

Core Service Report

Residential Living Options for People with Disabilities

Consumer Category:
With / At Risk of Health Conditions

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



February 2007

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COMPANION REPORTS

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

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SNAPSHOT

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

AIRS Code Level II: Family Substitute Services (PF)

Core Service: Residential Living Options for People with Disabilities (PF-700)

Investment Committee: Health & Caring for All

Cluster: Rehabilitation/Specialized Treatment

AIRS Definition: AIRS Taxonomy updated 06/24/05 no longer lists Residential Living Options for People with Disabilities. Appropriate categories may include:

Community Care Facilities for People with Disabilities (PF-600.150): Facilities, usually located in residential neighborhoods, that provide 24-hour non-medical care for children, youth, and adults with developmental disabilities, sensory impairments, physical disabilities, emotional problems or multiple disabilities who are in need of personal services, supervision, and/or assistance essential for self-protection or sustaining the activities of daily living. Community care facilities are licensed by the state/province and may be distinguished according to the level of care service residents require. Service levels depend on the self-care skills residents possess, their limitations in the areas of physical coordination and mobility, and the presence and extent of behavior problems including disruptive or self-injurious behavior.

OR

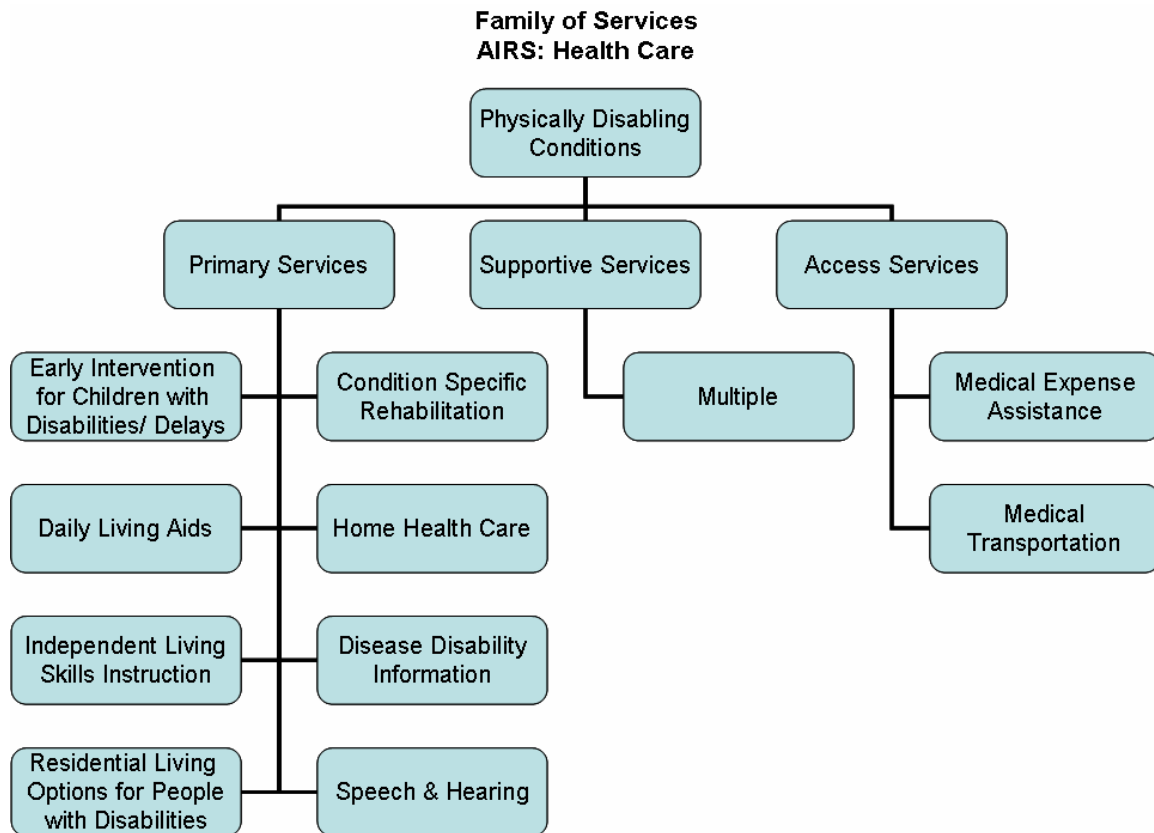
Group Homes for Children with Disabilities (PF-700.150-20): Agency-owned or operated facilities that provide an alternative living environment for children and youth with developmental disabilities, sensory impairments, physical disabilities, emotional problems, or multiple disabilities who are in need of personal services, supervision and/or assistance essential for self-protection or sustaining the activities of daily living and who are unable to live with their own or a foster family. Residents often attend on-grounds schools or public schools and also receive services that focus on the development of self-help, self-care, socialization, prevocational and independent living skills. Group homes for children with disabilities are licensed by the state and may be distinguished according to the level of service residents require. Service levels depend on the self-care skills residents possess, their limitations in the areas of physical coordination and mobility, and the presence and extent of behavior problems including disruptive or self-injurious behavior.

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

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

- **Home Health Care** is for people of all ages who need temporary (weeks or months) in-home care from medical professionals for rehabilitation from a hospital stay, recovery from illness, injury or surgery or for a terminal medical condition.
- **In-Home Assistance** is for older adults (60+) who need long-term (many months or years) care in home custodial services by paraprofessionals for chronic medical conditions, chronic severe pain, permanent disabilities, dementia, ongoing need for help with activities of daily living, or need for supervision. While the narrative of this report covers an entire package of services to support community-based long term care needs of homebound older adults, this report only includes “homemaker,” “personal care,” and “chore” in the funding and consumer data. There are separate reports for medical transportation, home-delivered meals, daily living aids, independent living skills, and adult day care.
- **Residential Living Options for People with Disabilities** discusses both in-home and institutional care for adults who are disabled and under 60 years.

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



Core Service Environment

Residential living options may be characterized as short- or long-term supportive housing arrangements that provide protection, support and services for disabled adults. Long-term arrangements enable chronically disabled adults to live independent lives, care for themselves, hold jobs and be self sufficient, but with the possibility of some supports from an outside organization as may be needed. There are different combinations of these based on the level of disability and the availability of caregivers from the informal network. Essentially there are two primary modes of housing for persons with disabilities: institutional and community-based supported living. Within each, there are multiple options.

Community or residential living options for adults with a variety of disabling conditions is an outcome of the deinstitutionalization movement, the Americans for Disabilities Act, and educational and human service policies such as mainstreaming and using the least restrictive environment. As the population of older Americans increases with the aging of the baby boomer generation and improved health, the need for supported and assisted living facilities for older citizens will also fuel the need for such living options.

The basic policy issue relevant to residential living options for persons with disabilities is how the various options are paid, especially for those who do not have sufficient resources to bear the full cost of housing, support, and health care. There are a variety of public policies that support persons with disabilities. Some of the resources, such as the Section 8 Housing Choice Voucher Program, are for housing only; others, such as the Medicaid waivers, are for supportive services only; and still others are for both housing and supportive services such as Section 811.

A major issue in the Section 811 program is the cost of renewing vouchers funded under the tenant-based component. The Consortium for Citizens with Disabilities Housing Task Force has projected that unless appropriations levels rise to keep pace with increasing renewal costs, funding for new unit production will be eliminated by 2012 (National Low Income Housing Coalition, 2006).

Medicaid reform is a major concern for parents and service providers. Budget cuts and more restrictive policies on eligibility, services, etc. from the federal government and states impact the provision of service.

Core Service Consumers

The target population addressed in this core service report is adults 18 to 64 years with severe disabilities who need a structured environment, personal assistance, and various therapies to manage and learn to manage the activities of daily living.

Disabilities can consist of intellectual disabilities and related developmental disabilities (ID/DD) and/or multiple disabilities, a host of medical conditions, or behavioral problems. This population includes persons with moderate, severe, and profound mental retardation with multiple disabling problems who may need assistance throughout their lives. It does not include older persons with moderate to severe disabilities (they are discussed in the In-Home Assistance report).

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

In Cuyahoga County in 2000, 143,094 persons 21 to 64 years had one or more disabilities. Of the 75,046 persons with one disability, employment-related disabilities were most prevalent at

50 percent, followed by physical at 22 percent. Among those 68,048 with two or more disabilities, 78 percent did not include self-care issues and 48 percent had other combinations of issues.

Mental retardation is one of the major disabilities that greatly affects residential living options for people with disabilities. The American Network of Community Options and Resources (2006) estimates that, nationally, 1.58 percent (4.618 million) had MR/DD; and 0.78 percent or 2.308 million had MR only. In Ohio, there were 178,471 people with MR/DD and 88,106 with MR (based on U.S. prevalence rates).

In 2000, an estimated 64,649 persons 18 to 64 years in Cuyahoga County were severely disabled and in need of residential living options for people with disabilities. This number is projected to decrease to 63,714 by 2015 because of population shifts.

Core Service Delivery

The definition of residential living options for people with disabilities for this report is: short- or long-term supportive housing arrangements that provide protection, support, and services for disabled adults. The types of housing can include intermediate care facilities or community-based options at either market rate or government subsidized. A variety of supportive services are provided, including personal assistance, health, and therapies.

Long-term arrangements enable chronically disabled adults to live independent lives, care for themselves, hold jobs and be self sufficient, but with the possibility of some supports from an outside organization as may be needed. There are different combinations of these based on the level of disability and the availability of caregivers from the informal network. Essentially there are two primary modes of housing for persons with disabilities: institutional and community-based supported living. There are multiple options within each.

Many of the residents in the facilities described above require personal care services. These include, but are not limited to, assistance with activities of daily living, supervision in the self-administration of medication (unless a nurse is on site), and special diet preparation. Specific services can include meals, transportation, housekeeping, laundry, linens, personal care, nursing care, medication monitoring, respite, hospice, dementia care, and activities. The number and type of services vary from facility to facility.

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are 25 providers of residential living options for people with disabilities operating from 37 sites in Cuyahoga County. Twenty-three are nonprofits and 2 are government agencies. One agency was funded by United Way. According to FCFH data, requests for residential living options for people with disabilities in the county increased from 80 in 2000 to 99 by year 2004, which represented about a 24 percent increase. Between the years 2000 and 2004, there were 502 requests for this core service and 98 percent of them were met.

The major government funders for housing and the supportive services package needed by severely disabled persons are from Medicaid for intermediate care facilities and waivers, the U.S. Department of Housing and Urban Development for Section 811 and Section 8, and locally from the Cuyahoga County Department of Mental Retardation and Developmental Disabilities. Other sources of funding such as housing tax credits through the Ohio Housing Finance Agency can also be used.

The Medicaid program, which is federally supported but state administered, is the primary source of economic aid for both nursing homes and “intermediate care facilities, although other funds are available.” In general, individuals with developmental disabilities qualify for Medicaid benefits by meeting the disability and financial criteria established for the Supplemental Security Income (SSI) funding.

As of May 11, 2006, nearly \$135.7 million in revenues for residential living options for people with disabilities has been identified countywide. More than 99 percent of the revenues are from contracts or grants from government organizations; federated fundraising organizations account for 0.51 percent, and United Way of Greater Cleveland’s funds account for 0.15 percent of the total.

What Works; What Doesn’t

A more efficient and effective model for service delivery ensures that people with disabilities have greater control over the resources that are spent on them and that there is more “self-determination.” This means that more time is spent with the individual and his or her family in determining necessary services.

In an ICF-MR, there is an emphasis on consumer outcomes and facilities are surveyed annually to examine staff performance in achieving client ICF-MR service: active treatment, client rights, client behaviors and facility practice, and health care services (American Health Care Association, 2001).

A Livable Community for Adults with Disabilities strives to maximize people's independence, assure safety and security, promote inclusiveness, and provide choice (National Council on Disabilities, 2004).

A study by Baker and Blacher on the impact of residential placement found that

...family members’ well-being following placement was related to the age of the child and to the child’s level of functioning. Respondents with younger children reported more visits to the child, greater caretaker burden and stress, lower marital adjustment, and lower advantages to placement than those with older adolescents or adult offspring ... family members of adults living away from the parental home reported very low levels of burden and practically all reported that the placement was, on balance, for the better. These age-related findings are consistent with the societal and professional pressures to keep children at home and to move adults to greater independence.

Facilities for residential services are licensed by the state and must meet minimum regulations for building, safety, client to staff ratios, etc. In addition they must meet standards under the Medicaid rules and regulations. Staff is licensed according to the rules and regulations for their professional practice.

Gap Analysis

The estimated universe of possible consumers is 16,162, including both realized access (1,382) and unrealized access (14,780).

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

Community or residential living options for adults with a variety of disabling conditions is an outcome of the deinstitutionalization movement, the Americans with Disabilities Act, and educational and human service policies such as mainstreaming and using the least restrictive environment. As the population of older Americans increases with the aging of the baby boomer generation and improved health, the need for supported and assisted living facilities for older citizens will also fuel the need for such living options.

The historic deinstitutionalization movement has already had a tremendous impact on the disabled population. A major implication of these policy decisions was a shift to expect families to provide care and more services for their disabled family member. Families who are aging care for their adult disabled children, who are also aging. Families are also doing more at home with their disabled young children. The shift from large institutional settings to community-based care is largely complete, although many disabled persons are still cared for in nursing homes.

Community-based care facilities are not always embraced by a neighborhood or community. Neighborhood residents and communities may rail against the incursion of a residential change that brings a group of unrelated disabled persons into their neighborhood. The usual arguments concern property values, zoning, and myths and fears about the effects and problems disabled persons will bring to their neighborhood. In short, the perspectives of communities and neighborhoods focus on negative stereotypes about disabled persons. Communities may not be aware of the limited services for the disabled community. One participant in a focus group conducted for United Way of Greater Cleveland (2005) indicated that communities need to alter their attitudes about the disabled community.

Being part of the community and living as independently as possible are among the most important values and goals shared by people with disabilities, their families, and advocates. A home of one's own – either rented or owned, is the cornerstone of independence for people with disabilities. However, across the nation, people with cerebral palsy, mental retardation and related disabilities face a crisis in the availability of decent, safe, affordable, and accessible housing. (Disability Policy Collaborative, n.d.)

Today many still live in large congregate facilities or other inappropriate places like institutions. Approximately 750,000 people (national) with developmental disabilities live with aging parents (one of whom is over age 65). For people who use wheelchairs or other mobility devices, finding housing with even basic accessibility features (e.g. an entrance with no steps) ranges from daunting to impossible. This difficulty is magnified in rural areas where there is a scarcity of any rental housing and new units are rarely developed. In addition, the designation as 'elderly-only' of almost half a million units of Department of Housing and Urban Development (HUD) funded public and assisted housing over the

past 12 years has had a devastating impact on people with disabilities.
(Disability Policy Collaborative, n.d.)

According to *Priced Out in 2002*, for the first time ever, the national average rent was greater than the amount of income received by 3.7 million Americans with disabilities who rely on monthly Supplemental Security Income (SSI) of \$545 to pay for all their basic needs. Specifically, the average national rent for a modest one bedroom rental unit in the United States rose to 105 percent of SSI – up from 98 percent in 2000. In 2002, of the nation’s 2,702 housing market areas, there was not one single area where modestly priced rental units were affordable to people with disabilities receiving SSI (Disability Policy Collaborative, n.d.).

Concerted efforts must be mounted to meet the housing needs of diverse populations. People from different cultures approach their service needs in various ways, and significant diversity exists in regard to the definition of family, willingness to seek out-of-home placement, decision-making, permanency planning, and a host of other issues related to the support needs of individuals with mental retardation and their families (e.g., Heller & Factor, 1988; Magaña, 1999 in Parish, 2003).

PUBLIC POLICY ISSUES

There are a variety of public policies that support persons with disabilities on a continuum from relatively independent functioning to severely impaired. Some of the resources such as the Section 8 Housing Choice Voucher Program are for housing only; others, such as the Medicaid waivers, are for supportive services only; and still others are for both housing and supportive services such as Section 811. Below is further explanation of these major programs.

Section 8 Housing Choice Voucher Program

While speaking of the past budget period, this excerpt from the Disability Policy Collaborative (n.d.) offers a flavor of the current Administration’s attitude about Section 8 in general and, more specifically, for availability of vouchers for persons with disabilities. Seventy-five percent of Section 8 households are required to have extremely low incomes, i.e., under 30 percent of the area median income (\$18,400/4) and the remaining 25 percent must be very low income, i.e., 30 to 50 percent of AMI (\$21,500 to \$30,700/4). They pay 30 percent of their adjusted income in privately owned housing scattered throughout various communities.

The Administration’s FY 2006 budget requested a total of \$15.9 billion for the Section 8 Housing Choice Voucher program, \$14.1 billion of which was for voucher renewals. No funding was proposed for new/incremental vouchers targeted for people with disabilities. This request would have funded approximately 2 million vouchers – only 94 percent of the vouchers currently administered by PHAs (public housing authorities). Full funding would allow PHAs to use all vouchers authorized by Congress. Prior to FY 2004, Congress fully funded all vouchers, including (from 1997-2001), vouchers targeted to people with disabilities. Since 2004 PHAs have not had sufficient funding to use all of their authorized vouchers.

Funding information will be discussed in Section IV of the report.

Section 811 Supported Housing

Section 811 provides housing for people with physical or developmental disabilities, or people with chronic mental illness who are 18 years of age or older and have very low incomes (at or below 50 percent of the area median income). Section 811 participants may live in supportive housing units developed and owned by nonprofit organizations or they may receive tenant-based rental assistance that helps them rent decent and safe housing in the private rental market. As with Section 8, tenants pay 30 percent of their adjusted income for rent which historically has ensured affordability for those receiving SSI benefits (Disability Policy Collaborative, n.d.).

Section 811 has two separate program components: (1) the Capital Advance/Project Rental Assistance Component (PRAC) component administered by HUD's Office of Housing; and (2) a completely separate tenant-based rental assistance component administered by HUD's Office of Public and Indian Housing under the Section 8 Mainstream Housing Opportunities for Persons with Disabilities program. The Capital Advance/PRAC component provides interest-free capital advances to nonprofit sponsors to help finance the development of permanent supportive rental housing such as independent living projects, condominium units, and small group homes that also offer voluntary supportive services for people with disabilities. The capital advance can finance the construction, rehabilitation or acquisition (with or without rehabilitation) of supportive housing. The capital advance does not have to be repaid as long as the housing remains available for very low income people with disabilities for at least 40 years. A five-year renewable PRAC is also awarded with the capital advance and covers the difference between the HUD-approved cost of operating the housing (maintenance and repairs, utilities, insurance etc.) and tenant rents which are set at 30 percent of income. (National Low Income Housing Coalition, 2006)

A recent Section 811 "Mixed-Finance" regulation published by HUD on September 13 2005 permits Section 811 funding to be used in conjunction with low income housing tax credits as well as other sources of funding. The rule sets standards for the participation of limited partner investors (who may be for-profit entities) in partnership with a sole-purpose nonprofit general partner. (National Low Income Housing Coalition, 2006)

Since 1997, new Section 811 tenant-based assistance funding has been made available through a separate Section 8 Mainstream Housing Opportunities for Persons with Disabilities NOFA (Notice of Funding Availability). According to the statute, up to 25 percent of Section 811 appropriations can be used for tenant-based rental assistance. HUD has used 811 tenant-based rental assistance funds to create 14,000 rental vouchers in the Section 8 Mainstream Housing Opportunities for Persons with Disabilities program. These vouchers are administered by an estimated 145 Public Housing Agencies (PHAs) and 40 nonprofit organizations. Under current HUD policy, these mainstream vouchers are

administered in virtually the same manner as regular Section 8 vouchers in terms of programmatic rules, even though they are funded and renewed from HUD's Section 811 appropriation. Guidance issued by HUD in 2004 and 2005 requires that: (1) PHAs track mainstream vouchers separately from other PHA Section 8 vouchers; and (2) PHAs issue and re-issue mainstream vouchers only to people with disabilities. The number of new vouchers made available and the requirements of the NOFA have varied greatly from year to year, depending on HUD policies. (National Low Income Housing Coalition, 2006)

The excerpt below outlines the funding policy direction of the Section 811 program.

The Administration's FY 2006 budget proposed to slash Section 811 by 50 percent - dropping funds to \$120 million from \$238 million enacted in FY 2005. Most critically, the budget proposed to completely eliminate all funding for new unit production in FY 2006 by zeroing out the capital advance component of the program. This unprecedented cut ends an over 30 year commitment to support the production of new housing targeted to non-elderly people with severe disabilities.

Section 811 is the only HUD program that produces affordable and accessible housing for non-elderly people with disabilities.... Many people with severe disabilities either require supports or units with a higher degree of physical accessibility than is available in the private market. By limiting Section 811 funding solely as tenant based vouchers, the Administration proposes a major change in the targeting of the Section 811 program—away from people with severe disabilities, who have the most significant housing needs. (Disability Policy Collaborative, n.d.)

Unless appropriations are increased, voucher renewals will consume a greater percentage of the Section 811 appropriation each year and funding for new units will continue to decline. The Consortium for Citizens with Disabilities Housing Task Force has projected that unless appropriations levels rise to keep pace with increasing renewal costs, funding for new unit production will be eliminated by 2012 (National Low Income Housing Coalition, 2006).

HUD monitoring and PHA tracking of Section 811-funded mainstream vouchers has also been a major concern. In most respects, the mainstream vouchers HUD awarded to certain PHAs are identical to the Section 8 housing choice vouchers administered by those PHAs. Advocates are concerned that recent Section 8 fiscal problems at many PHAs—and a lack of 811 mainstream program guidance and tracking from HUD—may result in these vouchers not being fully or properly utilized. A HUD notice issued to PHAs in early 2005 now permits HUD to track mainstream voucher utilization, but advocacy at the local level is also needed to ensure that scarce 811 funding is used only for people with disabilities (National Low Income Housing Coalition, 2006).

Funding information will be discussed in Section IV of the report.

Intermediate Care Facilities for Mentally Retarded (ICF-MR).

The Medicaid program, which is federally supported but state administered, is the primary source of economic aid for both nursing

homes and intermediate care facilities (ICFs), although other funds are available. In general, individuals with developmental disabilities qualify for Medicaid benefits by meeting the disability and financial criteria established for the Supplemental Security Income (SSI) funding. ICFs must meet federal standards intended to ensure that residents live in a safe environment, are supervised by qualified staff, and receive appropriate habilitation and medical treatment. Individuals who meet the disability criteria for Medicaid funding generally must be both mentally impaired (with an IQ of 50 or less) and functionally disabled (incapable of performing the ordinary activities appropriate for persons of their age). Financial eligibility is based upon the economic resources of the developmentally disabled individual (Thomson-Gale, 2005).

The ICF/MR benefit is an optional Medicaid benefit. The Social Security Act created this to fund “institutions” (4 or more beds) for people with mental retardation, and specifies that these institutions must provide “active treatment,” as defined by the Secretary. Currently, all 50 states have at least one ICF/MR facility. Most have residents with other disabilities as well as mental retardation. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. All must qualify financially for Medicaid assistance.

Since the implementation of the current regulations in 1988, there has been a major shift in thinking in the field of developmental disabilities. Emphasis is now on people living in their own homes, controlling their own lives, and being an integral part of their home community.

Consistent with this philosophical shift, the Health Care Financing Administration sought to reform the Medicaid ICF/MR (Intermediate Care Facilities for Mentally Retarded) program during FY’s 2006-2007 budget development process. The goal was to enable consumers to receive services in cost-effective settings they prefer; to control expenditure growth in the long term; to mitigate the state’s fiscal liability; and to achieve federal compliance. The drive to eliminate ICF/MR in Ohio was unsuccessful due to the efforts of advocates.

Medicaid reform is a major concern for parents and service providers. Budget cuts and more restrictive policies on eligibility, services, etc. from the federal government and states impact the provision of service. In Ohio, the proposed

...elimination of the ICF/MR program would have cost Ohio an estimated \$111 million a year in lost federal funds. One reason for this is that the federal government has never agreed to pay for room and board in an alternative waiver program. It is an allowable expense with an ICF/MR. In addition, there is an additional \$18 of federal money that is generated from a state tax on ICF/MR services based on “every day and every bed.” This tax generates a total of \$30 million a year that is used solely for waiver services. This would be lost with the elimination of Ohio’s ICF/MR’s. This is a loss of more than \$129 million per year that the state would have to make up—just to maintain the current level of services. (Partners for Choice and Quality Care, 2005)

According to Plante & Moran:

The state's 2005 biennial state budget bill, House Bill (H.B. 66), had a major impact on the operations and profitability of many health care providers in the state of Ohio. As many trade associations have stated, the new catch phrase is "Rebalancing," which is a shifting of public dollars from "institutional" care to home and community-based care (HCB). The following are some of the highlights of H.B. 66 that will shape the future of the continuing care industry.

- ICF/MR rates will be frozen at the June 30, 2005 rate.
- There will be no adjustments for acuity in FY2006 or FY2007.
- There are no provisions for rate adjustments for CHOPs or capital projects during FY2006.
- New ICF's/MR in FY2006 will receive the statewide median rate.
- Due to the elimination of the CAFS program, facilities will receive an add-on of approximately \$32.00 per day to assist in covering these additional costs.
- While Governor Taft proposed to eliminate the ICF/MR benefit and establish a waiver program, the final version of House Bill 66 creates a pilot program. There will be a three year pilot waiver program which will include 200 beds. The pilot can not be expanded into a statewide program without approval from the General Assembly along with the federal government. (Plante & Moran, 2005)

Funding information will be discussed in Section IV of the report.

Medicaid and the Deficit Reduction Act of 2005.

The Deficit Reduction Act of 2005 offers reforms in both Medicare and Medicaid that could, according to Congress, save the federal government \$26.5 billion in Medicaid expenditures over a ten-year period (Pear, 2005). Although some believe that a \$10 billion cut from Medicaid's \$300 billion program is not extraordinary (and perhaps not even enough), others are wary of the problems that this already taxed system and much-needed source of health provision will encounter with its paring. Under this legislation, states are allowed to charge premiums and higher co-payments for services including prescription drug coverage, physicians' services, and hospitalization (to encourage personal responsibility); scale back benefits or eliminate coverage for services currently guaranteed by federal law; and end coverage for people who do not pay premiums after 60 days (Pear, 2005; American Public Health Association, 2006). Beneficiaries (which include children) may also be required to share costs for what would be deemed "inappropriate use" of emergency services in the hospital (Corlett, 2006). The act also makes it more difficult for older adults to qualify for coverage of skilled nursing facility care after transferring assets to children or other relatives (Pear, 2005).

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

Other areas of change from the Act that specifically affect residential options for persons with disabilities are:

- Expands access to home- and community-based services (HCBS) for the elderly and disabled by allowing states to establish new HCBS as a state plan option for those who would not qualify for Medicaid coverage for nursing home care and without applying for a waiver. Qualified individuals would need incomes up to 150 percent of federal poverty level and they would not need to meet institutional level of care requirements.
- Permits states to provide, as a state plan option, payment for self-directed personal assistance services based on a written plan of care for persons eligible for personal assistance services or HCBS services.
- Makes individuals with home equity in excess of \$500,000 ineligible for Medicaid long-term care services and creates a state option to increase this threshold to not more than \$750,000. Provision would not apply if the spouse, a child under age 21, or a blind or disabled child resides in the home.
- Requires residents of continuing care retirement facilities (CCRF) to require residents to spend their resources on their care first before applying for Medicaid.

According to the Disability Policy Collaboration (2005), people with disabilities and their families believe Medicaid can be improved in several ways:

- Eliminating the institutional bias and creating a structure that makes home and community services the basic long-term service in Medicaid.
- Ensuring individual and family choice and control over long-term services and supports.
- Improving community-based workforce stability through increased reimbursement rates (for) direct service workers.
- Allowing families of children with severe disabilities to buy into the Medicaid program for health care and long term supports for their children.

Medicaid Waivers

Prior to the development of ICFs, care of individuals with developmental disabilities had been the responsibility of individual states. Most individuals with developmental disabilities who did not live with their families were placed in large state facilities, generally in rural and isolated locations, that emphasized custodial care rather than treatment. By the 1950s, parents and advocates of individuals with developmental disabilities began to push for the reform of such large state institutions and for the development of community-based services, whereby individuals with developmental disabilities could receive special services but continue to live at home. In 1962, a panel appointed by President Kennedy recommended that only developmentally disabled individuals whose specific needs were appropriately met by institutional services should be placed within state facilities. This panel also recommended that federal and state agencies and local communities cooperate in the establishment of community services for individuals with developmental disabilities. In the 1960s and 1970s, with the press reporting on the often harsh conditions to which institutionalized individuals with developmental disabilities were subjected, the movement to reform and provide

alternatives to large custodial facilities gained momentum. (Thomson-Gale, 2005)

Until the 1970s, individual states bore the economic burden of providing for individuals with developmental disabilities. In that decade, however, Congress began enacting legislation to provide federal funds for the treatment of developmentally disabled individuals. In 1971, Congress authorized the use of federal Medicaid funding for the services to be provided by ICFs. The purpose of Congress' substituting federal for state funding was to encourage reform by imposing federal standards on state facilities. Throughout the 1970s, federal expenditures on ICFs rose rapidly, initially due to an increase in the enrollment of individuals with developmental disabilities who qualified for Medicaid benefits. In 1981, the congressional Omnibus Budget Reconciliation Act authorized home- and community-based waivers whereby states could apply Medicaid funding for individuals with developmental disabilities to services provided in non-institutional settings. Since that time, increasing numbers of individuals who otherwise would have been directed to ICFs are being treated within their homes and communities. . (Thomson-Gale, 2005)

Currently every state in the nation has at least one waiver program and, in fact, there are nearly 300 waivers in operation serving 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 Access and Medicaid Waiver Redesign.

In Ohio, the review of the system as it exists today, coupled with feedback from consumers and their advocates, led the agencies involved in Ohio Access to call for a new vision of a service delivery system for persons with disabilities. Ohio Access honors the commitment of families who provide care and supports them in their efforts. Eighty percent of all long-term care is provided by an informal network of care that includes family, friends, and neighbors. Government programs should respect and integrate with the family's historic and primary role in care giving.

This vision emphasizes consumer choice, control, and autonomy. The cornerstone of the vision is consumer self-determination and a person-centered planning approach with assistance from family, friends, and caregivers. Consumers will be given more control over the funds available for their care and be integrally involved in their choice of services and caregivers that comprise their individual service plan. A holistic approach to person-centered planning and care will ensure consideration of each consumer's physical, mental, emotional, and spiritual needs (Johnson et al, 2001).

Ohio Access calls for the redesign of several waiver programs affecting individuals with MR/DD. Below is a summary of waivers directly affecting individuals with MR/DD and residential living options for people with disabilities.

Level One - This waiver, offering limited support such as respite services and home modification for persons with cognitive disabilities and their families, is funded with a combination of federal, state, and local dollars.

ODMR/DD developed this waiver in FY 2003 to provide 6,000 waiver slots over three years to individuals for whom \$5,000 per year in services and supports is enough for them to stay in a home or community setting. By SFY 2006, ODMR/DD will release at least 1,000 additional Level One waiver slots to county boards of MR/DD to serve additional individuals, as funds are available. (Ohio Access, 2004)

Individual Options (IO) and Level Three — The IO waiver serves approximately 7,000 Ohioans with developmental disabilities. Ohio recently received approval from CMS to serve an additional 2,000 individuals on the IO waiver. Reform efforts will result in two distinct waivers with different cost caps: a redesigned IO waiver which will serve individuals who rely on publicly funded services of approximately \$5,001 to \$79,500 per year, and the Level Three waiver, which will serve individuals with publicly funded service costs that exceed \$79,501 per year. Individuals will be assigned to one of these waivers based on an assessment of their need and existing amounts and types of support that they receive. IO was to have been renewed March 1, 2004. At that time, an individual cost cap would have been equal to the average cost of providing services to a person with similar needs in a licensed ICF/MR setting. Current waiver enrollees whose service costs were above the newly established cap were to have been grandfathered into IO in the first year. As Level Three was implemented, these consumers' needs were to be evaluated to determine whether the Level Three waiver met their needs. (Ohio Access, 2004)

Residential Facilities Waiver (RFW) — This waiver serves approximately 2,500 Ohioans with developmental disabilities in licensed facility-based settings. RFW will be redesigned to enable money to follow the person, meaning that an RFW consumer can change service providers and retain their waiver "slot." (Currently, the "slot" belongs to the licensed facility, not the individual receiving services.) This is consistent with the Ohio Access goal of offering individuals meaningful choices. ODMR/DD and ODJFS will redesign RFW to enable money to follow the person and, by SFY 2008, move all RFW consumers to the IO waiver and eliminate RFW. (Ohio Access, 2004)

CAFS Skills Development and Supports — ODJFS and ODMR/DD are redesigning the Community Alternative Funding System (CAFS) state plan program to move some services onto ODMR/DD-operated waivers and to modify other services to better manage the program. These changes will make it easier for individuals and families to understand their options under CAFS and Medicaid. For example, CAFS covers skills development and supports provided through day services, but in order to access these services, a person must be enrolled in a Medicaid waiver. The redesign will make skills development and supports provided through day services available through waivers. (Ohio Access, 2004)

Independence Plus for People with Developmental Disabilities— ODMR/DD received a three-year grant from the Centers for Medicare and Medicaid Services to develop an Independence Plus waiver. This waiver would enable individuals to self-direct some or all of their waiver services. Individuals would be assigned a "personal budget" based on an assessment of their medical need and existing amounts and types of support that they receive. After that, a "fiscal intermediary" would be appointed in order to provide assistance to consumers and their families as they choose specific services and providers. (Ohio Access, 2004). Pilot is scheduled for implementation FY 2007. (Ohio Department of Mental Retardation and Developmental Disabilities, 2006)

Community Access Model Waiver — As the Apple Creek and Springview Developmental Centers close over the next two years, ODMR/DD remains committed to self-determination strategies for residents who want to leave these facilities and live in a community setting. The Community Access Model Waiver will enable ODMR/DD to support these individuals as they opt to leave Developmental Centers in favor of smaller community settings. (Ohio Department of Mental Retardation and Developmental Disabilities, 2006)

ICF/MR to Waiver Conversion - As was previously discussed, Ohio proposed removing the federal entitlement for Intermediate Care Facility for the Mentally Retarded (ICF/MR) services from the state's Medicaid plan. This change would have eliminated the institutional entitlement and replaced those services with a new waiver. Under the new plan, individuals currently living in an ICF/MR would have been able to choose where they received those services. However, Ohio's General Assembly chose to modify the plan in favor of a pilot program test the concept with 200 volunteers over a 3-year period. The pilot program was included in the state's 2006- 2007 biennial budget. (Ohio Access, 2004)

Family Opportunity Act

On February 8, 2006, the Family Opportunity Act (FOA) was enacted as part of the final federal budget law, the Deficit Reduction Act (DRA). Supported by many organizations that advocate for children and adults with disabilities, the purpose of the FOA is to allow middle-income families with children who have severe mental or physical disabilities to purchase health care coverage through the Medicaid. Under the legislation, individual states:

- can create a new *optional* Medicaid eligibility group for children with disabilities under age 19:
 - a) who meet the severity of disability required under SSI without regard to any asset or eligibility requirements under SSI for children, and
 - b) whose family income does not exceed 300 percent of the federal poverty level (approximately \$58,500 for a family of four).
- can require cost-sharing (premiums and co-pays) on a sliding scale based on income, but cannot exceed five percent of family income up to 200 percent of the federal poverty

level, and 7.5 percent of family income from 200-300 percent of federal poverty. The state may waive payment of a premium in any case where the state determines that requiring a payment would create an undue hardship. (Ohio Legal Rights Services, 2006)

The provision goes into effect on January 1, 2007. The federal law includes a phase-in approach. In the first year, states can offer Medicaid services to families with incomes up to \$60,000 for a family of four if their child is under the age of 6. In the next year, children up to age 12 can participate and in the third year, children under the age of 18 can participate. (Ohio Legal Rights Services, 2006)

States now need to pass legislation to implement the Family Opportunity Act. Ohio currently does not have a Medicaid buy-in program for children with disabilities. The Ohio Disabilities Council is actively advocating for this provision, and it is a component of their 2007 Public Policy Platform (Ohio Developmental Disabilities Council, 2006).

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

For this core service report, the target population is defined as adults 18 to 64 years with severe disabilities who need a structured environment, personal assistance, and various therapies to manage and learn to manage the activities of daily living. Disabilities can consist of intellectual disabilities and related developmental disabilities (ID/DD) and/or multiple disabilities, a host of medical conditions, or behavioral problems. This population includes persons with moderate, severe, and profound mental retardation with multiple disabling problems and may need assistance throughout their lives. It does not include older persons with moderate to severe disabilities (they are discussed in the In-Home Assistance report).

DEMOGRAPHIC CHARACTERISTICS

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

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

In Cuyahoga County in 2000, 143,094 persons 21 to 64 years had one or more disabilities. Of the 75,046 persons with one disability, employment-related disabilities were most prevalent, followed by physical disabilities. Of those with two or more types of disability, 20,442 were go-outside home and employment disabilities, (See Table 1.)

Table 1: Persons with Disabilities, 21-64 Years, by Disability Type, Non-Institutionalized, Cuyahoga County , 2000

	Total Population	With Disability	Specific Disability	Percent of Age Cohort
21 to 64 years:	775,695	143,094		18.4%
With one type of disability:		75,046		9.7%
Sensory disability			7,675	
Physical disability			16,274	
Mental disability			6,614	
Self-care disability			360	
Go-outside-home disability			6,886	
Employment disability			37,237	
With two or more types of disability:		68,048		8.8%
Includes self-care disability			15,021	
Does not include self-care disability:			53,027	
Go-outside home and employment only			20,442	
Other combination			32,585	
* "Disability" is defined by the US Census as a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business.				
Source: U.S. Census 2000, SF3 (PCT26)				

Mental retardation is one of the major disabilities that greatly affects residential living options for people with disabilities. Its prevalence in North America is a subject of heated debate. Mental retardation is thought to be between 1 and 3 percent, depending upon the population, methods of assessment, and criteria of assessments used (minddisorders.com, n.d.). The American Network of Community Options and Resources (2006) estimates that, nationally, 1.58 percent (4.618 million) had MR/DD; and 0.78 percent or 2.308 million had MR only. In Ohio, there were 178,471 people with MR/DD and 88,106 with MR (based on applying U.S. prevalence rates).

Mental retardation begins at birth and developmental disabilities begin before the age of 22 and persist throughout adult life. Mental retardation is diagnosed if an individual has an intellectual functioning level well below average, as well as significant limitations in two or more adaptive skill areas. Intellectual functioning level is defined by standardized tests that measure the ability to reason in terms of mental age (intelligence quotient or IQ). Mental retardation is defined as an IQ score that is 1 standard deviation below 100 (minddisorders.com, n.d.).

Mental retardation varies in severity. The *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (*DSM-IV-TR*), which is the diagnostic standard for mental health care professionals in the United States, classifies four different degrees of mental retardation: *mild*, *moderate*, *severe*, and *profound*. These categories are based on the person's level of functioning (minddisorders.com, n.d.).

- *Mild mental retardation.* Approximately 85 percent of the mentally retarded population is in the mildly retarded category. Their IQ score is 1 standard deviation below 100 and they can often acquire academic skills up to about the sixth-grade level. They can become fairly self-sufficient and in some cases live independently with community and social support (minddisorders.com, n.d.).
- *Moderate mental retardation.* About 10 percent of the mentally retarded population is considered moderately retarded. Moderately retarded persons have IQ scores that are 2 standard deviations below 100. They can carry out work and self-care tasks with moderate supervision. They typically acquire communication skills in childhood and are able to live and function successfully within the community in such supervised environments as group homes (minddisorders.com, n.d.).
- *Severe mental retardation.* About 3–4 percent of the mentally retarded population is severely retarded. Severely retarded persons have IQ scores that are 3 standard deviations below 100. They may master very basic self-care skills and some communication skills. Many severely retarded individuals are able to live in supported or assisted living homes (minddisorders.com, n.d.).
- *Profound mental retardation.* Only 1–2 percent of the mentally retarded population is classified as profoundly retarded. Profoundly retarded individuals have IQ scores that are 4 standard deviations below 100. They may be able to develop basic self-care and communication skills with appropriate support and training. Their retardation is often caused by an accompanying neurological disorder. Profoundly retarded people need a high level of structure and supervision (minddisorders.com, n.d.).

Many people with mental retardation exist at the economic and social margins of American society (Edgerton, 2001; Tymchuk, Lakin, & Luckasson, 2001). They are much more likely to live in poverty and have substantially lower employment rates than do people in the general population. Approximately one third of adults with mental retardation lived below the federal poverty level in 1994, as compared with 13 percent of adults without mental retardation (Larson, Lakin, Anderson, Kwak, & Lee, 2000).

Determining the living arrangements for persons with disabilities is a challenge. A study from the 1990 U.S. Census that gathered information on persons with work disabilities, mobility limitations, or self-care limitations provided the most current picture. The study found that 10.4 percent of the civilian non-institutional population aged 16 to 64 (16.4 million) had at least one of these disabilities. Of these 76.8 percent (12.6 million) lived with a spouse; 812,214 of them lived alone (5 percent); 137,534 lived in group quarters (0.8 percent); and the remainder lived with a relative other than a spouse, or some other person (17.4 percent). (See Table 2.)

Table 2: Living Arrangements of Persons 16 to 64 YEARS with ONE or More Disability, 1990

Living Arrangement	#	%
Lives with Spouse	12,602,825	76.8%
Lives Alone	812,214	5.0%
Lives in Group Quarter	137,534	0.8%
Lives with Relative (non-spouse)	2,855,115	17.4%
TOTAL	16,407,688	100.0%

Source: 1990 Census; Schafer, R., 1998

The living arrangements for persons with disabilities are not static. Research has shown that adults with disabilities change their housing arrangements for many reasons. For example, they may not be able to maintain their household, have trouble doing everyday activities, need therapy or nursing services, or are lonely. In a study conducted by Newcomer, King, Kaye, and LaPlante (2002), it was found that almost one out of every five adults with disabilities moved between 1994 and 1996. About 10 percent of those moving went to an institution or supportive housing setting.

People ages 65 or younger were twice as likely to move as those over age 65. Those over age 65 were four times more likely to move into a supported housing setting. Among all age groups, a move is more common from apartments than from homes. (Newcomer, et al., 2002)

Contrary to their expectations, the ability to do daily living activities was not the most important factor in deciding to move. Income, living by self, and other reasons also were important, and additional reasons such as personality weren't included in the study. Of daily living activities studied, bathing, dressing, eating, and toileting typically increased the likelihood of moving. Transferring from beds or chairs seemed to be the least likely cause for moving. (Newcomer et al., 2002)

In addition to housing, supportive services are often an essential component of housing for persons with disabilities. A recent study published in the *Journal of Gerontology* (LaPlante, Kaye, and Harrington, 2004) found that more than 3 million people in the U.S. need help from another person to live independently, and many of them face going hungry, falling, or other problems that increase the risk of institutionalization and death.

This study by researchers at the Disability Statistics Center at the University of California at San Francisco describes how well adults with long term care needs who are living in houses or apartments in the community rather than in nursing homes are doing. Such individuals need assistance from another person in activities of daily living (ADL) that are essential for their survival, including bathing, dressing, getting into or out of bed or a chair, toileting, and eating and other activities that are necessary to maintain their homes, such as shopping and preparing meals. The study, funded by the National Institute on Disability and Rehabilitation Research, is the first to estimate how many additional hours of help people need. (LaPlante et al., 2004)

Most of these adults receive some help, but not enough to fill their unmet needs. Individuals with unmet need for personal assistance with two or more of the five basic ADLs (activities of daily living) have a shortfall of 16.6 hours of help per week compared with those whose needs are met. (LaPlante et al., 2004)

Having unmet needs with ADLs is linked with numerous adverse consequences, especially for people who live alone. Those with unmet need are 10 times as likely to go hungry because no one is available to help them eat as those whose needs are met (24.5 versus 2.1 percent), 20 times more likely to miss a meal because of lack of help with shopping (15.3 versus 0.7 percent), 5 times as likely to lose weight unintentionally (52.2 versus 10.0 percent), and almost three times as likely to fall because no one was around to prevent their falling (64.5 versus 24.5 percent). As a result, these people are at risk of being forced to leave their homes and move into institutions, such as nursing homes. (LaPlante et al., 2004)

Among adults whose assistance needs are not fully met, people living alone fare worse than those who live with others. Those living by themselves receive only 56 percent of the help they need, while those living with family members or friends receive 80 percent of the hours of help they need. The shortfall is twice as great for persons who live alone as for those who live with others, the researchers found. People who live alone and have unmet needs fare worse than people with unmet needs who live with others, and both groups are more likely than those whose needs are met to experience adverse consequences. (LaPlante et al., 2004)

The causes of unmet need are many. Informal helpers, such as family and friends, may have to balance other responsibilities that limit the amount of help they can provide. People without informal help depend largely on formal assistance, if affordable and available. Such public help remains biased toward institutional living. (LaPlante et al., 2004)

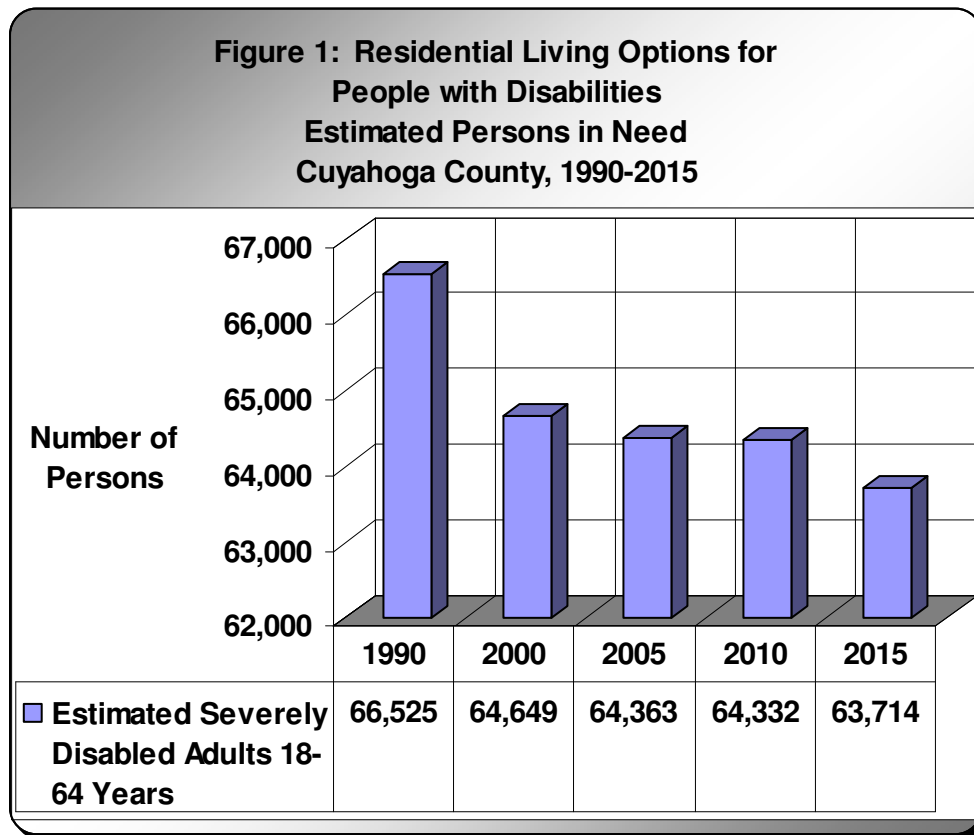
Working-age adults account for half the prevalence of met and unmet need among those needing help in two or more ADLs. The researchers analyzed the working-age population separately and found that the relative shortfall in needed hours was somewhat smaller than for all ages combined (18 versus 23 percent). However, unmet need among people living alone is more an issue for the elderly, because two-thirds of those living alone and needing more help are age 65 or older. (LaPlante et al., 2004)

Access to paid help is critical for people who live alone because they are much more likely to receive paid help than are people who live with others (62 versus 24 percent). Of people who live alone, those whose needs are met are more likely than those whose needs are unmet to get paid help (70.2 versus 50.3 percent). More than half of that help is reported to be paid by Medicare or Medicaid. (LaPlante et al., 2004)

Thus, the study found, expanding access to paid PAS appears crucial in reducing unmet need among those who live alone. If the estimated shortfall in hours were to be provided through public funds, the cost of eliminating unmet need among people who live alone with low income ranges from \$1.2 to \$2.7 billion, a relatively small amount. However, the cost for people who live with others is almost twice as large, from \$2.2 to \$7.1 billion. (LaPlante et al., 2004)

Estimated Persons in Need

In 2000, an estimated 64,649 persons 18 to 64 years in Cuyahoga County were severely disabled and in need of residential living options for people with disabilities. This number is projected to decrease to 63,714 by 2015 because of population shifts. (See Figure 1.)



Sources:
 * U.S. Census 1990, STF 1 (P11); 2000, SF1 (P12); 2005-2015, Ohio Department of Development, (July, 2003). Note: Ages 18 to 20 in 2005-2015 prorated from ages 20+ using ratio of 18 to 20 in 2000.
 ** "People have a physically severe functional limitation if they are unable to perform a physical function or if they need the help of another person to perform the function. An estimated 7.8 percent of those age 15 and older (15.2 million people) are severely limited in the functions of seeing, hearing, having speech understood, lifting or carrying, walking, or using stairs" (Chartbook on Disability in the U.S., 1996). This percentage was applied to the population 18-64 years across all periods.

This estimate begins to provide clarity about the potential need for residential living options for people with disabilities.

REALIZED ACCESS TO SERVICE

Realized access to service is represented by the number of consumers actually served. It includes the actual number of consumers reported by agencies funded by United Way and by government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

In FY 2004, United Way funded 83 persons for Residential living options for people with disabilities. (See Attachment 3.) Other funders included Catholic Charities (366), the Cuyahoga County Board of Mental Retardation and Developmental Disabilities (MRDD) (1,382), and Medicaid (1,348).

Per the 2000 U.S. Census, while 48 percent of the county's total 18-64 population was male and 52 percent female, providers funded by United Way served 64 percent males and 36 percent females, and Catholic Charities served 41 percent male/59 percent female. This data was not available for Medicaid or MRDD consumers.

Racially, according to the 2000 U.S. Census, 68 percent of the county's 18-64 population was Caucasian, 26 percent African American, and 2 percent Asian. United Way funded 68 percent white, 29 percent African American, and 0 percent Asian. Catholic Charities funded 40 percent white, 49 percent African American, and 0 percent Asian; Medicaid funded 65 percent white, 36 percent African American, 0 percent Asian.

Three percent of the county's 18-64 population was Hispanic. United Way funded 1 percent Hispanic consumers, Catholic Charities 0.3 percent, and Medicaid 2 percent.

The largest proportion of consumers funded by United Way was between 15 and 64 years (86.7 percent). However, there were a few (20 percent) between 5 and 14 years. For the most part, age was unreported for Catholic Charities' consumers, and Medicaid's were primarily 20 to 64 years (64.7 percent), followed by 33.8 percent ages 55 to 74 years. Slightly more than five percent were under age 14.

One hundred percent of United Way consumers had household income between \$0 and \$9,999. This information was not available from the other funders.

Geographically, 100 percent of consumers funded by United Way were in suburbs, specifically in four zip codes: 44117 (Euclid/Cleveland), 44120 (Shaker Heights/Cleveland Heights), 44124 (Pepper Pike/Mayfield Heights/Lyndhurst), and 44121 (University Heights/South Euclid). No data was available for Catholic Charities. Medicaid consumers were 14 percent Cleveland and 86 percent suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The types of housing provided through residential living options for people with disabilities can include intermediate care facilities or community-based options at either market rate or government subsidized. A variety of supportive services are provided, including personal assistance, health, and therapies

BACKGROUND ON CORE SERVICE

Residential living options may be characterized as short- or long-term supportive housing arrangements that provide protection, support and services for disabled adults. Long-term arrangements enable chronically disabled adults to live independent lives, care for themselves, hold jobs and be self sufficient, but with the possibility of some supports from an outside organization as may be needed. There are different combinations of these based on the level of disability and the availability of caregivers from the informal network. Essentially there are two primary modes of housing for persons with disabilities: institutional and community-based supported living. There are multiple options within each.

Institutional Options:

Residential Care Facility (Assisted Living): licensed by the Ohio Department of Health to provide supervised accommodations for 17 or more adults, and personal care services for at least 3 residents. A limited amount of skilled nursing care can be provided.

Nursing Home: a facility licensed by the Ohio Department of Health to provide intermediate and skilled nursing care on a 24 hour a day basis, 365 days per year. Nursing homes are licensed by the state and fall into various categories, including county and rest homes, homes for the aging, mental health nursing homes, skilled nursing facilities (SNF's), and intermediate care facilities (ICF's). (WRAAA, 2002)

- A skilled nursing facility (SNF) provides skilled nursing or rehabilitative services supervised by a physician and rendered by technical and professional personnel, including a registered nurse, licensed practical nurse, physical therapist, speech therapist, etc. (WRAAA, 2002)
- An intermediate care facility (ICF) is defined by the *Code of Federal Regulations* (4-1-93 Edition) as

...a proprietary facility or a facility of a private nonprofit corporation or association licensed or regulated by the State...for the accommodation of persons, who, because of incapacitating infirmities, require minimum, but continuous care, but are not in need of continuous medical or nursing services. The term also includes additional facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day. (Thomson-Gale, 2005)

ICFs provide inpatient nursing and rehabilitative services, predominantly to individuals with developmental disabilities. Though they operate 24

hours a day, services are not provided on a continuous basis. Personnel in ICFs must include 24-hour staff in addition to a licensed nurse on duty full-time each day. The term “developmental disabilities” generally refers to mental retardation. Therefore, ICFs often are designated as ICF/MRs—Medicaid-funded facilities that provide residential care and services for individuals with developmental disabilities. ICF/MR services were used primarily by the aged (34.9 percent) and the disabled (6.9 percent), and not by low-income children or low-income adults. (Thomson-Gale, 2005)

Although the majority of individuals with mental retardation or related conditions are able to live with their families or other adults in ordinary homes, other individuals with developmental disabilities are cared for in ICFs. Alternatively, individuals with developmental disabilities who require continuous medical or nursing care can be placed in nursing facilities. Many patients reside in ICF/MRs from youth until old age. (Thomson-Gale, 2005)

ICFs also can provide care to individuals with cerebral palsy, epilepsy, or other severe impairments of the central nervous system, not attributable to mental illness, that result in physical, mental, and behavioral disabilities comparable to those caused by mental retardation. (Thomson-Gale, 2005)

The individuals with developmental disabilities in ICFs typically require both health care and special services due to limited capabilities for self-care—housekeeping, language, social, and vocational skills. The health care offered by ICFs must include a consultation by a registered nurse at least once a week on the delivery of health care to individual inpatients and a licensed nurse on full-time duty for each day shift. Other services that ICFs provide include habilitation (training) in daily living, self-help, socialization, prevocational skills (such as focusing on tasks and observing time schedules), and vocational skills. Some ICF programs sponsor sheltered workshops, whereby disabled individuals receive less than minimum wages, calibrated to individual productivity, for economic output; and supported employment, whereby disabled individuals join non-disabled persons in work settings. ICFs sometimes provide recreational activity centers for inpatients and respite care (temporary care of individuals with developmental disabilities who generally reside with and are cared for by their families). (Thomson-Gale, 2005)

Many individuals reside in ICFs/MR from youth until old age, which means that these facilities become a true home and staff become a second—and sometimes only—family for some residents. Direct care staffing requirements are based on client age and level of disability. Direct care staffing is defined as on-duty staff that is present, calculated over all shifts in a 24-hour period for each defined residential living unit. For each defined residential unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, clients who are aggressive and pose security risks, or clients who are severely hyperactive or demonstrate psychotic-like behavior, the staff to client ratio is 1 to 3.2.

Community-based Supported Living Options:

Over time, the State of Ohio has been phasing out the large developmental center institutions that once were the primary housing resource for persons with mental retardation and developmental disabilities (MR/DD). In Cuyahoga County, only the Warrensville Developmental Center remains, and plans are underway to reduce its current population of over 200. In place of the traditional institutional setting, the Cuyahoga County Board of Mental Retardation and Developmental Disabilities (CCBMRDD) offers a range of options for persons with MR/DD to live in the community in the least restrictive environment. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

The Family Resources Program helps families in their efforts to care for a relative with MR/DD at home, avoiding the need for residential placement. Families can receive respite care, special equipment, home modifications, special diets and counseling. A sliding scale based on taxable income determines the family's financial participation in the costs. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

Individuals with MR/DD who can no longer live with their families are assisted in finding new homes with the help of the Board of MR/DD's Community & Residential Services. Often, their parents are elderly or in poor health and simply can not care for them any longer. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

Within Cuyahoga County, there are 58 community group homes serving more than 400 residents in 39 different communities. More than 900 other individuals live in homes of their own choosing through supported living options. The development and operation of community supported living is a public-private venture among the Board of MR/DD, North Coast Community Homes, a nonprofit housing development and management corporation, and more than two dozen community agencies that provide staffing and handle day-to-day operations. The CCBMRDD has also been able to place clients in private market units using Housing Choice Vouchers set aside for special needs housing through the Gateway Program. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

The underlying philosophy of supported living is that full inclusion, community integration, and quality living in the community are both valuable and possible. The individuals being served are expected to contribute to their rental and other living costs and are encouraged to access existing local, state and federal community programs to assist them. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

The Cuyahoga County Board of Mental Retardation and Developmental Disabilities, the Ohio Department of Mental Retardation and Developmental Disabilities and Federal Medicaid Waiver provide the funding for the service staff needed to maintain individual clients in their chosen settings. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

Some of the other community-based options are:

- Market-rate owner-occupied or rental housing in the community. For those with physical disabilities, universal design is an important housing feature. In addition, the housing can be retrofitted with special amenities for specific disabilities, including wheel chair accessible bathrooms, ramps, etc.
- Subsidized housing either in public housing facilities or through a Section 8 housing choice voucher. The same kinds of handicapped accessible features as noted in the market-rate housing would be needed in subsidized housing. Capital costs for housing development can be supported by federal HUD Section 811 funds. Section 811 housing is built specifically for persons with physical and/or mental disabilities.

There are a small number of federally-subsidized housing facilities constructed specifically for persons with physical disabilities. These include the 36 unit Maximum Independent Living building, the 40 unit Rainbow Place II and the 40 23 unit Koinonia Village, all on Cleveland's East Side. The nonprofit Maximum Independent Living organization also operates a 40 unit facility in Parma which draws new tenants from nearby Cleveland neighborhoods. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

For many years it has been a HUD policy to allow persons with disabilities to reside in public housing and other subsidized buildings for the elderly, many of which have specific wheelchair accessible units. However, policies allowing buildings to be designated specifically for the elderly can greatly reduce access of younger physically disabled adults to these affordable housing resources. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

The current focus on meeting the housing needs of persons with physical disabilities is on increasing the accessibility of units throughout the housing market. Federal regulations require that for all new or substantially rehabilitated multifamily housing developments receiving HOME, CDBG or other HUD assistance, 5 percent of the units in the project (but not less than one unit) must be accessible to persons with mobility impairments, and an additional 2 percent of the units (but not less than one unit) must be accessible to persons with sensory impairments. For more moderate rehabilitation projects receiving assistance, these same standards must be met to the maximum extent feasible. (City of Cleveland: The Consolidated Plan, 2005 to 2010)

- Adult foster homes are certified residences that provide accommodations and supervision for one or two adults. There are 50 homes in Cuyahoga County (City of Cleveland: The Consolidated Plan, 2005 to 2010).
- Adult family homes are residences licensed by the Ohio Department of Health to provide accommodations and supervision for 3 to 5 adults (WRAAA, 2002). According to the City of Cleveland's 2005 to 2010 consolidated plan, there are 125 homes of this type in Cuyahoga County.
- Adult group homes are residential facilities licensed by the Ohio Department of Health to provide accommodation to 6 to 16 adults (WRAAA, 2002). According to the City of

Cleveland's 2005 to 2010 consolidated plan, there are 60 homes of this type in Cuyahoga County.

Many of the residents of these facilities described above require personal care services. These include, but are not limited to, assistance with activities of daily living, supervision of the self-administration of medication (unless a nurse is on site), and special diet preparation. Specific services can include meals, transportation, housekeeping, laundry, linens, personal care, nursing care, medication monitoring, respite, hospice, dementia care, and activities. The number and type of services vary from facility to facility.

The HCBS Medicaid waivers can provide resources for supportive services needed in the community-based options. In addition, the Residential State Supplement (RSS) is a cash supplement for low income adults who are aged, blind, or disabled and reside in a certified or licensed facility. To qualify for the program, applicants must meet at least a protective level of care and income eligibility criteria. RSS recipients have a case manager from the PASPORT program staff of the Western Reserve Area Agency on Aging (WRAAA). According to the City of Cleveland's 2005 to 2010 consolidated plan, only 325 slots are available, down from 438 five years ago. Currently, there are 450 on the waiting list. No growth in capacity for this program is expected; new participants will be accepted only when someone leaves the program.

While increasing numbers of ID/DD (intellectual and/or developmental disabilities) persons are living longer because of better health care and are outliving their aging parents, the levels of care and supervision needed is very different than the non-ID/DD elderly seeking assisted living facilities. The housing choices of the elderly are classified into five types: assisted communities, unassisted 60 plus communities, shared housing, supported housing, and conventional housing. Shared housing is favored by householders having difficulties with instrumental activities of daily living or with activities of daily living and by householders without any nonresident children. Supported housing is favored by householders having difficulties with activities of daily living or with instrumental activities of daily living. Education, income, net worth and sex have little to do with the selection of the living arrangements (Rimer & Glanz, 2003).

Nationally, the population of large state ID/DD (intellectual and/or developmentally disabled) facilities per 100,000 of the general population continues to fall. On June 30, 2003, there were 15.2 persons in large state ID/DD facilities per 100,000 of the general population. This compares with 15.3 persons in 2002, 16.1 persons in 2001, 16.8 in 2000, 18.0 in 1999, 19.0 in 1998, ... 23.5 in 1995, and 99.7 in 1967 ... The number of residential settings for persons with ID/DD is growing very rapidly ... Of all the residential service settings on June 30, 2003, 2,712 were operated by states, with the remaining 142,869 residential settings operated by non-state agencies. In 1977 there were only 11,088 state licensed or state operated residential service settings ... Between 1977 and 2003, there was a steady increase in the total number of persons with ID/DD receiving residential care ... recipients grew 62.4 percent from 247,780 to a reported 402,281 ... The national average rate of placement in residential settings for persons with ID/DD in 2003 was 142.9 persons per 100,000 of the general population. (Research and Training Center on Community Living Institute on Community Integration, 2004)

In FY 2005, there were 21,124 persons with MR/DD residing in a variety of facilities in Ohio: 6,959 living in ICFs-MR, (intermediate care facilities for the mentally retarded), 11,736 receiving HCBS (home- and community-based services) waivers, and 2,429 living in nursing homes (American Network of Community Options and Resources, 2006). In FY 2003, there were 1,854 persons in state institutions (Research and Training Center on Community Living Institute on Community Integration, 2004).

Among the mentally retarded and developmentally disabled, in Cuyahoga County in 2004:

...there were 1,382 persons in Community Residential Services in a variety of settings: Supported Living (154), Individual Options Waivers (766), Level One Waivers (58) and Group Homes (404) ... Meeting the needs of an ever-growing number of individuals who can no longer live at home with their families consumes a significant portion of our (MRDD) efforts and funds. In many instances, aging parents can no longer care for their sons and daughters who are in their 40's and 50's and who have lived in their family homes since childhood ... the state's announcement that it will close two large residential facilities within the next two years [will result in] the return of individuals originally from Cuyahoga County. (Cuyahoga County Board of Mental Retardation and Developmental Disabilities [CCBMRDD], 2004)

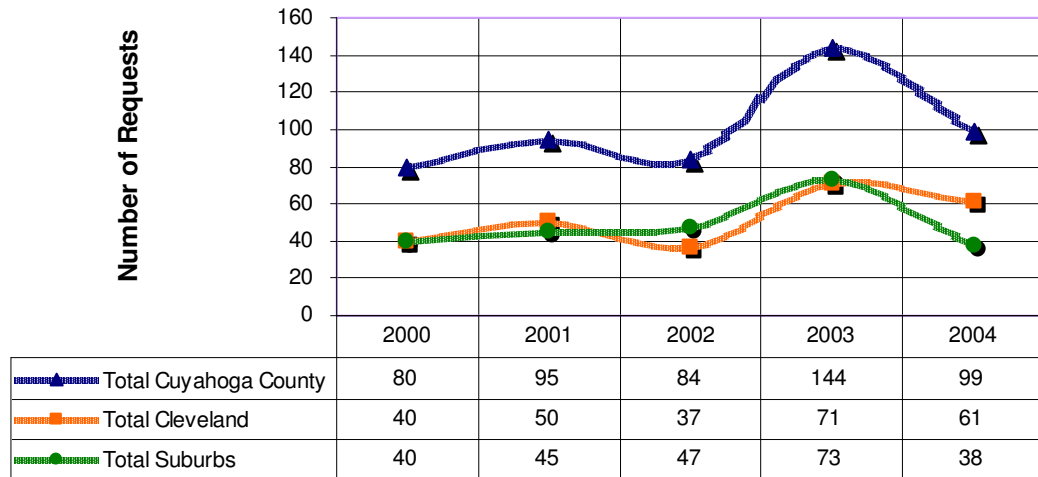
United Way - First Call for Help Call Data

In 2005, there were 25 providers of residential living options for people with disabilities operating from 37 different sites in Cuyahoga County. Twenty-three were operated by nonprofit providers and 2 by governmental agencies. Fourteen sites were located in the City of Cleveland and 23 in the surrounding suburbs. United Way funded one nonprofit agency with two locations in the Cleveland area. (See Attachments 5 and 6.)

Attachment 6 lists organizations that provide a variety of residential living options for children, young adults, and independent adults. Some are decidedly oriented toward treating and/or caring for persons who can return to community living situations with their own or other families, while others cannot because they suffer from chronic disabling conditions. Some of these facilities are focused on acute conditions or problems that can be improved while others are focused on stabilizing an acute problem before an individual returns to the community.

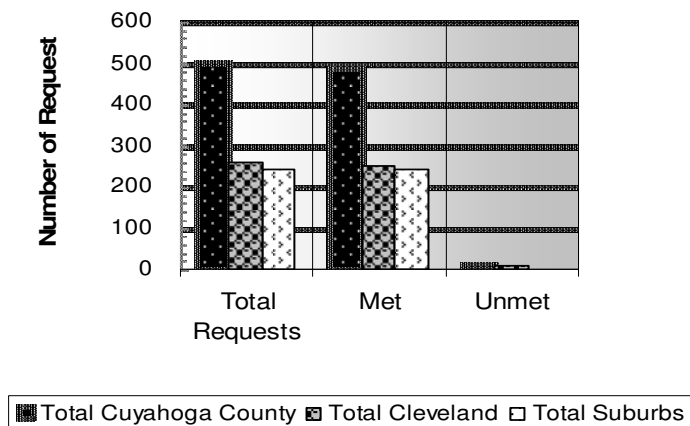
According to FCFH data, requests for residential living options for people with disabilities in the county increased from 80 in 2000 to 99 by year 2004, which represented about a 24 percent increase. Requests in the City of Cleveland increased from 40 to 61 (53 percent increase) and were relatively flat in the suburbs with 40 calls in 2000 and 38 in 2004. (See Figure 2 and Attachment 7.)

**Figure 2: Residential Living Options for People with Disabilities
United Way - First Call for Help Requests 2000-2004
Greatest Increase/(Greatest Decrease)**



Between 2000 and 2004, the vast majority (98 percent) of requests for residential living options for people with disabilities were met. Of the 502 requests, only 2 percent, (or 11) of the consumers' requests were unmet. Nine of the unmet needs were in Cleveland and 2 in the suburbs. (See Figure 3 and Attachment 8.)

**Figure 3: Residential Living Options for People with Disabilities
United Way - First Call for Help Requests 2000-2004
(TOTAL REQUESTS: n=502,
TOTAL UNMET NEED: n=11)**



FUNDING OF CORE SERVICES

Major Government Funders

The major sources of government funding for residential living options for people with disabilities are:

- HUD's Section 811 and Section 8 Programs
- Cuyahoga County Department of Mental Retardation and Developmental Disabilities
- Medicaid for Intermediate Care Facilities (ICF)
- Medicaid Waivers

Other sources of funding such as housing tax credits through the Ohio Housing Finance Agency can also be used.

Housing and Urban Development (HUD)

The two primary HUD supported programs for persons with disabilities are the Section 811 and Section 8 Housing Opportunities for Persons with Disabilities program.

Funding for the Section 811 program has been greatly at-risk during recent years. HUD's FY 2006 budget request for Section 811 (which was not adopted by Congress) would have cut the program's funding by 50 percent. In addition, the need to renew expiring five-year tenant-based rental assistance contracts for the Section 811-funded Section 8 Mainstream program (estimated in the FY 2006 budget at \$78 million) will continue to drain funding away from the production of new 811 units unless appropriations are increased. (National Low Income Housing Coalition, 2006)

For FY 2006, Congress level funded the 811 program at approximately \$238 million despite the fact that the cost of renewing the tenant-based vouchers continues to grow. Advocates estimate that after renewals are funded, fewer than 1,000 new units of supportive housing can be created from the FY 2006 appropriation. During each of the last two years, Congress also set-aside \$5 million for an estimated 230 new mainstream vouchers. (National Low Income Housing Coalition, 2006)

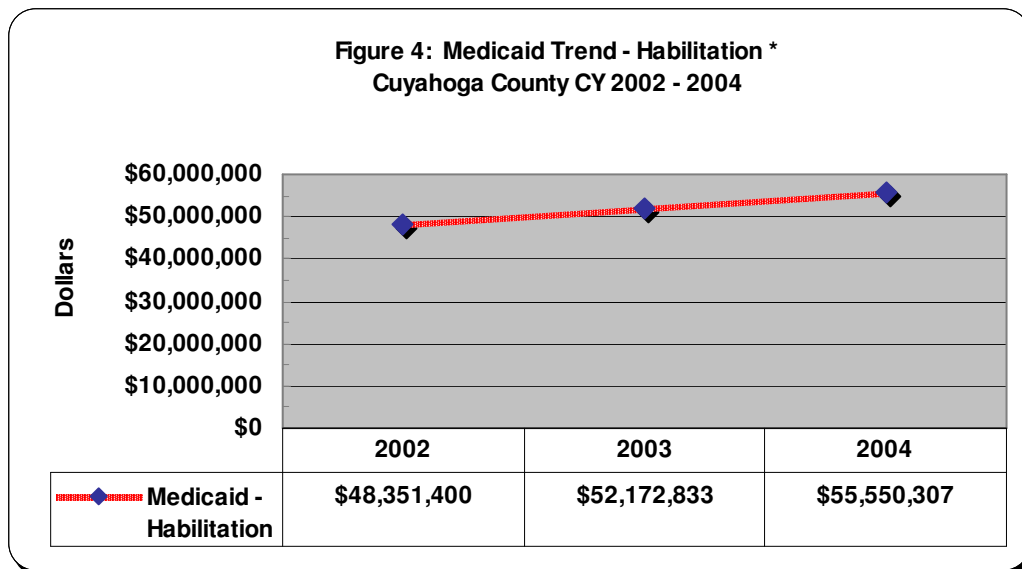
New Section 811 funding is announced each year through two separate NOFAs (Notification of Funding Availability) included in HUD's SuperNOFA published in the spring. The Capital Advance/PRAC NOFA specifies the number of Section 811 units allocated to each HUD field office according to needs factors that include the number of persons with disabilities age 16 years or older. Applications for capital advance/PRAC funding must include a supportive services plan that is well-designed to meet the needs of persons with disabilities. This determination is made by the appropriate state or local agency prior to the submission of the application. Examples of supportive services offered in conjunction with Section 811 projects include case management, assistance with housing or residential skills such as landlord/tenant obligations, housekeeping assistance, assistance with skills of daily living, and others. However,

residents cannot be required to accept any supportive services as a condition of tenancy. (National Low Income Housing Coalition, 2006)

The level of funding in Cuyahoga County for Section 811 and Section 8 mainstream housing opportunities for persons with disabilities has not been identified.

Medicaid Habilitation

In Cuyahoga County, Medicaid funding for habilitation which covers early intervention for children w/disabilities, condition specific rehabilitation, residential living options for people with disabilities, and independent living skills, rose from \$48.4 million to \$55.6 million between 2002 and 2004. (See Figure 4.)



* Includes the following core services: Condition Specific Rehabilitation, Early Intervention for Children with Disabilities/Delays, and Residential Living Options for People with Disabilities.

Medicaid Intermediate Care Facilities (ICF)

Nationally Medicaid spent \$8.3 billion or 7.7 percent of its \$108.3 billion budget for ICFs for the mentally retarded in 1994.... In 1994, Medicaid served 159,000 ICF/MR persons, up an average of 4.5 percent per year for each year during the previous decade. In 1995 there were 200,000 ICF/MR recipients for whom \$10.4 billion was paid by Medicaid to vendors. This amount represented 9 percent of the total payments to all Medicaid vendors for all Medicaid services. By 1996 the total of Medicaid recipients in ICFs/MR had receded to 100,000. (Thomson-Gale, 2005)

In 1999, Medicaid spent \$9.3 billion, or 6.1 percent of its \$152.6 billion budget, for ICFs for the mentally retarded. Medicaid spending on intermediate care facilities has continued to rise over the last several years, even as ICF facilities continue to decline (Thomson-Gale, 2005).

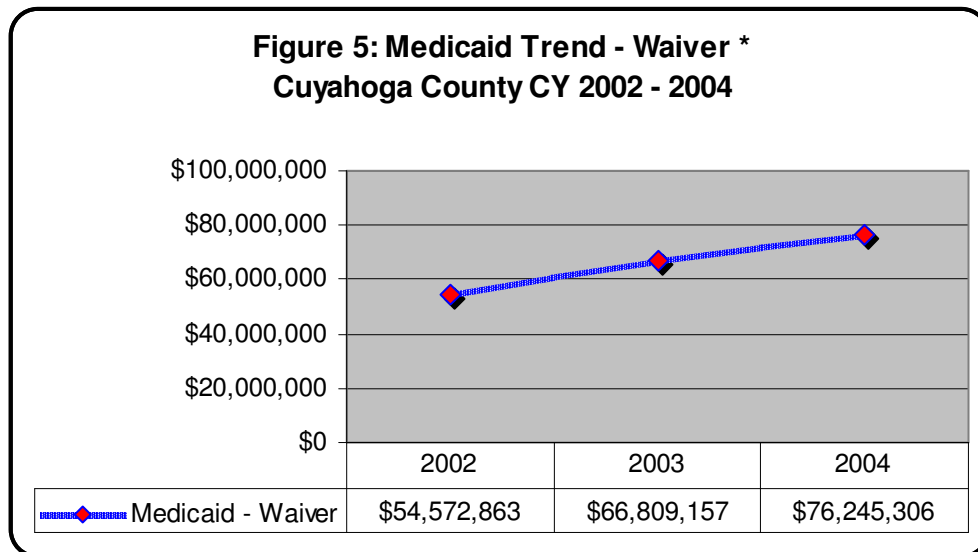
Medicaid Waivers

Medicaid waivers are a source of combined federal and state or county funding for services.

...in a waiver system, the federal government allows the state to offer a limited menu of services to a limited number of people—this gives the state a great deal of control over what services will be offered and to whom they will be available. Waiver programs can be changed easily—they're simply an agreement between the state and federal government ...There is no need for legislative action to change a waiver program ...A waiver program provides NO guarantee that individuals and families will receive the services they need—now and into the future. It doesn't provide the kind of stability and certainty that aging parents desire for their adult children. (Partners for Choice and Quality Care, 2005)

Waivers are available to persons with mental retardation or a developmental disability (MR/DD) who are eligible for Medicaid, whose needs require an ICF/MR level of care, who choose to remain in a family member's home or live in a place of their own in the community. The Ohio Department of Job and Family Services (ODJFS) administers waivers to individuals with MR/DD. Ohio's goal is to provide residential supports through an expansion of Medicaid Home and Community Based Services (HCBS) waiver program to 7,000 individuals on waiting lists. The state hopes to accomplish this by refinancing the individual supported living budgets of up to 4,000 people by providing up to 2,000 individuals residing in ICFs/MR with waiver enrollment (United Way of Greater Cleveland, 2005). The vast majority of group homes are funded through waivers in Ohio.

In Cuyahoga County, funding for Medicaid waivers for persons with disabilities (excluding PASSPORT for older adults) increased from \$54.6 million in CY 2002 to \$76.2 million in CY 2004. (See Figure 5.)



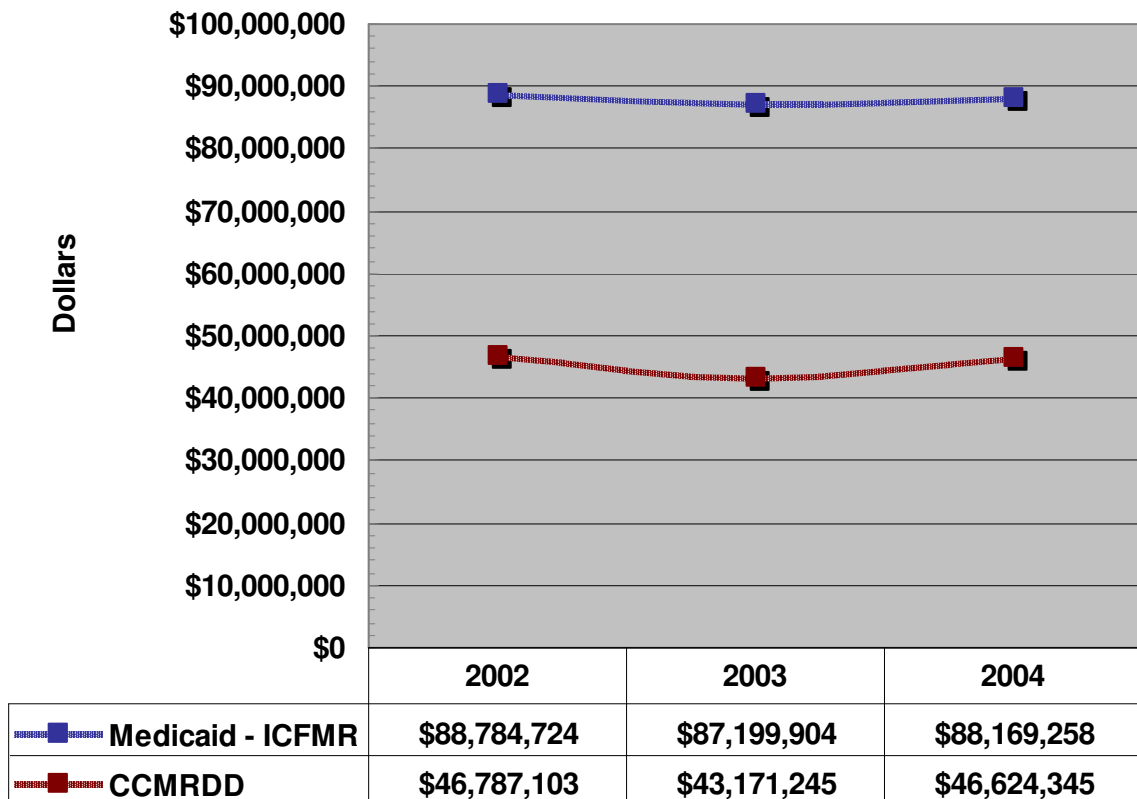
* PASSPORT dollars were removed from totals. Waiver includes the following core services: Adult Day Programs, Case/Care Management, Home Delivered Meals, Home Health Care, In-Home Assistance, and Residential Living Options for People with Disabilities.

Trends of Identified Government Funders in Cuyahoga County

In the last ten years, the number of Medicaid recipients has increased by 120 percent. The Medicaid cost in the same time has increased 78 percent. The Medicaid recipient increase has been faster in Cuyahoga County than any other urban county. Non-Medicaid funding is not keeping in line with the Medicaid funding.

In Cuyahoga County, Medicaid funding for ICF's decreased slightly with \$88.8 million spent in CY 2002 and \$88.2 million in CY 2004. During the same period, the Cuyahoga County Board of Mental Retardation and Developmental Disabilities funding for ICF's went from \$46.8 million to \$46.6 million, respectively. (See Figure 6.)

Figure 6: Identified Government Funding for Residential Living Options for People with Disabilities Cuyahoga County, CY 2002-2004



IDENTIFIED REVENUES

As of May 11, 2006, nearly \$135.7 million in revenues for residential living options for people with disabilities 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.)

More than 99 percent of the revenues are from contracts or grants from government organizations; federated fundraising organizations account for 0.51 percent, and United Way of Greater Cleveland's funds account for 0.15 percent of the total. The major government contractors are the Board of Mental Retardation and Developmental Disabilities (MRDD) and Medicaid.

Table 3: Identified Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Residential Living Options for People with Disabilities, 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%	3,200	0.04%
Total - Special Events - Growth			0.00%	82,400	0.91%
Catholic Charities Service Corporation	2004	46,900		39,500	
Jewish Community Federation	2004	643,000			
Total - Federated Fundraising Organizations		689,900	0.51%	39,500	0.44%
Other Federal Funders - Not Elsewhere Classified				45,600	
Subtotal Federal Government		0	0.00%	45,600	0.51%
Department of Job and Family Services				3,982,900	
Subtotal State of Ohio		0	0.00%	3,982,900	44.22%
Board of Mental Retardation and Developmental Disabilities (169 Board)	2004	46,624,345		3,473,600	
Subtotal Cuyahoga County Funding Sources		46,624,345	34.36%	3,473,600	38.56%
Medicaid *	2004	88,169,258			
Subtotal Third Party Payee/Direct Bill		88,169,258	64.98%	0	0.00%
Other Board of Education				837,200	
Subtotal Other Govt Funding Sources		0	0.00%	837,200	9.29%
Total - Contracts/grants from government organizations		134,793,603	99.34%	8,339,300	92.58%
Total - Investment Income			0.00%	327,900	3.64%
Total - All Other Revenue			0.00%	13,400	0.15%
Subtotal Non - UWGrCle Support		135,483,503	99.85%	8,805,700	97.76%
Total - UWGrCle investment committee allocation		201,720	0.15%	201,720	2.24%
Subtotal UWGrCle Support - 4001, 4701 & 4703		201,720	0.15%	201,720	2.24%
Total Support/Revenue		135,685,223	100%	9,007,420	100%

* Not all Medicaid dollars were entered under countywide total because not all Medicaid services are a one-to-one match with United Way core services. 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, Early Intervention for Children with Disabilities/Delays, and Residential Living Options for People with Disabilities. Medicaid Service - Waiver (\$76,245,306 in 2004) - Falls into AIRS 1 Basic Needs, Health Care and Individual & Family Life and includes the following core services: Adult Day Programs, Case/Care Management, Home Delivered Meals, Home Health Care, In-Home Assistance and Residential Living Options for People with Disabilities. PASSPORT dollars were removed from Medicaid Waiver totals.

REIMBURSEMENT/COST

As noted in Section II, Medicaid reimbursement rates for ICF/MR in Ohio, a major source of funding for residential living options for individuals with disabilities programs, are frozen at FY 2005 levels. ICF/MR services represent a significant segment of the long-term care spectrum. Because adults with developmental disabilities require lifelong support, they are highly dependent on public programs to finance their long-term care needs.

In 2002, the average annual expenditure per ICF/MR resident was \$88,900 compared to \$35,300 for a person in the HCBS program. According to the U.S. General Accounting Office, individuals with developmental disabilities “receive more than \$13 billion annually in public funding for long term care—second only to the elderly.” Medicaid is the primary payer of ICF/DD services, although some clients are considered disabled children and may access their parents’ Medicare and Social Security (United Way of Greater Cleveland, 2005).

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

Philosophy

A more efficient and effective model for service delivery ensures that people with disabilities have greater control over the resources that are spent on them and that there is more “self-determination.” This means that more time is spent with the individual and his or her family in determining necessary services.

Consistent with this philosophy, a gubernatorial executive order in June 2000 created the Ohio ACCESS task force to undertake a comprehensive review of Ohio’s systems of care for people with disabilities, and to make recommendations for improvements by 2006 (Fox-Grage, Folkemer, Straw, & Hansen, 2002). Among the recommendations to improve long-term care services for Ohioans with disabilities was one to overcome policy constraints on self-sufficiency and personal and family responsibility by providing better information and assistance for consumers and their caregivers (Scripps Gerontology Center, 2003). As Ohio ACCESS recommendations are implemented, it is clear that the type of services, the locations of services, and the management of long-term care services will change in the near future in Ohio.

Outcomes

A study by Baker and Blacher on the impact of residential placement found that

...family members’ well-being following placement was related to the age of the child and to the child’s level of functioning. Respondents with younger children reported more visits to the child, greater caretaker burden and stress, lower marital adjustment, and lower advantages to placement than those with older adolescents or adult offspring ... family members of adults living away from the parental home reported very low levels of burden and practically all reported that the placement was, on balance, for the better. These age-related findings are consistent with the societal and professional pressures to keep children at home and to move adults to greater independence.

The researchers note that parental ambivalence (cognitive dissonance) about the placement of a child can be reduced by “maintain(ing) high involvement with the family member in placement and thus, be able to view the child as less isolated from family life” (Baker & Blacher, 2002).

In an ICF-MR, there is an emphasis on consumer outcomes and facilities are surveyed annually to examine staff performance in achieving client goals.

There are four core pillars of ICF-MR service:

- Active Treatment involves a team approach to teaching residents instrumental skills and socially responsible behaviors so that individuals can live a meaningful, happy and productive life. This approach helps individuals acquire the skills necessary to gain maximum independence, to maintain optimal functioning, or to prevent regression. Major components ... include admission and assessment and individualized plan and review.
- Client Rights ... ICFs-MR promote the exercise of individual rights and rigorously uphold the rights of all clients, such as freedom from unnecessary drugs and physical restraints, freedom from abuse, and the provision of opportunities to participate in social, religious, and community activities. In essence, for many clients, ICF/MR staff act as frontline advocates ensuring and protecting client rights inside or outside the facility.
- Client behaviors and facility practice. Individual programs emphasize positive techniques to teach socially responsible behavior.
- Health care services. ICF/MR staff develops a medical care plan for clients who require one and physician services are accessible for those who need it. (American Health Care Association, 2001)

Active treatment can include physical, occupational, speech and language therapy, behavior modification, and acquisition of skills for daily living.

What Doesn't Work

Placement in large congregate care institutions is being phased out and two state facilities—Springview and Apple Creek—will close and disperse the residents to other residential care options including ones in the communities from which they came.

IMPACT ON COMMUNITY

The Framework of a Livable Community for Adults with Disabilities is inspired, in part, by a similar framework developed for the AdvantAge Initiative, a project that helps communities measure and improve their “elder-friendliness.” It was informed further by research on the concept of livability, results of recent surveys of people with disabilities, countless interviews with key informants and people with disabilities, and a focus group session involving people with disabilities aged 30 and older in Washington, D.C. Similar themes emerged from each of these activities and were synthesized into the framework. Thus, a Livable Community for Adults with Disabilities is defined as one that achieves the following:

- Provides affordable, appropriate, accessible housing;
- Ensures accessible, affordable, reliable, safe transportation;
- Adjusts the physical environment for inclusiveness and accessibility;
- Provides work, volunteer, and education opportunities;
- Ensures access to key health and support services; and
- Encourages participation in civic, cultural, social, and recreational activities. (National Council on Disabilities, 2004)

Within each of these six areas, a livable community strives to maximize people's independence, assure safety and security, promote inclusiveness, and provide choice. (National Council on Disabilities, 2004)

While no one community in the United States has addressed all six of these livability goals to equal degrees, many states, counties, and local communities have made extraordinary improvements in their livability for people with disabilities in one or even several of these areas. Their experiences and achievements can serve as inspiration and provide replicable 'best practices,' which other communities can emulate as they strive to become more livable. (National Council on Disabilities, 2004)

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Facilities for residential services are licensed by the state and must meet minimum regulations for building, safety, client to staff ratios, etc. In addition, they must meet standards under the Medicaid rules and regulations.

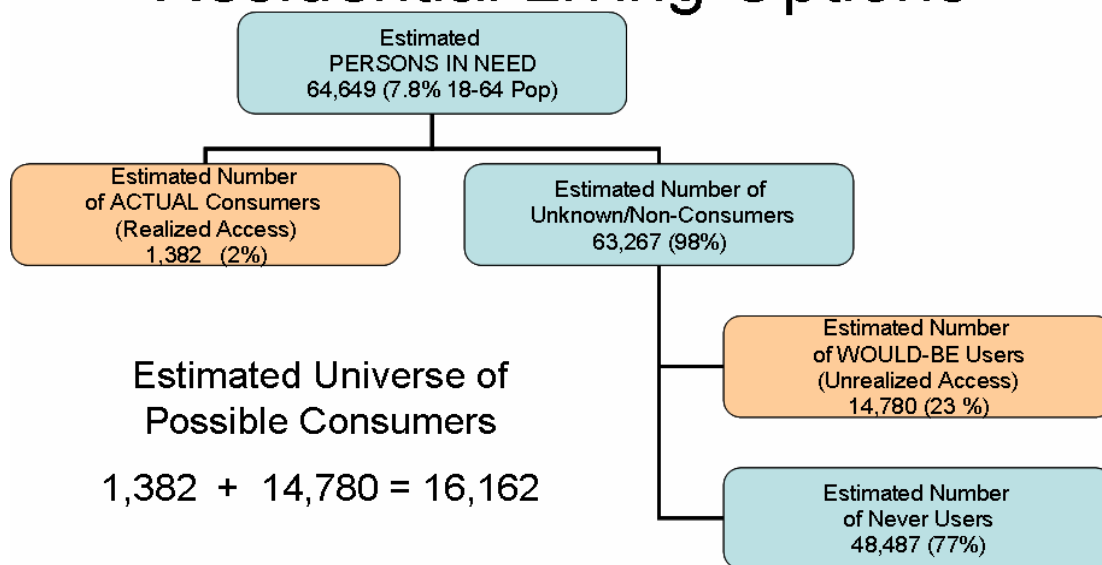
Staff is licensed according to the rules and regulations for their professional practice.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Residential Living Options for People with Disabilities:

- An estimated 64,649 persons need residential living options for people with disabilities, which is the estimated number of persons 18-64 years with severe disabilities.
- The identified number of persons receiving residential living options for people with disabilities in Cuyahoga County in FY 2004 was 1,382 (realized access). This includes consumers funded by MRDD. There are also consumers funded by United Way (83), Medicaid (1,348), and Catholic Charities (366). It was assumed that these were duplicated.
- Typically most research indicates that only 20 percent of persons needing long term care are cared for in the formal care giving system (Young, 2003). However, as was noted previously, because of persistent downturns in Northeast Ohio's economy, 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, Roman, Wellin, Ritchey, & Kunkel, n.d.). Thus, applying 25 percent, the mid-point between 20 and 30 percent, to the estimated persons in need results in an estimated universe of possible consumers of 16,162 (64,649 x 25%).
- The 14,780 would-be users (unrealized access) are estimated by subtracting the number of realized access (1,382) from the estimated number of possible consumers. (16,162 – 1,382). (See Figure 7.)

Figure 7 - Consumer Estimates: Residential Living Options



Service Site Index

Countywide, there are 37 service sites for residential living options for people with disabilities. This is a ratio of 437 possible consumers (estimated 16,162 total) to one service site countywide. There is no service site for this report because the United Way- First Call for Help provider list is broader than this service. It includes the following categories:

- Group Homes for Children with Disabilities
- Group Residences for Adults with Disabilities
- Foster Care for Adults with Disabilities
- Foster Care for Children with Disabilities
- Intermediate Care Facilities for Developmentally Disabled
- Semi-independent Living Residences for Disabled Adults
- State Institutions for the Developmentally Disabled
- Supported Living Services for Adults with Disabilities

Service Capacity

A complex network of services funded by federal, state, and local resources provides an array of residential, employment, case management, family support, personal assistance, and other supports to people with mental retardation and their families (Braddock, Hemp, Parish, & Westrich, 1998). However, these services—particularly residential services—are provided to a relatively small minority of people with mental retardation (Fujiura, 1998). Critical service shortages exist in most states (Prouty, Smith, & Lakin, 2001), and demand for residential services will exceed the supply for the foreseeable future (Lakin, 1998 in Parish, 2003).

Participants in focus groups conducted for United Way of Greater Cleveland (2005) indicated that the number of underserved individuals and families will likely increase because of diminishing resources. They noted funding cuts in Ohio's budget, with particular emphasis on cuts in Medicaid and potentially in community alternative funding sources (CAFS).

VII.SUMMARY

The following are the major findings from research on residential living options for people with disabilities:

- Community or residential living options for adults with a variety of disabling conditions is an outcome of the deinstitutionalization movement, the Americans for Disabilities Act, and educational and human service policies such as mainstreaming and using the least restrictive environment. As the population of older Americans increases with the aging of the baby boomer generation and improved health, the need for supported and assisted living facilities for older citizens will also fuel the need for such living options.
- Mental retardation is one of the major disabilities that greatly affects consumers of residential living options for people with disabilities.
- The basic policy issue relevant to residential living options for persons with disabilities is how the various options are paid, especially for those who do not have sufficient resources to bear the full cost of housing, support, and health care.
- A major issue in the Section 811 program is the cost of renewing vouchers funded under the tenant-based component. The Consortium for Citizens with Disabilities Housing Task Force has projected that unless appropriations levels rise to keep pace with increasing renewal costs, funding for new unit production will be eliminated by 2012.
- Reform of Medicaid, the primary source of economic aid for both nursing homes and “intermediate care facilities, is a major concern for parents and service providers. While the number of persons using ICF facilities has been decreasing, the amount of Medicaid funds has increased in recent years.
- As of May 11, 2006, nearly \$135.7 million in revenues for residential living options for people with disabilities has been identified countywide.
- A more efficient and effective model for service delivery ensures that people with disabilities have greater control over the resources that are spent on them and that there is more “self-determination.”
- The Framework of a Livable Community for Adults defines a livable community for adults with disabilities as one that provides affordable, appropriate, accessible housing; ensures accessible, affordable, reliable, safe transportation; adjusts the physical environment for inclusiveness and accessibility; provides work, volunteer, and education opportunities; ensures access to key health and support services; and encourages participation in civic, cultural, social, and recreational activities.
- The estimated universe of possible consumers is 16,162, including both realized access (1,382) and unrealized access (14,780).
- Countywide, there are 37 service sites for residential living options for people with disabilities. This is a ratio of 437 possible consumers (estimated 16,162 total) to one service site countywide.

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ATTACHMENTS

Attachment 1: Researcher List

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Attachment 2: Technical Notes

Technical Notes: Methodology, Caveats, Limitations of Data

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

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

Unit of Analysis

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

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

United Way - First Call for Help Data

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

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

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

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

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

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

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

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

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

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

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

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

Funding Information for Core Services

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

Foundation Funding

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

Federated Funding Sources

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

Government Funding

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

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

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

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

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

Medicaid Funding

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

Entered as Aggregate Total Under Appropriate AIRS Level

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

Entered as Aggregate Total Under Third Party Payee/Direct Bill

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

United Way of Greater Cleveland Funding

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

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

United Way Agency Revenues

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

Consumer and Financial Data: Caveats

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

All Core Services

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

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

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

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

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

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

Gap Analysis Methodology & Limitations

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

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

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

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

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

Service Site Index

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

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

Specific Service Issues

Senior Services

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

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

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

References

- Anderson, Ronald M. (1995, March). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36(1): 1-10.
- Wan, Thomas T. H., Odell, Barbara Gill, & Lewis, David T. (1982). *Promoting the well-being of the elderly: A community diagnosis*. New York: The Halworth Press.

Attachment 3: Actual Consumer Demographics

Core Service: Residential Living Options for People with Disabilities - Adult PF-700							
PERIOD	Total Population (%) ¹ 1/1/2000-12/31/2000	Total Population 18-64 (%) ² 1/1/2000-12/31/2000	Estimated Persons in Need Population Severely Disabled 18-64 (%) ³ 1/1/2000-12/31/2000	Actual Number/Percent of Consumers by Funding Source ⁴			
				UW Program Report Data Cuy Cnty Only 100% (%)	Medicaid (%)	CC Board of MRDD (%)	Catholic Charities (%)
				7/1/2003-6/30/2004	2004	2004	2004
TOTAL	1,393,978	828,827	64,649	83	1,348	1,382	366
Percent		59.5%	7.8%				
GENDER							
Male	47.2%	47.0%	N/A	63.9%	0.0%	0.0%	41.3%
Female	52.8%	52.2%	N/A	36.1%	0.0%	0.0%	58.7%
Unknown Data ⁵				0.0%	0.0%	0.0%	0.0%
Missing Data ⁶				0.0%	100.0%	100.0%	0.0%
RACE⁷							
White alone	67.1%	68.4%	N/A	67.5%	65.4%	0.0%	39.9%
Black or African American alone/combination	27.9%	26.4%	N/A	28.9%	36.1%	0.0%	48.6%
Asian alone/combination	2.1%	2.2%	N/A	0.0%	0.0%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.2%	N/A	0.0%	0.3%	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%
Some other race alone/combination	2.1%	1.5%	N/A	3.6%	0.4%	0.0%	1.4%
Unknown Data ⁵				0.0%	1.0%	0.0%	8.2%
Missing Data ⁶				0.0%	0.0%	100.0%	1.6%
HISPANIC⁸	3.3%	3.3%	N/A	1.2%	2.0%	0.0%	0.3%
AGE							
0-4	6.5%			0.0%		0.0%	1.1%
5-9	7.3%			2.4%	5.7%	0.0%	0.0%
10-14	7.1%			9.6%		0.0%	0.0%
15-19	6.4%	4.1%	N/A	15.7%		0.0%	0.0%
20-34	19.1%	32.1%	N/A	30.1%		0.0%	0.0%
35-54	29.3%	49.1%	N/A	34.9%	64.7%	0.0%	0.0%
55-64	8.7%	14.7%	N/A	6.0%		0.0%	0.0%
65-74	7.8%			1.2%	33.8%	0.0%	1.1%
75+	7.8%			0.0%		0.0%	0.0%
Unknown Data ⁵				0.0%	0.0%	0.0%	18.3%
Missing Data ⁶				0.0%	0.0%	100.0%	0.0%
INCOME⁹							
Average Household Size	2.4	N/A	N/A	N/A	N/A	N/A	N/A
\$0-\$9,999	11.3%	N/A	N/A	N/A	0.0%	0.0%	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	N/A	0.0%	0.0%	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	N/A	0.0%	0.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	N/A	0.0%	0.0%	0.0%
\$30,000 and above	61.5%	N/A	N/A	N/A	0.0%	0.0%	0.0%
Unknown Data ⁵					0.0%	0.0%	0.0%
Missing Data ⁶					100.0%	100.0%	100.0%
Totals	100.0%	N/A	N/A	N/A	100.0%	100.0%	100.0%

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census 2000, SF1 (P1); SF4 (PCT 144)
**U.S. Census 2000, SF1 (P12) SF4 (PCT 144)
*** "People have a physically severe functional limitation if they are unable to perform a physical function or if they need the help of another person to perform the function. An estimated 7.8 percent of those age 15 and older (15.2 million people) are severely limited in the functions of seeing, hearing, having speech understood, lifting or carrying, walking, or using stairs." (Chartbook on Disability in the U.S., 1996) This percentage was applied to the population 18 to 64 across all periods.
****Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms.
*****Missing Data - For United Way Data - represents computational errors or incorrect completion of online report. For all other data - represents data funder was unable to provide.
*****The race categories and data utilize US Census SF4 "Race Iterations," which allow for multiple races to be selected by census respondents. As a result, totals will add to > 100% of population. Universe is "Total Races Tallied." Except "White Alone", all racial categories are "... alone or in combination with some other race". This method isolates and minimizes the non-minority population ("White alone").
*****Hispanic - Amount in this field is from data provided by clients on intake forms and may not be accurate as clients may either deliberately or inadvertently provide incomplete data, or data may not be collected by the agency.
*****The U.S. Census reports income by household or family, not individuals. Estimates by income category were derived by applying the ratio of total county population (1,393,978) to total households (571,606) = 2.4. The number of households in each income category was multiplied by 2.4 to arrive at an estimate of individuals by income category. The assumption is that the average household size applies to each income category, which may result in more conservative estimates for children and the "old old," which may actually have larger proportions of persons in the lower income categories.

Attachment 4: Actual Consumer Zip Codes

Core Service: Residential Living Options for People with Disabilities PF-700									
					Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****			
	City/Town (% Cleveland)	Total Population (%) *	Total Population 18-64 (%)**	Population Severely Disabled 18-64 (%)***	UW Program Report Data (%)	Medicaid (%)	CC Board of MRDD (%)	Catholic Charities (%)	
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004	2004	2004	2004	
TOTAL		1,393,978	828,827	64,649	83	1,348	1,382	366	
Percent			59.5%	7.8%					
44017	Berea	1.4%	1.5%	NA	0.0%	5.5%	0.0%	0.0%	
44022	Bentleyville	1.3%	1.2%	NA	0.0%	0.1%	0.0%	0.0%	
44040	Gates Mills/Mayfield Village	0.2%	0.2%	NA	0.0%	0.0%	0.0%	0.0%	
44070	North Olmsted	2.4%	2.5%	NA	0.0%	0.4%	0.0%	0.0%	
44101	Cleveland (100%)	0.0%	0.0%	NA	0.0%	0.0%	0.0%	0.0%	
44102	Cleveland/Brooklyn (95%)	3.7%	3.8%	NA	0.0%	5.3%	0.0%	0.0%	
44103	Cleveland (100%)	1.8%	1.7%	NA	0.0%	4.0%	0.0%	0.0%	
44104	Cleveland (100%)	2.1%	1.8%	NA	0.0%	0.2%	0.0%	0.0%	
44105	Cleveland/NewburghHts/GarfieldHts (75%)	3.9%	3.8%	NA	0.0%	0.4%	0.0%	0.0%	
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.5%	NA	0.0%	1.2%	0.0%	0.0%	
44107	Lakewood/Cleveland	4.1%	4.5%	NA	0.0%	1.4%	4.0%	0.0%	
44108	Cleveland/Bratenahl (90%)	2.6%	2.3%	NA	0.0%	0.4%	0.0%	0.0%	
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.4%	NA	0.0%	0.8%	0.0%	0.0%	
44110	Cleveland/East Cleveland (98%)	1.9%	1.8%	NA	0.0%	0.7%	0.0%	0.0%	
44111	Cleveland (100%)	3.1%	3.3%	NA	0.0%	0.0%	0.0%	0.0%	
44112	East Cleveland/Cleveland	2.4%	2.3%	NA	0.0%	12.9%	0.0%	0.0%	
44113	Cleveland (100%)	1.4%	1.6%	NA	0.0%	0.6%	0.0%	0.0%	
44114	Cleveland (100%)	0.3%	0.3%	NA	0.0%	0.2%	0.0%	0.0%	
44115	Cleveland (100%)	0.6%	0.6%	NA	0.0%	0.1%	0.0%	0.0%	
44116	Rocky River	1.5%	1.4%	NA	0.0%	0.1%	0.0%	0.0%	
44117	Euclid/Cleveland	0.9%	0.8%	NA	74.7%	4.9%	0.0%	0.0%	
44118	ClevelandHts/UniversityHts/ShakerHts	3.2%	3.4%	NA	0.0%	0.6%	0.0%	0.0%	
44119	Cleveland/Euclid (50%)	1.0%	1.0%	NA	0.0%	0.1%	0.0%	0.0%	
44120	Shaker Hts/Cleveland	3.4%	3.3%	NA	9.6%	1.3%	0.0%	0.0%	
44121	University Hts/South Euclid	2.5%	2.6%	NA	6.0%	1.4%	0.0%	0.0%	
44122	Beachwood/Highland Hills/ShakerHts	2.5%	2.2%	NA	0.0%	4.4%	0.0%	0.0%	
44123	Euclid	1.3%	1.3%	NA	0.0%	0.0%	0.0%	0.0%	
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	2.7%	NA	0.0%	1.2%	0.0%	0.0%	
44125	Valley View/Garfield Hts	2.1%	2.1%	NA	0.0%	0.1%	0.0%	0.0%	
44126	Fairview Park/Cleveland	1.2%	1.2%	NA	0.0%	0.0%	0.0%	0.0%	
44127	Cleveland (100%)	0.6%	0.6%	NA	0.0%	0.1%	0.0%	0.0%	
44128	Warrensville Hts/Cleveland	2.4%	2.3%	NA	0.0%	16.5%	0.0%	0.0%	
44129	Brooklyn/Parma/Cleveland	2.1%	2.1%	NA	0.0%	1.6%	0.0%	0.0%	
44130	Parma/Cleveland	3.8%	3.8%	NA	0.0%	2.7%	0.0%	0.0%	
44131	Independence/Seven Hills/BrooklynHts	1.5%	1.4%	NA	0.0%	1.6%	0.0%	0.0%	
44132	Euclid	1.1%	1.1%	NA	0.0%	2.2%	0.0%	0.0%	
44133	North Royalton	2.1%	2.2%	NA	0.0%	7.1%	0.0%	0.0%	
44134	Parma/Cleveland	2.9%	2.8%	NA	0.0%	1.0%	0.0%	0.0%	
44135	Cleveland/Linddale (90%)	2.0%	2.1%	NA	0.0%	0.1%	0.0%	0.0%	
44136	Strongsville	3.1%	3.3%	NA	0.0%	2.2%	0.0%	0.0%	
44137	Maple Hts/Cleveland	1.9%	1.8%	NA	0.0%	0.6%	0.0%	0.0%	
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	NA	0.0%	0.3%	0.0%	0.0%	
44139	Bentleyville/Glenwillow/Solon	1.6%	1.6%	NA	0.0%	6.3%	0.0%	0.0%	
44140	Bay Village	1.2%	1.2%	NA	0.0%	0.0%	0.0%	0.0%	
44141	Brecksville	1.0%	1.0%	NA	0.0%	0.9%	0.0%	0.0%	
44142	Brookpark/Cleveland	1.5%	1.5%	NA	0.0%	1.4%	0.0%	0.0%	
44143	Highland Hts/Richmond Heights	1.7%	1.7%	NA	0.0%	1.2%	0.0%	0.0%	
44144	Brooklyn/Cleveland	1.6%	1.6%	NA	0.0%	0.3%	0.0%	0.0%	
44145	Westlake	2.3%	2.3%	NA	0.0%	1.8%	0.0%	0.0%	
44146	Walton Hills/Oakwood/Bedford	2.3%	2.3%	NA	0.0%	3.1%	0.0%	0.0%	
44147	Broadview Hts	1.1%	1.2%	NA	0.0%	0.5%	0.0%	0.0%	
Unknown Cuyahoga County Zip Codes*****									
Missing*****									
Unknown*****									
Total Cuyahoga County*****		100.0%	100.0%	NA	100.0%	100.0%	0.0%	0.0%	0.0%
Total Known Cleveland		30.5%	30.5%	NA	0.0%	14.3%	0.0%	0.0%	0.0%
Total Known Suburbs		69.5%	69.5%	NA	100.0%	85.7%	0.0%	0.0%	0.0%
Unknown & Missing					0.0%	0.0%	100.0%	100.0%	100.0%

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census SF1 (P1)
** U.S. Census 2000, SF1 (P12)
*** "People have a physically severe functional limitation if they are unable to perform a physical function or if they need the help of another person to perform the function. An estimated 7.8 percent of those age 15 and older (15.2 million people) are severely limited in the functions of seeing, hearing, having speech understood, lifting or carrying, walking, or using stairs" (Chartbook on Disability in the U.S., 1996). This percentage was applied to the population 18 to 64 across all periods.
**** Note: Consumers could be funded by more than one funding source; thus the columns are not necessarily mutually exclusive.
*****Missing Data - For United Way - represents computational errors or incorrect completion of online report. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County. For all other data - represents data funder was unable to provide.
*****Unknown Data - Represents data not collected by agency because no tracking system is available or type of service delivered makes it difficult (i.e., group presentations, telephone information and referral, and drop-ins). Also represents data not completed by clients either deliberately or inadvertently on intake forms. This data may contain zip codes outside of Cuyahoga County so it is not included in the total number served for Cuyahoga County.
***** Totals vary because of rounding. County total population 1,393,978 does not correspond to the total of zip codes because some zip codes include data from adjacent counties

Attachment 5: Profile of Core Service Providers – 2005

PROFILE OF CORE SERVICE PROVIDERS – 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
Total Number of Providers	25	1
Number of Providers by Type		
Nonprofit	23	1
For-profit	-	-
Government	2	-
Other	-	-
Total Number of Sites	37	7
Number of Service Sites per Provider		
1	19	-
2 – 5	5	-
6 – 10	1	1
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	2	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	-	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	1	-
44103 – Cleveland	-	-
44104 – Cleveland	-	-
44105 – Newburgh Hts/Garfield Hts	1	-
44106 – Cleveland Hts/Cleveland	3	-
44107 – Cleveland/Lakewood	-	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	2	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	2	-
44112 – Cleveland/East Cleveland	1	-
44113 – Cleveland	1	-
44114 – Cleveland	1	-
44115 – Cleveland	3	-
44116 – Rocky River	1	-
44117 – Cleveland/Euclid	4	4
44118 – Euclid/University Hts	1	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	3	1
44121 – University Hts/South Euclid	2	1
44122 – Orange/Warrensville Hts	2	-
44123 – Euclid	-	-
44124 – Pepper Pike/Mayfield Village	1	1
44125 – Valley View/Garfield Hts	2	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-

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

PROFILE OF CORE SERVICE PROVIDERS – 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44128 – Cleveland/Warrensville Hts	-	-
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	-	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	1	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	1	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	-	-
44141 – Brecksville	1	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	1	-
44146 – Walton Hills/Oakwood/Bedford	-	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-
Total Cuyahoga County	37	7
Total Cleveland	14	0
Total Suburbs	23	7

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Alliance Human Services	Foster Care and Adoption
Beech Brook	Treatment Foster Care
Bellefaire Jewish Children's Bureau	Specialized Foster Care, Therapeutic Foster Care, Transitional Living Program, Independent Living Program
Berea Children's Home and Family Services	Supportive Living - Youth - MR/DD, Foster Care - Treatment - Emotionally Troubled Children, Foster Care - Treatment - Medically Fragile Infants/Children, Foster Care - Therapeutic - Severely Mentally Ill Children, Group Homes - Emotionally Disturbed Boys
Bridgeway	Pilot Managed Care Program, Independent Living, Secondary Case Management, Supported Residential Living
The Catherine Horstmann Home	Residential Care - Mentally Retarded Women
Catholic Charities Health and Human Services - Disability Services	Supported Living/Medicaid Waiver
Children Forever Haven	Supported Living Services - Mentally Retarded, Residential Care - Mentally Retarded Adults
Cuyahoga County Board of Mental Retardation and Developmental Disabilities	Residential Services, Supported Living/Community Supports/Medicaid Waivers
Help Foundation	Supported Living - MR/DD Adults, Semi-Independent Living - Mr/DD Adults, Group Homes - MR/DD Youth, Independent Living with Assistance - MR/DD Adults, Group Homes - MR/DD Adults
Jewish Family Service Association of Cleveland	MR/DD - Group Residences
Koinonia Homes	Residential Care - Adults with Developmental Disabilities, Foster Care - Adults/Youth with Developmental Disabilities, Supported Living Services
L'arche Cleveland	Group Homes - Adults with Developmental Disabilities
Murtis H. Taylor Multi-Service Center	Residential Treatment
New Avenues to Independence	Group Homes, Supported Living/Home & Community Based Waiver Programs
North Coast Community Homes	Housing - Mental Retardation/Developmental Disabilities
North East Ohio Health Services	Residential Care Facility - Seniors/Mental Illness
Northcoast Behavioral Healthcare	Mental Health Services
Northeast Care Center	Group Homes for Adults - Mental Retardation
Ohio Boys Town	Group Home for Boys
Positive Education Program	Group Home/Adolescent Boys
Rose-Mary Center	Comprehensive Residential Services for MR/DD Children, Adult MR/DD Group Home, Semi-Independent Living Residences for The Mentally Ill



Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Spectrum of Supportive Services	Combined Residential/Vocational Support
United Cerebral Palsy Assn. of Greater Cleveland	Group Home
Welcome House	Group Homes for Adults with Mental Retardation

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Residential Living Options for People with Disabilities Requests – 2000-2004: Greatest Increase/Greatest Decrease

PF-700 Residential Living Options for People with Disabilities								
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		
44107	Lakewood/Cleveland	1	4	7	4	8	700%	5
44106	Cleveland/Cleveland Hts	2	0	4	11	9	350%	5
44105	Cleveland/Newburgh Hts/Garfield Hts	2	4	3	7	9	350%	5
44108	Cleveland/Bratenahl	1	4	3	4	4	300%	3
44125	Valley View/Garfield Hts	1	2	2	3	3	200%	2
44146	Walton Hills/Oakwood/Bedford	1	1	2	2	3	200%	2
44104	Cleveland	2	3	2	1	4	100%	2
44130	Parma/Cleveland	1	1	6	7	2	100%	3
44136	Strongsville	1	0	1	2	2	100%	1
44121	University Hts/South Euclid	1	2	0	1	2	100%	1
44115	Cleveland	4	9	3	3	6	50%	5
44113	Cleveland	4	3	1	4	5	25%	3
44118	ClevelandHts/UniversityHts/ShakerHts	4	7	1	7	0	(100%)	4
44123	Euclid	2	6	0	4	0	(100%)	2
44126	Fairview Park/Cleveland	1	0	0	0	0	(100%)	0
44143	Highland Hts/Richmond Heights	1	0	2	1	0	(100%)	1
44134	Parma/Cleveland	1	2	0	2	0	(100%)	1
44124	Pepper Pike/Mayfield Hts./Lyndhurst	2	0	0	3	0	(100%)	1
44109	Cleveland/Brooklyn Hts	4	7	2	9	1	(75%)	5
44128	Warrensville Hts/Cleveland	4	2	7	5	1	(75%)	4
44137	Maple Hts/Cleveland	5	0	1	1	2	(60%)	2
44144	Brooklyn/Cleveland	2	0	0	1	1	(50%)	1
44103	Cleveland	2	3	1	6	1	(50%)	3
44117	Euclid/Cleveland	2	0	0	0	1	(50%)	1
44131	Independence/Seven Hills/Brooklyn Hts	2	0	0	0	1	(50%)	1
44070	North Olmsted	2	2	1	2	1	(50%)	2
44111	Cleveland	3	1	3	5	2	(33%)	3
44135	Cleveland/Linndale	3	1	3	1	2	(33%)	2
**Total Cuyahoga County		80	95	84	144	99	24%	100
**Total Cleveland		40	50	37	71	61	53%	52
**Total Suburbs		40	45	47	73	38	(5%)	49
* 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 Residential Living Options for People with Disabilities 2000-2004: Unmet Need

PF-700 Residential Living Options for People with Disabilities					
United Way - First Call for Help Requests 2000-2004					
Unmet Need					
Zip Code		TOTALS00-04			%
		Requests	Met	Unmet	Unmet
44135	Cleveland/Linndale	10	8	2	20%
44104	Cleveland	12	11	1	8%
44108	Cleveland/Bratenahl	16	15	1	6%
44102	Cleveland/Brooklyn	33	31	2	6%
44130	Parma/Cleveland	17	16	1	6%
44107	Lakewood/Cleveland	24	23	1	4%
44115	Cleveland	25	24	1	4%
44105	Cleveland/Newburgh Hts/Garfield Hts	25	24	1	4%
44106	Cleveland/Cleveland Hts	26	25	1	4%
*Total Cuyahoga County		502	491	11	2%
*Total Cleveland		259	250	9	3%
*Total Suburbs		243	241	2	1%
FCFH DATA NOTES					
<p>Met = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)</p> <p>Unmet = service request for which there was no referral.</p> <p>Note: Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.</p> <p>* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.</p>					



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