

Core Service Report

Senior Centers

Consumer Category:
Age

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



February 2007

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COMPANION REPORTS

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

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SNAPSHOT

AIRS Code Level I: Organizational & Community Services (T)

AIRS Code Level II: Community Services (TF)

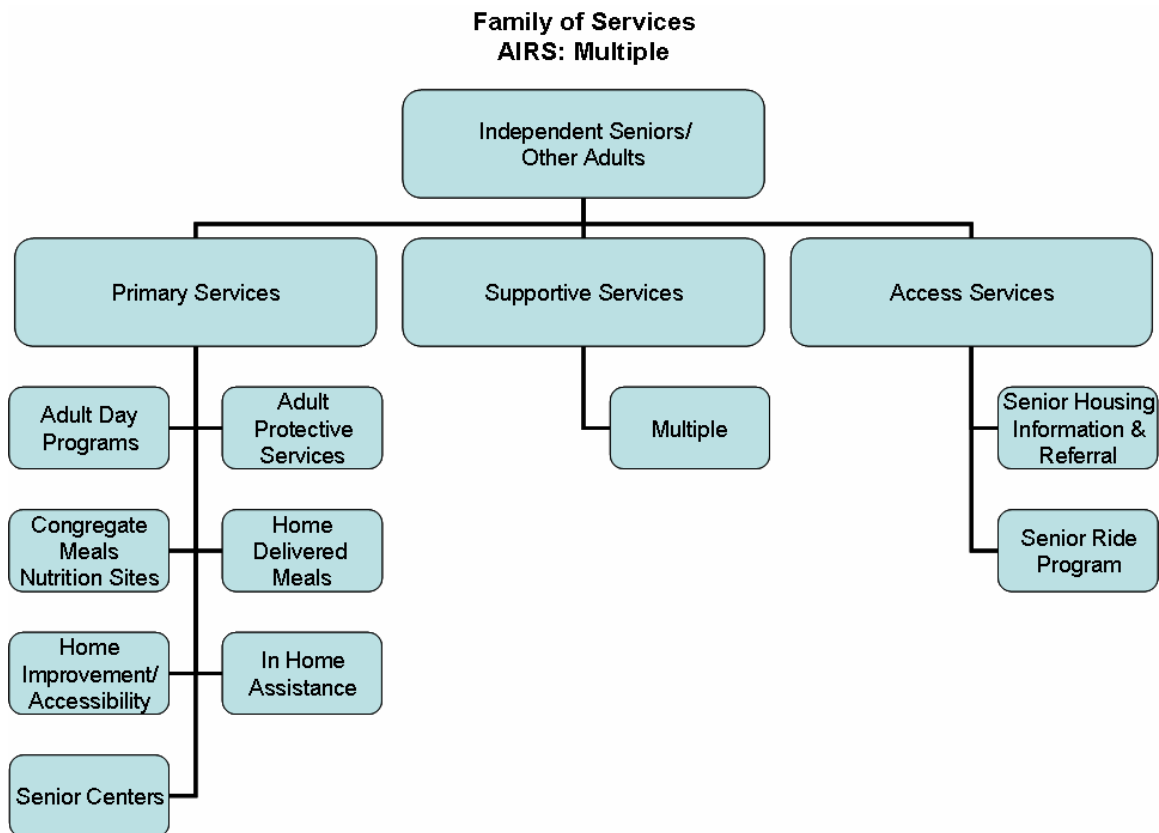
Core Service: Senior Centers (TF-200.550-80)

Investment Committee: Senior Success

Cluster: Senior Centers

AIRS Definition: Multipurpose centers that serve as focal points for older adults in the community and that offer, at a single location, a wide variety of services and activities that are needed by and of interest to this population.

Senior Centers are part of a family of services for older adults. The service targets independently functioning older adults and other adults and is one of seven services targeting this consumer group. In addition, there are two services that are necessary to access other services.



Core Service Environment

Most older adults live, and want to remain living, in the community. According to “Older Americans 2004: Key Indicators of Well-Being,” nationally, the majority of older Americans live in traditional community settings (93 percent), while only 2.5 percent live in community housing with services, and 4.4 percent live in long-term care facilities. In addition, according to a national public opinion survey conducted by AARP (2003), an overwhelming majority of older adults want to stay in their own homes for as long as possible. Senior centers help enable individuals to live independently by providing a centralized location for multiple services that encourage physical and mental well-being, and often by facilitating the identification of needed services before an individual becomes too frail.

The combination of declining federal and state funding for senior centers and a growing senior population will dominate the public policy arena. In 2003, Older Americans Act Title III funds were worth approximately 57 cents compared to 1980 Title III funds worth one dollar. In Ohio, senior community services funding has been reduced by 25 percent since 2001 (Ohio Association of Area Agencies on Aging, 2005b). Senior service levies and other local public and private funds will likely take up larger portions of center budgets. This will be extremely challenging in the Greater Cleveland area given the weak economy and the competition for scarce dollars from all service providers. Other issues that affect older adults, such as Social Security and medical care and coverage, could also influence the utilization level of centers.

Core Service Consumers

The target population addressed in this core service report is defined broadly as independently functioning older adults aged 60 years and older who are under 200 percent of poverty and living in the community.

In Cuyahoga County, 15.6 percent of the population were over 65 in both 1990 (221,066) and 2000 (217,161). In that decade, both the county’s general population and its 65+ older adult population fell, but by approximately the same amount (minus 1-2 percent). The number of residents ages 75 and older, however, experienced net increases ranging from 11 percent (ages 75-79) to 33 percent (ages 85+) during the same period.

“Senior Centers: Ohio Blueprint for the Future” reports the following characteristics of senior center participants in Ohio: 25 percent are male; 12 percent work full or part-time; and 50 percent are at or above middle income (Martin et. al., 2002).

Locally, senior centers are viewed as a resource for a significant percentage of the older population. A 2006 survey of 600 adults age 55 and older living in the five-county area (Cuyahoga, Geauga, Lake, Lorain, and Medina) served by the Western Reserve Area Agency on Aging (WRAAA) found some variation among those who agreed that they can picture themselves attending activities at a senior center. Those more apt to agree included:

- Respondents 55 to 59 years (65 percent);
- Respondents 60 to 64 years (74 percent);
- Respondents who were married (65 percent); and
- Respondents who were minorities (71 percent).

An important group of senior centers consumers is comprised of those individuals who are in “double jeopardy”; that is, older adults with mental retardation or developmental disabilities whose caregivers are also aging. Senior centers are increasingly providing services to

individuals enrolled with the Cuyahoga County Board of Mental Retardation and Developmental Disabilities, and the needs of this population will influence the provision of services at senior centers.

In 2000, an estimated 70,943 individuals were 60 years and older and below 200 percent of poverty in Cuyahoga County. This number has been decreasing mainly due to shifts in the population, but it is projected to increase to 73,123 by 2015 as the baby boomers come of age.

Core Service Delivery

The National Institute of Seniors Centers defines senior centers as places where “older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interest, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community.” For this report, senior centers are defined as in the AIRS definition, i.e. multipurpose centers that serve as focal points for older adults in the community and offer, at a single location, a wide variety of services and activities that are needed by and of interest to this population.

In Ohio, senior centers can be either not-for-profit or governmental entities. The majority of the governmental programs are satellites of a larger program (48 percent) and the majority of the not-for-profit programs are stand-alone (47 percent) (Martin et. al., 2002).

The most common services provided at senior centers are: health and wellness, arts and humanities, intergenerational programs, employment assistance, community action and social networking, transportation, volunteer activities, education, information and referral, financial assistance, meal and nutrition programs, and leisure travel (National Council on the Aging, 2005).

“Senior Centers: Ohio Blueprint for the Future” reports the following characteristics of senior centers in Ohio: 12 percent of senior centers are open on weekends or evenings; 25 percent centers offer in-home services; 25 percent of centers offer services for disabled persons under 60 years; and volunteering is the most common activity (Martin et. al., 2002).

Based on United Way - First Call for Help’s (FCFH) database (February 2005), there are 52 senior centers providers operating from 76 different sites, 29 of which are government and 23 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded 10 of these providers. FCFH call data shows an increase in the number of total requests for senior centers in the county: from 225 in 2000 to 271 in 2004 (20 percent); however, the increase in requests was seen only in the suburbs. Over the same five-year period, FCFH had 1,242 requests for information about senior centers. Of these requests, they were able to make referrals to 98 percent of callers.

Funding for senior centers has been mixed. Between 2002 and 2004, the City of Cleveland Community Development Block Grant (CDBG) funding increased while the Department of Senior and Adult Services funding has remained flat. The Older American’s Act (OAA) funding, administered by the Western Reserve Area Agency on Aging (WRAAA), increased in 2003 and then decreased in 2004. Most dramatically, the county’s CDBG funding plummeted from about \$256,000 in 2002 to about \$8,000 in 2004. Overall, government funding decreased substantially from \$1,697,785 in 2002, to \$1,558,234 in 2003, to \$1,469,445 in 2004. Note that in 2002, Westlake Senior Center received a one-time \$200,000+ CDBG grant for senior center construction/rehabilitation.

From 2002-2004, funding of senior centers at the municipal level decreased from \$983,572 to \$949,167 in 2002, and then increased to \$984,427 in 2004 (just over 2002's level). Note that only 11 Cuyahoga County municipalities reported revenue sources for core services (eight reported funding senior centers).

As of May 11, 2006, over \$5.9 million in revenues for senior centers has been identified countywide. Forty-three percent of reported revenues are from contracts or grants from government organizations. Federated fundraising organizations represented 35 percent of revenues for this core service. United Way of Greater Cleveland's funds account for 19 percent of the total from Investment Committee allocations.

Reimbursement for senior centers is difficult to classify given their role as a focal point for providing multiple types of core services to older adults both on-site (socialization, health education, and congregate meals) and off-site (home-delivered meals and transportation). Reimbursement rates and definitions of a unit of service vary by type of providers and funders of this service.

What Works; What Doesn't

Several research studies have shown that "senior centers have a positive impact ... such as a heightened or renewed self-worth, individual growth, and a new social network" (National Council on the Aging, 2005).

"A Plan for Successful Aging in Greater Cleveland," submitted to The Cleveland Foundation by the Healthy Aging Task Force, recommended that Lifelong Learning and Development Centers be established in the Greater Cleveland area. These centers would encourage persons to "engage in planning and thus promote successful aging."

As senior centers frame their programs, they must realize that people's staying in the workforce longer, chronic health problems, and need to care for family members may limit the time available to participate in center activities. Hours of operation and location of programming may need to be adjusted.

Centers also offer benefits to the community in general by providing "information on aging, support for family caregivers, training of professional and lay leaders and students, and development of innovative approaches to addressing aging issues" (National Council on the Aging, 2005).

Certification and accreditation for senior centers began in the 1990's through the Ohio Association of Senior Centers (OASC) and the National Senior Center Accreditation Program established by the National Institute of Senior Centers. Senior center professionals, including senior center managers, program managers, and aging services administrators, can also be certified. There are 200 certified senior center professionals in Ohio (Ohio Department of Aging Development Brief #6).

Gap Analysis

The estimated universe of possible consumers is 14,189 included both realized access (7,618) and unrealized access (6,571).

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

Staying physically, mentally, and socially active is important to older adults' good health and well-being. Traditionally, senior centers are seen as focal points where community-dwelling older adults come (and are often transported to as a service of the senior center) for meals, recreation and socialization, and other programming where important links to community services are provided.

Participation in senior centers and the associated social networks that participants form contribute to the well-being of older adults. For example, one survey of senior center participants found that 90 percent of respondents felt that their health was better or at least as good as the previous year, and 75 percent reported that the center helped them remain independent (Aday, 2003 as quoted in Miltiades, Grove, and Drenovsky, n.d.)

Most older adults live, and want to remain living, in the community. According to "Older Americans 2004: Key Indicators of Well-Being," nationally, the majority of older Americans live in traditional community settings (93 percent), while only 2.5 percent live in community housing with services, and 4.4 percent live in long-term care facilities. In addition, according to a national public opinion survey conducted by AARP (2003), an overwhelming majority of older adults want to stay in their own homes for as long as possible. Senior centers help enable individuals to live independently by providing a centralized location for multiple services. The centers encourage physical and mental well-being, and often facilitate the identification of needed services before an individual becomes too frail.

National studies have found that older adults are healthier, less disabled, and living longer due to improved socio-economic conditions and advances in health care. This trend is expected to continue and perhaps improve even further. Life expectancy for all Americans reached an all-time high at 77.6 years in 2003 with the gap between male and female life expectancy closing to 5.3 years. While disparities remain among races, ethnicities, and gender, record-high life expectancies were found for white males (75.4 years) and black males (69.2 males), as well as for white females (80.5 years) and black females (76.1 years) (National Center for Health Statistics & Disease Control, 2005).

According to researchers at Duke University, disability rates among older persons have declined substantially. The rate of disability in the adult population has been declining consistently by 1.5 percent per year since the early 1980s (Johnson et al., 2001). The National Long Term Care Survey found that the number of older persons with a chronic disability has remained essentially unchanged at 7 million since 1989 though the older population has grown substantially. This has resulted in 2.3 million fewer older persons with disabilities than would have been predicted based on 1982 rates. Continued declines in disability are expected. Additionally, even though the prevalence of some chronic conditions has been increasing, the debilitating effects of many of those conditions have been reduced. Based on such findings, researchers have concluded that both treatment and prevention of potentially disabling chronic conditions contribute significantly to decreasing disability rates (Redfoot & Pandya,

2002). Less disability can mean that older adults stay more active and function more independently (The Institute for Research on Women and Gender, 2002).

When viewing these advances in health and longevity, it is important to note that it is not a result of chance that much variability in health status emerges later in life. Such things as access to medical care, behavioral patterns, educational background, and working conditions all influence the quality of one's later years. Higher rates of disability and chronic diseases remain for disadvantaged populations (The Institute for Research on Women and Gender, 2002).

A general change in the way society and science understands aging is being observed. There are multiple definitions of old age. Some point to the chronological age of 65—a political throwback from the late 1800s—to mark the onset of old age. Others break later life into stages with colorful names such as “young old” (ages 65-74), “old old” (ages 74-84), and “oldest old” (ages 85 and older). Still others eschew chronological markers to focus on a person's appearance and abilities (functional age) or on the roles and expectations society places on persons based on their chronological and functional ages (sociogenic age). Each of these approaches to defining age serves a purpose, but none provides a complete picture of the older population (The Institute for Research on Women and Gender, 2002).

Defining aging is complex, in part because it is not a single experience. Although often associated with grey hair, wrinkles, and a host of chronic diseases that may or may not be age-related, aging is also about how we view people (including ourselves), how we look and act, and how long we've lived (Karasik, n.d.). Additionally, the psychological resiliency of older age is being recognized. A majority of older people are at least as satisfied with their lives as younger people are. Added years often bring deep emotional satisfaction. As people grow older, they also tend to become more satisfied with their personal relationships, learn to control their emotions more successfully, and increase available stores of useful knowledge. Chronological age, then, will tell us less and less about the circumstances, needs, or chances for successful aging of the individual (The Institute for Research on Women and Gender, 2002).

Converging health and social trends have considerable repercussions for the model upon which many senior centers are based. The current senior center model—that of being a focal point for service provision and access and, importantly, social support—is based on historical social trends that may not be consistent with the needs and preferences of today's “coming of age” older adults. With the changes to be expected from this very different generation of “coming of age” baby boomers, senior centers will be attracting and serving a different population. Some insights about baby boomers are:

- They have a broader range of interests than the current 60-70 year olds.
- They report high interest in travel, computers, physical fitness, and adult education offerings.

- They have low interest in the programs currently offered in centers (i.e., volunteering, games, participating in musical activities).
- Their major reason to attend a senior center is for the opportunity to be with friends, which is the same as with older adults of past (Martin et. al., 2002).
- They will be better educated, and so “will be more interested in consumer issues, health issues, and self-help activities than older adults of the 1970s, 1980s, and 1990s” (Miltiades, Helen, Grove, Sara, and Drenovsky, Cynthia, n.d.).

Other trends about the older adult population that will affect senior centers include the following:

- *The older adult population is exploding.*
Growth in the older adult population will also be a major factor in the direction of senior centers. In 1900, 4 percent of the United States population was 65 or older; at the beginning of 2000, 13 percent of the population was in that age group. In less than thirty years, 20 percent of the population is projected to be 65 or older (Martin et. al., 2002).
- *Older adults as a cohort are more diverse.*
As the society ages, older adults are becoming more diverse. In 2000, 16 percent of persons 65 and over identified themselves as being from one of the four minority populations (Native American/Alaska native, Asian/Pacific Islander, African American, Hispanic). It is projected that by mid-century over one-third (36 percent) of all older Americans will come from these groups. Older people of color not only have higher rates of chronic diseases such as diabetes, hypertension, and cancer, they also have elevated substance abuse rates and shorter life expectancies (The Institute for Research on Women and Gender, 2002). There are social and psychological correlates to observed health and mental health problems among ethnic elders. Older age for many is characterized by higher rates of poverty, greater likelihood of living alone, lower availability of good health insurance, and fewer private pensions, which result in greater dependency on government support (The Institute for Research on Women and Gender, 2002).
- *Older adults have higher incomes.*
Although there remain disparities by race and gender, the proportion of destitute people among persons aged 65 and older has dramatically declined from roughly 30 percent in 1959 to just over 10 percent today. However, it is important to note that many are still at risk of impoverishment in a downturn. Almost two thirds of elderly households have incomes below \$20,000 a year. While median income for white Americans 65 and older is \$16,954, median income for African Americans is \$9,649. Net wealth, or the accumulation of assets over a lifetime, varies even more than incomes.
- *About 60 percent of the population age 65 and older own their own homes.*
One-half of the population aged 65 and older has less than \$9,500 in financial assets. By comparison, 20 percent of the population aged 65 or older has net worth in excess of \$355,000 with only 40 percent invested in their homes. These differences, of course, carry vast implications for the quality of extended lives. For myriad reasons, divorced, widowed, and never-married women age 75 or older are at far greater risk of impoverishment than are men. African American men, too, are particularly vulnerable to the burdens that can come with aging. They are poorer and far more likely than their white counterparts to suffer debilitating chronic health conditions and disabilities in older age (The Institute for Research on Women and Gender, 2002).

- *Older adults are staying in the workforce longer.*
Key informants for United Way’s core service planning (2005) indicated that over the next five years they expect an increase in the number of older people leaving the work force earlier in their careers, but that a majority would continue to be employed or would volunteer after they leave their full-time jobs. The key informants cited research that indicates that 78 percent of older adults say they will either have to work during their retirement or wish to work while they are retired. As baby boomers start retiring, they will look for activities and programs in which they can participate.

The primary issues for senior centers, as articulated in the “Senior Centers: Ohio Blueprint for the Future,” are attracting baby boomers, fostering diversity, linking the generations, redefining the image of the senior center, and partnering for resources and community development. Since people are expected to live longer, the need for services is likely to increase. Unless the service provider network changes dramatically, it will be unable to serve the baby boomer population, which has extremely different expectations than previous senior populations. In the coming years, there will be an unprecedented demand for all goods and services required by individuals in their seventh through tenth decades of life. To meet the growing need, both the impressive heterogeneity of the aging population, and the diversity of preferences, requirements, and trajectories of health and life must be appreciated (Young, 2003). To remain relevant, the role of the senior center must be modified as views of old age and the general characteristics of older adults continue to change. The major challenge, however, will be to continue to serve the “traditional” senior center user effectively while at the same time changing to meet the needs and preferences of baby boomers as they become senior center participants.

PUBLIC POLICY ISSUES

As is addressed in section IV of this report, government funding is a key issue for senior centers. The combination of declining federal and state funding for senior centers and a growing senior population will dominate the public policy arena.

Older Americans Act (OAA)

A significant source of government funding for many of the services offered at senior centers is the Older Americans Act (OAA). The National Council on Aging (NCOA) has made appropriations for services funded through OAA a top priority in its policy platform for 2007-2008.

The OAA funds critical programs and services to keep older adults healthy and independent, including: nutrition, senior centers, home and community services, family caregiver support, protection against abuse and neglect, older worker training and employment, transportation, and health promotion/disease prevention. OAA programs save tax dollars by reducing premature nursing home placement, averting malnutrition and controlling chronic health conditions.

Congress accomplished the number one priority from the 2005 White House Conference on Aging--reauthorization of the OAA. With that step completed, NCOA’s key goal turns now to boosting OAA appropriations. OAA appropriations have been essentially frozen at \$1.8 billion since FY 2003, meaning purchasing power has been seriously eroded, both by

inflation and by the growing numbers of older adults in need. \$1.8 billion can not go as far today as it did in 2003. NCOA urges Congress to increase OAA appropriations by 10 percent in FY 2008 and again in FY 2009, and to continue 10 percent increases through FY 2014, which would double the 2007 amount. (National Council on Aging, 2007)

Supportive Services (Title III-B) of OAA provides funding for services, including senior center services, designed to enable older persons to remain in their own homes rather than enter institutions. In 2003, the Older Americans Act Title III funds were worth approximately 57 cents compared to 1980 Title III funds worth one dollar. In Ohio, senior community services funding has been reduced by 25 percent since 2001 (Ohio Association of Area Agencies on Aging, 2005b).

III. THE CORE SERVICE CONSUMERS

DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is defined broadly as independently functioning older adults aged 60 years and older who are under 200 percent of poverty and living in the community.

DEMOGRAPHIC CHARACTERISTICS

Older Adults

National

Nationally, the impact of the aging of the largest cohort of the population—the baby boomer generation (individuals born between 1946 and 1964 who began turning 60 in 2006)—is expected to be enormous. In 2000, 35 million Americans were over age 65, and almost 4.5 million were over age 85. By 2030, the number of older Americans will more than double, and 9 million older adults will be over age 85.

Ohio

In Ohio, there were approximately 1.4 million adults over 65 in 1990, or 13 percent of the total state population. In 2000, about 1.5 million older adults (or 13.3 percent) lived in the state. The state’s 65+ population grew 7.2 percent between 1990 and 2000, while the general population grew 4.7 percent.

Cuyahoga County

In Cuyahoga County, 15.6 percent of the population were over 65 in both 1990 (221,066) and 2000 (217,161). In that decade, both the county’s general population and its 65+ older adult population fell, but by approximately the same amount (minus 1-2 percent). The number of residents ages 75 and older, however, experienced net increases ranging from 11 percent (ages 75-79) to 33 percent (ages 85+) during the same period.

Below are some additional demographic characteristics of older adults in Cuyahoga County that are pertinent to understanding senior center participants. These are primarily based on U.S. Census 2000 data:

- Almost 20 percent of Cuyahoga County’s population is age 60+ (or 273,378 individuals).
- By 2020, there will be 312,000 individuals age 60+ in Cuyahoga County (a 14 percent increase in the 60+ population from present).
- Nearly three in four individuals age 85+ are female.
- Disability increases with age: only 3 percent of 60-69 year olds have a severe disability, compared to 44 percent of those 90+.
- Over one third of individuals age 60+ have at least one disability.
- By 2020, almost 25,000 individuals age 60+ with a severe disability will reside in Cuyahoga County.
- Almost 14 percent of the population age 60+ live in poverty.
- Almost 1 in 4 individuals age 60+ are racial or ethnic minorities.
- Of men age 60+, 69 percent are married, compared to only 40 percent of women.

- Nearly 7 in 10 individuals age 60+ have 12 or fewer years of education (Mehdizadeh et al., n.d.).

Senior Center Participants

National

Nationally, close to ten million older adults are served by senior centers (National Council on Aging, U.S. Administration on Aging). The majority of older adults, though, do not utilize centers as demonstrated in one study where less than 20 percent of the 65 years and older population participated in a senior center (Krout & Cohen-Mansfield, 2005). Several multivariate studies with large representative samples provide some insight into who utilizes senior centers (e.g. Krout, Cutler & Coward, 1990 in Calsyn & Winter, 2000). Some of the findings include:

- Age is positively related to senior center utilization until about age 85 (Ozawa & Morrow-Howell, 1992 in Calsyn, 2000).
- Women use centers more than men, though this may be because women comprise a larger portion of the senior population (Krout, 1989; Ozawa & Morrow-Howell, 1992; Ralston, 1987 in Calsyn & Winter, 2000).
- Race has not consistently been a predictor of participation (Krout, 1989; Ozawa & Morrow-Howell, 1992; Ralston, 1987 in Calsyn & Winter, 2000).
- Income has not consistently been a deciding factor (Ralston, 1987 in Calsyn & Winter), but the one study with the most representative sample found that users had less income than non-users (Krout, Cutler & Coward, 1990).
- There is a relationship between social activity level and use of senior centers (Ralston, 1987 in Calsyn & Winter, 2000).

A more recent study by Calsyn & Winter (1999) looked at a sample of 4,903 Missouri residents over 60 years of age. Only 8.3 percent of the sample was attending a center. Those that were more likely to attend a senior center had the following characteristics:

- Older;
- More socially active;
- Living in a less urban area;
- Fewer days when their mental health was not good;
- Fewer ADL (activities of daily living) problems;
- Aware of more agencies;
- Had used formal agencies in seeking service information; and
- Had used more older adult services.

However, researchers note that study findings have been inconsistent about who participates at senior centers (Miltiades, Helen, Grove, Sara, and Drenovsky, Cynthia, n.d.).

Ohio

“Senior Centers: Ohio Blueprint for the Future” reports the following characteristics of senior center participants in Ohio:

- On average, 25 percent of the participants are male.
- Twelve percent of the participants work full- or part-time.
- Fifty percent are at or above middle income (Martin et. al., 2002).

Greater Cleveland

Locally, senior centers are viewed as a resource for a significant percentage of the older population. In a 2006 random sample survey of adults age 55 and older living in the five-county area (Cuyahoga, Geauga, Lake, Lorain, and Medina) served by the Western Reserve Area Agency on Aging (WRAAA), 29 percent of respondents stated that they would contact a senior center or community center for information on aging (Triad Research, 2006). Fifty-nine percent agreed that they can picture themselves attending programs and activities at a senior center, while 36 percent disagreed with this statement. There was also some variation among those who agreed that they can picture themselves attending activities at a senior center. Those more apt to agree included:

- Respondents 55 to 59 years (65 percent);
- Respondents 60 to 64 years (74 percent);
- Respondents who were married (65 percent); and
- Respondents who were minorities (71 percent).

Those less apt to agree were:

- Respondents 75 to 84 year olds (52 percent);
- Respondents 85 years and over (43 percent);
- Respondents who were widowed (53 percent);
- Respondents who were divorced, separated and single (55 percent); and
- Respondents in the older suburbs in Cuyahoga County (53 percent).

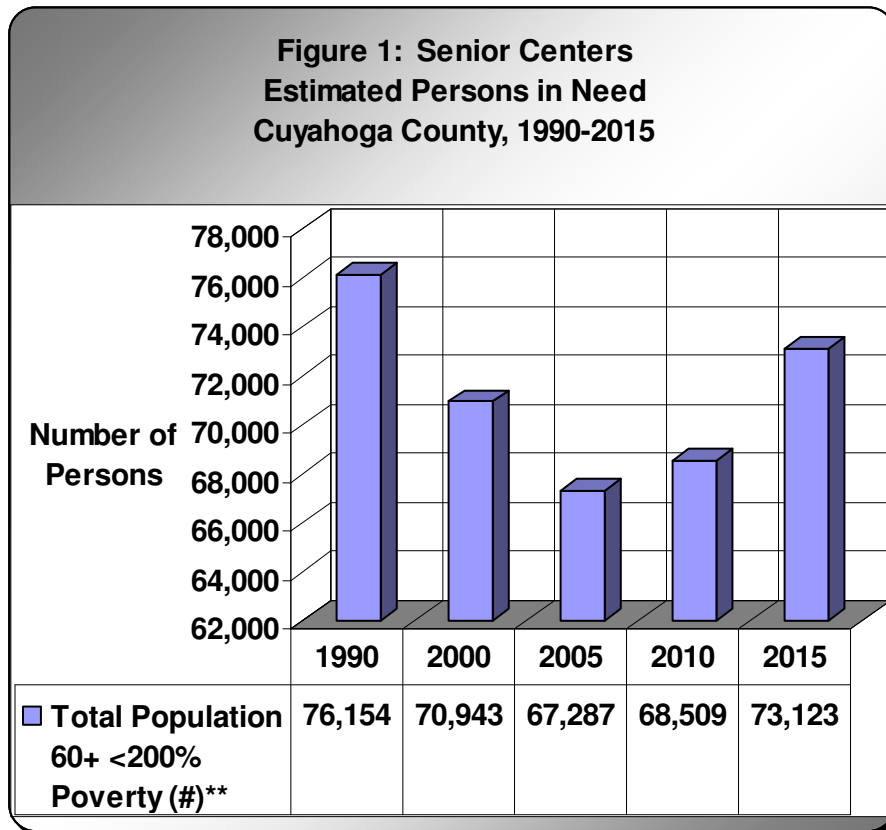
Clearly, the reputation of senior centers as a resource in the community remains strong.

Participants in the 2005 United Way core service focus groups expect to be serving more older adults with diseases and disabilities, as well as individuals with mental retardation and/or developmental disabilities. Some clients have been diagnosed with mental health issues as well.

In the context of senior centers, it is essential to mention an additional population of aging individuals with developmental disabilities and mental retardation. Additionally, there are compounding issues for these “double jeopardy individuals” who are aging and yet remain under the guardianship of aging parents. This cohort of the older adult population is new to this generation as policy changes, improved medical care, and advocacy for this historically marginalized population have resulted in longer life expectancy and less institutionalization (Kornblau & Hinds, 1998). These individuals have pervasive developmental needs and may have secondary diagnoses of cerebral palsy, Down's syndrome, or childhood psychiatric syndromes. Many have long experience with rehabilitation services provided to boost physical, social, and cognitive capabilities to maximize self care skills, independent living, and quality of life. A common problem for aging persons with developmental disabilities is reduced independence in self-care activities commonly due to long-standing impairments and high incidence of disability, compounded by aging and increased likelihood of age-associated conditions (Watkins & Weiner, 1997 in Horowitz, n.d.). Senior centers are increasingly providing services to individuals enrolled with the Cuyahoga County Board of Mental Retardation and Developmental Disabilities, and the needs of this population will influence the provision of services at senior centers.

Estimated Persons in Need

In 2000, an estimated 70,943 individuals were need of senior centers. This number represents persons 60 years and older and below 200 percent of poverty. In 2007 for a family of one 200 percent of poverty is \$20,420 and for a family of two, \$27,380. The number has been decreasing since 1990, mainly due to shifts in the population, but it is projected to increase to 73,123 by 2015 as baby boomers come of age. (See Figure 1.)



Sources:

* U.S. Census: 1990, STF1 (P11); 2000, SF1 (P12); 2005-2015, Ohio Department of Development, (July, 2003).

** U.S. Census: 2000, SF3 (PCT50); Other years estimated using 2000 proportion of 26.0% of Age 60+

It is recognized that this is a conservative estimate of persons in need of senior center programs, perhaps even more so as many senior centers add learning opportunities and become information centers to accommodate the changing needs and preferences of aging baby boomers. In addition, persons with incomes greater than 200 percent of poverty are also consumers of senior centers. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

REALIZED ACCESS TO SERVICE

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

In FY 2004, United Way funded 6,021 persons for senior centers. (See Attachment 3.) In CY 2004, the Western Reserve Area Agency on Aging funded 7,618 actual annual consumers. In FY 2004, the Cuyahoga County Department of Senior and Adult Services funded 685. Five municipalities that reported data for CY 2004 ranged from 1,146 from the City of Cleveland Height's general revenue fund to 3,191, also for the City of Cleveland funded through its Community Development Block Grant program.

In 2000, according to the U.S. Census, 64 percent of the county's estimated total 60+ population under 200 percent of poverty was Caucasian, 33 percent African American, and 1 percent Asian.

- United Way funded senior center participants were 59 percent Caucasian, WRAAA was 65 percent, DSAS was 22 percent, and reporting municipalities ranged from 72 percent to 99 percent Caucasian.
- United Way funded senior center participants were 30 percent African American, WRAAA was 13 percent, DSAS was 74 percent, and reporting municipalities ranged from 1 percent to 28 percent African American.

Catholic Charities (16 percent) and United Way (7 percent) funded higher proportions of Hispanics 60+ than the county average of 2 percent.

Eighty-six percent of those funded by Catholic Charities, and 68 percent of those funded by United Way reported annual household income less than \$14,999. The rest were unreported.

Geographically, 41 percent of estimated persons 60+ who were below 200 percent of poverty resided in Cleveland and the remaining 59 percent lived in the suburbs. Known residences of United Way and WRAAA funded clients were split almost evenly between City of Cleveland and the suburbs. (See Attachment 4.)

IV. CORE SERVICE DELIVERY

CORE SERVICE DEFINITION

The National Institute of Seniors Centers defines senior centers as places where “older adults come together for services and activities that reflect their experience and skills, respond to their diverse needs and interest, enhance their dignity, support their independence, and encourage their involvement in and with the center and the community.” For this report, senior centers are defined as in the AIRS definition, i.e. multipurpose centers that serve as focal points for older adults in the community and offer, at a single location, a wide variety of services and activities that are needed by and of interest to this population.

BACKGROUND ON CORE SERVICE

The senior center movement was started in 1943 in Brooklyn, New York, where the William Hodson Community Center was established under the auspices of the New York City Department of Welfare. Its primary services were nutrition and recreation. By the late 1940’s, there were senior centers in Philadelphia and San Francisco, and by 1961 approximately 218 centers were operating (National Council on Aging, U.S. Administration on Aging, 2005). Currently there are approximately 16,000 senior centers in the United States (Ohio Department of Aging Development Brief #6, n.d.). Since 1965, with the passage of the Older Americans Act (OAA), OAA funding has been available to over 6,000 senior centers (National Council on Aging, U.S. Administration on Aging). In 1995, there were 1.85 senior centers for every 10,000 persons 60 years or over. Nationally, 75 percent of senior centers are considered “focal points,” defined by OAA as facilities established to encourage maximum co-location and coordination of services for older people (Martin et. al., 2002).

In 1954, Muriel Bertsch started the first center in Hamilton, Ohio. Currently, Ohio has more than 400 senior centers (Ohio Department of Aging Development Brief, n.d.) with Cuyahoga, Franklin, and Hamilton Counties having the largest number. Using the 2000 Census, there are 1.94 senior centers in Ohio per 10,000 persons 60 years or older, slightly higher than the national average (Martin et. al., 2002).

Centers vary widely in their organizational structure, amount of funding, services, and activities. According to the Ohio Senior Center Director Survey, 25 percent of senior centers are part of a public system and 75 percent are not-for-profit organizations. The majority of the governmental programs are satellites of a larger program (48 percent) and the majority of the not-for-profit programs are stand-alone (47 percent) (Martin et. al., 2002).

The most common services provided at senior centers are:

- Health and wellness;
- Arts and humanities;

- Intergenerational programs;
- Employment assistance;
- Community action and social networking;
- Transportation;
- Volunteer activities;
- Education;
- Information and referral;
- Financial assistance;
- Meal and nutrition programs; and
- Leisure travel (National Council on Aging, 2005).

“Senior Centers: Ohio Blueprint for the Future” reports the following characteristics of senior centers in Ohio:

- Twelve percent of senior centers are open on weekends or evenings.
- Fifty-four percent of the older adults drive themselves to the center.
- Twenty-five percent of centers offer in-home services.
- Twenty-five percent of the centers offer services for persons under 60 years with disabilities.
- Volunteering is the most common activity (Martin et. al., 2002).

The United Way core service focus group participants (2005) believe that older adults from the baby boomer generation will have different expectations of senior centers than what current senior centers provide. This generation is accustomed to the Internet, cable, cell phones, and other modern conveniences that previous generations did not have. At the same time, there will be older adults from lower-income areas and various ethnic groups that will not be as comfortable with computers. As one focus group participant noted:

I would say a good 25 percent of our people will not touch technology and we work very, very hard not only on computers but also at integrating every type of technology into all of our programs. And there still is that 25 percent that will not touch anything that they think is technology just basically out of fear. And we just can't...we have worked very hard on this issue.

Thus, a major issue for senior centers will be making technology available, which includes both providing access to computers as well as helping older adults understand and use technology.

Also according to focus group participants, there are some negative connotations associated with senior centers; for example, that they are only for older adults who “need” them or they have “less than exciting activities.” Centers need to determine who is best served by their organization; they need to develop the type of programming that motivates participation; and they need to market their offerings.

Senior centers need to be relevant to many different populations reflected in the diversity of gender, income, education, geography, ethnicity, and activity preferences. It will be a significant challenge to balance the participants’ differences and create a center that is satisfying to all. To further complicate the situation, older adults and baby boomers are looking for people like themselves in addition to a relaxed and friendly place. Center directors need to be familiar with

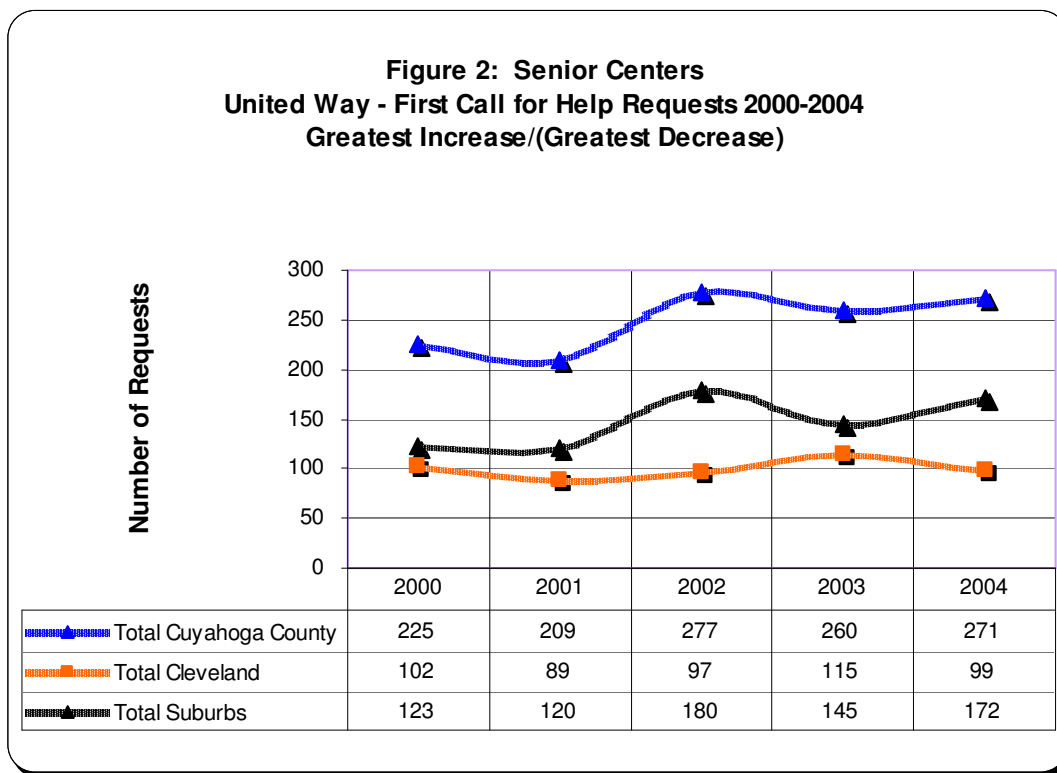
the findings of current research, as well as with their particular community. They need to be effective in engaging the senior population in defining the direction of their centers.

While senior centers have traditionally provided important opportunities for socialization, nutrition, and linkages to services, they are not a service only for those with limited education and income. There are many models of more “up-scale” senior centers that provide space, technology, and atmosphere conducive to learning, discussion, and seeking help while satisfying needs for companionship and human interaction.

United Way - First Call for Help Call Data

Based on United Way - First Call for Help’s (FCFH) database (February 2005), there are 52 senior centers providers operating from 76 different sites, 29 of which are government and 23 are nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded 10 of these providers. (See Attachments 5 & 6.)

FCFH call data shows an increase in the number of total requests for senior center programs in the county: from 225 in 2000 to 271 in 2004—an increase of 20 percent; however, the increase in requests was seen only in the suburbs (40 percent) and the City of Cleveland experienced a slight decrease (3 percent) in number of requests. (See Figure 2.)



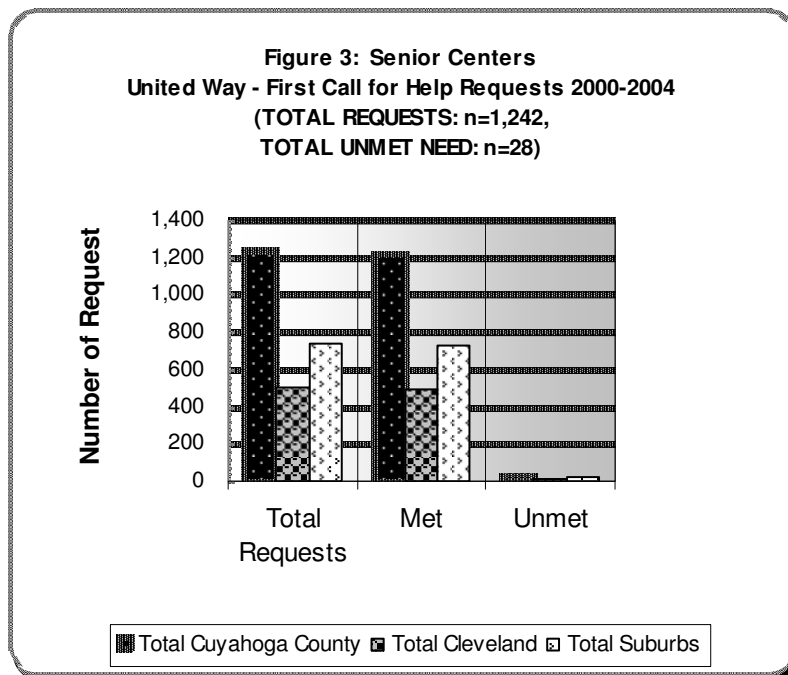
The highest average number of calls from 2000-2004 came from the following Cuyahoga County zip codes:

- 44120 (Shaker Heights/Cleveland) – 13 calls;
- 44112 (East Cleveland/Cleveland) – 10 calls;

- 44110 (Cleveland/East Cleveland) – 9 calls;
- 44111 (Cleveland) – 9 calls;
- 44124 (Pepper Pike/Mayfield Heights/Lyndhurst) – 8 calls;
- 44102 (Cleveland/Brooklyn) - 8 calls; and
- 44109 (Cleveland/Brooklyn Hts) – 8 calls.

(See Attachment 7.)

Between 2000 and 2004 FCFH received 1,242 calls for senior centers countywide and was able to meet 98 percent of requests for senior center programs, meaning it was able to provide callers with an appropriate referral. Two percent had an unmet need countywide as well as in Cleveland and the suburbs. (See Figure 3 and Attachment 8.)



FUNDING OF CORE SERVICES

Major Government Funders

The major sources of government funding for senior centers are:

- Community Development Block Grant (CDBG);
- Older Americans Act (OAA);
- Ohio Senior Community Services Funding;
- Cuyahoga County General Fund (through the Department of Senior and Adult Services); and
- Municipalities.

Below is further description of these sources.

FEDERAL

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

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

Older Americans Act (OAA)

As described in Section II of this report, the Administration on Aging awards formula grants under Title III of the Older Americans Act (OAA) to the 57 state units on aging to plan, develop, and coordinate systems of in-home and community-based services under which senior centers fall. The AoA's FY 2005 budget totaled approximately \$1.397 billion. In FY 2006, the budget decreased to \$1.366 billion. This program's appropriation declined from \$183 million in FY 2005 to \$182 million in FY 2006, and is expected to decrease by \$181 million in FY 2007 (U.S. Department of Health and Human Services, 2006).

STATE

Ohio Senior Community Services Funding

In Ohio, Senior Community Services funding, which funds senior centers, has been reduced by 25 percent since 2001 (Ohio Association of Area Agencies on Aging, 2005b).

LOCAL

Cuyahoga County General Fund

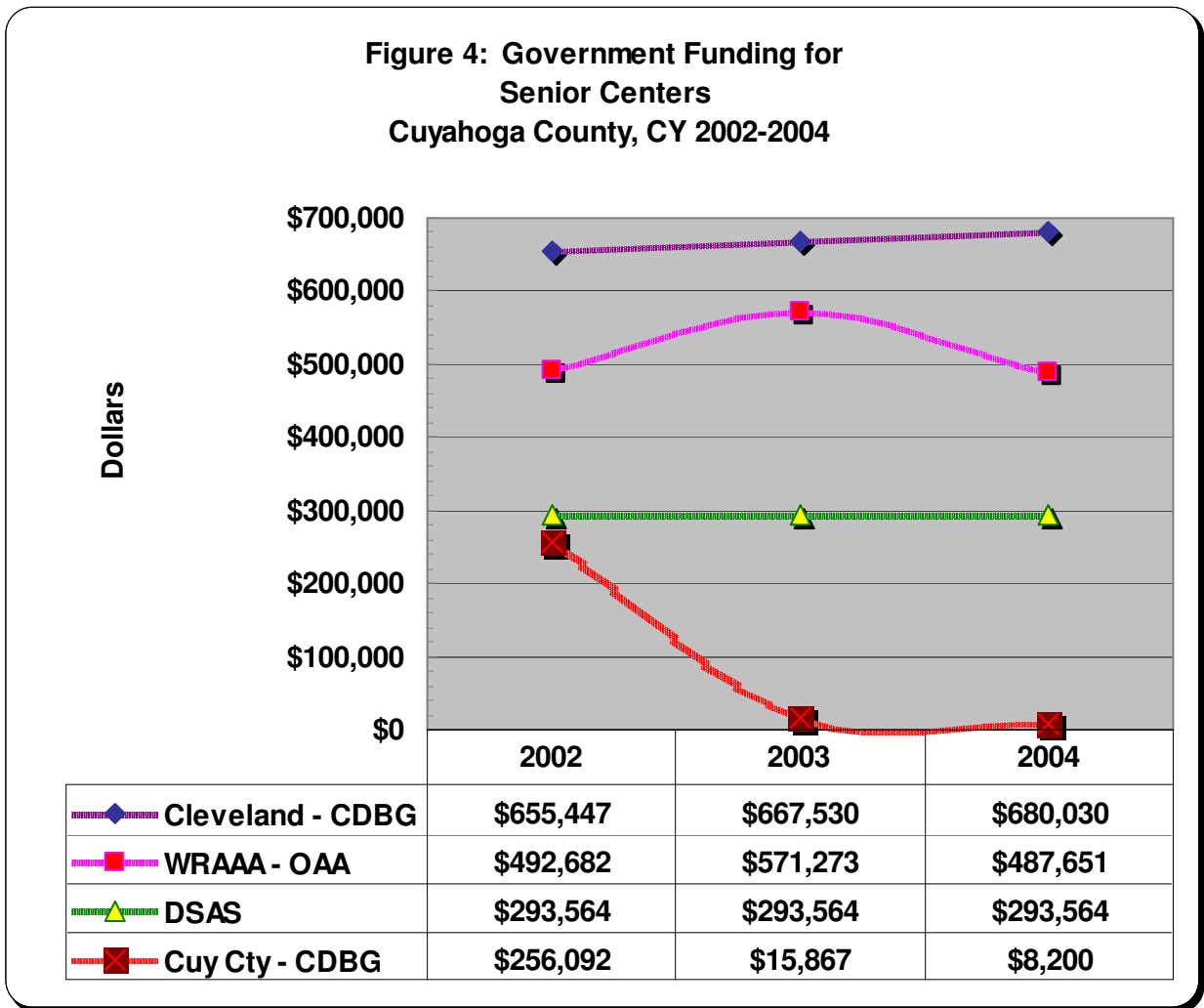
General funds from Cuyahoga County are used to support senior centers as administered through the Cuyahoga County Department of Senior and Adult Services.

Trends of Identified Government Funders in Cuyahoga County

Total budgets and funding sources for senior centers vary. In Ohio, budgets ranged from \$750 to \$6 million a year (Martin et. al., 2002). Funding is provided from all levels of government, local philanthropic organizations such as United Way, and individual contributions.

Funding for senior centers has been mixed. Between 2002 and 2004, the City of Cleveland Community Development Block Grant (CDBG) funding increased modestly for senior centers. The Department of Senior and Adult Services funding has remained flat. The Older American's Act (OAA) funding, administered by WRAAA, increased in 2003 and then decreased in 2004. Most dramatically, the county's CDBG funding plummeted from about \$256,000 in 2002 to about \$8,000 in 2004. Note that in 2002, Westlake Senior Center received a one-time \$200,000+ CDBG grant for senior center construction/rehabilitation. Overall, government

funding has decreased substantially from \$1,697,785 in 2002 to \$1,558,234 in 2003, to \$1,469,445 in 2004. (See Figure 4.)

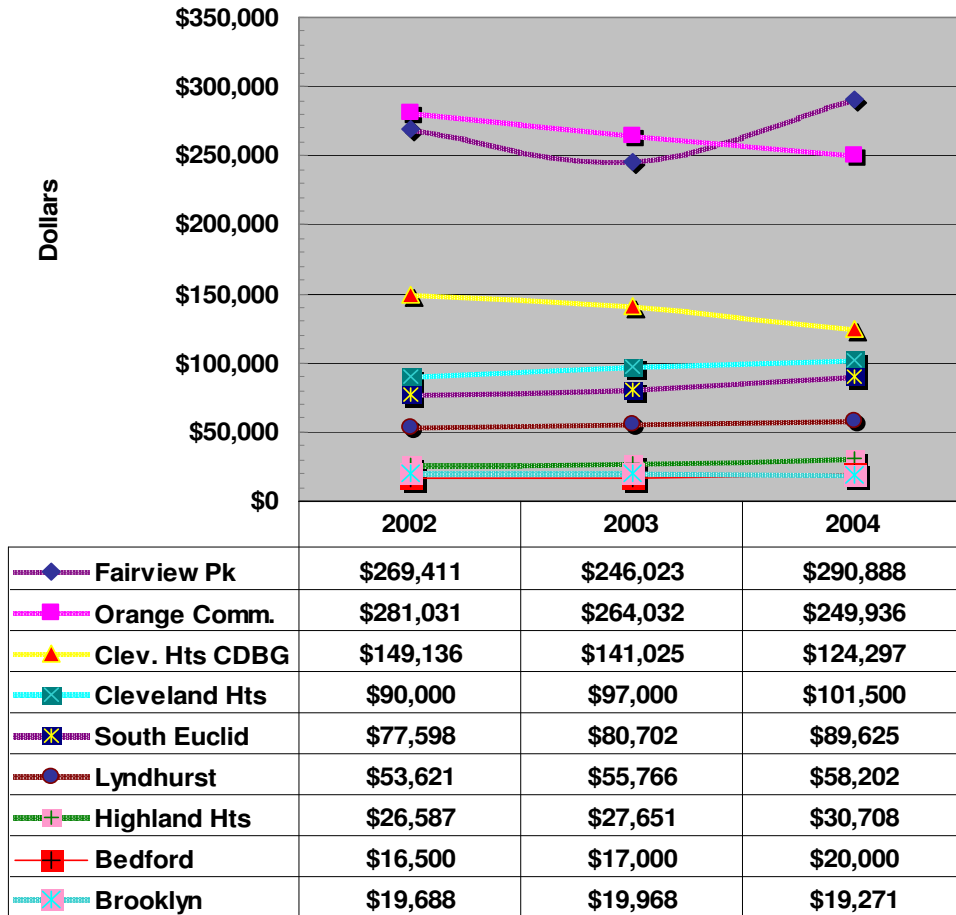


Source: Respective Funding Sources

Nine municipalities reported that they fund senior centers from their general revenue fund (GRF). This is over and above funding they receive from WRAAA (Western Reserve Area Agency on Aging), DSAS (Cuyahoga County Department of Senior and Adult Services), or any other funding source. Between 2002 and 2004, four of the reporting municipalities increased funding and one decreased it. Cleveland Heights CDBG decreased as well (though their GRF funding increased slightly), two kept funding basically flat, and one had a variable pattern.

From 2002-2004, total funding of senior centers at the municipal level decreased from \$983,572 to \$949,167 in 2002, and then increased to \$984,427 in 2004 (just over 2002's level). Note that only 11 Cuyahoga County municipalities reported revenue sources for core services and nine of them reported funding senior centers. Some municipalities like Orange serve multiple municipalities. (See Figure 5.)

**Figure 5: Municipal Funding for Senior Centers
Cuyahoga County, CY 2002-2004**



Sources: Respective Funding Sources

IDENTIFIED REVENUES

As of May 11, 2006, over \$5.9 million in revenues for senior centers has been identified countywide. (See Table 1.) This includes information from foundations; federated fundraising organizations; regional, county and municipal government; and United Way of Greater Cleveland.

Forty-three percent of reported revenues are from contracts or grants from government organizations. Federated fundraising organizations represented 35 percent of revenues for this core service. United Way of Greater Cleveland's funds account for 19 percent of the total from Investment Committee allocations.

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

Funder	Period	A		B	
		Identifiable Total Dollars County-wide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Total - Contributions and dues (less UW designations)			0.00%	200,361	3.49%
Cleveland Foundation, The				99,150	
Deaconess Community Foundation	2004	40,000			
McGregor Foundation, The	2004	98,000			
Mt. Sinai Health Care Foundation, The	2003	36,500			
Sisters of Charity Foundation of Cleveland				9,910	
Other Private Foundations - Not Elsewhere Classified				22,000	
Cleveland Electric Illuminating Co. Foundation	2004	4,000			
Eaton Charitable Fund	2003	500			
Other Corporate Foundations - Not Elsewhere Classified				13,500	
Total - Foundations & Trusts		179,000	3.03%	144,560	2.51%
Total - Special Events - Growth			0.00%	44,523	0.77%
Catholic Charities Service Corporation	2004	14,300			
Jewish Community Federation	2004	2,032,000		311,150	
United Black Fund of Greater Cleveland	FY2005	43,000			
Other Federated Organizations - Not Elsewhere Classified				19,980	
Total - Federated Fundraising Organizations		2,089,300	35.36%	331,130	5.76%
Department of Agriculture (USDA)				180,000	
Department of Housing and Urban Development				48,549	
Other Federal Funders - Not Elsewhere Classified				258,218	
Subtotal Federal Government		0	0.00%	486,767	8.47%
Department of Job and Family Services				55,392	
State Department of Education				11,400	
Other State Funders - Not Elsewhere Classified				15,000	
Subtotal State of Ohio		0	0.00%	81,792	1.42%
Western Reserve Area Agency on Aging (WRAAA)				1,660,735	
WRAAA-OAA-Title III B (Supportive Services)	CY2004	487,651			
Subtotal Regional Funding Sources		487,651	8.25%	1,660,735	28.89%
Department of Senior and Adult Services	2004	293,564		306,590	
Other Cuyahoga County Funders - Not Elsewhere Classified				37,953	
Community Development Block Grant Program	2004	8,200			
Subtotal Cuyahoga County Funding Sources		301,764	5.11%	344,543	5.99%
Community Development Block Grant	2004	680,030		159,141	
Other City of Cleveland Funders - Not Elsewhere Classified	2004	67,000		67,600	
Subtotal City of Cleveland Funding Sources		747,030	12.64%	226,741	3.94%
City of Bedford General Fund	2004	20,000			
City of Brooklyn	2004	19,271			
City of Cleveland Heights General Fund	2004	101,500			
City of Fairview Park General Fund	2004	290,888			
City of Highland Hts	2004	30,708			
City of Lyndhurst	2004	58,202			
City of South Euclid	2004	89,625			
Cleveland Heights CDBG	2004	124,297			
Orange Community Education & Recreation Dept.	2004	249,936			
Subtotal Other Municipal Funding Sources		984,427	16.66%	0	0.00%
Medicaid				96,270	
Medicare				1,064	
Other Private Insurer				532	
Subtotal Third Party Payee/Direct Bill		0	0.00%	97,866	1.70%
All Other Funding - Not Elsewhere Classified				631,525	
Subtotal Other Govt Funding Sources		0	0.00%	631,525	10.99%
Total - Contracts/grants from government organizations		2,520,872	42.66%	3,529,969	61.40%
Private Pay/Fee for Service				56,855	
Client Donation (Title III - OAA)				22,190	
Total - Program Service Fees				79,045	1.37%
Total - Investment Income				4,188	0.07%
Total - All Other Revenue				286,777	4.99%
Total - Prior Period balances/interfund transfers				8,606	0.15%
Subtotal Non - UWGrCle Support		4,789,172	81.05%	4,629,159	80.52%
Total - UWGrCle investment committee allocation		1,119,776	18.95%	1,119,776	19.48%
Subtotal UWGrCle Support - 4001, 4701 & 4703		1,119,776	18.95%	1,119,776	19.48%
Total Support/Revenue		5,908,948	100%	5,748,935	100%



REIMBURSEMENT/COST

Reimbursement for senior centers is difficult to classify given their role as a focal point for providing multiple types of core services to older adults both on-site (socialization, health education, and congregate meals) and off-site (home-delivered meals and transportation). Senior centers are reimbursed for their various services. Those services that are provided on-site and unique to senior centers are socialization, adult development, and supportive services. Sometimes transportation is also included. Reimbursement rates and even definitions of a unit of service vary among various types of providers and funders of this service.

V. WHAT WORKS; WHAT DOESN'T

IMPACT ON INDIVIDUALS/FAMILIES

What Works

Several research studies have shown that “senior centers have a positive impact on their participants... such as a heightened or renewed self-worth, individual growth, and a new social network” (National Council on Aging, 2005).

There is no single model for a successful senior center and organizational structure, finances, and activities vary widely.

Some of the features of successful centers are the opportunities for older adults to socialize, contribute to the development of programming, participate in activities that meet their varied interests, and interact with people from other generations in an organized and controlled manner. The Ohio Reads/STARS (Seniors Teaching and Reaching Students) program is an example of a successful intergenerational program funded by the Ohio Department of Aging. It allows adults 55 years or older to tutor at-risk children in kindergarten through fifth grade. By the end of the 2001/2002 school year, this program was found to benefit both the children and adults. Children showed improvements in reading (73 percent), math (69 percent) and writing (68 percent). The adult volunteers reported they were making new friends (96 percent) and 95 percent believed they were making a difference in the life of a child (Martin et. al., 2002).

“A Plan for Successful Aging in Greater Cleveland,” submitted to The Cleveland Foundation by the Healthy Aging Task Force, recommended that Lifelong Learning and Development Centers be established in the Greater Cleveland area. These centers would encourage persons to “engage in life planning and thus promote successful aging.” It was suggested that this resource should be located within existing organizations, including senior centers. Six organizations in Cuyahoga County received grants from The Cleveland Foundation to develop lifelong learning centers. Two of the grantees were senior center providers who used the funding to transform their senior centers into lifelong learning centers. This programmatic addition to a senior center could be helpful in engaging the baby boomer population.

As the baby boom generation reaches retirement age, the number of Americans over age 65 in 2030 is projected to be 71.5 million—or one in five people. To help cities and counties better meet the needs of an aging population, five national organizations joined forces to assess the “aging readiness” of America's communities and to identify solutions. The initiative was funded by a grant from MetLife Foundation. Known as The Maturing of America - Getting Communities on Track for an Aging Population, the project is being led by the National Association of Area Agencies on Aging (n4a), in partnership with the International City/County Management Association, National Association of Counties, National League of Cities and Partners for Livable Communities. The assessment began in November 2005, and a “promising practices” guide is to be developed. The assessment survey will answer three key preparedness questions concerning whether efforts are being made to assess and put into place programs, policies and services that address the needs of older adults and their caregivers; whether cities and counties are able to ensure that their communities are “livable” for all ages—not only good places to grow up but good places to grow old; and how well equipped an area is to harness the talent, wisdom, and experience of older adults who can contribute to the community at large. This

publication may be a useful resource for the community's future planning as it continues to evaluate its opportunities around senior centers (MetLife Foundation, 2005).

A similar initiative occurred recently in Cuyahoga County as part of the Elder Friendly Communities component of the Successful Aging Initiative of The Cleveland Foundation. Six municipalities received grants on behalf of themselves and other partner municipalities to assess the elder friendliness of their respective communities and to develop plans for improvements. The assessment indicators were structured around three dimensions of daily living of older adults: home life, community life, and mobility.

Linking the generations through senior center activities is generally viewed in a positive way. Programs where older adults reach out to children or older adults seem to benefit all who are involved. Blending age groups in the same facility is an issue that is not as readily addressed. The earlier observation that older adults want to be with people like themselves runs counter to this idea. A critical element to co-location is that older adults still maintain a separate space. The Cleveland Heights Senior Center is an example of co-location in a community recreation center that still maintains separate programming and space. The Strongsville Recreation Center includes a senior complex that occupies a distinct area, but older adults have access to the entire facility. There are many opportunities for all generations to be together in this space and the 37-acre preserve adjacent to the center.

Centers will continue to play a vital role for older adults, their families, and the community if, as the 2005 core service focus group participants noted, they offer programming that considers varied interests and needs, market their service, establish partnerships with community organizations, and identify new and varied funding options.

What Doesn't Work

Senior centers have been growing since their inception and have avoided outdated approaches in responding to the needs of their participants. Today, however, they face a major challenge as the baby boomers begin to turn 60. As they frame their programs, senior center providers must realize that people's staying in the workforce longer, chronic health problems, and need to care for family members may limit the time available to participate in center activities. Hours of operation and location of programming may need to be adjusted. The Ohio Department of Aging offers a roadmap for future success that includes attracting baby boomers, fostering diversity, linking the generations, redefining the image of centers, and partnering for resource and community development.

There are other barriers to accessing needed services. The 2005 United Way core service focus group participants noted issues with information and data exchange. Currently, there is no centralized location of information that all agencies can use to discover data about where to access services for their clients. As one participant noted, *"I wish there was a central point where everyone can post or go to just exchange information about things that are going on within their particular program."* It is difficult for service providers to navigate existing sources of information and determine which program should be selected. Service providers tend to utilize programs they are familiar with: *"...the programs you know, you end up using them more..."* The program selection is based on the service providers' awareness and penetration in the service community. This appears to be the case not only for providers, but for older adults as well:

In the years that I have been in the aging field, I have never seen a senior that knew what type of resources were in the community.

Also, there may be preconceived notions about agencies serving only specific groups that may present a further barrier to older adults accessing those services. For instance, the Jewish Community Center is open to anyone, regardless of their faith. However, some older adults may mistakenly believe that one has to be Jewish to access such services. Furthermore, some older adults may be “too proud” to accept a meal from an agency. As one participant stated, *“It becomes very difficult for us to get through these preconceived ideas of what the centers are.”*

A focus group participant also pointed out that the rigid requirements for clients to sign for services such as meals or transportation may impede older adults’ utilization of those services. As one participant noted, *“I think that we put older adults through an awful lot to get a service.”* Furthermore, older adults may not wish to provide Social Security numbers or “how much money comes in the house” for fear that Social Security numbers may be misused or that services might be taken away if their income level is disclosed.

IMPACT ON COMMUNITY

Centers also offer benefits to the community in general with “information on aging, support for family caregivers, training professional and lay leaders and students, and developments of innovative approaches to addressing aging issues” (National Council on the Aging, 2005).

ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Certification and accreditation for senior centers began in the 1990’s through the Ohio Association of Senior Centers (OASC) and the National Senior Center Accreditation Program, established by the National Institute of Senior Centers. There are 102 nationally accredited programs and approximately 60 have started the process (National Council on Aging, 2005). As of 2006, there are currently 10 certified senior centers in Ohio, but none in Cuyahoga County (National Council on Aging, 2006).

The accreditation process includes self-assessment, peer review, on-site evaluation, adherence to standards and guidelines, and recommendation for accreditation. Both nationally and in Ohio, only a small percentage of senior centers have achieved accreditation (Martin et. al., 2002). Though there are obvious benefits in reaching national standards for quality, the costs and time required are obstacles that need to be overcome.

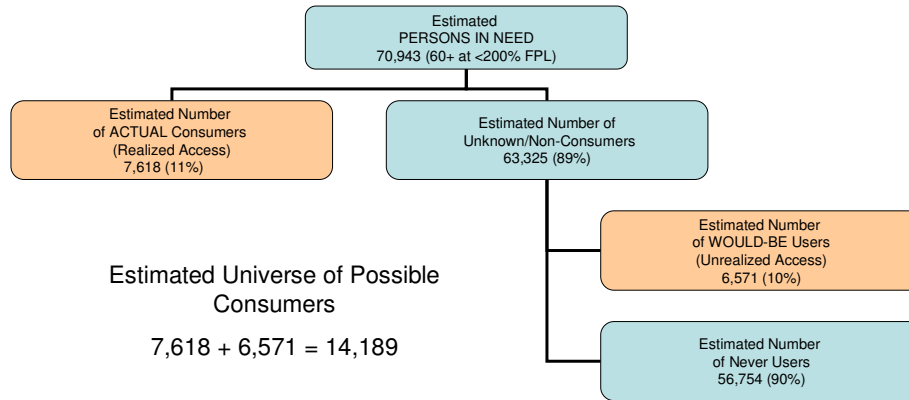
Senior center professionals, including senior center managers, program managers, and aging services administrators, can also be certified. There are 200 certified senior center professionals in Ohio (Ohio Department of Aging Development Brief #6). Certification is based on position and years of experience. In addition to meeting criteria, individuals must pass the test designated for their certification level. The certification is helpful in establishing a common understanding of professionalism for consumers, funders, center staff, and the public.

VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Senior Centers:

- A conservative estimate of 70,943 persons need senior centers. This number represents the number of Cuyahoga County persons 60+ living under 200 percent of poverty in 2000.
- Based on available information about actual consumers, approximately 7,618 persons 60+ have realized access to senior center services, which is the number of individuals reported to WRAAA as being served. This assumes duplication across the numbers reported by DSAS and municipalities.
- This leaves a net estimate of 9,964 who are either receiving services from unaccounted-for sources or are not receiving any senior center service. $(70,943 - 7,618 = 63,325)$
- Research by Krout and Cohen-Mansfield (2005) found nationally that 20 percent of the population 65 years and older are consumers of senior centers. Applying this percentage to the estimated persons in need (70,943) results in an estimated universe of possible consumers of 14,189. $(70,943 \times 20\% = 14,189)$
- The would-be users, i.e., those who would use a senior centers if they knew about it, could access it, and could afford it is the difference between the estimated universe of possible consumers (14,189) and those with realized access (7,618), 6,571. $(14,189 - 7,618 = 6,571)$
- In summary, the estimated universe of possible consumers is 14,189 included both realized access (7,618) and unrealized access (6,571). $(7,618 + 6,571 = 14,189)$ (See Figure 6.)

Figure 6: Consumer Estimates Senior Centers



Service Site Index

Countywide, there are 76 service sites for senior centers. This is a ratio of 187 possible consumers (estimated 14,189 total) to one service site countywide. Service providers report to United Way - First Call for Help which zip codes are included in their respective service areas. The Service Site Index in Attachment 9 lists the number of sites per zip code and provides a ratio of consumers to service sites for each zip code. This is a measure of potential service accessibility by possible universe of service consumers per zip code area. The lower the ratio, the greater is the chance of receiving a service from a senior center. Note that this measure does not include the capacity of providers to offer services. It is only capturing whether there is a possibility of participating in a service. It is also important to note that though a provider may accept clients from a broad geographic area, senior centers are most often community based, and geographic location is a major restriction to access.

The ratios on the Service Site Index range from a high of 15:1 in zip code 44105 (Cleveland/NewburghHts/GarfieldHts), a high minority area, to a low of less than 1:1 in zip codes 44040 (Gates Mills/Mayfield Village), 44022 (Bentleyville), 44115 (Cleveland), and 44141 (Brecksville).

- 44108 (Cleveland/Bratenahl), a high minority area – 13:1;
- 44102 (Cleveland/Brooklyn), a high minority area – 11:1;
- 44130 (Parma/Cleveland) - 11:1;
- 44112 (East Cleveland/Cleveland), a high minority area - 11:1;
- 44106 (Cleveland/Cleveland Hts), a high minority area - 11:1;
- 44109 (Cleveland/Brooklyn Hts), a high minority area - 11:1;
- 44120 (Shaker Hts/Cleveland), a high minority area – 10:1; and
- 44103 (Cleveland), a high minority area – 10:1.

(See Map in Attachment 10.)

Service Capacity

Gaps in Services Provided

Providing additional data on current and potential consumers, the Cleveland Department of Aging surveyed about 800 participants in 2003. It provides important information on service use and perceived service need. This information is important for the planning of senior centers since they offer a broad range of services. Survey respondents indicated that they are currently receiving the following services in order of frequency:

- Recreation/Education, 37 percent;
- Transportation, 25 percent;
- Housing, 21 percent;
- Banking and Finance, 20 percent;
- In Home Service, 20 percent;
- Legal Assistance, 11 percent;
- Health Care, 7 percent; and
- Respite Care, 4 percent.

Survey respondents indicated that they currently need, but did NOT receive the following services in order of frequency:

- Housing, 52 percent;
- Recreation/Education, 41 percent;
- Transportation, 34 percent;
- In Home Services, 32 percent;
- Banking and Finance, 31 percent;
- Legal Assistance, 31 percent;
- Health Care, 21 percent; and
- Respite Care, 13 percent (Cleveland Department of Aging, 2003).

From this survey, older adults in the City of Cleveland clearly felt the need for, but were not receiving, several services, many of which senior centers either provide or can assist older adults in accessing.

United Way Core Service Focus group participants (2005) provided feedback on gaps in services provided at senior centers. The group mentioned there is a need for more therapeutic types of adult day care and clients who need RNs (registered nurses), funding for case management, education for the entire family as to how they can help a senior member of their family, subsidized assisted living, and help with basic household duties such as window washing or mowing the lawn.

Socialization is a service that is very much in demand, one that older adults want, but one that is difficult to fund. One organization offered line dancing classes and a “sittercise” class that was very popular among the older adults. But they do not have those classes anymore because they no longer have funding for it. As one participant noted:

I think that there are services that we would like to provide or that are needed out there. Socialization becomes part of what we do as part of our routine thing but actual funding for socialization really doesn't exist. So

the very core kind of services, the nutrition services, the supportive services, and the transportation seems to be what is funded.

Gaps in Special Populations Not Served

The United Way core service key informants (2005) identified groups of individuals that currently need but are not receiving services:

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

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

Gaps in Communities Served

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

Gaps in Funding

Due to the relocation of some of Northeast Ohio's senior population, key informants for United Way's core service planning (2005) indicated that there has been a decrease of funding available for senior services. They indicated that they will have to learn how to do more with less to provide services to older adults. They also expect to see many of the baby boomer generation entering senior centers and believe that it will be a challenge to identify more funding sources to serve this anticipated increase in clients.

One participant noted that *"this is the most difficult time for aging funding in 30 years because every level faces cuts."* Some participants also said that their programming choices are determined more by what funding organizations are willing to fund than by what older adults say they want:

Very often what we would like to do is what the older adults want, but we are tied to what the people that fund us say we can do. Sometimes the unfortunate truth is that you go after funding because it is funding and it will keep you going. Sometimes the funding standards and rules are so

restrictive that you can't do what you need to do, that you can't provide access to what this person needs, wants, or must have for his/her survival. And it is no one's fault; it is everyone's fault in a way. But it is the climate and the environment that we are in. It is very frustrating as a provider.

This fact has important implications for senior centers' ability to respond to the preferences of the aging baby boomer population and to remain relevant. Another participant pointed out that the lack of funding may impact issues such as space allocation. Sometimes, agencies simply do not have the space to conduct events and may lack the funding to rent or use additional space.

The lack of funding for socialization activities is of major importance to senior centers. In recent years, the Western Reserve Area Agency on Aging (WRAAA) drastically cut socialization services, an essential component of senior center services. Participants indicated that there is very little funding available from any sources for these services. One focus group participant also noted that budget cuts required their senior center to reduce the number of meals offered daily. There is also concern that funding limitations will impact the workforce with difficulty retaining quality workers. An example is that agencies are already being asked to provide more services with less support staff than historically was available.

Duplication

Members of the 2005 core service focus group also noted that the utilization of senior center services was duplicated at times insofar as some older adults attend multiple senior centers; however, they noted that "the clientele was not duplicated" on any given day.

VII. SUMMARY

In summary, there are several major findings from the research on senior centers:

- According to a national public opinion survey conducted by AARP (2003), an overwhelming majority of older adults want to stay in their own homes for as long as possible. Senior centers help enable individuals live independently by providing a centralized location for multiple services. These services encourage physical and mental well-being, and often facilitate access to needed services before an individual becomes too frail.
- The combination of declining federal and state funding for senior centers and a growing senior population will dominate the public policy arena.
- Senior service levies and other local public and private funds will likely take up larger portions of center budgets. This will be extremely challenging in the Greater Cleveland area given the weak economy and the competition for scarce dollars from all service providers.
- Overall, government funding for senior centers has decreased substantially from \$1,697,785 in 2002, to \$1,558,234 in 2003, to \$1,469,445 in 2004.
- From 2002-2004, funding of senior centers at the municipal level decreased from \$983,572 to \$949,167 in 2002, and then increased to \$984,427 in 2004 (just over 2002's level).
- As of May 11, 2006, over \$5.9 million in revenues for senior centers has been identified countywide.
- Several research studies have shown that "senior centers have a positive impact ... such as a heightened or renewed self-worth, individual growth, and a new social network."
- As senior centers frame their programs, they must realize that people's staying in the workforce longer, chronic health problems, and need to care for family members may limit the time available to participate in center activities. Hours of operation and location of programming may need to be adjusted.
- The estimated universe of possible consumers is 14,189 included both realized access (7,618) and unrealized access (6,571).
- Countywide, there are 76 service sites for senior centers. This is a ratio of 187 possible consumers (estimated 14,189 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

PERIOD	Estimated Persons in Need			Actual Number/Percent of Consumers by Funding Source ****									
	Total Population (%) 1/1/2000-12/31/2000	Total Population 60+ (%)** 1/1/2000-12/31/2000	Total Population 60+ <200% Poverty (%)*** 1/1/2000-12/31/2000	UW Program Report Data Cuy Cty Only (%) 7/1/2003-6/30/2004	Catholic Charities (%) 2004	WRAAA (%) CY2004	DSAS (%) 2004-2005	Cuy Cty CDBG, Cities of Bedford, Highland Hts, Lyndhurst, South Euclid and Orange (%) 2004	Cleveland CDBG (%) 2004	City of Brooklyn (%) 2004	City of Cleveland Heights (%) 2004	City of Fairview Park (%) 2004	Cleveland Hts CDBG (%) 2004
TOTAL	1,393,978	273,378	70,943	6,021	330	7,618	685	Missing	3,157	2,726	1,146	2,500	3,191
Percent		19.6%	26.0%										
GENDER													
Male	47.2%	40.4%	N/A	31.2%	31.5%	29.7%	29.6%	0.0%	0.0%	10.0%	26.0%	0.0%	0.0%
Female	52.8%	59.6%	N/A	68.8%	68.5%	69.7%	70.4%	0.0%	0.0%	90.0%	74.0%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****				0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%
RACE*****													
White alone	67.1%	77.2%	63.8%	59.2%	53.0%	64.9%	21.9%	0.0%	0.0%	99.0%	72.1%	0.0%	0.0%
Black or African American alone/combination	27.9%	20.6%	33.2%	30.1%	28.8%	12.9%	74.3%	0.0%	0.0%	1.0%	27.9%	0.0%	0.0%
Asian alone/combination	2.1%	1.1%	1.1%	0.4%	0.3%	0.5%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.4%	0.6%	0.1%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	0.0%	7.4%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone/combination	2.1%	0.6%	1.4%	0.0%	2.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				0.0%	0.0%	17.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****				0.0%	16.1%	4.4%	3.1%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%
HISPANIC*****													
	3.3%	1.1%	2.1%	7.4%	16.1%	4.4%	3.1%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%
AGE													
0-4	6.5%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
5-9	7.3%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10-14	7.1%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
15-19	6.4%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20-34	19.1%			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
35-54	29.3%			0.5%	0.6%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
55-64	8.7%	N/A	28.1%	8.4%	8.8%	39.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
65-74	7.8%	N/A	32.1%	33.8%	45.8%		0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
75+	7.8%	N/A	39.8%	43.6%	41.8%	69.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				13.7%	0.9%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****				0.0%	2.1%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%
INCOME*****													
Average Household Size	2.4	N/A	N/A										
\$0-\$9,999	11.3%	N/A	N/A	29.6%	54.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$10,000-\$14,999	6.9%	N/A	N/A	22.7%	31.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	15.2%		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	2.7%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$30,000 and above	61.5%	N/A	N/A	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Data*****				27.8%	13.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing Data*****				0.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Totals	100.0%	N/A	N/A	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* U.S. Census 2000, SF1(P1); SF4 (PCT144)
 ** U.S. Census 2000, SF1(P1); SF3 (P52); SF4 (PCT144)
 *** U.S. Census 2000, SF4 (PCT144); Because the Census Bureau does not explicitly provide poverty figures for age 60+, figures were prorated from Age 55+ using proportions from overall population of 80.7%.
 ****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: Senior Centers TF-200.550.80													
Period	City/Town (% Cleveland)	Total Population (%) 1/1/2000-12/31/2000	Total Population 60+ (%) 1/1/2000-12/31/2000	Estimated Persons in Need Total Population 60+ <200% Poverty (%)***	Actual Number/Percent of Consumers by Funding Source ****								
					UW Program Report Data (%) 7/1/2003-6/30/2004	WRAAA Cuy Cty Only (%) 2004	DSAS (%) 2004	Cuy/Cty CDBG, Cities of Bedford, Highland Hts, Lyndhurst, South Euclid and Orange (%) 2004	Cleveland CDBG (%) 2004	City of Brooklyn (%) 2004	City of Cleveland Heights (%) 2004	City of Fairview Park (%) 2004	Cleveland Hts CDBG (%) 2004
TOTAL		1,393,978	273,378	70,943	6,021	7,618	685	Missing	3,157	2,726	1,146	2,500	3,191
Percent			19.6%	26.0%									
44017 Berea	1.4%	1.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44022 Bentleyville	1.3%	1.3%	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44040 Gates Mills/Mayfield Village	0.2%	0.3%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44070 North Olmsted	2.4%	2.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44101 Cleveland (100%)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44102 Cleveland/Brooklyn (95%)	3.7%	2.3%	4.0%	12.3%	4.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44103 Cleveland (100%)	1.8%	1.5%	3.5%	3.5%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44104 Cleveland (100%)	2.1%	1.4%	3.3%	4.3%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44105 Cleveland/Newburgh/Hts/Garfield/Hts (75%)	3.9%	3.1%	5.4%	7.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44106 Cleveland/Cleveland Hts (60%)	2.3%	2.3%	3.9%	9.5%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44107 Lakewood/Cleveland	4.1%	3.1%	3.0%	0.1%	7.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44108 Cleveland/Bratenah (80%)	2.6%	2.5%	4.4%	1.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44109 Cleveland/Brooklyn Hts (98%)	3.3%	2.3%	3.6%	1.0%	4.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44110 Cleveland/East Cleveland (88%)	1.9%	1.5%	2.8%	0.8%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44111 Cleveland (100%)	3.1%	2.5%	3.0%	3.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44112 East Cleveland/Cleveland	2.4%	2.1%	3.0%	3.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44113 Cleveland (100%)	1.4%	0.8%	1.5%	2.5%	1.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44114 Cleveland (100%)	0.3%	0.3%	0.8%	0.3%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44115 Cleveland (100%)	0.6%	0.2%	0.4%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44116 Rocky River	1.5%	2.2%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44117 Euclid/Cleveland	0.9%	1.4%	1.9%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44118 Cleveland/Hts/University/Hts/Shaker/Hts	3.2%	2.6%	2.1%	15.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44119 Cleveland/Euclid (50%)	1.0%	1.1%	1.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44120 Shaker Hts/Cleveland	3.4%	3.1%	3.8%	7.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44121 University Hts/South Euclid	2.5%	2.2%	2.1%	5.5%	2.3%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44122 Beachwood/Highland Hts/Shaker/Hts	2.5%	3.7%	1.9%	5.5%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44123 Euclid	1.3%	1.4%	1.3%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44124 Pepper Pike/Mayfield/Hts/Lyndhurst	2.9%	4.5%	3.3%	4.9%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44125 Valley View/Garfield Hts	2.1%	2.5%	2.6%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44126 Fairview Park/Cleveland	1.2%	1.5%	1.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44127 Cleveland (100%)	0.6%	0.4%	1.0%	2.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44128 Wrensville Hts/Cleveland	2.4%	2.8%	2.9%	4.6%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44129 Brooklyn/Parma/Cleveland	2.1%	2.4%	1.8%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44130 Parma/Cleveland	3.8%	5.2%	3.8%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44131 Independence/Seven Hills/Brooklyn/Hts	1.5%	2.2%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44132 Euclid	1.1%	1.1%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44133 North Royalton	2.1%	1.7%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44134 Parma/Cleveland	2.9%	3.7%	2.8%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44135 Cleveland/Lindale (90%)	2.0%	2.0%	1.8%	0.2%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44136 Strongsville	3.1%	2.5%	1.3%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44137 Maple Hts/Cleveland	1.9%	1.9%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44138 Olmsted Twp/Olmsted Falls	1.3%	1.3%	1.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44139 Bentleyville/Glenwillow/Solon	1.6%	1.2%	0.6%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44140 Bay Village	1.2%	1.1%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44141 Brecksville	1.0%	1.1%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44142 Brookpark/Cleveland	1.5%	1.8%	0.9%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44143 Highland Hts/Richmond Heights	1.7%	2.0%	1.1%	2.7%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44144 Brooklyn/Cleveland	1.6%	1.9%	1.9%	0.2%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44145 Westlake	2.3%	2.6%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44146 Walton Hills/Oakwood/Bedford	2.3%	2.6%	2.5%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44147 Broadview Hts	1.1%	1.1%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44148 Strongsville				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown Cuyahoga County Zip Codes****					0.8%	66.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Missing****					0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%
Unknown*****					1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Cuyahoga County*****		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Known Cleveland		30.5%	24.2%	40.6%	49.0%	17.1%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Total Known Suburbs		69.5%	75.8%	59.4%	50.2%	16.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown & Missing					1.1%	0.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%

* U.S. Census Bureau, 2000, SF1 (P1)
 ** U.S. Census Bureau, 2000, SF1 (P1)
 *** U.S. Census 2000, SF3 (PCT50); Because the Census Bureau does not explicitly provide poverty figures for age 60+, figures were prorated from Age 55+ using proportions from overall population of 80.7%.
 **** 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	52	10
Number of Providers by Type		
Nonprofit	23	10
For-profit	-	-
Government	29	-
Other	-	-
Total Number of Sites	76	15
Number of Service Sites per Provider		
1	44	7
2 – 5	7	3
6 – 10	1	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	-	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	1	-
44070 – North Olmsted	-	-
44101 – Cleveland	1	-
44102 – Brooklyn/Cleveland	-	-
44103 – Cleveland	4	3
44104 – Cleveland	6	1
44105 – Newburgh Hts/Garfield Hts	4	1
44106 – Cleveland Hts/Cleveland	2	1
44107 – Cleveland/Lakewood	2	1
44108 – Cleveland/East Cleveland	3	-
44109 – Cleveland/Brooklyn Hts	1	1
44110 – Cleveland/Bratenahl	2	-
44111 – Cleveland	1	-
44112 – Cleveland/East Cleveland	1	-
44113 – Cleveland	2	-
44114 – Cleveland	3	1
44115 – Cleveland	2	-
44116 – Rocky River	1	-
44117 – Cleveland/Euclid	1	-
44118 – Euclid/University Hts	-	-
44119 – Cleveland/Euclid	1	1
44120 – Cleveland/Shaker Hts	-	-
44121 – University Hts/South Euclid	2	1
44122 – Orange/Warrensville Hts	1	-
44123 – Euclid	3	2
44124 – Pepper Pike/Mayfield Village	1	-
44125 – Valley View/Garfield Hts	3	-
44126 – Cleveland/Fairview Park	2	-
44127 – Cleveland	1	-
44128 – Cleveland/Warrensville Hts	1	1
44129 – Cleveland/Brooklyn/Parma	2	1

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

PROFILE OF CORE SERVICE PROVIDERS - 2005		
Source: United Way - First Call for Help Refer Database February 2005		
	Count	Sub-Count: UW-Affiliated
44130 – Cleveland/Parma	-	-
44131 – Seven Hills/Brooklyn Hts	2	-
44132 – Euclid	1	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	1	-
44135 – Cleveland/Linndale	1	-
44136 – Strongsville	3	-
44137 – Maple Hts/Cleveland	1	-
44138 – Olmsted Twp/Olmsted Falls	1	-
44139 – Bentleyville/Glenwillow/Solon	1	-
44140 – Bay Village	1	-
44141 – Brecksville	2	-
44142 – Cleveland/Brookpark	1	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	1	-
44145 – Westlake	2	-
44146 – Walton Hills/Oakwood/Bedford	1	-
44147 – Broadview Hts	2	-
44149 – Strongsville	1	-
Total Cuyahoga County	76	15
Total Cleveland	34	9
Total Suburbs	42	6

Attachment 6: Providers and Functions – 2005

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Alta House	Recreation/Senior Center
Barton Center	Senior Center
City of Bay Village Department of Community Services	Senior Center - General Description
City of Bedford Heights	Senior Center
City of Brecksville	Senior Center - General Description
City of Broadview Heights	Senior Center - General Description
City of Brooklyn Senior Center	Senior Center
Catholic Charities Services of Cuyahoga County	Senior Center: Broadway Golden Hours, Senior Center: Hispanic Senior Center, Senior Center: St. Martin De Porres, Senior Center: West Rose-Mt. Carmel
Cleveland Chinese Senior Citizen Association	Senior Center
City of Cleveland Heights Department of Community Services	Senior Center
City of East Cleveland Helen S. Brown Senior Citizen Center	Senior Center
East End Neighborhood House	Senior Center
Eliza Bryant Village	Senior Center
City of Euclid	Senior Center
City of Fairview Park	Senior Center - General Description
City of Garfield Heights	Senior Center
Geauga County Department on Aging	Senior Center - Recreation and Exercise for Seniors
Golden Age Centers of Greater Cleveland	Senior Center
Goodrich-Gannett Neighborhood Center	Senior Center
Harvard Community Services Center	Senior Center
Village of Highland Hills	Senior Center
City of Independence	Senior Center - General Description
Jewish Community Center of Cleveland	Senior Center
Jewish Family Service Association of Cleveland	Eldercare - Money Management / Forms Completion
City of Lakewood Department of Human Services	Senior Center
Lesbian/Gay Community Service Center of Greater Cleveland	Senior Center
City of Maple Heights	Senior Center
Merrick House	Senior Center
Murtis H. Taylor Multi-Service Center	Senior Center
Village of Newburgh Heights	Senior Center
City of North Olmsted Department of Human Resources	Senior Center
City of North Royalton	Senior Center - General Description
City of Olmsted Falls Senior Center	Senior Center
Orange City School District	Senior Center - General Description
City of Parma Service Department	Senior Center - General Description
City of Parma Heights	Senior Center - General Description
Phillis Wheatley Association	Senior Center
City of Rocky River Office On Aging	Senior Center - General Description

Attachment 6: Providers and Functions – 2005 (continued)

Service Providers & Functions	
Source: United Way - First Call for Help Refer Database February 2005	
Agency	Services
Schnurmann House	Senior Center
Senior Citizen Resources	Senior Center
Senior Outreach Services	Senior Center
City of Shaker Heights	Senior Center
City of Solon	Senior Center - General Description
City of Strongsville	Senior Center - General Description
Tri-City Consortium on Aging	Senior Center
Tri-City Senior Center	Senior Center
University Settlement	Senior Center
Village of Valley View	Senior Center -General Description
Vocational Guidance Services	Senior Center
City of Warrensville Heights	Senior Center
West Side Community House	Services for The Elderly
City of Westlake	Community Center - General Description

Bold represents agencies funded by United Way for this service.

Attachment 7: United Way - First Call for Help Senior Centers Requests – 2000-2004: Greatest Increase/Greatest Decrease

BTF-200.550-80 Senior Centers								
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	2	3	8	8	12	500%	7
44146	Walton Hills/Oakwood/Bedford	1	7	4	5	6	500%	5
44138	Olmsted Twp/Olmsted Falls	1	5	4	5	5	400%	4
44129	Brooklyn/Parma/Cleveland	1	1	9	1	4	300%	3
44117	Euclid/Cleveland	2	0	4	4	8	300%	4
44143	Highland Hts/Richmond Heights	1	2	6	4	4	300%	3
44017	Berea	1	1	2	2	3	200%	2
44123	Euclid	1	1	2	6	3	200%	3
44126	Fairview Park/Cleveland	1	1	4	0	3	200%	2
44137	Maple Hts/Cleveland	4	2	3	4	11	175%	5
44112	East Cleveland/Cleveland	8	9	9	5	18	125%	10
44109	Cleveland/Brooklyn Hts	6	10	7	8	11	83%	8
44111	Cleveland	7	6	12	9	11	57%	9
44125	Valley View/Garfield Hts	2	1	1	3	3	50%	2
44132	Euclid	3	3	2	4	4	33%	3
44110	Cleveland/East Cleveland	7	6	9	16	9	29%	9
44144	Brooklyn/Cleveland	4	6	6	2	5	25%	5
44113	Cleveland	4	2	4	4	5	25%	4
44070	North Olmsted	0	0	5	7	5	N/A	3
44145	Westlake	0	1	2	2	4	N/A	2
44147	Broadview Hts	0	1	1	2	3	N/A	1
44131	Independence/Seven Hills/Brooklyn Hts	0	4	2	1	3	N/A	2
44133	North Royalton	0	2	4	4	2	N/A	2
44140	Bay Village	0	0	2	0	1	N/A	1
44139	Bentleyville/Glenwillow/Solon	3	1	3	1	0	(100%)	2
44142	Brookpark/Cleveland	2	2	3	2	0	(100%)	2
44115	Cleveland	1	3	0	4	0	(100%)	2
44149	Strongsville	2	0	2	0	0	(100%)	1
44116	Rocky River	5	1	4	4	1	(80%)	3
44122	Beachwood/Highland Hills/Shaker Hts.	7	6	4	6	3	(57%)	5
44104	Cleveland	12	3	6	8	6	(50%)	7
44127	Cleveland	4	1	0	2	2	(50%)	2

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

BTF-200.550-80 Senior Centers								
United Way - First Call for Help Requests 2000-2004								
Greatest Increase/(Greatest Decrease)								
Zip Code		TOTAL REQUESTS					%Change*	Avg. #
		2000	2001	2002	2003	2004	00&04	Calls 00-04
44119	Cleveland/Euclid	4	1	3	3	2	(50%)	3
44124	Pepper Pike/Mayfield Hts./Lyndhurst	9	10	8	6	5	(44%)	8
44103	Cleveland	8	6	8	7	5	(38%)	7
44102	Cleveland/Brooklyn	11	8	6	8	7	(36%)	8
44136	Strongsville	3	3	8	1	2	(33%)	3
44121	University Hts/South Euclid	7	5	5	5	5	(29%)	5
44120	Shaker Hts/Cleveland	17	12	13	10	13	(24%)	13
**Total Cuyahoga County		225	209	277	260	271	20%	248
**Total Cleveland		102	89	97	115	99	(3%)	100
**Total Suburbs		123	120	180	145	172	40%	148
<p>* Extremely high percentages are due to low numbers.</p> <p>** 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.</p>								

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

BTF-200.550-80 Senior Centers United Way - First Call for Help Requests 2000-2004 Unmet Need					
Zip Code		TOTALS 00-04			% Unmet
		Requests	Met	Unmet	
44149	Strongsville	4	3	1	25%
44143	Highland Hts/Richmond Heights	17	14	3	18%
44147	Broadview Hts	7	6	1	14%
44115	Cleveland	8	7	1	13%
44122	Beachwood/Highland Hills/Shaker Hts.	26	23	3	12%
44127	Cleveland	9	8	1	11%
44144	Brooklyn/Cleveland	23	21	2	9%
44121	University Hts/South Euclid	27	25	2	7%
44129	Brooklyn/Parma/Cleveland	16	15	1	6%
44118	ClevelandHts/UniversityHts/ShakerHts	33	31	2	6%
44138	Olmsted Twp/Olmsted Falls	20	19	1	5%
44111	Cleveland	45	43	2	4%
44110	Cleveland/East Cleveland	47	45	2	4%
44134	Parma/Cleveland	25	24	1	4%
44105	Cleveland/Newburgh Hts/Garfield Hts	57	55	2	4%
44102	Cleveland/Brooklyn	40	39	1	3%
44109	Cleveland/Brooklyn Hts	42	41	1	2%
44135	Cleveland/Linndale	49	48	1	2%

* Total Cuyahoga County	1,242	1,214	28	2%
* Total Cleveland	502	491	11	2%
* Total Suburbs	740	723	17	2%

FCFH DATA NOTES

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

Unmet = service request for which there was no referral.

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

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

Attachment 9: Service Site Index

Core Service: Senior Centers TF-200.550-80									
Service Site Index									
Zip	Number of Sites*****	City/Town (% Cleveland)	Proportion of Minorities in Geographical Area	Total Population (#)*	Total Population 60+ (#)**	Total Population 60+, <200% Poverty (#)***	Estimated Universe of Possible Consumers per Geographical Area****	Number of Service SITES Serving Geographical Area (Per Agencies Reported Intended Service Area to First Call for Help)*****	Potential Service ACCESSIBILITY by Service Consumers per Geographical Area Ratio of CONSUMERS to Service SITES
Period				1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/2005	
TOTAL	76			1,393,978	273,378	70,943	14,189	76	187:1
Percent						19.6%	26.0%		
44117	1	Euclid/Cleveland	African Am 53.1%	12,078	3,744	1,355	271	48	6:1
44105	4	Cleveland NewburghHts/GarfieldHts (75%)	African Am 61.9%	54,834	8,540	3,821	764	52	15:1
44106	2	Cleveland/Cleveland Hts (60%)	African Am 62.2%	32,417	6,224	2,750	550	52	11:1
44110	2	Cleveland/East Cleveland (98%)	African Am 74.7%	26,536	4,126	2,008	402	48	8:1
44120	-	Shaker Hts/Cleveland	African Am 76.7%	47,349	8,406	2,681	536	52	10:1
44103	4	Cleveland (100%)	African Am 80.2%	25,348	4,174	2,506	501	50	10:1
44108	3	Cleveland/Bratenahl (90%)	African Am 94.9%	36,456	6,939	3,142	628	49	13:1
44112	1	East Cleveland/Cleveland	African Am 95.2%	33,222	5,702	2,666	533	50	11:1
44128	1	Warrensville Hts/Cleveland	African Am 95.8%	33,612	7,641	2,040	408	53	8:1
44104	6	Cleveland (100%)	African Am 97.5%	28,904	3,734	2,348	470	51	9:1
44115	2	Cleveland (100%)	African Am 98.4%	8,186	489	289	58	49	1:1
44114	3	Cleveland (100%)	Asian 20.3%	3,891	877	580	116	50	2:1
44109	1	Cleveland/Brooklyn Hts (98%)	Hispanic 20.3%	45,783	6,409	2,532	506	48	11:1
44102	-	Cleveland/Brooklyn (95%)	Hispanic 20.4%	52,108	6,361	2,813	563	51	11:1
44113	2	Cleveland (100%)	Hispanic 23.5%	19,466	2,282	1,089	218	49	4:1
44017	-	Berea		19,005	3,544	577	115	48	2:1
44022	-	Bentleyville		17,720	3,665	251	50	49	1:1
44040	1	Gates Mills/Mayfield Village		2,883	740	27	5	49	1:1
44070	-	North Olmsted		34,081	6,734	1,073	215	48	4:1
44101	1	Cleveland (100%)		-	-	-	0	19	N/A
44107	2	Lakewood/Cleveland		56,710	8,645	2,147	429	48	9:1
44111	1	Cleveland (100%)		42,967	6,767	2,134	427	49	9:1
44116	1	Rocky Rwer		21,122	6,135	834	167	48	3:1
44118	-	ClevelandHts/UniversityHts/ShakerHts		45,279	7,014	1,512	302	53	6:1
44119	1	Cleveland/Euclid (50%)		13,493	3,041	773	155	48	3:1
44121	2	University Hts/South Euclid		35,185	6,118	1,506	301	52	6:1
44122	1	Beachwood/Highland Hills/ShakerHts		34,883	10,212	1,368	274	55	5:1
44123	3	Euclid		18,363	3,780	955	191	48	4:1
44124	1	Pepper Pike/MayfieldHts/Lyndhurst		40,334	12,459	2,321	464	52	9:1
44125	3	Valley View/Garfield Hts		29,876	6,831	1,854	371	48	8:1
44126	2	Fairview Park/Cleveland		17,196	4,014	708	142	48	3:1
44127	1	Cleveland (100%)		8,403	1,151	717	143	50	3:1
44129	2	Brooklyn/Parma/Cleveland		29,658	6,581	1,276	255	49	5:1
44130	-	Parma/Cleveland		53,615	14,364	2,697	539	49	11:1
44131	2	Independence/Seven Hills/BrooklynHts		20,666	6,063	1,025	205	49	4:1
44132	1	Euclid		15,322	2,963	717	143	48	3:1
44133	-	North Royalton		28,685	4,544	805	161	49	3:1
44134	1	Parma/Cleveland		40,396	10,242	2,015	403	48	8:1
44135	1	Cleveland/Linddale (90%)		28,561	5,366	1,282	256	48	5:1
44136	3	Strongsville		43,858	6,943	935	187	48	4:1
44137	1	Maple Hts/Cleveland		26,107	5,204	1,212	242	49	5:1
44138	1	Olmsted Twp/Olmsted Falls		18,046	3,681	677	135	48	3:1
44139	1	Bentleyville/Glenwillow/Solon		22,231	3,223	392	78	48	2:1
44140	1	Bay Village		16,076	3,075	371	74	48	2:1
44141	2	Brecksville		13,676	3,146	332	66	49	1:1
44142	1	Brookpark/Cleveland		21,132	4,811	669	134	48	3:1
44143	-	Highland Hts/Richmond Heights		23,730	5,483	776	155	52	3:1
44144	1	Brooklyn/Cleveland		21,805	5,203	1,372	274	49	6:1
44145	2	Westlake		31,972	7,122	864	173	48	4:1
44146	1	Walton Hills/Oakwood/Bedford		31,648	7,018	1,748	350	49	7:1
44147	2	Broadview Hts		15,954	3,059	405	81	49	2:1

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

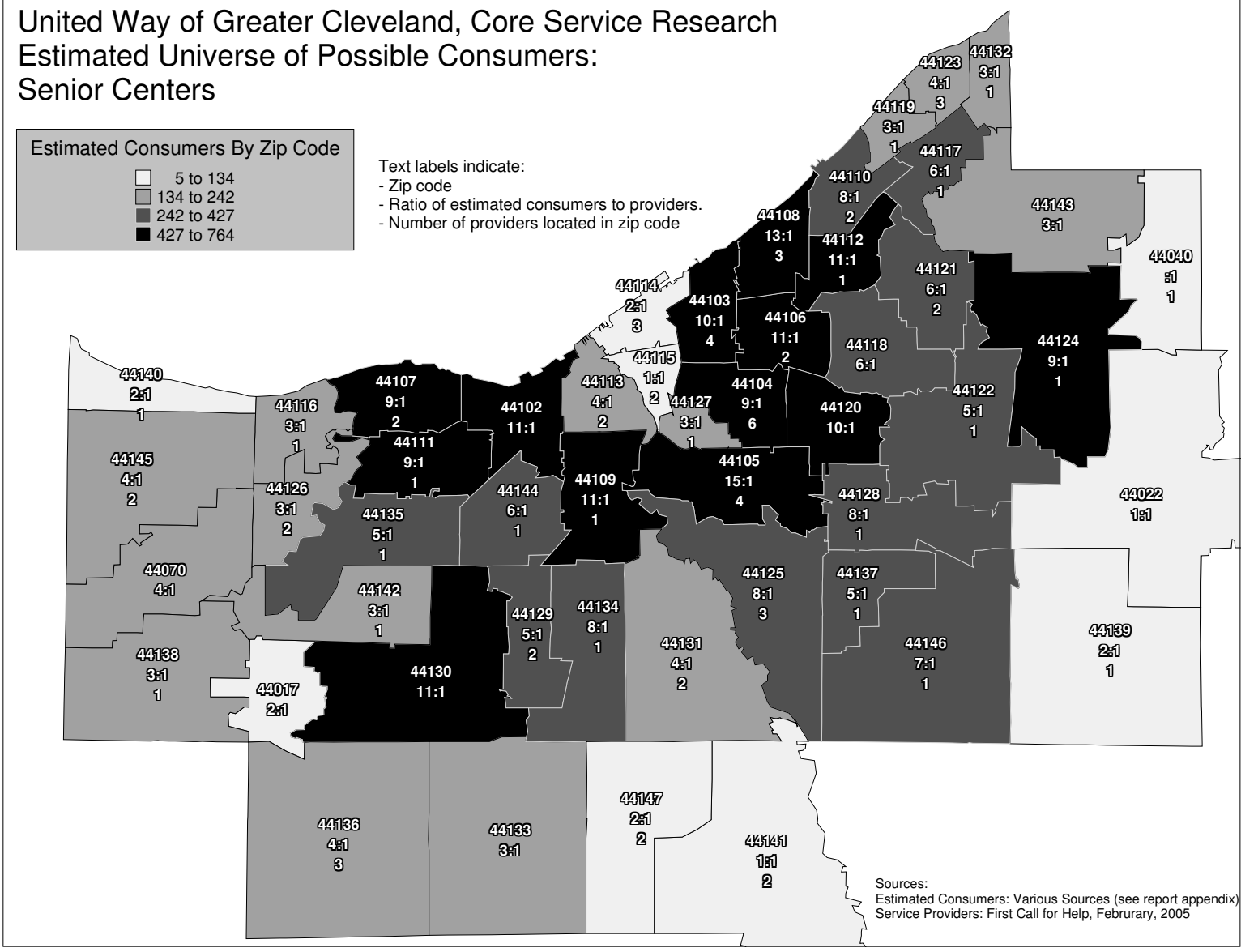
** U.S. Census 2000, SF1 (P1)

*** U.S. Census 2000, SF3 (PCT50); Because the Census Bureau does not explicitly provide poverty figures for age 60+, figures were prorated from Age 55+ using proportions from overall population of 80.7%.

**** Research by Krout and Cohen-Mansfield (2005) found nationally that 20 percent of the population 65 years and older are consumers of senior centers. Applying this percentage to the estimated persons in need (70,943) results in an estimated universe of possible consumers of 14,189. (70,943 x 20% = 14,189)

***** United Way First Call for Help Call Data, February 2005

Attachment 10: Map





**United Way of
Greater Cleveland**

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