moderate disabilities in the future. Almost 14 percent of the population over age 60 live in poverty, and 25 percent of the individuals of the age 60+ belong to a racial or ethnic minority group. Nearly 7 in 10 individuals age 60+ in the county have 12 or fewer years of education. In the U.S., higher education and income attainment is usually associated with improved health (Mehdizadeh et al., n.d.).

Of men age 60+, 69 percent are married, compared to only 40 percent of women. Marriage is a predictor of needing in-home assistance. Older married couples are more likely to receive informal in-home assistance than singles. In the county, nearly 3 in 4 individuals age 85+ are female. Older females, especially white, require more care than other individuals (Mehdizadeh et al., n.d.).

By 2020, it is predicted that 312,000 individuals age 60+ will reside in Cuyahoga County, which represents a 14 percent increase in the 60+ population. Of these, almost 25,000 are predicted to have a severe disability. The national average for informal care among all racial groups is nearly 80 percent. However because of persistent downturns in Northeast Ohio's economics, informal care may be lower in the future. Therefore, it is concluded that between 70 and 80 percent will receive informal care from family, friends, and the community. This suggests that between 20-30 percent, or 5,000 to 7,500 severely disabled persons, will need in-home assistance per year between 2006 and 2010. (See Table 1 for more detail.)

Table 1: Projections of Total Older Population by Age and Levels of Disability Cuyahoga County, 2000-2020

Year	Age Group	Total Population	No Disability	Moderate Disability	Severe Disability
2000*	60 - 69	108,950	92,444	13,151	3,355
	70 - 79	103,502	78,305	17,972	7,225
	80 - 89	51,959	28,737	13,043	10,179
	90+	8,967	2,106	2,909	3,952
	Total Age 60+	273,378	201,592	47,075	24,711
2005	60 - 69	109,590	93,053	13,177	3,360
	70 - 79	87,796	66,306	15,316	6,174
	80 - 89	54,084	29,975	13,559	10,550
	90+	9,827	2,346	3,203	4,278
	Total Age 60+	261,297	191,680	45,255	24,362
2010	60 - 69	127,302	108,233	15,193	3,876
	70 - 79	78,119	59,204	13,510	5,405
	80 - 89	51,721	28,351	13,070	10,300
	90+	10,814	2,587	3,532	4,695
	Total Age 60+	267,956	198,375	45,305	24,276
2015	60 - 69	148,838	126,542	17,748	4,548
	70 - 79	79,918	60,783	13,687	5,448
	80 - 89	45,164	24,607	11,464	9,093
	90+	12,059	2,887	3,943	5,229
	Total Age 60+	285,979	214,819	46,842	24,318
2020	60 - 69	163,395	138,924	19,474	4,997
	70 - 79	94,233	72,038	15,900	6,295
	80 - 89	41,901	23,042	10,568	8,291
	90+	12,056	2,850	3,940	5,266
	Total Age 60+	311,585	236,854	49,882	24,849

Source: U.S. Census Bureau, 2000: Public Use Microdata Sample: 5-Percent. Year 2000 data is actual population counts, years 2005-2020 are projections. (Mehdizadeh et al., n.d.).

The Western Reserve Area Agency on Aging administers the PASSPORT program for the Greater Cleveland region, which includes Cuyahoga, Geauga, Lake, Lorain, and Medina counties. Table 2 indicates that in 2005 the Cleveland Area had 20.6 percent (35,663) of Ohio's population with severe disabilities (173,327) and 19.4 percent (4,377) of the state's total PASSPORT consumers (22,560). In the Cleveland region, PASSPORT consumers represented 12.3 percent of the region's severely disabled compared to 13 percent for the entire state (Mehdizadeh & Applebaum, 2005).

Table 2: Cleveland Area and Ohio Population 60+ and Number Receiving PASSPORT, 2005

	Est. 60+ Population	Est. 60+ with Severe Disabilities	Proportion of OH's 60+ Populations with Severe Disabilities (AAA)	Number of PASSPORT consumers	Proportion of OH's PASSPORT consumers (AAA)	PASSPORT Consumers: Percent of Severely Disabled Pop.
Cleveland Area	399,349	35,663	20.6%	4,377	19.4%	12.3%
Ohio	2,009,390	173,327	100.0%	22,560	100.0%	13.0%

(Mehdizadeh & Applebaum, 2005)

In Cuyahoga County, the OPTIONS for Elders program serves persons who are slightly less disabled and have slightly higher incomes and assets than PASSPORT with in-home services. Clients must meet the protective level of care as defined in the Ohio Administrative Code. This requires *at least one* of the following:

- Supervision of 1 activity of daily living (ADL) and assistance with 3 instrumental activities of daily living (IADL);
- Supervision of self-administration of medications and assistance with 3 IADLs; or
- Supervision to prevent harm due to cognitive impairment (on less than 24-hour basis).

As of July 31, 2002, the profile of OPTIONS 531 consumers over the first three years of the program was overwhelmingly female, 75 years or older, living alone, and widowed, single, divorced or separated.

- Slightly more than half were African American and had a caregiver although a large proportion (47 percent) had no caregiver.
- Seventy-seven percent (410) were female and 23 percent (121) male.
- Fifty-two percent (274) were African American, 44 percent (236) Caucasian, and 4 percent (21) other races.
- Fifty-five percent (290) were widow(er)s; 27 percent (145) were single, divorced or separated; and only 18 percent (96) were married.
- The average age of OPTIONS clients was 78 with the youngest at 60 years and the oldest at 100 years. Thirty-seven percent (194) were between 60 and 74 years, 40 percent (214) between 75 and 84 years, and 23 percent (123) 85 years and over.
- Sixty-five percent (347) lived alone; 20 percent (106) lived with a relative; 14 percent (75) lived with a spouse; and 1 percent (3) lived with an unrelated person.
- Forty-seven percent (248) had no caregiver; 20 percent (106) had an adult child as the caregiver; 13 percent (68) had another family member; 6 percent (34) had a spouse; 3 percent (17) had an unrelated person; and 11 percent (58) had no response to this characteristic (Stoiber and Sunmonu, 2003).

Over half of OPTIONS 227 terminated clients left the program either because they transferred to PASSPORT (21 percent), passed away (18 percent), or failed to cooperate (17 percent). The remaining clients were terminated from the program for the following reasons.

- Moved to nursing home – 15 percent;
- Transferred to another community program – 6 percent;

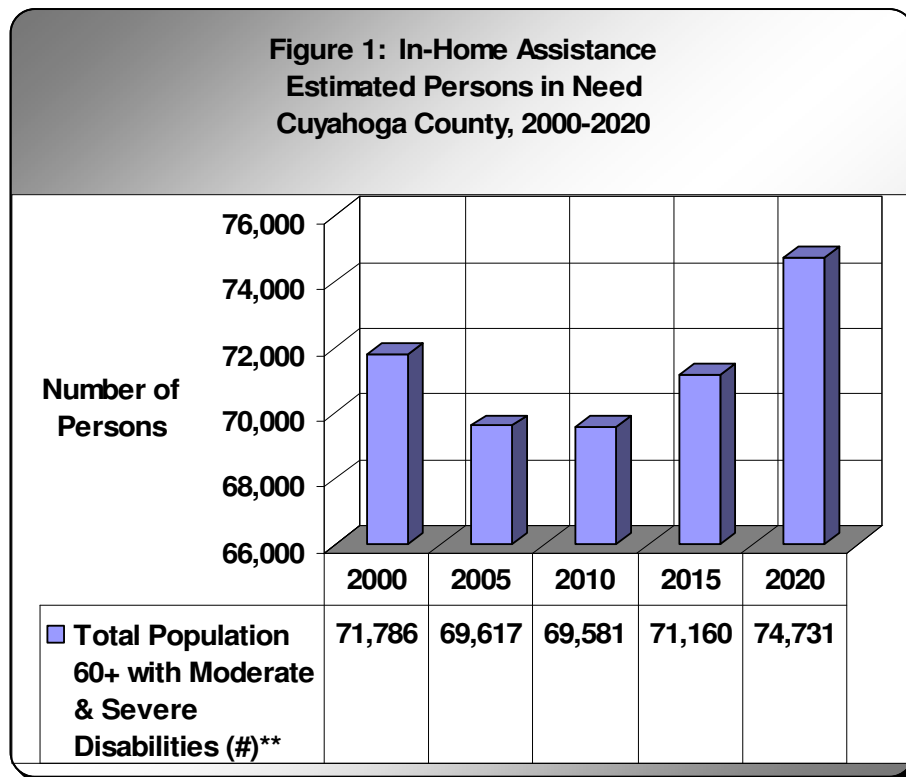
- Increased community support – 6 percent;
- Moved out of the County – 6 percent;
- Stabilized ADLs/IADLs – 4 percent;
- Moved to assisted living facility – 4 percent; and
- Over income – 3 percent (Stoiber and Sunmonu, 2003).

According to participants in focus groups conducted for United Way (2005), clients' needs will be more complex due to co-morbidity, longer life spans due to availability of medications, and a range of other needs to remain independent, such as “*maintaining their homes, putting food on the table, having someone come in to clean their home.*” Affordability of this package of services will continue to be an issue.

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.

Estimated Persons in Need

In 2000 there were 71,786 persons 60 years and older with severe or moderate disabilities in Cuyahoga County. This number is projected to decrease through 2010 and then begin to increase as the baby boomers come of age. By 2020, it is projected that 74,731 persons 60+ will have a severe or moderate disability. (See Figure 1.)



Source:

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

This estimate begins to provide clarity about the potential need for in-home assistance.

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 35 persons for in-home assistance. (See Attachment 3.) Other funders included the Western Reserve Area Agency on Aging (Older American's Act), 752; PASSPORT, 5,827¹; Cuyahoga County Department of Senior and Adult Services (DSAS), 92; Cleveland Community Development Block Grant (CDBG), 304; OPTIONS for Elders, 414²; and Cleveland Heights CDBG, 32.

Per the 2000 U.S. Census, 40 percent of the county's total 60+ population was male and 60 percent female, while United Way funded providers served 91 percent females and 9 percent males, WRAAA was 20 percent male/80 percent female; PASSPORT was 21 percent male/79 percent female; and DSAS (OPTIONS) was 27 percent male and 73 percent female. The other funder data was unavailable. 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.

¹ Note that PASSPORT covers multiple core services. Client totals for each service follow (numbers may be duplicated across core services): Adult Day Care - 640; Daily Living Aids - 7,144; Home Delivered Meals - 1,356; Home Improvement/Accessibility - 42; In-home Assistance (includes personal care, chore, homemaker, fumigation/pest control, etc.) - 5,827; Senior Ride - 1,849; Disaster Services - 180; General Counseling - 119; Emergency Response Service - 180; and Escort Service - 7.

² Note that like the PASSPORT program, this number for OPTIONS covers multiple core services. However, the number reported is all OPTIONS consumers not just those receiving services provided in the home: personal care and homemaker.

According to the 2000 U.S. Census, 77 percent of the county's 60+ population were Caucasian, 21 percent African American, and 1 percent Asian. United Way funded 91 percent white, 9 percent African American, and 0 percent Asian. WRAAA funded 75 percent white, 19 percent African American, and less than 1 percent Asian. PASSPORT funded 51 percent white, 45 percent African American, and 0% Asian. DSAS funded 45 percent white, 52 percent African American, and 0% Asian.

One percent of the county's 60+ population was Hispanic. Hispanics served ranged from 3 percent to 0.4 percent.

Household income was unreported for all funders.

Geographically, 100 percent of consumers funded by United Way were in Cleveland, specifically in two zip codes: 44109 (Cleveland/Brooklyn Heights) and 44102 (Cleveland/Brooklyn). WRAAA consumers were 17 percent in Cleveland and 53 percent in suburbs; PASSPORT consumers were 36 percent Cleveland and 64 percent suburbs. Countywide, 24 percent of 60+ cohort resides in Cleveland and 76 percent in the suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

For this core service report, in-home assistance services are either ancillary custodial service provided with skilled care along with home health care, or a package of services that is part of the community-based long-term care system. It is distinguished from home health care, which is short-term medical skilled care for persons of all ages provided in a person's home.

BACKGROUND ON CORE SERVICE

Home care, which includes in-home assistance, is usually categorized as formal or informal based on who delivers the care and how payment is provided (Litwack, 1985 in Porter et. al., 2004). An IADL (instrumental activities of daily living) scale is used to assess the areas of need for the older person. Capacity to execute the function is evaluated according to the range of an individual's ability to handle activities entirely themselves, or not at all and needing help. The eight sections within the Lawton/Brody IADL Scale are: ability to use telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances (Lawton et. al., 1969). Another approach is the measurement of activities of daily living such as walking dressing, bathing, taking medicine, eating, getting in and out of bed, and toileting (Riemer and Glanz, 2003).

In-home assistance services allow older persons with limitations in IADL's or ADL's (activities of daily living) to recuperate from illness and live independently in their home. Service providers aid the healing process and help prevent discomforts such as going hungry, losing weight, dehydration, and injuries due to falls and burns.

Personal assistance services refer to assistance as "tasks ... that individuals would normally do for themselves if they did not have a disability" (Litvak, Zukas, & Heumann, 1987). More specifically, they consist of help with:

- Personal care/activities of daily living, including bathing, dressing, eating, mobility, toileting, and transfer
- Instrumental activities of daily living, including meal preparation, menu planning, laundry, housekeeping, shopping, money management, and transportation
- Communication, such as reader services for the blind and interpreter services for the deaf
- Paramedical services, including, but not limited to, medication administration, catheterization, injections, and ventilator care (Scala & Mayberry, 1997).

In-home assistance might also involve home modifications, assistive devices and technologies, case management, and other services (Doty, Kasper, & Litvak, 1996). The persons who provide this assistance may be called personal assistants, attendants, aides, home care workers, or consumer-directed care attendants (Scala & Mayberry, 1997).

Research has consistently indicated that informal caregivers provide about 80 percent of the long-term care of older adults (Young, 2003). When informal caregivers were asked about their activities, in addition to the hands-on tasks of daily living as described above, they also noted

psychological support (Mehdizadeh & Applebaum, 2005). Almost one-half of all primary caregivers identified emotional support as one of their caregiving activities. Activities such as transportation and shopping (36 percent); meal preparation, housekeeping, yard work (25 percent); and personal care and supervision (20 percent) were also key caregiver tasks. Assistance with tasks such as money management (27 percent) and medication management (9 percent) complete the list.

As was discussed in the previous section, there are two major government supported programs that are the primary formal caregiving services for homebound older adults in Cuyahoga County: PASSPORT and Cuyahoga OPTIONS for Elders.

Since 1984, PASSPORT, Ohio's Medicaid waiver program, has provided in-home services to older Ohioans with disabilities. It was first operated as a demonstration project but became a statewide program in 1990. The program is administered by the Ohio Department of Aging (ODA) serving persons age 60 and older. In 2005, it had an active caseload of 24,300 older persons, compared to about 30,000 older people in 2004. A second waiver administered by ODA provides consumer-directed services to PASSPORT clients on a demonstration basis (Mehdizadeh & Applebaum, 2005).

Program operations for PASSPORT are divided between the Ohio Department of Aging (ODA) and the regional area agencies on aging (AAA). ODA is responsible for program planning and waiver development, budgeting and contracting, quality assurance, information system development and information processing and, in conjunction with ODJFS and the state Medicaid agency, financial monitoring. The regional area agencies on aging (and one private nonprofit agency) are responsible for all of the client level program implementation functions, service provider recruitment and contracting, and quality assurance. The federal government, through the Centers for Medicare and Medicaid Services, has responsibility for waiver approval and monitoring, which includes both financial and quality of care auditing (Mehdizadeh & Applebaum, 2005).

Cuyahoga OPTIONS for Elders is a flexible, affordable program that provides in-home care to older Cuyahoga County residents who, because of income and/or assets, are not eligible for PASSPORT or other Medicaid waiver programs. It is for Cuyahoga County residents who are 60+ years of age and live in a private home or apartment (excluding assisted living residences, adult care homes, nursing homes, and group homes). The services provided include:

- Medical Transportation;
- Emergency Response System;
- Adult day services;
- Personal care;
- Homemaker services;
- Home delivered meals;
- Information and assistance; and
- Case management by skilled social workers.

Consumer-Directed Community-Based Long Term Care

One of the major philosophical trends in community-based long-term care is consumer direction. Consumer direction is being tested in Ohio and several other states and is an innovative service delivery model that is actually a continuum of approaches ranging from professionally managed

services to client-managed and purchased services (Stone, 2000 in Tilly, Wiener, & Cuellar, 2000).

Typically, consumer-directed care programs allow the consumer to hire, train, supervise, and fire the home care worker. In some programs, beneficiaries receive cash payments enabling them to purchase the services they want. (Tilly, Wiener, & Cuellar, 2000)

A key issue in the design of home and community services programs is the extent to which clients control their services. Consumer involvement in managing publicly funded Medicaid and state-funded programs currently ranges from very little to virtually complete control over services. In their programs, states use two broad models of consumer control—agency-directed and consumer-directed services. Advocates for younger adults with disabilities insist that consumers be able to direct individual workers rather than having to rely on home care agencies for services. Among advocates for older people, however, there is some controversy about whether that population should control their home and community services in this way. (Tilly & Wiener, 2001)

The agency-directed model represents one end of the continuum where consumers have relatively little direct control. Under this approach, states contract with home care agencies that are responsible for hiring and firing home care workers, directing services, monitoring quality of care, disciplining workers if necessary, and paying workers and applicable payroll taxes. The agency-directed model operates from the assumption that professional expertise matters a good deal more than the opinions of consumers. At its extreme, a “medical model” is imposed and individuals with disabilities are considered to be “sick,” as opposed to simply needing compensatory services (Parsons 1951 in Tilly & Wiener, 2001). In the agency-directed model, beneficiaries can express preferences for services or workers but have no formal controls over them. (Tilly & Wiener, 2001)

The consumer-directed model, offered by some Medicaid and state-funded programs, represents the other end of the management continuum. In this approach, beneficiaries are responsible for decisions about their services, including recruiting, training, hiring, directing, and firing their workers. (NCOA 1996 in Tilly & Wiener, 2001)

There are several types of consumer-directed programs (Mahoney & Simon-Rusinowitz 1997 in Tilly & Wiener, 2001). In most programs, consumers take on all worker management tasks with the exception of paying the worker. Alternatively, some state-funded consumer-directed programs provide cash payments to beneficiaries, who then shop for services that fit their needs and budgets and pay for them. Medicaid-funded programs, however, must abide by the federal rule that prohibits Medicaid beneficiaries from receiving their benefits in cash. (Flanagan & Green 1997 in Tilly & Wiener, 2001)

Recognizing that different consumers may have different needs, abilities, and preferences regarding their involvement in service management, there is a range of consumer-directed models that vary in the level at which consumers participate in directing their services. The models listed below represent a continuum of models from most to least consumer control:

- *Direct pay/cash and counseling*—This term is used to describe a home services program in which the client manages both funds and services. Clients are the employer of record and handle all responsibilities associated with attendant, including: recruiting, interviewing, screening, hiring/firing, scheduling, training, monitoring quality, payroll, and paperwork. Assistance and support from case managers is available to clients. Clients may receive an actual check or vouchers to use to pay for services.
- *Fiscal intermediary*—In this model an intermediary agency (either the state/program or another agency designated by the state) handles payroll, taxes, and paperwork for clients. However, clients still manage their services, including: recruiting, interviewing, screening, hiring, scheduling, training attendants, monitoring quality, and firing attendants (if necessary).
- *Supportive intermediary*—In this model the consumer remains the employer of record. However, the program/agency may offer supportive services to consumers and assistants on a limited basis. These services may include: recruitment assistance, criminal background checks on assistants, training, case management, and more. (Scala & Mayberry, 1997)

Advocacy for consumer direction in the United States began during the 1970s with the Independent Living Movement and continues today. Younger adults with disabilities demand the right to receive and manage their own services in home and community settings to become part of mainstream society. The movement rejects societal perceptions that persons with disabilities are vulnerable and need protection (Cohen 1988; Simon-Rusinowitz & Hofland 1993; Wiener & Sullivan 1995 in Tilly & Wiener, 2001). The Independent Living Movement contends that people with disabilities have the ability and the right to make the decisions about the services that affect their lives. Despite the origins of the movement among younger adults, advocates for younger people have long argued that the need to maintain independence and control applies to older people as well. (Litvak 1987 in Tilly & Wiener, 2001)

Several key observers of the long-term care system for older persons have identified barriers to adoption of the Independent Living Movement's ideology among advocates for older persons and professionals. Cohen (1990 in Tilly & Wiener, 2001) writes of an "elderly mystique" that dominates the thinking of older persons and their advocates, which assumes that the potential for growth, development, and involvement in

the community disappears with the development of serious disabilities. In essence, there is a presumption that older people with disabilities are too sick, too frail, too disabled, and too often cognitively impaired to take on the tasks of directing their own care (Kane 1999 in Tilly & Wiener, 2001). Moreover, given the fragmentation of the financing and delivery system, the assumption is that professional expertise is needed to navigate the system. A final supposition is that traditional agency services are necessary to provide aged beneficiaries with reliable access to good-quality care from trained workers. For older people, the agency model is intended to compensate for the perceived lack of capacity on the part of people who need services and to ensure safety. (Tilly & Wiener, 2001)

Although there are barriers to adoption of the Independent Living Movement's precepts by the aging community, there is growing interest in applying the concepts of consumer direction to the older population. A growing number of states are incorporating consumer direction into their home care programs for older people, as are a number of other countries, including France, the Netherlands, the United Kingdom, Austria, and Germany (Tilly, Wiener, & Cuellar 2000; Cuellar & Wiener 2000; Tilly & Bectel 1999). In addition, as part of its health reform proposal in 1993, the Clinton administration would have required that all states offer people with disabilities the option of consumer-directed services. The U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation are sponsoring 'cash and counseling' demonstrations in Florida, Arkansas, and New Jersey, where Medicaid personal care beneficiaries of all ages are being given the opportunity to receive cash rather than service benefits. Moreover, some groups representing older people, most notably the National Council on the Aging, strongly advocate that consumer-direction principles be built into home and community services programs. Thus, a key policy question is whether programs serving older persons should provide them the opportunity to manage home and community services and, if so, under what conditions. (Tilly & Wiener, 2001)

A Tilly and Wiener (2001) study of consumer-directed programs in eight states found that:

Many older beneficiaries want to and can manage their services, although significant issues arise about the ability of persons with cognitive impairment to manage. Research results also point to better quality of life for beneficiaries when they direct their services, although quality of services remains a contentious issue. For workers, consumer-directed care has some disadvantages, including fewer fringe benefits. With exceptions, state agencies have not provided extensive consumer or worker support or aggressively regulated quality of care.

Ohio's "Independent Choices" initiative is evaluating the cost, quality, and effectiveness of consumer directed options (ODJFS, 2002a in Scripps Gerontology Center, 2003). The program is based on the philosophy of consumer-direction, which assumes that individuals who receive home care services have the most knowledge about how their needs should be met. Consumers have the ability to tailor services to meet their preferences by hiring, training, and

managing their own services. For instance, consumers might need a worker with a flexible schedule who could come for a short time, multiple times a day. In addition, consumers can choose to hire workers with whom they feel most comfortable—including family members. Daughters, sons, and friends can be hired as paid workers. Finally, consumers train their workers in the way they feel most comfortable, and/or they can hire informal caregivers who have already provided the kind of assistance the consumers need and want (Kunkel & Nelson, 2005).

The primary goal of the Choices program is to allow individuals receiving home- and community-based services (HCBS) through PASSPORT to have more voice and control over services. This increased level of control should lead to greater consumer satisfaction and improvement in quality of services for those who choose self-direction (Kunkel & Nelson, 2005).

United Way - First Call for Help Call Data

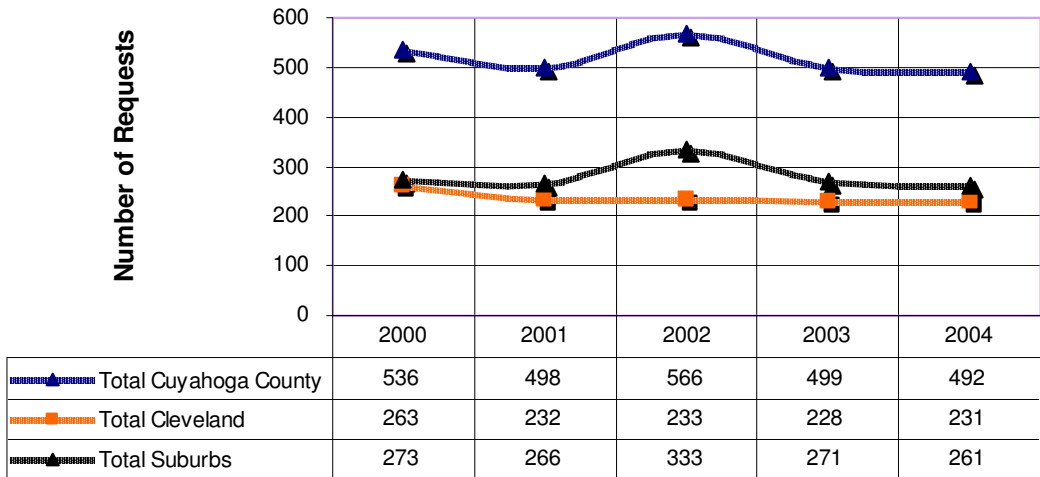
In 2005, there were 61 providers of in-home assistance service located in Cuyahoga County. Thirty-seven were located in the City of Cleveland and 46 were located in the surrounding suburbs. The majority of the sites (61 percent) were located in Cleveland. Twenty-nine were operated by nonprofit providers and 32 by government agencies. One nonprofit agency with two locations in the Cleveland area was funded by United Way. (See Attachments 5 and 6.)

According to FCFH data, those requesting in-home assistance help in the county declined from a high of 26 in 2000 to 22 by 2004, which represented a 15 percent decline. Calls in Cleveland decreased by 9 percent and in the suburbs by 20 percent over the same time period, although the numbers were small and thus inflate the percentages. Zipcodes with the highest number of average calls over the five year period were:

- 44128 (Warrensville Hts/Cleveland) -32 calls;
- 44105 (Cleveland/Newburgh Hts/Garfield Hts) – 30 calls;
- 44108 (Cleveland/Bratenahl) – 28 calls;
- 44120 (Shaker Hts) – 27 calls;
- 44102 (Cleveland/Brooklyn) – 23 calls;
- 44112 (East Cleveland/Cleveland) – 21 calls; and
- 44106 (Cleveland/Cleveland Hts) – 21 calls.

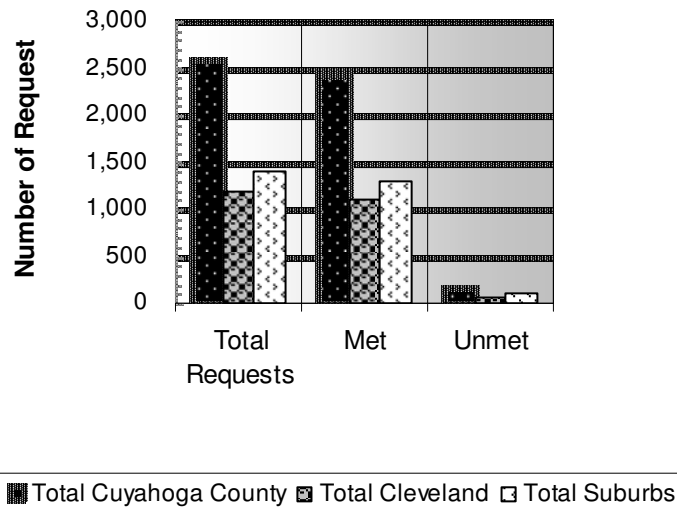
See Figure 2 and Attachment 7.)

**Figure 2: In Home Assistance
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)**



Between the years 2000 and 2004, the vast majority (93 percent) of the requests for in-home assistance were met. Of the 2,591 requests, only 7 percent, or (171) of the consumers' requests were unmet. (See Figure 3 and Attachment 8.)

**Figure 3: In Home Assistance
United Way - First Call for Help Requests 2000-2004
(TOTAL REQUESTS: n=2,591,
TOTAL UNMET NEED: n=171)**



FUNDING OF CORE SERVICES

Long-term care is paid for through many sources which include individuals and their families, federal, state, and local dollars, and insurance (Scripps Gerontology Center, 2003).

“Private pay” refers to payments made by the person receiving long-term care services or their families. Not all long-term care expenses are covered even for people with Medicare or Medicaid. Care recipients and their families often have co-payments for needed services. Some examples are medications and products such as special clothing and special foods that make caregiving easier (Scripps Gerontology Center, 2003).

Nearly one-third of all long-term care costs (not only care for older adults) were paid by private payers (Tilly, Goldenson, & Kasten, 2001). Nearly one quarter (24 percent) of Ohio’s nursing home stays are paid for privately (Annual Survey of Long term Care Facilities, 2000). In per capita terms, the State of Ohio’s public long-term care expenditure for the population age 65 and over was \$1,915, of which \$1,554 came from the Medicaid program. The private per capita contribution to long-term care expenditures for formal and informal services was \$4,685 (Mehdizadeh & Murdoch, 2003).

Major Government Funders

There major sources of government support for in-home assistance services are:

- Community Development Block Grant (CDBG);
- Medicare;
- Medicaid (through waivers); and
- Local Levies.

Below is further explanation of major government funders of in-home assistance.

FEDERAL

Community Development Block Grant (CDBG) – County and City of Cleveland

Community Development Block Grant funds are intended to develop viable urban communities by providing decent housing and a suitable living environment and by expanding economic opportunities, principally for low- and moderate-income persons. The U.S. Department of Housing and Urban Development (HUD) determines the amount of federal funds that cities and counties are entitled to receive each year through a formula based upon population, growth lag, poverty level, age of housing, and overcrowding. CDBG provides federal funding for locally initiated neighborhood improvement projects. In-home assistance services are eligible to be funded with CDBG funds. City of Cleveland CDBG funding has been trending downward from \$31.2 million in FY 2002 to \$24.6 million in FY 2006. Cuyahoga County CDBG funds have increased slightly from \$3.4 million to \$3.6 million.

Medicare

Medicare pays for limited home health care service when an enrollee requires skilled nursing care at home. To qualify for Medicare home health care benefits, a person must be confined to his or her home, need at least one skilled nursing or therapy service, and have a doctor-established plan of care. Skilled services can include IV administration, medication administration, physical, speech, and occupational therapy (Scripps Gerontology Center, 2003). Medicare will pay for 100 percent of home care expenses that are medically necessary but will

not pay for help with ADLs or IADLs when those are the only kinds of services needed. Medicare also pays 80 percent of the Medicare-approved cost of durable medical equipment.

In 1998, 69 percent of Ohioans with Medicare coverage also had Medigap coverage (HIAA, 2002). Only some of the benefits of Medigap policies are related to long-term care. 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).

There are a variety of federally approved Medigap plans. Each includes the basic benefits package and different sets of additional benefits. Low coverage policies include only basic benefits, mid-level policies also include some coverage of skilled nursing co-payments, and high coverage policies also include limited home care benefits (Scripps Gerontology Center, 2003).

Medicaid

Medicaid is the primary funder of both institutional and community-based long-term care, including in-home assistance. Medicaid is a state-administered health benefit for persons with limited incomes and assets. This program uses both state and federal funding. In Ohio, the federal government provides approximately 58 percent of all Medicaid funds for Ohio while the state provides 42 percent (ODA, 2002). The Medicaid program provides both home- and community-based services and facility-based services (Scripps Gerontology Center, 2003). The Medicaid waiver programs such as PASSPORT, as discussed previously, are the primary funders of community-based long-term care programs, i.e., in-home assistance.

“Dual eligibility” means a person is eligible for both Medicare and Medicaid benefits. This person is typically a Medicare beneficiary (Medicare eligible either because of age or disability) who is low income and, therefore, Medicaid eligible. There are different levels of dual eligibility based on the person’s income and assets. In the lowest income category (up to 100 percent of poverty level), the Medicaid program pays for Medicare premiums and deductibles, co-payments, prescription medications, and long-term care expenses as needed (Scripps Gerontology Center, 2003).

LOCAL

Local Levies

Local levies fund a wide variety of elder services, not all of which are classified as long-term care. The way in which the funds are used is up to each community and the purpose(s) can change each time the levy comes up for vote. Levies can be used for building and running local senior centers as well as elderly service programs that provide home care, home-delivered and congregate meals, transportation, and other services (Scripps Gerontology Center, 2003).

These levies are voted on in local elections and must be renewed every 3-5 years. In some counties, levy funds are administered through a local governmental agency or department. In other counties, the area agency on aging or a social service agency controls these funds. As of December 2001, 56 counties in Ohio had senior citizen levies that generated over \$68 million per year (ODA, 2002e in (Scripps Gerontology Center, 2003). Older adult services in Cuyahoga County are paid for from the Health and Human Services levy.

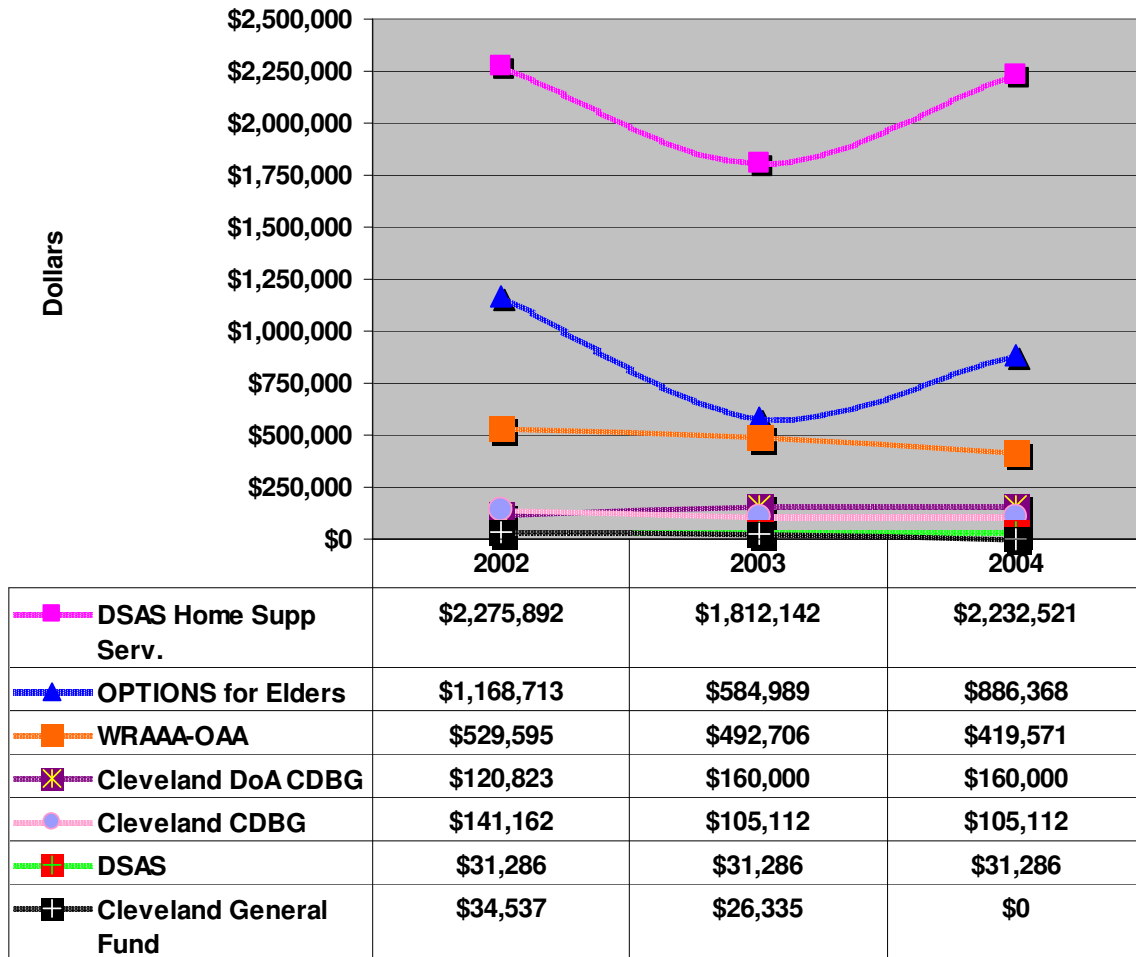
The Cuyahoga County Department of Senior and Adult Services administers the OPTIONS home support program that provides in-home care to older Cuyahoga County residents who,

because of income and/or assets, are not eligible for PASSPORT or other Medicaid waiver programs. Funding for this program comes from the Cuyahoga County Commissioners through the county's health and human services levies. There are currently two Cuyahoga County health and human services (HHS) levies—one at 2.9 mils set to expire in 2011 (as passed in November 2006 as Issue 19), and the other at 4.9 mils set to expire in 2008. The levy provides a flexible source of funds for the county. The amount of money generated through these levies has been increasing: in 2002 \$119.3 million was available, in 2006 \$168.4 million was expected to be available. The replacement levy of November 2006 will generate an additional \$27.3 million annually.

Trends of Identified Government Funders in Cuyahoga County

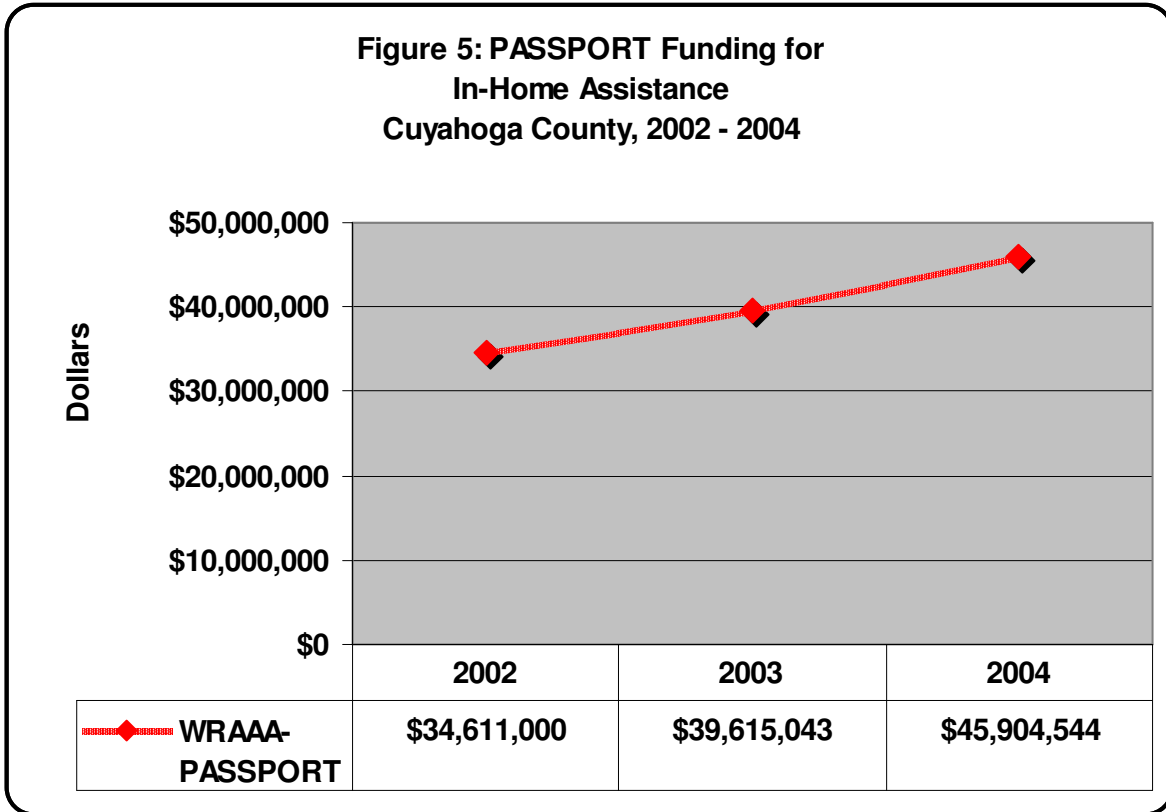
Between 2002 and 2004, each of the government funding sources for in-home assistance had a different funding pattern. The Cuyahoga OPTIONS for Elders Program increased from \$576,109 in 2002 to \$1,969,221 in 2004. The 2006 budget is for \$6.9 million and the estimate by 2008 is for \$7.1 million. This includes the cost of administration, case management, and contracted client services. The Older American's Act funding has decreased from \$529,595 in 2002 to \$419,751 in 2004. While the Cleveland Department of Aging Community Development Block Grant (CDBG) funding increased, the CDBG for the community decreased over the same period. Cleveland's general fund funding remained stable. (See Figure 4.)

Figure 4: Government Funding for In-Home Assistance Cuyahoga County, 2002 - 2004



Source: Respective Funding Sources; Cuyahoga County 2006 Budget for OPTIONS

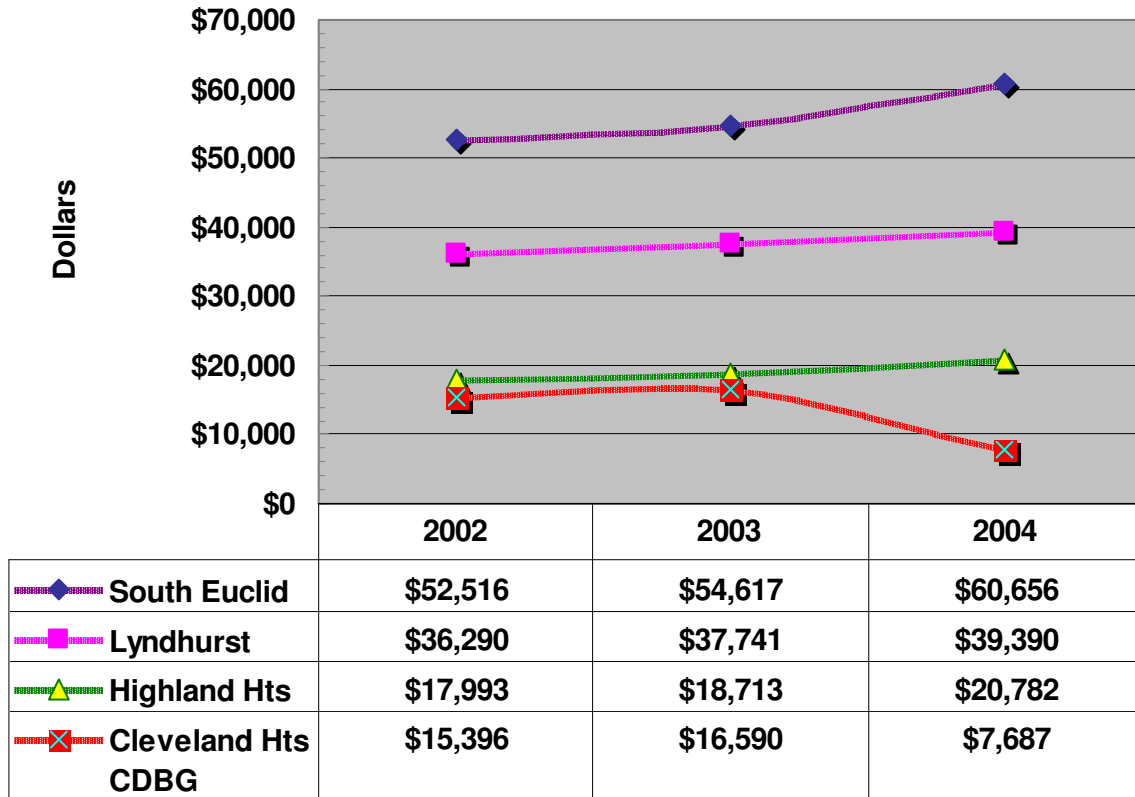
PASSPORT funding for Cuyahoga County increased from \$34.6 million in 2002 to \$45.9 million in 2004. (See Figure 5.)



Source: Western Reserve Area Agency on Aging

With the exception of the City of Cleveland Heights, the other municipalities have increased funding for in-home assistance annually between 2002 and 2004. (See Figure 6.)

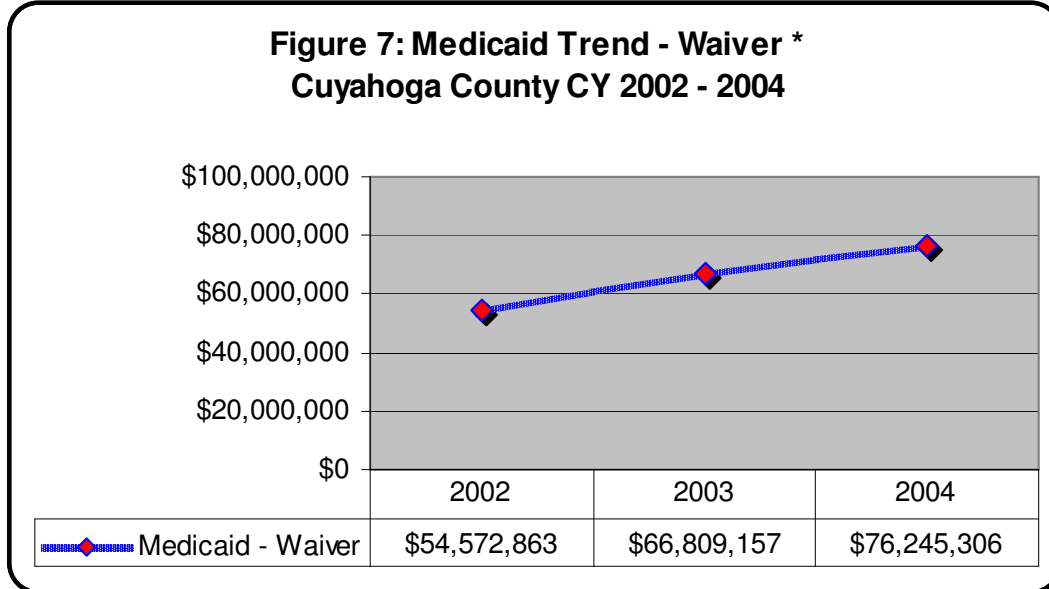
**Figure 6: Municipal Funding for In-Home Assistance
Cuyahoga County, CY 2002-2004**



Source: Respective Funding Sources

Medicaid dollars, excluding PASSPORT, increased from \$54.6 million in 2002 to \$76.2 million in 2004. (See Figure 7.)

Figure 7: Medicaid Trend - Waiver *
Cuyahoga County CY 2002 - 2004



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

Participants in focus groups conducted for United Way (2005) were very concerned about cuts in Medicaid and Medicare. They project increased numbers of clients at the same time the Medicaid and Medicare benefits may shrink. They also anticipate cuts on the 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.” “...as the baby-boomers require services and there will be a greater demand for service, we have had budgetary cuts and there will be a greater demand, so how do we handle that?”*

IDENTIFIED REVENUES

As of May 11, 2006, nearly \$49.9 million in revenues for in-home assistance 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 3.) 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 with the exception of OPTIONS consumer demographics data. The 414 individuals identified received one or more of the following services: Homemaking/Personal Care, Adult Day Care, Home Delivered Meals, and Medical Transportation.

Close to 100 percent of the revenues are from contracts or grants from government organizations and United Way of Greater Cleveland’s funds account for 0.04 percent of the total.

Table 3: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland In-Home Assistance, 2003/2004.

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			0.00%	634	0.63%
O'Neill Foundation, The William J. and Dorothy K.	2003	3,000			
Total - Foundations & Trusts		3,000	0.01%	0	0.00%
United Black Fund of Greater Cleveland	FY2005	9,000			
Total - Federated Fundraising Organizations		9,000	0.02%	0	0.00%
WRAAA-PASSPORT	2004	45,904,544			
Subtotal State of Ohio		45,904,544	92.00%	0	0.00%
Western Reserve Area Agency on Aging (WRAAA)				21,056	
WRAAA-OAA- Alzheimer	CY2004	43,430			
WRAAA-OAA Title III B and Block	CY2004	376,141			
Subtotal Regional Funding Sources		419,571	0.84%	21,056	21.00%
Department of Senior and Adult Services	2004	31,286			
DSAS Home Support Services	2004	2,232,521			
OPTIONS for Elders	2004	886,368			
Subtotal Cuyahoga County Funding Sources		3,150,175	6.31%	0	0.00%
Community Development Block Grant	2004	105,112		18,573	
Community Development Block Grant (Department of Aging)	2004	160,000			
Subtotal City of Cleveland Funding Sources		265,112	0.53%	18,573	18.52%
City of Highland Hts	2004	20,782			
City of Lyndhurst	2004	39,390			
City of South Euclid	2004	60,656			
Cleveland Heights - CDBG	2004	7,687			
Subtotal Other Municipal Funding Sources		128,515	0.26%	0	0.00%
Total - Contracts/grants from government organizations		49,867,917	99.94%	39,629	39.52%
Total - All Other Revenue			0.00%	41,192	41.08%
Subtotal Non - UWGrCle Support		49,879,917	99.96%	81,455	81.23%
Total - UWGrCle investment committee allocation		18,819	0.04%	18,819	18.77%
Subtotal UWGrCle Support - 4001, 4701 & 4703		18,819	0.04%	18,819	18.77%
Total Support/Revenue		49,898,736	100%	100,274	100%

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

REIMBURSEMENT/COST

For PASSPORT, the consumer's plan of care is finalized by the care manager after completing a comprehensive assessment and after a face-to-face meeting with the consumer and his/her family.

The design and cost of the care plan varies widely across PASSPORT consumers, although the average cost of the plan of care for the PASSPORT caseload must be less than 60 percent of the average nursing home cost. However, an individual's care plan could be higher than that amount. Sixty-percent of the Medicaid monthly nursing home cost is \$2,800 per month; PASSPORT care plans average about \$1,050 per month (Mehdizadeh & Applebaum, 2005).

Personal care is the largest expenditure category, accounting for 72 percent of all service costs. Home-delivered meals (11 percent) and adult

day services (6 percent) are the next highest expenditure categories. Homemaking, emergency response systems, and medical equipment and supplies each account for about 3 percent of total service costs. It should be noted that actual program service expenditures are about 20 percent lower than plan of care estimates. The differences occur for a range of reasons that involve both the PASSPORT consumers' circumstances and problems with providers' ability to deliver the ordered services. Ohio's care plan and expenditure patterns are similar to other waiver programs around the nation (Mehdizadeh & Applebaum, 2005).

A detailed review of the care plan costs for PASSPORT consumers indicates that demographics, social supports, and health and functional characteristics all affect the plan's cost. The health and functional status of the consumer have the largest impact on the cost of the plan of care. For example, PASSPORT consumers with extreme disability (5 or 6 ADL impairments) have an average care plan cost of \$1,425 per month, compared to \$900 per month for those with moderate levels of disability (2 or fewer ADL impairments). PASSPORT consumers with a primary diagnosis of diseases of the central nervous system (Alzheimer's and Parkinson's) had care plans that averaged \$1,258 per month and those with mental disorders had care plans that averaged around \$1,300 per month, compared to about \$1065 per month for the overall caseload. PASSPORT consumers in need of 24-hour supervision, a result of high physical or mental disability, averaged \$1,420 per month in care plan costs (Mehdizadeh & Applebaum, 2005).

Demographic and support factors also had an impact on care plan costs. PASSPORT consumers ages 85 and older had higher costs than the younger age groups. Participants who were unmarried recorded higher care plan costs than those who were married, although, gender differences were minimal. PASSPORT consumers without an active caregiver had higher care plan costs (Mehdizadeh & Applebaum, 2005).

In looking at the care plan costs for participants no longer enrolled in PASSPORT, some differences are noted. PASSPORT consumers who left the program due to death or a move to hospice care had higher than average monthly care plan costs (\$1,200 and \$1,360 respectively). Those participants who left the program to enter a nursing home had care plan costs slightly below the overall average, which suggests that cost was not the driving force behind the nursing home admission (Mehdizadeh & Applebaum, 2005).

A number of combined factors ultimately explain the care plan costs for an individual PASSPORT consumer. The data indicates that disability level and health diagnosis are the most critical factors in determining the cost of the plan of care. Select supports, such as the presence of an active caregiver, also affect the amount of services needed to maintain a PASSPORT consumer at home (Mehdizadeh & Applebaum, 2005).

Estate recovery is a federally mandated program to recover the cost of long-term care services received by Medicaid recipients from their estate after their death. All property and assets in the deceased's estate can be subject to recovery. For example, the deceased's home can be sold by the state and the money used to repay a portion of the cost of care. Estate recovery occurs only when the care recipient and the surviving spouse have both died and when there is no surviving child under 21 years of age or a blind or disabled child of any age. Ohio has a conservative estate recovery program in comparison to other states. In Ohio, the ratio of recovered expenditures to total Medicaid expenditures is 0.06 percent; the national average is 0.26 percent (ODHS, 1999 in Scripps Gerontology Center, 2003).

The OPTIONS for Elders program uses a sliding fee scale. The total package of services cannot be more than \$700 per month. Both the sliding fee scale grid and the monthly ceiling are updated as needed (Cuyahoga County Department of Senior and Adult Services, n.d.).

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

Caregiver Supports

In-home assistance is a critical component of the long-term care system of services. The issues of appropriate utilization, capacity, quality, and affordability are challenges faced by the community-based long-term care system and its component parts such as in-home assistance. Though the majority of these services are provided through informal sources, they are available through case management based programs such as PASSPORT and the OPTIONS for Elders Program. Family caregivers are an important aspect to consider with in-home assistance since they provide such a large percentage of support. Stress and burn-out can be minimized with quality care provided by others or in combination with the family caregiver. (Scripps Gerontology Center, 2003).

Efforts to better support caregivers are now underway. Both state and federal programs designed to provide a range of services to caregivers have been enacted. Programs that allow payment directly to caregivers are also being tested nationally and in Ohio. Such programs allow consumers to pay family members, friends, or neighbors to provide services that would normally be delivered by formal agencies. Although these programs are still under study, preliminary concerns about quality or fraud have not been substantiated. Some states are also exploring tax credits or other tax system incentives to assist with the caregiving role. Although the optimum strategies have yet to be designed, the need for the caregiving system to be strong as the baby boom generation reaches old age will be critical. (Scripps Gerontology Center, 2003).

Other countries have addressed the challenges of family caregiving by providing supports in the form of payment, tax credits, and respite services for families (Merlis, 2000). There is evidence that families do not willingly relinquish care to formal systems even when they are available; instead they use these programs to augment their own efforts (Tennstedt et al., 1993). Solutions that improve communication and support between formal systems and families have the potential to influence the quality of life and care for individuals and their caregivers (Young, 2003).

Quality of Home Care

In recent studies of home care quality assurance, consumers have provided information about their perceptions of quality. Consumers have identified a number of factors that contribute to quality home care, including the opportunity to maintain independence, autonomy, and choice; a good consumer/worker relationship; flexibility of care plan and worker tasks; and reliable, honest, and competent workers (Woodruff & Applebaum, 1996; Kane, Kane, Illston, & Eustis, 1994; Eustis, Kane & Fischer, 1993). In a Commonwealth Commission survey of Medicaid

personal care services home care clients, consumers' overall satisfaction with assistants was found to be related to higher levels of control, including knowing the assistant prior to employment, helping to schedule the assistant, and supervising the assistant (Commonwealth Commission, 1993; Doty, Kasper & Litvak, 1996 in Scala & Mayberry, 1997).

Most important is the inclusion of older service recipients themselves in the process of defining quality, and in the design of quality assurance policy (Woodruff & Applebaum, 1996). In a majority of programs surveyed, quality monitoring was considered to be a shared responsibility between the consumer and the home services program (Scala & Mayberry, 1997).

With diminishing resources, it is imperative that subgroups are carefully defined and interventions are appropriately targeted to assure the greatest possible benefit. The solution begins with an appreciation of the diversity of the older population—diversity of health trajectory, functional ability, cultural background, personal preferences, resources, and priorities. With attention to factors that meaningfully group needs and preferences of older adults, those designing programs have a higher likelihood of tailoring efficacious interventions (Young, 2003).

Care Coordination

A new model that aims to address the care coordination issue is a social health management organization (SHMO). This is a social HMO that provides the same Medicare benefits as a standard HMO with additional services such as care coordination, prescription drug benefits, short-term nursing home stays, and a full range of community- and home-based services. Some SHMOs also provide vision, hearing, and dental benefits. This program began in the 1980s to test the feasibility of integrating acute care and long-term care services (CDHS, 2001 in Scripps Gerontology Center, 2003).

A number of coordination models have evolved to deliver in-home assistance services in settings with critical masses of older people:

- A fragmented or “patchwork” approach describes the common situation in which consumers, families, neighbors, housing managers, and local agencies piece together services as best they can.
- Service clustering (or cluster care), usually involves supportive services, appears to improve efficiency and flexibility and keep costs low in delivering services to older people living in senior housing or naturally occurring retirement communities (NORC's) (Balinsky & LaPolla, 1997; Feldman et al., 1996, in Lansprey, 1998).
- Typically, home care workers are assigned for a predetermined number of hours (often with two-, or even four-hour minimums) to individual consumers, without considering geography or setting. Services clustered in senior housing or NORCs decrease the minimums and increase flexibility. For example, one worker may help four people get up and dressed for 30 minutes each; then do laundry for three people at once; then shop for two people at the same time. NORCs are buildings or neighborhoods in which a disproportionate number of residents are age 60 or over.
- On-site service coordination, usually carried out by a property management company or social service agency staff, serves all residents rather than providing case management for the few who are most frail. The coordinator helps residents learn about and obtain existing services, organize new services, and arrange building events (Lansprey, 1998). (Scripps Gerontology Center, 2003).

What Doesn't Work

Management Practices

Private-pay agencies consistently report a lower proportion of pre-employment activities such as criminal background checks, finger printing, physical exams, drug screens, and skills testing. The private-pay agencies are also less likely to have in-service training for staff. Four of five report the use of client satisfaction surveys and about two-thirds make either random calls or home visits to check on the quality of services. The private-pay agencies are consistently less likely to have monitoring activities compared to the affiliated or government agencies. For example, about three-quarters of the affiliated and government agencies reported making random home visits, compared to one-quarter of the private-pay agencies. The private-pay group was also less likely to have liability insurance protection for staff members (Straker & Applebaum, 1999).

Evaluation of Outcomes

Evaluation of community-based programs is complicated by the multiple trajectories of service recipients and the array of potential outcome measures. An early motivation in distributing funds away from nursing homes was to encourage transfer of inappropriately placed residents to lighter and less costly levels of care. While there has been progress in achieving discharge of these inappropriately placed residents (Swan & Newcomer, 2000), the cost savings anticipated by shifting Medicaid dollars has not consistently materialized (Merlis, 2000; Waters et al., 2001 in Young, 2003).

Systematic reviews and meta-analyses of research on the efficacy of community-based programs have identified positive outcomes in consumer and family satisfaction with services, but have not substantiated global improvements in health or functional status for participants, nor cost savings for care (Weissert & Hedrick, 1994; Zarit, Gaugler, & Jarrott, 1999). These reviews raise issues regarding appropriate outcome measures. What outcome is expected for individuals who are already on a declining functional and health trajectory? What is the value of services that improve quality of life for caregivers even when care recipients do not improve in function? Finally, the reviews highlight the importance of setting appropriate goals for the different subgroups that would receive targeted interventions (Young, 2003).

Continuity of Care

Medicare is the main financing mechanism for medical services in the last phase of life (Last Acts, 2002). Medicare covers 83 percent of all who die in the United States. However, federal payments are not designed to promote continuity of care over the long-term. Federal payments do not cover supportive home health care, prescription medication, symptom control, family and caregiver support, or even professional services meant to reduce the rate of decline in patient function. Medicaid does cover

nursing home care for those who are utterly impoverished and quite disabled.

Under the usual fee-for-service program, doctors, hospitals, and other service providers are paid for each billed service, although hospitalization services are mostly packaged and paid with one fee for the entire hospitalization. This arrangement encourages billable services, but not continuity of care. No coverage is ordinarily available for caregiver training, classroom education of patients, on-call advice, bereavement support, or spiritual counseling, so they are ordinarily unavailable as well. 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 (Lynn & Adamson, 2003).

Fragmentation of the Home Health Care System

Fragmentation of the home health care system has major issues that suggest the system does not always work as effectively as it should:

- The lack of a comprehensive system of care results in countless examples of inadequate, duplicative and costly care for older Americans who experience a chronic disability. Limited access, coupled with a fragmented delivery system and high cost of care, characterizes the current approach (Applebaum, Straker, Mehdizadeh, Warshaw & Gothelf, 2002).
- Home care recipients often require a combination of personal care, home health, and acute care services with no mechanisms to coordinate care from these distinct settings (Applebaum, 1997 in Applebaum et al., 2002).
- Case managers consistently report poor communication across providers of acute and long-term care services (Applebaum et al., 2002).
- Hospitals change alliances or affiliations, thus affecting their management information systems. Small demonstration efforts are typically displaced by needs for overall information system modification. Because there is little or no financial or regulatory support for this effort, even a well thought of idea became a lower priority for organizations with serious competing demands for their time and resources (Applebaum et al., 2002).
- Consumer advocates often voice the concern that the structure of the Medicaid program is exactly backwards—instead of community services being “optional” or “waiver” services, these should be the norm and a “waiver” should be needed for institutional care.
- A repeated concern with efforts to transition residents of institutions to community settings is “how will the cost of housing, including security deposits, be paid?”
- Fragmentation in funding and policy exists between various different federal programs. There are a number of different programs and funding sources used to

- provide services to persons with disabilities, including Medicare, Medicaid, Supplemental Security Income, food stamps, Social Services Block Grant, the Ryan White Care Act, Maternal and Child Health Block Grant, and the Older Americans Act.
- The Medicare program contains incentives that lead to the sometimes unnecessary institutionalization of beneficiaries with the expectation that Medicaid funding for institutional placement will be available once Medicare coverage has been exhausted (a period of no greater than 100 days) (Johnson et al., 2001).
 - Fragmentation of programs also has created problems for states by creating a framework that allows costs for health-related services to be shifted to state Medicaid programs. There is little, if any, recognition that state-funded services such as prescription drug benefits, respite care, and other services actually save money for the federal Medicare program. This has led state governors to issue a call for budget neutrality across federal programs as opposed to a strategy that too often pits one program's objectives against another's (Johnson et al., 2001).
 - Freedom of Choice requires states to contract with any provider that is willing to become a Medicaid provider. This federal requirement prohibits states from using market-driven concepts such as competitive bidding and direct negotiation to control service costs and ensure consumer access to higher quality services (Johnson et al., 2001).
 - Yet another example are the federal requirements of "comparability of benefits" and "state-wideness" that inhibit the flexibility of states to customize a package of optional benefits tailored to meet the needs of specific consumer groups and to experiment with new programs (Johnson et al., 2001).
 - Policies inherent in other federal programs impede progress toward community integration. Federal programs such as Housing and Urban Development (HUD), Medicare, and Rehabilitation Services have historically provided essential support to persons with disabilities, and in each of these programs there are either operative policies or an erosion of focus on disability issues which work against disabled consumers in community settings. For example, Medicare only pays fifty cents on the dollar for psychiatric services provided in community settings (Johnson et al., 2001).
 - This causes a potential range of issues regarding the use of local dollars as match for Medicaid, and local board control of program delivery. Complicating factors include the differing fiscal capacities and program priorities that each local board introduces into a state wide Medicaid program.
 - Furthermore, failure of local levies or changes in board priorities could create serious equity issues that could be solved with additional state funding or by reducing the number of waiver slots to fit the funding available (Johnson et al., 2001).
 - Fragmentation of care, and serious gaps in [medical] coverage are the most obvious resulting shortcomings. When someone needs assistance to function—such as help in eating, getting out of bed, using the toilet, taking a bath, managing medications, or

getting to appointments with health care providers—these gaps are most poignantly apparent (The Institute for Research on Women and Gender, 2002).

Ageism

Ageism is often a factor underlying the lack of choice and control in programs that serve disabled older adults. Older disabled people are stereotyped as confused, fragile, passive recipients in need of help, and therefore in need of protection. Unfortunately, some older persons begin to exhibit these characteristics whether they exist or not, leaving them stressed and isolated. When older persons are treated and related to as functional adults, the result is usually improved cognitive abilities and functionality.

IMPACT ON COMMUNITY

The economic values assigned to institutional care and formal community-based care were computed from reports submitted by the organizations providing services for the Ohio Department of Health, the Ohio Department Job and Family Services, and the Ohio Department of Aging. To estimate the value of informal services, we multiplied the number of people estimated to be receiving such services by average weekly service hours and hourly pay rates obtained from several large national surveys of community-based care. We also considered including the estimated value of current and future income loss by caregivers because some caregivers had to reduce employment. The total economic value of long-term care to older people in Ohio was almost \$10 billion. When this total was broken down by type of care, the value of institutional care was about \$3.8 billion, the value of community-based formal services was \$1.1 billion, and the value of care provided by family, friends, and neighbors was nearly \$4.9 billion (Mehdizadeh & Murdoch, 2003).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

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 (Straker & Applebaum, 1999).

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 review a sample of ongoing and closed client cases for adherence to clinical practice standards (42 CFR 484).

At the state level, the Community Health Care Facilities and Services Board of the Ohio Department of Health is responsible for assuring compliance with Medicare certification

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

Need for Change in Regulatory Approaches

Despite these and other efforts, experts in the field have called for a revamping of regulatory approaches in long-term care. Critics suggest that consumer outcomes have been secondary to structural factors such as training requirements, facility structural reviews, and paper work compliance. There is considerable agreement that the regulatory system can be improved (Scripps Gerontology Center, 2003).

The National Institute on Consumer-Directed Long-Term Services (n.d.) offers this definition for “consumer direction:”

Consumer direction is a philosophy and orientation to the delivery of home and community-based services whereby informed consumers make choices about the services they receive. They can assess their own needs, determine how and by whom these needs should be met, and monitor the quality of services they received.

Consumer direction may exist in differing degrees and may span many types of services. It ranges from an individual independently making all decisions and managing services directly, to an individual using a representative to manage needed services. The unifying force in the range of consumer directed and consumer choice models is that individuals have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services. (Scripps Gerontology Center, 2003).

The following are some guidelines for consumer direction from this definition and other sources:

- Consumers are the experts on their service needs.
- Consumers participate in all of their home- and community-based services including their design, development, operation, and evaluation.
- Different types of services need different levels of providers. With more complex services, consumers may want professional expertise to get the services they need. Consumers participate in assessing needs, decides which service is best and also decides how to get services and if the services are right for them.
- Consumer direction means that there are different service types, different providers, and delivery methods to choose from. Information about these services needs to be accessible.
- Consumers have the right to choose, manage, and fire their workers. Managing a worker means that consumers decide what, when and how things are done. Consumers decide how much control to have over services. Consumers can select, manage, or dismiss workers with assistance. Consumers have the right to make final decisions. If they want to, consumers can participate in an agency-based program.
- Consumers can decide to have a family member (or someone else they choose) make decisions for them. If it is the consumer’s choice, this can be consumer directed. (Scripps Gerontology Center, 2003).

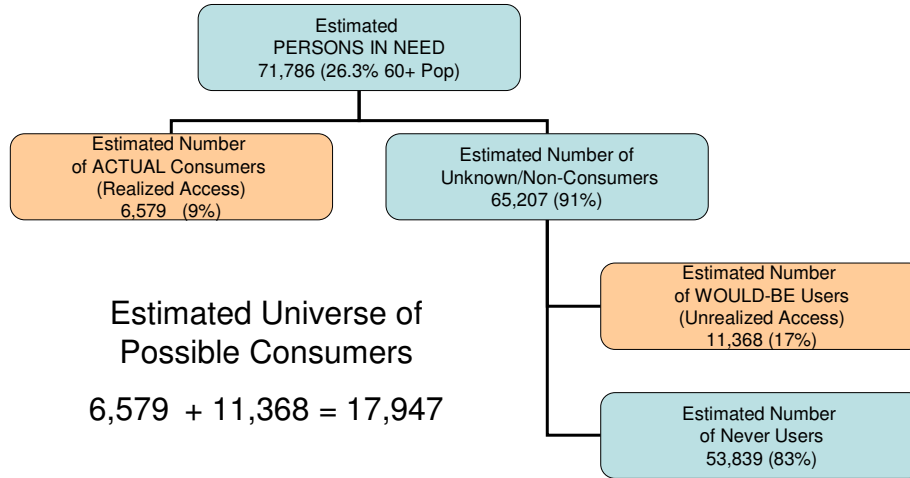
VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for In-Home Assistance:

- An estimated 71,786 persons need in-home assistance, which is the number of moderately and severely disabled persons 60+ in Cuyahoga County in 2000.
- In FY 2004, 6,579 persons had realized access to in-home assistance in Cuyahoga County. This includes consumers funded by PASSPORT (5,827), and Older American's Act (752). There was no available consumer data for OPTIONS consumers who received homemaker or personal care services although 414 consumers were served in 2004. This also assumes duplication with municipalities that provided support for in home assistance.
- Typically most research indicates that only 20 percent of persons needing long-term care are cared for in the formal caregiving system (Young, 2003). However, as was noted previously, because of persistent downturns in Northeast Ohio's economics, informal care may be lower in the future. Therefore, it is concluded that between 70 and 80 percent will receive informal care from family, friends, and the community, or 20 to 30 percent will need formal care (Mehdizadeh et al., n.d.).
- By multiplying the estimated persons in need by 25 percent (the mid-point between 20 and 30 percent) the estimated universe of possible consumers is 17,947. (71,786 x 25%)
- The would-be users (unrealized access), i.e., those who would use the service if they knew about it, it were accessible and affordable, are estimated at 11,368. (17,947 – 6,579)
- In summary, the estimated universe of possible consumers is 17,947 included realized (6,579) and unrealized (11,368) access.

(See Figure 8.)

Figure 8 - Consumer Estimates: In-Home Assistance



Service Site Index

Another way of viewing service need is through the Service Site Index, which measures the ratio of possible consumers per service site.

Countywide, according to First Call for Help (February 2005), there are 83 service sites for in-home assistance programs. This is a ratio of 216 possible consumers (an estimated 17,947 total) per service site countywide. Service providers report to First Call for Help which zip codes are included in their respective service areas. The Service Site Index in Attachment 9 lists the number of sites located in each zip code, and the number of service sites that report servicing a particular zip code. Dividing the estimated number of possible consumers in each zip code by the number of service sites that could serve that zip code provides a ratio of consumers to service sites for each zip code. This is a measure of potential service accessibility by possible universe of service consumers per zip code area. Note that this measure does not include the capacity of providers to offer the service, for example, the number of homebound clients that can be served on a daily basis. It is only capturing whether there is a possibility of being a client. The lower the ratio, the greater is the chance of being a client.

The ratios on the Service Site Index range from a high of 21:1 in zip code 44130 (Parma/Cleveland) to a low of 1:1 in zip codes 44114 (Cleveland), 44115 (Cleveland), and 44040 (Gates Mills/Mayfield Village). In addition to 44130, two other zip codes have ratios greater than or equal to 15 consumers per service site that could serve that zip code:

- 44124 (Pepper Pike/Mayfield Hts/Lyndhurst) – 19:1; and
- 44134 (Parma/Cleveland) – 16:1.

(See map in Attachment 10.)

Service Capacity

Gaps in Services Provided

Thirty-two percent of respondents to a survey (n=827) conducted by the City of Cleveland Department of Aging (2003) indicated that they *currently needed, but did NOT receive* in-home services. The same survey found the following limitations in respondents having “difficulty doing activities of daily living on their own”:

- Doing housework & laundry (35 percent);
- Shopping (29 percent);
- Using public transportation (28 percent);
- Driving a car (23 percent);
- Getting around by yourself (21 percent);
- Preparing meals (21 percent);
- Completing medical forms (16 percent);
- Bathing (15 percent);
- Getting in/out of bed (13 percent);
- Taking medication properly (12 percent);
- Using telephone (11 percent);
- Dressing (11 percent);
- Handling your money to pay bills (11 percent);
- Grooming (combing hair, shaving) (10 percent);
- Eating (8 percent); and
- Toileting (7 percent).

A significant issue, in terms of potential negative consequence, is the unmet need for in-home assistance services. Though the number of older adults with unmet need is not overwhelming, the adverse consequences can be serious and include discomfort, going hungry, losing weight, dehydration, injuries due to falls and burns (LaPlante, Kaye, Stephen, Kang & Harrington, 2000). The issue of unmet need and potential negative impact is further aggravated for those who live alone. Another area of concern relates to the heavy burden placed on family and friends to provide these supports. Respite must be available to avoid negative consequences for the caregivers that try to provide this support within already stressful and busy lives.

Gaps in Populations Served

To the extent that social policies are based on the hypothetical “average” person, they often fail to serve the variable needs of a country characterized by diversity (The Institute for Research on Women and Gender, 2002). Participants in focus groups conducted for United Way (2005) stated:

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 that have 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.

Focus group participants noted that there are a lot of providers who provide 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.

Within the Asian and Hispanic communities, it is difficult to reach individuals because of their close family ties and language barriers. Some key informants felt that the insufficient supply of services to the Asian and Hispanic communities was due to the lack of funds and volunteers, specifically those who are bilingual.

Gaps in Geographical Areas Served

Areas that do not have a sufficient supply of services according to focus group participants (2005) are the outer suburbs in Cuyahoga and surrounding counties. There are a lot of services available in the City of Cleveland, but it is difficult to serve people in the outer suburbs because there are not a lot of services there.

In Cleveland itself and in the first ring suburbs, there are services that are available for people who are eligible or who know about them. But it's in the outer-ring suburbs where it is much more difficult. We had somebody who lived in Solon who needed services and was qualified for our program but it is hard to find a provider who would go out there because it takes a long time to get there if you are not driving.

When the key informants (2005) were asked about which specific communities in Cleveland have an insufficient supply of services, they indicated that this tends to be in some of the first-tier suburban areas, as well as the inner City of Cleveland where there is the greatest concentration of risk factors, such as poor economic conditions and low education status. There are fewer providers in the City of Cleveland despite the greater need for services. Some obstacles among the minority communities which lack these services include: language barriers, cultural diversity, and the lack of understanding of these services.

Workforce Shortage

Paid in-home assistance services have a challenge in maintaining the number of necessary workers. Wages, benefits and working conditions are not consistently competitive with other entry-level positions. Ensuring quality assistance and avoiding situations where an older person is taken advantage of are other areas that deserve attention. Finally, communication and coordination with other home-based service providers is important.

Caregivers for the elderly are becoming scarce. Paraprofessional workers provide more than three-quarters of care in nursing homes and more than 90 percent of care at home. By 2010, when the baby boomers start to retire, the pool of middle-aged women who staff most of these positions



will be substantially smaller than it is now. Likewise, family caregiving—long the backbone of long-term care—will be heavily burdened. Smaller family sizes and changed family structures are leaving a smaller potential group of family caregivers. Longer durations of illness and greater numbers of women working outside the home also place greater burdens on the pool of potential caregivers. Meeting the need for caregivers may prove even more difficult than the financial strain imposed by the aging baby boomers. (Lynn & Adamson, 2003)

VII. SUMMARY

The following are the major findings from the research on in-home assistance:

- The current philosophical underpinning of public policies for in-home assistance at the national level is de-institutionalization, independent living, and a shift of policy decisions and responsibilities away from the federal government to the states.
- At the state and local levels, policies center around costs, community based care, and consumer choice. The role of planning, diet, and exercise is a major emerging theme in the prevention of premature aging and death.
- In addition to the waiver programs, other funding sources such as the Older American's Act (OAA) support in-home assistance services. OAA (P.L. 89-73) was signed into law in 1965 amid growing concern over older individuals' access to health care and their general well-being. In September 2005, Congress passed the bill to reauthorize the Older Americans Act (H.R. 6197).
- As of May 11, 2006, nearly \$49.9 million in revenues for in-home assistance has been identified countywide.
- Solutions that improve communication and support between formal systems and families have the potential to influence the quality of life and care for individuals and their caregivers.
- In recent studies of home care quality assurance, consumers have identified a number of factors that contribute to quality home care, including the opportunity to maintain independence, autonomy and choice; a good consumer/worker relationship; flexibility of care plan and worker tasks; and reliable, honest, and competent workers.
- Systematic reviews and meta-analyses of research on the efficacy of community-based programs have identified positive outcomes in consumer and family satisfaction with services, but have not substantiated global improvements in health or functional status for participants, nor cost savings for care.
- Fragmentation of the home health care system has major issues that suggest the system does not always work as effectively as it should.
- The estimated universe of possible consumers is 17,947 included realized (6,579) and unrealized (11,368) access.
- Countywide, according to First Call for Help (February 2005), there are 83 service sites for in-home assistance programs. This is a ratio of 216 possible consumers (an estimated 17,947 total) per service site countywide.

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ATTACHMENTS

Attachment 1: Researcher List

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Attachment 2: Technical Notes

Technical Notes: Methodology, Caveats, Limitations of Data

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

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

Unit of Analysis

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

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

United Way - First Call for Help Data

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

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

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

Because, in many instances, FCFH codes its data with a different level of core services than the 80 core services identified by the United Way Community Investment staff as fundable services, it was necessary to develop a crosswalk. This crosswalk was used for a number of services, however, seven services did not have a match in the FCFH database. The staff of United Way - First Call for Help gave explanations which follow each core service):

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

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

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

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

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

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

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

Funding Information for Core Services

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

Foundation Funding

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

Federated Funding Sources

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

Government Funding

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

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

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

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

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

Medicaid Funding

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

Entered as Aggregate Total Under Appropriate AIRS Level

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

Entered as Aggregate Total Under Third Party Payee/Direct Bill

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

United Way of Greater Cleveland Funding

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

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

United Way Agency Revenues

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

Consumer and Financial Data: Caveats

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

All Core Services

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

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

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

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

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

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

Gap Analysis Methodology & Limitations

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

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

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

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

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

Service Site Index

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

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

Specific Service Issues

Senior Services

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

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

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

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Attachment 3: Actual Consumer Demographics

Core Service: In Home Assistance PH-330												
PERIOD	Total Population (%) 11/2000-12/31/2000	Total Population 60+ (%) 11/2000-12/31/2000	Estimated Persons in Need Total Population 60+ with Moderate or Severe Disabilities (%) 1/1/2000-12/31/2000	Actual Number/Percent of Consumers by Funding Source ****								
				UW Program Report Data City Only (%) 6/30/2004	PASSPORT (%) 2004	WRAAA (%) CY2004	DSAS (%) 2004-2005	DSAS Home Support Services (%) 2004	OPTIONS for Elders (%) 2004	Cleveland CDBG (%) 2004	Clev DoA CDBG, South Euclid, Lyndhurst, Highland Hts (%) 2004	Cleveland Hs CDBG (%) 2004
TOTAL	1,393,978	273,378	71,786	35	5,827	752	92	Missing	414	304	Missing	32
Percent		19.6%	26.3%									
GENDER												
Male	47.2%	40.4%	N/A	8.6%	21.0%	19.9%	72.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Female	52.8%	59.6%	N/A	91.4%	79.0%	80.1%	27.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****			-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			-	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
RACE*****												
White alone	67.1%	77.4%	N/A	91.4%	60.6%	74.7%	44.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Black or African American alone/combination	27.9%	20.7%	N/A	8.6%	45.3%	18.6%	52.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Asian alone/combination	2.1%	1.1%	N/A	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.4%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	0.8%	N/A	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Two or more races		0.8%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****			-	0.0%	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			-	0.0%	2.0%	0.3%	3.3%	100.0%	100.0%	100.0%	100.0%	100.0%
HISPANIC*****												
	3.3%	1.1%	N/A	2.9%	2.0%	0.4%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%
AGE												
0-4	6.5%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
5-9	7.3%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10-14	7.1%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-19	6.4%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-24	19.1%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
25-34	29.3%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
35-44	8.7%	20.6%	N/A	0.0%		19.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
45-54	7.8%	39.5%	N/A	28.6%	34.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
55-64	7.8%	39.5%	N/A	71.4%	66.0%	80.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
65-74	7.8%	39.5%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
75+	7.8%	39.5%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****			-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			-	0.0%	0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
INCOME*****												
Average Household Size	2.4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80-89 999	11.3%	N/A	N/A	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$30,000 and above	61.5%	N/A	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****			-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****			-	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000, SF1(P1); SF3 (P52); SF4 (PCT144)
*** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
***** PASSPORT covers multiple core services. Client totals for each service follow (numbers may be duplicated across core services): Adult Day Care - 640; Daily Living Aids - 7,144; Home Delivered Meals - 1,356; Home Improvement/Accessibility - 42; In-home Assistance (includes personal care, chore, homemaker, fumigation/pest control, etc.) - 5,827; Senior Ride - 1,849; Disaster Services - 180; General Counseling - 119; Emergency Response Service - 180; and Escort Service - 7. OPTIONS covers consumers of all services provided, not just personal care or homemaker.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
*****The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category which may result in more conservative estimates for children and the "old old" which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: In-Home Assistance PH-330												
City/Town (% Cleveland)	Total Population (%) 1/1/2000-12/31/2000	Total Population 60+ (%) 1/1/2000-12/31/2000	Estimated Persons in Need Population 60+ with Moderate or Severe Disabilities (%) 1/1/2000-12/31/2000	Actual Number/Percent of Consumers by Funding Source ****								
				UW Program Report Data (%) 7/1/2003-6/30/2004	PASSPORT Cuy City Only (%) 2004	WRAAA Cuy City Only (%) CY2004	DSAS (%) 2004-2005	DSAS Home Support Services (%) 2004	OPTIONS for Elders (%) 2004	Cleveland CDBG (%) 2004	Clev DoA CDBG, South Euclid, Lyndhurst, Highland Hts (%) 2004	Cleveland Hts CDBG (%) 2004
				Period	Period	Period	Period	Period	Period	Period	Period	Period
TOTAL	1,393,978	273,378	71,786	35	5,827	752	92	Missing	414	304	Missing	32
Percent		19.6%	26.3%									
44017 Berea	1.4%	1.3%	N/A	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44022 Bentleyville	1.3%	1.3%	N/A	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44040 Gates Mills/Mayfield Village	0.2%	0.3%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44070 North Olmsted	2.4%	2.5%	N/A	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44101 Cleveland (100%)	0.0%	0.0%	N/A	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44102 Cleveland/Brooklyn (95%)	3.7%	2.3%	N/A	20.0%	0.0%	0.3%		0.0%	0.0%	0.0%	0.0%	0.0%
44103 Cleveland (100%)	1.8%	1.5%	N/A	0.0%	3.6%	5.2%		0.0%	0.0%	0.0%	0.0%	0.0%
44104 Cleveland (100%)	2.1%	1.4%	N/A	0.0%	3.4%	1.6%		0.0%	0.0%	0.0%	0.0%	0.0%
44105 Cleveland/Newburgh/Hts/Garfield/Hts (75%)	3.9%	3.1%	N/A	0.0%	3.2%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44106 Cleveland/Cleveland Hts (60%)	2.3%	2.3%	N/A	0.0%	7.7%	6.3%		0.0%	0.0%	0.0%	0.0%	0.0%
44107 Lakewood/Cleveland	4.1%	3.1%	N/A	0.0%	1.5%	35.8%		0.0%	0.0%	0.0%	0.0%	0.0%
44108 Cleveland/Bratenah (90%)	2.6%	2.5%	N/A	0.0%	4.6%	1.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44109 Cleveland/Brooklyn Hts (98%)	3.3%	2.3%	N/A	74.3%	3.1%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44110 Cleveland/East Cleveland (98%)	1.9%	1.5%	N/A	0.0%	4.4%	0.4%		0.0%	0.0%	0.0%	0.0%	0.0%
44111 Cleveland (100%)	3.1%	2.5%	N/A	0.0%	1.3%	0.5%		0.0%	0.0%	0.0%	0.0%	0.0%
44112 East Cleveland/Cleveland	2.4%	2.1%	N/A	0.0%	7.8%	0.8%		0.0%	0.0%	0.0%	0.0%	0.0%
44113 Cleveland (100%)	1.4%	0.8%	N/A	5.7%	1.1%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44114 Cleveland (100%)	0.3%	0.3%	N/A	0.0%	0.5%	1.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44115 Cleveland (100%)	0.6%	0.2%	N/A	0.0%	0.8%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44116 Rocky River	1.5%	2.2%	N/A	0.0%	0.3%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44117 Euclid/Cleveland	0.9%	1.4%	N/A	0.0%	2.0%	0.3%		0.0%	0.0%	0.0%	0.0%	0.0%
44118 Cleveland/Hts/University/Hts/Shaker/Hts	3.2%	2.6%	N/A	0.0%	4.9%	0.5%		0.0%	0.0%	0.0%	0.0%	0.0%
44119 Cleveland/Euclid (50%)	1.0%	1.1%	N/A	0.0%	0.3%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44120 Shaker Hts/Cleveland	3.4%	3.1%	N/A	0.0%	4.1%	0.4%		0.0%	0.0%	0.0%	0.0%	0.0%
44121 University Hts/South Euclid	2.5%	2.2%	N/A	0.0%	3.4%	6.8%		0.0%	0.0%	0.0%	0.0%	0.0%
44122 Beschwood/Highland Hills/Shaker/Hts	2.5%	3.7%	N/A	0.0%	1.1%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44123 Euclid	1.3%	1.4%	N/A	0.0%	0.4%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44124 Pepper Pike/Mayfield/Hts/Lyndhurst	2.9%	4.5%	N/A	0.0%	4.1%	6.8%		0.0%	0.0%	0.0%	0.0%	0.0%
44125 Valley View/Garfield Hts	2.1%	2.5%	N/A	0.0%	0.4%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44126 Fairview Park/Cleveland	1.2%	1.5%	N/A	0.0%	0.4%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44127 Cleveland (100%)	0.6%	0.4%	N/A	0.0%	0.4%	0.8%		0.0%	0.0%	0.0%	0.0%	0.0%
44128 Warrensville Hts/Cleveland	2.4%	2.6%	N/A	0.0%	2.9%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44129 Brooklyn/Parma/Cleveland	2.1%	2.4%	N/A	0.0%	0.4%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44130 Parma/Cleveland	3.8%	5.2%	N/A	0.0%	0.8%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44131 Independence/Seven Hills/Brooklyn/Hts	1.5%	2.2%	N/A	0.0%	0.1%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44132 Euclid	1.1%	1.1%	N/A	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44133 North Royalton	2.1%	1.7%	N/A	0.0%	0.2%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44134 Parma/Cleveland	2.9%	3.7%	N/A	0.0%	1.2%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44135 Cleveland/Linndale (90%)	2.0%	2.0%	N/A	0.0%	1.1%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44136 Strongsville	3.1%	2.5%	N/A	0.0%	0.4%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44137 Maple Hts/Cleveland	1.9%	1.9%	N/A	0.0%	0.8%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44138 Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.0%	0.2%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44139 Bentleyville/Glenwillow/Solon	1.6%	1.2%	N/A	0.0%	0.4%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44140 Bay Village	1.2%	1.1%	N/A	0.0%	0.2%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44141 Brecksville	1.0%	1.1%	N/A	0.0%	0.1%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44142 Brookpark/Cleveland	1.5%	1.8%	N/A	0.0%	0.2%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44143 Highland Hts/Richmond Heights	1.7%	2.0%	N/A	0.0%	2.8%	1.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44144 Brooklyn/Cleveland	1.6%	1.9%	N/A	0.0%	0.6%	0.1%		0.0%	0.0%	0.0%	0.0%	0.0%
44145 Westlake	2.3%	2.6%	N/A	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44146 Walton Hills/Oakwood/Bedford	2.3%	2.6%	N/A	0.0%	20.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44147 Broadview Hts	1.1%	1.1%	N/A	0.0%	0.2%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
44149 Strongsville					0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes					0.0%	0.0%	29.5%	0.0%	100.0%	100.0%	100.0%	100.0%
Missing*****					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown*****					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Cuyahoga County*****	100.0%	100.0%	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Known Cleveland	30.5%	24.2%	N/A	100.0%	35.5%	17.4%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Known Suburbs	69.5%	75.8%	N/A	0.0%	64.5%	53.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown & Missing					0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000, SF1 (P1)
*** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).
**** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
***** PASSPORT covers multiple core services. Client totals for each service follow (numbers may be duplicated across core services): Adult Day Care - 640; Daily Living Aids - 7,144; Home Delivered Meals - 1,356; Home Improvement/Accessibility - 42; In-home Assistance (includes personal care, chore, homemaker, fumigation/pest control, etc.) - 5,827; Senior Ride - 1,849; Disaster Services - 180; General Counseling - 119; Emergency Response Service - 180; and Escort Service - 7. OPTIONS covers consumers of all services provided, not just personal care or homemaker.
*****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		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	61	1
Number of Providers by Type		
Non-profit	29	1
For-profit	-	-
Government	32	-
Other	-	-
Total Number of Sites	83	2
Number of Service Sites per Provider		
1	53	-
2 – 5	7	1
6 – 10	-	-
11+	1	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	2	-
44022 – Bentleyville	2	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	1	-
44103 – Cleveland	2	-
44104 – Cleveland	5	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	6	-
44107 – Cleveland/Lakewood	2	-
44108 – Cleveland/East Cleveland	2	-
44109 – Cleveland/Brooklyn Hts	2	-
44110 – Cleveland/Bratenahl	1	-
44111 – Cleveland	2	1
44112 – Cleveland/East Cleveland	1	-
44113 – Cleveland	5	1
44114 – Cleveland	4	-
44115 – Cleveland	3	-
44116 – Rocky River	1	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	1	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	1	-
44121 – University Hts/South Euclid	1	-
44122 – Orange/Warrensville Hts	5	-
44123 – Euclid	1	-
44124 – Pepper Pike/Mayfield Village	1	-
44125 – Valley View/Garfield Hts	3	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-
44128 – Cleveland/Warrensville Hts	4	-

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

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44129 – Cleveland/Brooklyn/Parma	1	-
44130 – Cleveland/Parma	-	-
44131 – Seven Hills/Brooklyn Hts	2	-
44132 – Euclid	-	-
44133 – North Royalton	1	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	4	-
44136 – Strongsville	1	-
44137 – Maple Hts/Cleveland	2	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	3	-
44140 – Bay Village	1	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	1	-
44143 – Highland Hts/South Euclid	2	-
44144 – Brooklyn/Cleveland	2	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	3	-
44147 – Broadview Hts	1	-
44149 – Strongsville	1	-
Total Cuyahoga County	83	2
Total Cleveland	37	2
Total Suburbs	46	0

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Alta House	Homemaking, Forms Completion - Seniors
Amistad Development Corporation	All-Season Yard Maintenance
City of Bay Village Department of Community Services	Senior Center - Outreach and Supportive Services
City of Bedford Heights	Street Maintenance/Yard Maintenance - Seniors and Disabled
Bellaire-Puritas Development Corporation	Assistance With Maintenance of Home Exteriors
Benjamin Rose	At Home Care for Elderly (3rd Party Payor/Sliding Scale), At Home Care for Elderly (Direct Full - Pay)
City of Berea Department of Recreation	Snow Removal for Seniors and Disabled
City of Broadview Heights	Senior Center - Supportive Services, Street Maintenance/Yard Maintenance
City of Brook Park City Hall	Street Maintenance/Yard Maintenance
City of Brooklyn Senior Center	Snow Removal and Grass Cutting for Seniors
Village of Brooklyn Heights	Chore Services for Seniors/Disabled, Street Maintenance/Yard Maintenance
City of Cleveland Department of Aging	Home Maintenance and Assistance for Seniors
City of Cleveland Heights Department of Community Services	Senior Center - Home Maintenance - Older Adults
Court Community Service	Contract Business Services
Cuyahoga County Department of Senior & Adult Services	Home Support Services, Home Care Assistance/Coordination - Elderly
Village of Cuyahoga Heights	Street Maintenance/Yard Maintenance
East End Neighborhood House	Senior Center - Social/Health Services/Forms Completion
Emerald Development and Economic Network	Housing Assistance for Mental Health Consumers
City of Euclid	Senior Center - Homemaker Assistance, Senior Center - Home Personal Care, Senior Center - Chore Services
Euclid-St. Clair Development Corporation	Yard Maintenance Assistance
Fairfax Renaissance Development Corporation	Neighborhood Organizing Support
City of Garfield Heights	Senior Center - Recreation/Screenings/Forms Completion, Senior Center - Yard Maintenance
Garrett Square Economic Development Corporation	Snow Removal for Disabled Older Adults
Glenville Development Corporation	Yard Maintenance
Village of Glenwillow	Street Maintenance/Yard Maintenance
Golden Age Centers of Greater Cleveland	Social Services - Seniors
Goodrich-Gannett Neighborhood Center	Senior Center - Forms Completion, Senior Center - Home Maintenance
Harvard Community Services Center	Yard Work, Chore Services
Village of Highland Hills	Senior Center - Social Services
City of Independence	Street Maintenance/Yard Maintenance, Senior Center - Outreach/Support/Blood Pressure Screening
Jewish Family Service Association of Cleveland	Homemaking & Personal Care, Eldercare - Money Management/Forms Completion

Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Judson at University Circle	Home Care
City of Lakewood Department of Human Services	In-Home Personal Care, Housekeeping Assistance, Grocery Shopping Assistance, Assistance With Forms, Street Maintenance/Yard Maintenance: Aging
City of Maple Heights	Street Maintenance/Yard Maintenance - Snow Removal, Senior Center - Support Services/Screenings/Forms Completion, Street Maintenance/Yard Maintenance
Village of Mayfield	Street Maintenance/Yard Maintenance
Menorah Park Center for Senior Living	Cleaning Services
Merrick House	Forms Completion - Seniors
Montefiore	Home Health Care
Village of Moreland Hills	Street Maintenance/Yard Maintenance
Village of North Randall	Street Maintenance/Yard Maintenance
City of North Royalton	Senior Center - Outreach/Social Services
Northeastern Neighborhood Development Corporation	Assistance With Yard Care
Village of Oakwood	Street Maintenance/Yard Maintenance
Village of Orange	Street Maintenance/Yard Maintenance
City of Parma Service Department	Home Maintenance - Seniors
City of Rocky River Office On Aging	Senior Center - Outreach/Forms Assistance/Notary
The Salvation Army	Social Services/Hot Meal/Home Delivered Meals - Seniors
Senior Citizen Resources	Forms Assistance
Senior Outreach Services	Homemaking Assistance, Personal Care Services
City of Shaker Heights	Housekeeping - Older Adults, Forms Completion - Seniors
City of Solon	Senior Center - Social Services/Outreach, Street Maintenance/Traffic Control
Solutions at Work	Contract Business Services
Southwest General Health Center	Supportive Services - Seniors, Outreach
St. Ignatius High School	Snow/Leaf Removal
City of Strongsville	Street Maintenance/Yard Maintenance, Senior Center - Outreach/Supportive Services
Tri-City Consortium on Aging	Housekeeping - Older Adults, Information/Outreach - Older Adults
Village of Valley View	Street Maintenance/Yard Maintenance
Visiting Nurse Association Healthcare Partners of Ohio	Independent Living Assistance, Older Adult Care, Private Nursing/Home Health Care Services, Special Care/Pre-Hospice Program, Home Care Aide Services
City of Warrensville Heights	Senior Center - Social Services/Recreation/Forms Completion
Western Reserve Area Agency on Aging	Information, Assessment and Home Care Services
Village of Woodmere	Street Maintenance/Yard Maintenance

Bold represents agencies funded by United Way for this service.

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

PH-330 In-Home Assistance United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change* 00&04	Avg. # Calls 00- 04
		2000	2001	2002	2003	2004		
44142	Brookpark/Cleveland	1	6	2	5	5	400%	4
44017	Berea	3	2	4	3	9	200%	4
44132	Euclid	3	3	0	3	8	167%	3
44117	Euclid/Cleveland	3	15	9	8	8	167%	9
44124	Pepper Pike/Mayfield Hts./Lyndhurst	8	14	21	9	21	163%	15
44138	Olmsted Twp/Olmsted Falls	2	0	1	6	5	150%	3
44123	Euclid	3	4	4	8	7	133%	5
44147	Broadview Hts	2	1	0	2	4	100%	2
44119	Cleveland/Euclid	3	3	6	3	6	100%	4
44131	Independence/Seven Hills/Brooklyn Hts	1	5	11	2	2	100%	4
44113	Cleveland	9	10	18	10	17	89%	13
44122	Beachwood/Highland Hills/Shaker Hts.	5	13	17	18	9	80%	12
44127	Cleveland	7	4	1	3	11	57%	5
44126	Fairview Park/Cleveland	4	2	4	4	6	50%	4
44143	Highland Hts/Richmond Heights	5	9	19	16	7	40%	11
44137	Maple Hts/Cleveland	6	3	4	9	8	33%	6
44105	Cleveland/Newburgh Hts/Garfield Hts	27	33	27	30	35	30%	30
44121	University Hts/South Euclid	8	8	14	14	10	25%	11
44120	Shaker Hts/Cleveland	28	20	37	18	34	21%	27
44134	Parma/Cleveland	15	15	5	8	3	(80%)	9
44133	North Royalton	4	1	7	6	1	(75%)	4
44107	Lakewood/Cleveland	16	8	5	15	5	(69%)	10
44144	Brooklyn/Cleveland	12	13	8	7	4	(67%)	9
44125	Valley View/Garfield Hts	6	4	16	7	2	(67%)	7
44103	Cleveland	17	13	11	17	7	(59%)	13
44139	Bentleyville/Glenwillow/Solon	4	1	2	2	2	(50%)	2
44110	Cleveland/East Cleveland	23	10	9	28	12	(48%)	16
44118	ClevelandHts/UniversityHts/ShakerHts	17	16	11	4	10	(41%)	12
44112	East Cleveland/Cleveland	30	21	25	13	18	(40%)	21
44130	Parma/Cleveland	13	12	17	24	8	(38%)	15
44102	Cleveland/Brooklyn	33	24	17	20	21	(36%)	23
44128	Warrensville Hts/Cleveland	38	40	35	24	25	(34%)	32
44145	Westlake	6	1	3	1	4	(33%)	3
44108	Cleveland/Bratenahl	31	30	38	21	21	(32%)	28
44106	Cleveland/Cleveland Hts	27	18	17	23	19	(30%)	21
44111	Cleveland	21	19	17	19	15	(29%)	18

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

PH-330 In-Home Assistance United Way - First Call for Help Requests 2000-2004 Greatest Increase/(Greatest Decrease)							
Zip Code	TOTAL REQUESTS					%Change* 00&04	Avg. # Calls 00- 04
	2000	2001	2002	2003	2004		
**Total Cuyahoga County	26	16	15	17	22	(15%)	19
**Total Cleveland	11	6	4	3	10	(9%)	7
**Total Suburbs	15	10	11	14	12	(20%)	12
* Extremely high percentages are due to low numbers.							
** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.							

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

PH-330 In-Home Assistance United Way - First Call for Help Requests 2000-2004 Unmet Need					
Zip Code		TOTALS 00-04			% Unmet
		Requests	Met	Unmet	
44140	Bay Village	2	1	1	50%
44022	Bentleyville	6	3	3	50%
44141	Brecksville	9	7	2	22%
44129	Brooklyn/Parma/Cleveland	23	18	5	22%
44125	Valley View/Garfield Hts	35	29	6	17%
44134	Parma/Cleveland	46	39	7	15%
44126	Fairview Park/Cleveland	20	17	3	15%
44131	Independence/Seven Hills/Brooklyn Hts	21	18	3	14%
44102	Cleveland/Brooklyn	115	100	15	13%
44135	Cleveland/Linndale	71	63	8	11%
44147	Broadview Hts	9	8	1	11%
44116	Rocky River	27	24	3	11%
44115	Cleveland	20	18	2	10%
44113	Cleveland	64	58	6	9%
44146	Walton Hills/Oakwood/Bedford	64	58	6	9%
44112	East Cleveland/Cleveland	107	97	10	9%
44139	Bentleyville/Glenwillow/Solon	11	10	1	9%
44144	Brooklyn/Cleveland	44	40	4	9%
44143	Highland Hts/Richmond Heights	56	51	5	9%
44122	Beachwood/Highland Hills/Shaker Hts.	62	57	5	8%
44114	Cleveland	26	24	2	8%
44123	Euclid	26	24	2	8%
44104	Cleveland	95	88	7	7%
44110	Cleveland/East Cleveland	82	76	6	7%
44145	Westlake	15	14	1	7%
44111	Cleveland	91	85	6	7%
*Total Cuyahoga County		2,591	2,420	171	7%
*Total Cleveland		1,187	1,115	72	6%
*Total Suburbs		1,404	1,305	99	7%

FCFH DATA NOTES

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

Unmet = service request for which there was no referral.

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

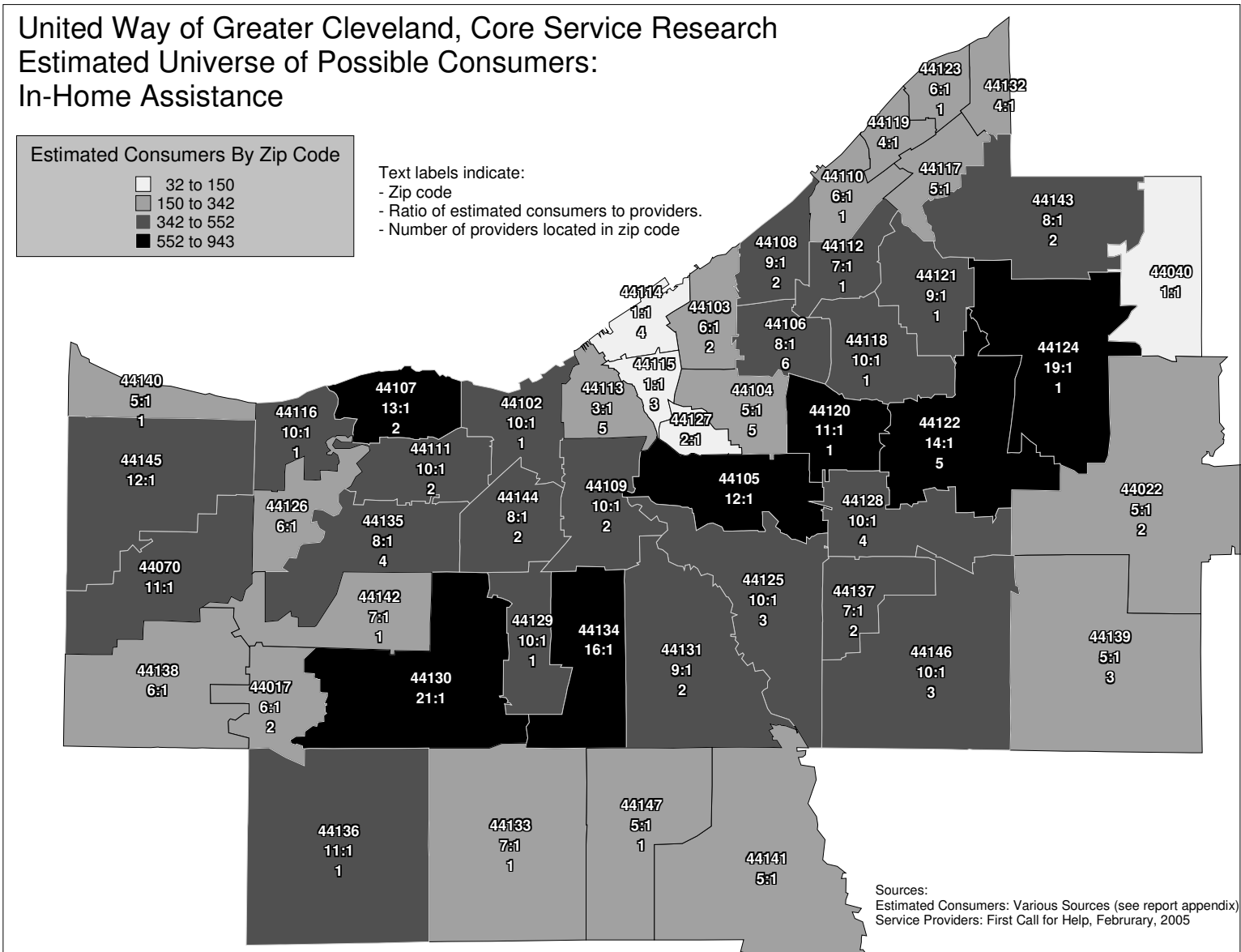
* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.

Attachment 9: Service Site Index

Core Service: In-Home Assistance PH-330									
Service Site Index									
Zip	Number of Sites ^{*****}	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#) [*]	Total Population 60+ (#) ^{**}	Estimated Persons In Need: Total Population 60+ with Moderate or Severe Disabilities ^{***}	Estimated Universe of Possible Consumers ^{****}	Number of Service SITES Serving Geographical Area (Per Agencies Reported Intended Service Area to First Call for Help) ^{*****}	Potential Service ACCESSIBILITY by Service Consumers per Geographical Area
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/2005	Ratio of CONSUMERS to Service SITES
TOTAL	83			1,393,978	273,378	71,786	17,947	83	216:1
Percent					19.6%	26.3%	25.0%		
44117	-	Euclid/Cleveland	African Am 53.1%	12,078	3,744	983	246	47	5:1
44105	-	Cleveland/NewburghHts/GarfieldHts (75%)	African Am 61.9%	54,834	8,540	2,243	561	47	12:1
44106	6	Cleveland/Cleveland Hts (60%)	African Am 62.2%	32,417	6,224	1,634	409	52	8:1
44110	1	Cleveland/East Cleveland (98%)	African Am 74.7%	26,536	4,126	1,083	271	46	6:1
44120	1	Shaker Hts/Cleveland	African Am 76.7%	47,349	8,406	2,207	552	49	11:1
44103	2	Cleveland (100%)	African Am 80.2%	25,348	4,174	1,096	274	47	6:1
44108	2	Cleveland/Bratenahl (90%)	African Am 94.9%	36,456	6,939	1,822	456	49	9:1
44112	1	East Cleveland/Cleveland	African Am 95.2%	33,222	5,702	1,497	374	51	7:1
44128	4	Warrensville Hts/Cleveland	African Am 95.8%	33,612	7,641	2,006	502	52	10:1
44104	5	Cleveland (100%)	African Am 97.5%	28,904	3,734	981	245	48	5:1
44115	3	Cleveland (100%)	African Am 98.4%	8,186	489	128	32	44	1:1
44114	4	Cleveland (100%)	Asian 20.3%	3,891	877	230	58	44	1:1
44109	2	Cleveland/Brooklyn Hts (98%)	Hispanic 20.3%	45,783	6,409	1,683	421	43	10:1
44102	1	Cleveland/Brooklyn (95%)	Hispanic 20.4%	52,108	6,361	1,670	418	43	10:1
44113	5	Cleveland (100%)	Hispanic 23.5%	19,466	2,282	599	150	43	3:1
44017	2	Berea		19,005	3,544	931	233	40	6:1
44022	2	Bentleyville		17,720	3,665	962	241	45	5:1
44040	-	Gates Mills/Mayfield Village		2,883	740	194	49	44	1:1
44070	-	North Olmsted		34,081	6,734	1,768	442	39	11:1
44101	-	Cleveland (100%)		0	-	0	0	8	N/A
44107	2	Lakewood/Cleveland		56,710	8,645	2,270	568	43	13:1
44111	2	Cleveland (100%)		42,967	6,767	1,777	444	43	10:1
44116	1	Rocky River		21,122	6,135	1,611	403	40	10:1
44118	1	ClevelandHts/UniversityHts/ShakerHts		45,279	7,014	1,842	460	44	10:1
44119	-	Cleveland/Euclid (50%)		13,493	3,041	799	200	45	4:1
44121	1	University Hts/South Euclid		35,185	6,118	1,607	402	47	9:1
44122	5	Beachwood/Highland Hills/ShakerHts		34,883	10,212	2,682	670	49	14:1
44123	1	Euclid		18,363	3,780	993	248	44	6:1
44124	1	Pepper Pike/MayfieldHts/Lyndhurst		40,334	12,459	3,272	818	44	19:1
44125	3	Valley View/Garfield Hts		29,876	6,831	1,794	448	47	10:1
44126	-	Fairview Park/Cleveland		17,196	4,014	1,054	264	43	6:1
44127	-	Cleveland (100%)		8,403	1,151	302	76	45	2:1
44129	1	Brooklyn/Parma/Cleveland		29,658	6,581	1,728	432	44	10:1
44130	-	Parma/Cleveland		53,615	14,364	3,772	943	45	21:1
44131	2	Independence/Seven Hills/BrooklynHts		20,666	6,063	1,592	398	45	9:1
44132	-	Euclid		15,322	2,963	778	195	44	4:1
44133	1	North Royalton		28,685	4,544	1,193	298	40	7:1
44134	-	Parma/Cleveland		40,396	10,242	2,689	672	43	16:1
44135	4	Cleveland/Lindale (90%)		28,561	5,366	1,409	352	43	8:1
44136	1	Strongsville		43,858	6,943	1,823	456	40	11:1
44137	2	Maple Hts/Cleveland		26,107	5,204	1,367	342	47	7:1
44138	-	Olmsted Twrp/Olmsted Falls		18,046	3,681	967	242	39	6:1
44139	3	Bentleyville/Glenwillow/Solon		22,231	3,223	846	212	45	5:1
44140	1	Bay Village		16,076	3,075	807	202	40	5:1
44141	-	Brecksville		13,676	3,146	826	207	39	5:1
44142	1	Brookpark/Cleveland		21,132	4,811	1,263	316	44	7:1
44143	2	Highland Hts/Richmond Heights		23,730	5,483	1,440	360	45	8:1
44144	2	Brooklyn/Cleveland		21,805	5,203	1,366	342	44	8:1
44145	-	Westlake		31,972	7,122	1,870	468	39	12:1
44146	3	Walton Hills/Oakwood/Bedford		31,648	7,018	1,843	461	45	10:1
44147	1	Broadview Hts		15,954	3,059	803	201	40	5:1

* U.S. Census 2000, SF1 (P1)
 ** U.S. Census 2000, SF1 (P1)
 *** Mehdizadeh, S.A., Kunkel, S. R., Ritchey, P.N. (2001). Projections of Ohio's older disabled population: 2015-2050. Oxford, OH: Scripps Gerontology Center, Miami University. A moderate disability is defined as needing help in at least one of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, bathing, remaining continent; or in at least two of the following instrumental activities of daily living: walking, shopping, meal preparation, housekeeping, or using transportation (47,075 persons). A severe disability is defined as needing help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairment (24,711 persons).
 ****Typically most research indicates that only 20 percent of persons needing long-term care are cared for in the formal caregiving system (Young, 2003). However, as was noted previously, because
 ***** United Way - First Call for Help, February 2005

Attachment 10: Map





**United Way of
Greater Cleveland**

1331 Euclid Avenue

Cleveland, Ohio 44115

uws.org/CoreServicesPlanning