

# Core Service Report

## Senior Housing Information and Referral

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>.

## **ACKNOWLEDGEMENTS**

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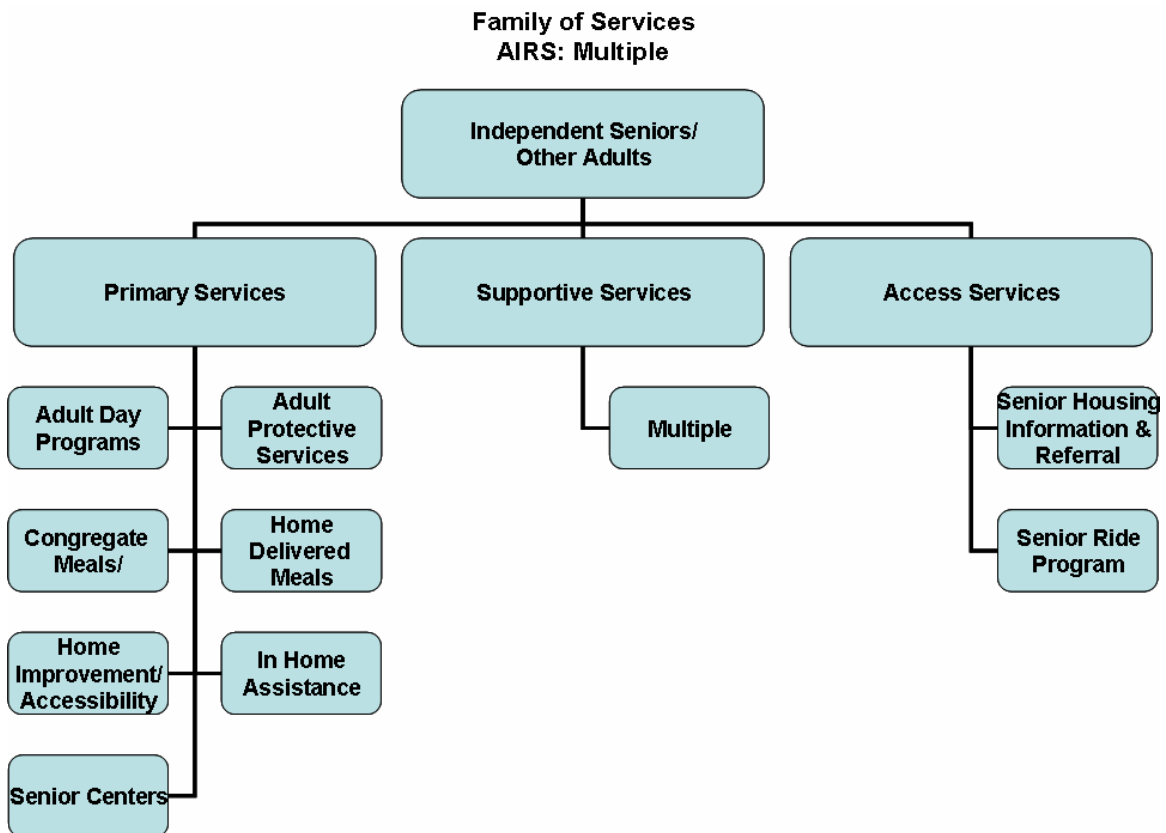
# SNAPSHOT

**AIRS Code Level I: Individual & Family Life (P)**  
**AIRS Code Level II: Family Support Services (PH)**  
**Core Service: Senior Housing Information and Referral (PF-200.800)**

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

**AIRS Definition:** Programs that maintain information about retirement residences, residential care facilities, and nursing homes, and link older adults who are looking for alternative living options with appropriate independent or supervised living resources.

This service targets independent seniors and other adults. It is an access service for this consumer group. (See figure below.)



### *Core Service Environment*

The number of older individuals and their life expectancy is growing substantially. With increasing age comes increasing risk for physical disability and cognitive impairments. In the future, a greater proportion of the older population will reach the advanced ages at which the need for long-term care is greatest. With the increase in the number of older adults, there will be increased demand for long-term care solutions. Approximately 60 percent of Americans who reach age 65 will need long-term care at some time in their lives (American Association of Homes and Services for the Aging, 2007). Senior housing information and referral provides assistance to older adults and their caregivers in finding options that meet their needs for level of care, type of facility, financial considerations, quality, and other issues of concern.

The federal Medicaid program has a long-established institutional bias. The federal government mandates that certain services be covered by state Medicaid programs. Services that are “optional” for states to pay for include the services most necessary for persons with disabilities to remain in community settings. As federal and state health plan policies shift to allow funding for home- and community-based waiver services, senior housing information and referral programs will need to address the demand for information related to these services.

A public policy issue affecting long-term care (and senior housing information and referral) identified by the core service focus groups conducted for United Way (2005) were livable wages for qualified staff and the lack of long-term care workers. The American Medical Association predicts that there will be 20 percent fewer registered nurses than will be needed by 2020. The Bureau of Labor Statistics predicts that personal and home care assistance will be the fourth fastest-growing occupation by 2006 (Mehdizadeh and Applebaum, 2003). Senior housing will be greatly affected by the projected lack of long-term care workers. Finally, services that link clients’ home care needs and preferences with providers are necessary. Ohio currently does not license home care providers.

The National Association of State Units on Aging adopted the strategic plan *Vision 2010: Toward a Comprehensive Aging Information Resource System* in 1999. Vision 2010 sets forth a vision and call to action to transform the nation’s aging I&R/A programs for the 21st century so that all states will have a comprehensive, integrated infrastructure capable of providing consumer-centered, consumer-directed services to meet the information needs of numerous and diverse communities of older adults and their caregivers (National Aging I&R Support Center, n.d.).

### *Core Service Consumers*

The target population addressed in this core service report is older adults and their caregivers who need to find residential living options that address older adults’ needs for assistance with medical care, daily activities, comfort, supervision, or advice. The need for this service is not limited to older adults, however, but also includes other adults who may need long-term care facilities due to a variety of reasons such as accidents, drug-related illnesses, and developmental abilities.

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.

In Cuyahoga County, 15.6 percent of the population was over 65 in both 1990 (221,066) and 2000 (217,161). In that decade, both the county's total population and its 65+ older adult cohort fell 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. Given that chronic disease and disability often increase with age, locally it is anticipated that there will be an increasing number of adults dependent on others for care and seeking information about housing for older adults.

Variables related to the prevalence of disability and the need for long-term care include higher poverty, racial and ethnic background (African-Americans are more often institutionalized), marital status (single individuals are more often institutionalized), living alone, and lower educational attainment (Mehdizadeh et al., n.d.).

In 2000, 24,711 individuals 60 and older in Cuyahoga County were estimated to have severe disabilities that required assistance with at least two activities of daily living such as bathing, eating, and toileting. The number of individuals 60 and older with severe disabilities is expected to decrease slightly through 2015 and then increase to 24,849 in 2020 as the baby boomers age.

#### *Core Service Delivery*

The definition of the core service for this report is as follows: programs that maintain information about retirement residences, residential care facilities, and nursing homes, and link older adults looking for alternative living options with appropriate independent or supervised living resources.

Finding the right kind of long-term care in the right place often requires making difficult decisions in difficult times. Consumers often start with little or no knowledge about the long-term care system and need information about the options available, costs of services, how to pay for care, and where to find needed services in a desired area. Older persons and caregivers may not be aware of the differences between types of services or levels of care, such as nursing homes and assisted living. Knowing how to assess quality of care is also important. Changing benefits to public programs and expansion of private sector services can be confusing. Individuals with Alzheimer's Disease and other forms of mental disorientation need specialized residential care options.

Consumers have a variety of resources available to them, including 800 numbers and Internet websites targeted to seniors and their families. According to the National Aging I&R Support Center, each year the 3,000+ aging information and referral/assistance (I&R/A) services at the state level and in communities across the country assist over 12 million older Americans negotiate the maze of options to make informed choices about the services and resources most appropriate for their needs.

United Way of Greater Cleveland funds the Long-term Care Ombudsman's (LTCO) selection assistance program, which has been classified with the AIRS Taxonomy of Senior Housing Information and Referral. Ombudsman programs, begun over 30 years ago, are established under the Older American's Act. They have many responsibilities as outlined in the Act, but one of them is providing information about long-term care services. Long-term care ombudsman programs provide consumers with information about the quality of care available in long-term care facilities, which differentiates them from many other information and referral providers (Department of Health and Human Services, 2004).

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are seven senior housing information & referral providers operating from seven different sites, six of which are government and one is nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded one of the providers: Long-term Care Ombudsman. FCFH refers calls for senior housing information and referral to Long-term Care Ombudsman. LTCO selection assistance call data shows a decrease in the number of total requests for senior housing information and referral in the county: from 1,872 in 2002 to 1,047 in 2006 (44 percent). Over the same five-year period, LTCO had 6,951 requests for information about senior housing. Of these requests, they were able to provide names of facilities that match the consumer's needs and preferences to 100 percent of callers. The decrease in calls may be attributed to changes in staffing patterns in handling selection calls.

Per a survey of state long-term care ombudsman programs conducted in 2003 by the National Long-term Care Resource Center, federal funding for LTCO programs in the state of Ohio comes from Older Americans Act Titles III and VII and Victims of Crime Act Funds. State funding comes from ombudsman specific funds, long-term care bed fee or tax, and county/local funds (National Association of State Units on Aging, 2003). It is not possible to determine what portion of the funding is allocated to selection service as it is only a small part of the overall services the ombudsman program is mandated to provide.

As of May 11, 2006, \$52,332 in revenues for senior housing information and referral has been identified countywide. One hundred percent of the identified revenues are from United Way Investment Committee allocations. No other funding was identified for this core service.

An average cost for senior housing information and referral was not found; however, information about average cost of calls to information and referral providers in Ohio was located. Based on a study conducted by the 211 Ohio Collaborative, the average cost of an I&R call is approximately \$10.99 per call, although there is a wide range. The cost per call varied from \$1.92 to \$25.00.

#### *What Works; What Doesn't*

Successful senior housing information and referral programs provide older adults with the information they need to make appropriate choices for residential options that meet their needs given the type and level of services they require, type of setting they prefer, their financial situation, and their geographical preference. These programs also provide residents and caregivers with information on quality of facilities.

Collaboration is a best practice in senior housing information and referral programs as managed by long-term care ombudsmen. The growing number of older adults, the increasing ethnic and cultural diversity of the older population, and the complex assortment of programs and services available to seniors and their families and caregivers coupled with the relatively flat funding of most Older Americans Act (OAA) programs highlight the necessity for creating partnerships and linkages among programs that provide information and assistance to older persons.

Despite the value of coordination with aging I&R/A programs, ombudsman programs must also consider their confidentiality constraints. The Older Americans Act, as amended, specifically prohibits disclosing the identity of complainants or residents making a complaint. Fundamentally, a best practice in ombudsman work is upholding strict confidentiality in written, spoken, and electronic files and communication.

Given the increasing diversity of the older population and their individual and specific needs, senior housing information and referral programs must be culturally competent and not have a “one size fits all” plan of providing information to older adults and their caregivers. Lack of coordination with other information and referral providers results in duplication of efforts and wasted resources.

Long-term care ombudsman programs are not required to be accredited or certified by any governmental authority. However, the Older Americans Act in Title 42, Chapter 35, Subchapter XI, Part A, subpart ii, Section 3058g established state long-term care ombudsman programs and outlines their mandates, functions, responsibilities, and policies and procedures.

*Gap Analysis*

The estimated universe of possible consumers is 6,178, including both realized (636) and unrealized (5,542) access.

# I. FOREWORD

## INTRODUCTION

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

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

## METHODOLOGY

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

The questions addressed are:

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

The primary information sources used for this report are:

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

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

## II. THE CORE SERVICE ENVIRONMENT

### CORE SERVICE ENVIRONMENT

The number of older individuals and their life expectancy are growing substantially. With increasing age comes increasing risk for physical disability and cognitive impairments. In the future, a greater proportion of the older population will reach the advanced ages at which the need for long-term care is greatest. In 1999, about 12 percent of the 65 and over population were 85 years or older. By 2050, this segment will grow to 34 percent of the total older population (Mehdizadeh & Murdoch, 2003). With the increase in the number of older adults, there will be increased demand for long-term care solutions.

According to “Older Americans 2004: Key Indicators of Well-Being,” nationally, the majority of older Americans live in traditional community-based settings (93 percent), while only 2.5 percent live in community housing with services and 4.4 percent live in long-term care facilities. According to a national public opinion survey conducted by the Association of Aging and Retired Persons, an overwhelming majority of older adults want to remain in their own homes or live in the home of a family member for as long as possible (AARP, 2000). Family, friends, and neighbors remain the backbone of the long-term care system and provide essential support that enables older adults to remain at home.

Estimates consistently report that the informal system, particularly adult children and spouses, provides more than 80 percent of all long-term care given in the home. However, because of demographic changes that include an increase in the oldest old and a decrease in the birth rate, pressure on future caregivers will continue to grow. Significant changes in caregiving are expected in future generations. Currently there are 11 caregivers for each person needing care. That ratio is expected to drop to 4:1 by 2040 (Mehdizadeh and Applebaum, 2003). Adult members of households in the labor force, fewer children to provide care due to smaller family sizes (making sharing of caregiving responsibility less feasible), and greater geographic mobility means adult children are less likely to provide care (Mehdizadeh & Murdoch, 2003). Older adults will increasingly need to find formal care sources.

Though older adults clearly prefer to “age in place,” life changes, need for care, availability of services, and whether family and friends are able to provide informal care can dictate older adults’ options for appropriate housing and may necessitate a move. Reasons to move are varied and sometimes hard to identify:

- The neighborhood has deteriorated and safety is a concern;
- To be near children (70 percent of those 65+ live within 1 hour of a child);
- To match home’s facilities to senior’s faculties;
- To avoid stairs in a home;
- Home is too large or costly to maintain;
- Home may not meet present needs, physical or otherwise;
- Assets are tied up in the home and cash is needed;
- Don’t drive and available transportation is not adequate; and
- Retired and looking for new lifestyle (Senior Resource, n.d.).

Since 1960 a trend for active seniors has been to move from cities to rural or suburban settings with warmer climate and recreational opportunities. Another trend in more recent years is to move to adult communities that offer medical care components and infilling in older neighborhoods. Opportunities to move to nearby metro or suburban senior communities offer the chance to “right-size” lifestyle without giving up proximity to friends and the familiar. Seniors who remain in their homes until they are in their late 70s or 80s want to stay close to their home of many years when they do relocate. Long distance moves occur when seniors want to be closer to adult children, siblings, or other close relatives, or go back to where they grew up or once lived. Relocating older adults find satisfaction in their new location if they have common interests with other residents or neighbors and can have friendly, helpful people around them (Senior Resource, n.d.).

At one time, options for disabled older adults no longer able to live independently at home were limited to nursing homes. This trend has changed over past decades as other less restrictive options such as assisted living facilities, congregate communities, facilities that deal with the special needs of patients with Alzheimer’s Disease, and the like are becoming increasingly popular, as are other home- and community-based services.

Options for older adults’ housing have expanded significantly, as have ways to pay. Still, much of long-term care is paid for out-of-pocket. The Medicare Current Beneficiary Survey notes that 45 percent of nursing home/long-term institutional health care services are paid out-of-pocket, with 48 percent paid by Medicaid (for those who qualify), and only 1 percent by Medicare and 6 percent paid by the Veterans Affairs Administration (Federal Interagency Forum on Aging Related Statistics, 2006). In the future, spending patterns for long-term care are expected to change. Family resources will pay an increasingly greater proportion, as will Medicaid. Likewise, Medicare projects that the number of its beneficiaries will double between the years 2000 and 2030. Between 2000 and 2025, long-term care spending for all adults 65 and over is expected to double, and to quadruple by 2050 (Mehdizadeh and Applebaum, 2003). Long-term care insurance is also gaining popularity. Because long-term care is expensive and has an enormous impact on the financial situation of older adults, having complete and accurate information on costs of housing options (and what types of insurance are accepted) is essential in making housing choices.

Finally, information about the quality of a long-term care facility, including customer satisfaction ratings and regulatory information, is essential when making choices about senior housing options.

Senior housing information and referral provides assistance to older adults and their caregivers in finding options that meet their needs for level of care, type of facility, financial considerations, quality, and other issues of concern. However, location, reimbursement, availability, and the characteristics and services of the facility can outweigh quality factors in making a decision.

## **PUBLIC POLICY ISSUES**

Public policy issues for senior housing information and referral programs are focused on providing the types and adequate amount of services older adult need to live in settings they prefer.

## ***NATIONAL***

### Home- and Community-Based Services

Home- and community-based services are an important component of the long-term care continuum and contribute greatly in allowing older adults to live in settings they prefer. However, the federal Medicaid program has demonstrated a long-established institutional bias. The federal government mandates that certain services be covered in state Medicaid programs. Mandatory services under Medicaid include in-patient hospital care, outpatient hospital services, physician care, and nursing facility care. Services that are “optional” for states to pay for include personal care, medical transportation, hospice care, and rehabilitative services—in other words, the services most necessary for persons with disabilities to remain in community settings. Consumer advocates often voice their concern that Medicaid’s program is structured exactly backwards—the current “optional” or “waiver” community services should be the norm and a “waiver” should be needed for institutional care (Johnson et al., 2001). Medicaid home- and community-based care programs do exist in Ohio (PASSPORT being one), but demand far exceeds supply of slots, although the state is expanding availability of the waiver. As federal and state health plan policies shift to allow funding for home- and community-based waiver services, senior housing information and referral programs will need to address the demand for information related to these services.

### Long-term Care Workers

Another public policy issue affecting long-term care (and senior housing information and referral) identified by the core service focus groups conducted for United Way (2005) were livable wages for qualified staff and the lack of long-term care workers. Because the level of disability will increase among both home-care clients and nursing home residents, and because the absolute numbers of persons needing care will continue to increase, the number of staff needed to care for them is expected to increase. In Ohio, an estimated 24,000 additional full-time equivalent (FTE) direct-care staff will be needed in long-term care between 2000 and 2010. However, the growth of the labor force is projected to slow down until about 2040 due to fewer people ages 25 to 34. The American Medical Association predicts that there will be 20 percent fewer registered nurses than will be needed by 2020. The Bureau of Labor Statistics predicts that personal and home care assistance will be the fourth fastest-growing occupation by 2006 (Mehdizadeh and Applebaum, 2003). Senior housing will be greatly affected by the projected lack of long-term care workers. The cost of gasoline and the lack of public transportation to long-term care facilities were also noted to be issues that will greatly affect the lack of long-term care workers.

### Licensing of Home Care Agencies

Ohio is one of the few states that does not license home care agencies. Medicare certifies home health care agencies that provide skilled services only. There are currently no agencies providing information for selecting a home care agency based on the needs and preferences of the consumer. A local agency expert noted that funding to long-term care ombudsman programs needs to be increased to be able to provide specialized facility selection services and home care selection.

### III. THE CORE SERVICE CONSUMERS

#### DEFINITION OF TARGET POPULATION

Senior housing information and referral is targeted to older adults and their caregivers who need to find residential living options that address older adults' needs for assistance with medical care, daily activities, comfort, supervision, or advice.<sup>1</sup> The need for information relating to long-term residential care is not limited to older adults, but also includes other adults who may need long-term care due to a variety of reasons such as accidents, drug-related illnesses, and developmental abilities.

#### DEMOGRAPHIC CHARACTERISTICS

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 adults will be over age 85.

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.

In Cuyahoga County, 15.6 percent of the population was over 65 in both 1990 (221,066) and 2000 (217,161). In that decade, both the county's total population and its 65+ older adult cohort fell 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. Given that chronic disease and disability often increase with age, locally we may face an increasing number of adults dependent on others for care and seeking information about housing for older adults.

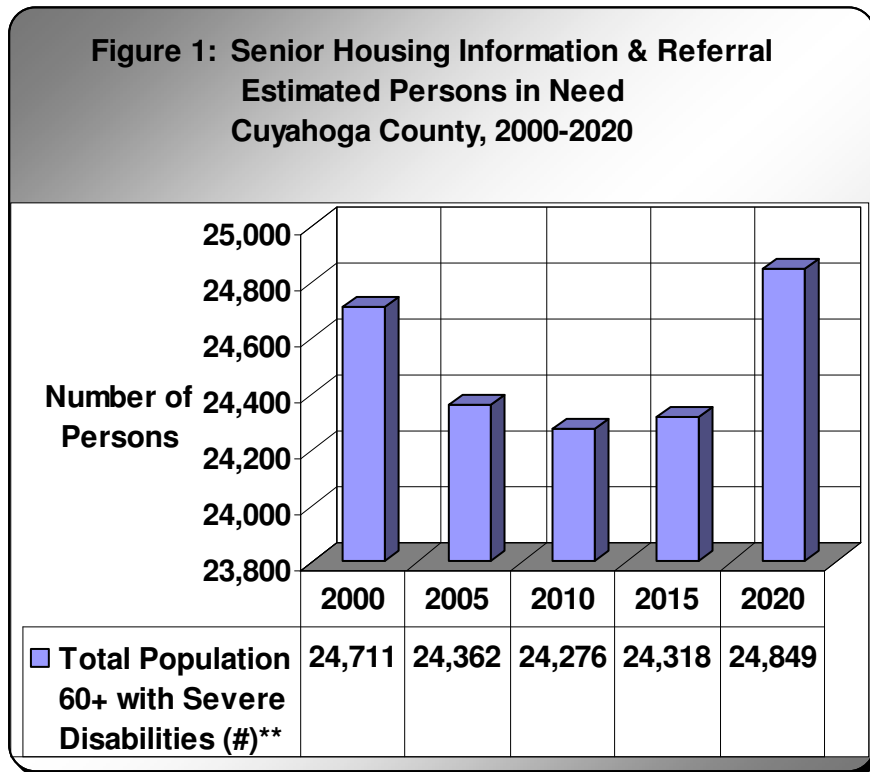
There are population characteristics that could affect need for care. Several variables are related to the prevalence of disability and the need for long-term care services as people age. These variables include higher poverty, racial and ethnic background (African-Americans are more often institutionalized), marital status (single individuals are more often institutionalized), living alone, and lower educational attainment (Mehdizadeh et al., n.d.).

Researchers have found that about 43 percent of persons turning age 65 will use a nursing home before they die. About 20 percent of users will spend 5 or more years there (Kemper and Murtaugh, 1991). Of those turning 65, 17 percent can expect to use a nursing home and receive Medicaid reimbursement (Spillman and Kemper, 1995). (*In AHCPH Research on Long-Term Care. AHCPH Program Note, 1997*)

<sup>1</sup> Residential living options could include licensed residential care facilities (17 beds and higher), unlicensed assisted living facilities, adult care facilities (3-16 beds), and adult foster homes (1-2 beds).

*Estimated Persons in Need*

In 2000, 24,711 individuals 60 and older in Cuyahoga County were estimated to have severe disabilities that required assistance with at least two activities of daily living such as bathing, eating, and toileting. The number of individuals 60 and older with severe disabilities is expected to decrease slightly through 2015 and then increase to 24,849 in 2020 as the baby boomers age. (See Figure 1.)



Sources:

\* U.S. Census 1990, STF 1 (P11); 2000, SF3 (P8); 2004, American Community Survey; 2010 & 2015, Ohio Department of Development, (July, 2003).

\*\* Mehdizadeh, S.A., Roman, S.P., Wellin, V.W., Ritchey, P.N. & Kunkel, S. R. (n.d.). Profile and projection of the 60+ population: Cuyahoga County, Ohio. Oxford, OH: Scripps Gerontology Center, Miami University. Severe disability is defined as receiving help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairments.

It is recognized that this is a conservative estimate of persons in need of senior housing information and referral programs since this service is not necessarily limited to older adults and could include other adults with illness or disability; however, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County. It is clear that this number is likely to increase over the next 5-10 years as the baby boomers age and increase the number of people in older age cohorts.

## 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 government funders from which it was possible to obtain data. Thus, it is an underestimate of actual numbers of consumers receiving service.

In Cuyahoga County, United Way funded 636 actual annual consumers through Lutheran Metropolitan Ministry's Long-term Care Ombudsman program in 2004. (See Attachment 3.)

Based on the 2000 U.S. Census, while 60 percent of the county's total 60+ population was female and 40 percent male, United Way funded 26 percent female and 12 percent male clients (62 percent were unknown).

Information on funded consumers' race/ethnicity is unavailable.

Household income was mostly unreported: 6 percent of consumers had household incomes of less than \$9,999; the income of the remaining 94 percent of consumers was unknown.

Geographically, 24 percent of persons 60+ resided in Cleveland and the remaining 76 percent in the suburbs. Nine percent of United Way funded consumers were from Cleveland, 36 percent were from the suburbs. Information for the rest is unavailable. (See Attachment 4.)

## IV. CORE SERVICE DELIVERY

### CORE SERVICE DEFINITION

The definition of the core service for this report is: programs that maintain information about retirement residences, residential care facilities, and nursing homes, and link older adults who are looking for alternative living options with appropriate independent or supervised living resources.

### BACKGROUND ON CORE SERVICE

In both Ohio and the nation, long-term care has become a major budget component, with national public expenditures totaling over \$85 billion in 1998. Medicaid, the federal/state program that is the primary funder of long-term care, has increased from \$14 billion in 1982 to \$59 billion in 1998. Ohio's cost increases mirror national trends, with Medicaid expenditures on nursing facilities rising from \$651 million in 1985 to \$1.78 billion in 1998 and home care expenditures increasing from \$20 million in 1985 to approximately \$300 million in 1998 (Applebaum, 1997; Burwell, 1999 in Mehdizadeh, Straker, and Applebaum, 2000). In 2000, the state spent \$2.5 billion on long-term care services for Medicaid recipients, which was 43 percent of the Medicaid budget (Scripps Gerontology Center, 2003).

Ohio has traditionally relied heavily on institutional long-term care. For example, in 1992 Ohio had 628 nursing home beds per 1,000 persons 85 and above, compared to a national average of 527 beds per 1,000. During the 1980s institutional care grew rapidly, with the number of nursing home days of care increasing by 47 percent. Only 10 other states had higher growth during this time period (Kane, Kane, & Ladd, 1998 in Mehdizadeh, Straker, and Applebaum, 2000). Below are some additional statistics on nursing homes:

- About 80,930 Ohioans (5.4 percents of 65+ persons) lived in nursing homes in 2001.
- In 2000, five percent of Ohio's nursing homes were cited for substandard or immediate jeopardy quality of care.
- Ohio has 220 freestanding residential care facilities and 218 residential care facilities attached to nursing homes.
- In 2002, the average cost for nursing home care in the state was \$4,345/month (Mehdizadeh and Applebaum, 2003).

Following the national trend of consumer choice and supporting individuals with disabilities to live in the least restrictive environment (which is most often at home), Ohio is beginning to shift its previous utilization patterns regarding institutionalization. Home care is increasingly being used as an alternative to institutional care for some older people. On the other hand, increased use of nursing homes as an

alternative to hospitalization is shifting acute care costs to the chronic care arena (Mehdzadeh, Straker, and Applebaum, 2000). So although home- and community-based services are gaining preference and use, nursing homes remain an important part of the long-term care continuum.

Finding the right kind of long-term care in the right place often requires making difficult decisions in difficult times. Consumers often start with little or no knowledge about the long-term care system and need information about the options available, costs of services, how to pay for care, and where to find needed services in a desired area (Miller, 2004). Older persons and caregivers may not be aware of the differences between types of services or levels of care, such as nursing homes and assisted living. Knowing how to assess quality of care is also important. Changing benefits to public programs and expansion of private sector services can be confusing. Getting the most out of Medicare, Medicaid, or other benefit programs and third-party payees is essential in choosing a facility. Individuals with Alzheimer’s Disease and other forms of mental disorientation need specialized residential care options. Consumers often need assistance in finding long-term living options that match their needs and preferences to the characteristics and services of facilities.

Consumers have a variety of resources available to them, including 800 numbers and Internet websites targeted to seniors and their families. Consumers may call a variety of agencies and help lines for information about long-term care or assistance with a care-related problem. Helping consumers find the information and assistance they need in a timely manner is crucial to empowering them to make informed decisions about long-term care options. As an increasing number of consumers and caregivers search for home-based, community-based, and residential long-term care options, efforts to improve consumer access to this vital information at the local and state level becomes more critical (Miller, 2004).

According to the National Aging I&R Support Center, each year the 3,000+ aging information and referral/assistance (I&R/A) services at the state level and in communities across the country assist over 12 million older Americans negotiate the maze of options to make informed choices about the services and resources most appropriate for their needs. The National Association of State Units on Aging adopted the strategic plan “Vision 2010: Toward a Comprehensive Aging Information Resource System in 1999.” The plan provides a conceptual framework for addressing the challenges facing society when America’s 76-million baby boomers retire. Vision 2010 sets forth a vision and call to action to transform the nation’s aging I&R/A programs for the 21st century so that all states will have a comprehensive, integrated infrastructure capable of providing consumer-centered, consumer-directed services to meet the information needs of numerous and diverse communities of older adults and their caregivers (National Aging I&R Support Center, n.d.).

The Western Reserve Area Agency on Aging’s emerging Aging and Disability Resource Network is a step in the direction of the integrated infrastructure envisioned in Vision 2010. Funded by a grant from the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services, the pilot network will link local and regional entities in Cuyahoga, Geauga, Lake, Medina and Lorain counties to create a seamless service experience for older Ohioans and people with disabilities. Consumers will access the network via phone, Internet or in person. In many communities, long-term support services are administered by multiple agencies and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services is difficult. Aging and Disability Resource Centers or Networks are a collaborative effort of the U.S. Administration on Aging and the Centers for

Medicare & Medicaid Services that supports state efforts to develop "one-stop shops" in the community to help people make informed decisions about their service and support options and serve as the entry point to the long-term support system. (Ohio Department of Aging, 2007)

In Ohio, the long term care ombudsman program is operated through 12 regional offices. Six area agencies on aging (AAA's) operate the program directly, while the other six AAA's contract with a non-profit organization to run the program.

United Way of Greater Cleveland funds Lutheran Metropolitan Ministry's Long-term Care Ombudsman program, which has been classified with the AIRS Taxonomy of Senior Housing Information and Referral. Ombudsman programs, begun over 30 years ago, are established under the Older American's Act. They have many responsibilities as outlined in the Act, but one key responsibility is providing information to individuals about long-term care services from their provider database. Long-term care ombudsman programs provide consumers with information about the quality of care available in long-term care facilities, which differentiates them from many other information and referral providers (Department of Health and Human Services, 2004). Cuyahoga's Long-term Care Ombudsman's provider database also includes information on characteristics and services of programs including cultural and linguistic variety in long-term care facilities.

Per the Ohio Department of Aging's 2005 Annual Report, Ohio's Office of the State Long-term Care Ombudsman employed 80 state and regional ombudsmen staff in 2005 and benefited from the services of 500 volunteers. Certified ombudsmen provided 42,930 hours of advocacy and information services and received 9,791 complaints about long-term care services. Ombudsmen handled 2,339 contacts regarding long-term care selection assistance and 6,101 regarding benefits, rights, and regulations (Ohio Department of Aging, n.d.).

*United Way - First Call for Help Data*

Based on United Way - First Call for Help's (FCFH) database (February 2005), there are seven senior housing information & referral providers operating from seven different sites, six of which are government and one is nonprofit. In FY 2004 (July 2003 to June 2004), United Way funded one of the providers: Long-term Care Ombudsman. (See Attachments 5 and 6.)

FCFH refers calls for senior housing information and referral to Long-term Care Ombudsman. LTCO selection assistance call data shows a decrease in the number of total requests for senior housing information and referral in the county: from 1,872 in 2002 to 1,047 in 2006 (44 percent decrease). Over the same five-year period, LTCO had 6,951 requests for information about senior housing. Of these requests, they were able to provide names of facilities that match the consumer's needs and preferences to 100 percent of callers.

The decrease in calls may be attributed to changes in LTCO's staffing patterns in handling selection calls. For many years, there were one full-time and one part time staff members dedicated to selection assistance and the complaint handling staff shared intake calls. In 2001, the receptionist and another staff member were moved to selection assistance and complaint intake and all calls were answered by an answering machine. This mixing of two separate activities of complaint intake and selection reduced the time and focus on selection. To increase public awareness about LTCO's selection assistance services, ombudsmen will be visiting short-term skilled nursing units and sharing brochures and flyers with residents, family members, and staff. In addition, the region's PASSPORT workers will be sharing flyers with home care recipients who need care in a facility.

## FUNDING OF CORE SERVICES

### *Major Government Funders*

Per a survey of state long-term care ombudsman programs conducted in 2003 by the National Long-term Care Resource Center, in Ohio the major sources of government funding are:

- Older Americans Act Titles III and VII;
- Victims of Crime Act;
- State General Revenue Fund; and
- State Special Revenue Fund -- Fee on Long-term Beds.

However, these sources of funding are for the entire Long-term Care Ombudsman program, and not necessarily for the specific service of senior housing information and referral.

Below is further explanation of these funding sources.

### ***FEDERAL***

#### Older American Act, Titles III and VII

As described in Section II, the Older Americans Act enables and provides funding for long-term care ombudsman programs. Two titles in particular are important: Title III is for Older Americans Supportive Services, which Ohio uses to fund long-term care ombudsman program, and Title VII - Allotments for Vulnerable Elder Rights Protection Activities. Title III and VII grants are formula grants based on a state's population aged 60+, but have a minimum allotment.

#### Victims of Crime Act

The Crime Victims Fund relies entirely on criminal fines, forfeitures, and assessments to support victim services with no money provided by taxpayer revenues. It offers financial compensation and direct assistance services to victims of all types of crimes. The Bush Administration is proposing to decrease this fund. Ombudsmen in Ohio have found a way to increase the funding for their programs through grants available as part of the Victims Crime Act. Three local ombudsman programs in Ohio have received funding from this source, which allows them to provide crime victim assistance to residents in nursing homes who have experienced a crime (National Long-term Care Resource Center, 2005). However, the LTCO serving the Cuyahoga County area does not receive these funds.

### ***STATE***

#### State General Revenue Fund

The state budget details funds that were allocated to the entire Long-term Care Ombudsman program, not just for senior housing information and referral. At the state level in both FY 2006 and FY 2007, \$689,437 was allocated for long-term care ombudsman programs out of general revenue funds. The line item "Ombudsman Support" was provided \$615,000 in FY 2006 and no funds were allocated in FY 2007. The regional long-term care ombudsman program was allocated \$910,000 in FY 2006 and \$935,000 in FY 2007. General revenue funding for long-term care ombudsman programs has decreased substantially from \$1.3 million in FY 2002 to about \$700 thousand in FY 2007 (Ohio Office of Budget and Management, 2005).

State Special Revenue Fund -- Fees on Long-term Beds

Ohio has established a special revenue fund for regional long-term care ombudsman programs through the fees on long-term care beds. Funding had almost doubled from this source. In 2001, \$403,679 was allocated to all Ohio regional long-term care ombudsman programs from this source. In FY 2005 \$829,321 was allocated.

**IDENTIFIED REVENUES**

As of May 11, 2006, \$52,332 in revenues for senior housing information and referral has been identified countywide. (See Table 1.) This includes information from foundations; federated fundraising organizations; and regional, county, and municipal government.

One hundred percent of the identified revenues are from United Way Investment Committee allocations. No other funding was identified for this core service.

**Table 1: Identified Revenue for Core Services: Countywide and United Way of Greater Cleveland Social Service for Senior Housing Information & Referral, 2003/2004.**

Funder	Period	A		B	
		Identifiable Total Dollars Countywide		Total Dollars UW-Funded Agencies (Actual FY2004)	
		Amount	% of Total (A)	Amount	% of Total (B)
Other Federated Organizations - Not Elsewhere Classified		0		2,500	
<b>Total - Federated Fundraising Organizations</b>		<b>0</b>	<b>0.00%</b>	<b>2,500</b>	<b>4.32%</b>
Western Reserve Area Agency on Aging (WRAAA)		0		3,000	
<b>Subtotal Regional Funding Sources</b>		<b>0</b>	<b>0.00%</b>	<b>3,000</b>	<b>5.19%</b>
<b>Total - Contracts/grants from government organizations</b>		<b>0</b>	<b>0.00%</b>	<b>3,000</b>	<b>5.19%</b>
<b>Subtotal Non - UWGrCle Support</b>		<b>0</b>	<b>0.00%</b>	<b>5,500</b>	<b>9.51%</b>
<b>Total - UWGrCle investment committee allocation</b>		<b>52,332</b>	<b>100.00%</b>	<b>52,332</b>	<b>90.49%</b>
<b>Subtotal UWGrCle Support - 4001, 4701 &amp; 4703</b>		<b>52,332</b>	<b>100.00%</b>	<b>52,332</b>	<b>90.49%</b>
<b>Total Support/Revenue</b>		<b>52,332</b>	<b>100%</b>	<b>57,832</b>	<b>100%</b>

According to Debby Allen, executive director of Long-term Care Ombudsman (LTCO) located in Cuyahoga County and serves a five-county area (personal communication, November 11, 2006), the state requires designated ombudsman programs to do three things: 1) complaint handling, 2) advocacy, and 3) provide information relating to long-term care. This last charge is relatively ambiguous although it may include providing information on long-term care facilities to a caller who is looking for a place for themselves or a loved one.

Funds designated by the state to operate ombudsman programs are insufficient to cover the expenses related to providing these three required services. The burden falls to the individual ombudsman program to raise funds and build a volunteer corps capable of meeting all of the state requirements. Debby Allen explained that LTCO provides specialized selection services that are not a requirement of the state and were made possible only by an investment made by area foundations and the annual allocation of funds from United Way of Greater Cleveland. A small amount of residential state supplement (RSS) money through WRAAA also has been allocated to LTCO to fulfill a contract, one part of which is to include updated information on over 400 adult care facilities in the area in the selection database.

The service that LTCO provides through its long-term care facility selection database cannot be duplicated by any other agency because LTCO provides callers not only with general information about location, cost, etc. but also with information that can only be obtained by a state designated ombudsman program with the legal right to enter a long-term care facility at any time and investigate complaints made against those facilities.

The funds allocated by United Way to LTCO pay for database maintenance, but the collection of information on facilities, visiting the facilities, and complaint handling, all of which contribute in some way to providing this service, are not covered by this funding nor are they entirely covered by the state. Because this service includes so many aspects of the ombudsman program, it is not possible to pull out revenues and expenses related to providing the service. Therefore, the data in Table 1 under United Way-funded agencies reflects only those dollars specifically allocated for the maintenance and operation of the selection assistance database.

## REIMBURSEMENT/COST

Average cost specifically for senior housing information and referral was not found; however, information about average cost of calls to information and referral providers in Ohio was located. Based on a study conducted by the 211 Ohio Collaborative, the average cost of an I&R call is approximately \$10.99 per call, although there is a wide range. The cost per call varied from \$1.92 to \$25.00. This large variance may be based on the pricing methods used by the reporting agencies (not defined by the survey), the nature of the delivery area (urban vs. rural), the nature of the population (calls from elderly consumers usually take longer, as do calls from people who are homeless or mentally ill), and the degree of computerization and use of technological advances in each county. Some agencies add a case management role to the more difficult and multi-problem calls, while other agencies use volunteers to supplement paid staff (211 Ohio Collaborative, 2004).

## V. WHAT WORKS; WHAT DOESN'T

### IMPACT ON INDIVIDUALS/FAMILIES

#### *What Works*

*This section addresses what works for the consumer education role of long-term care ombudsman programs.*

Best practices for cooperating with ombudsmen and other I&R/A providers include the following:

- Establishing and maintaining regular communication between ombudsmen and aging I&R/A programs;
- Sharing publications and program information;
- Discussing and deciding appropriate referral protocols;
- Inviting each other to training; and
- Coalition building to address particular consumer issues.

Specific best practices or guiding principles are discussed below.

#### **Collaboration with 211 and Other I&R Providers.**

Collaboration is another best practice in senior housing information and referral programs as managed by long-term care ombudsmen. The growing number of older adults, the increasing ethnic and cultural diversity of the older population, and the complex assortment of programs and services available to seniors and their families and caregivers coupled with the relatively flat funding of most Older Americans Act (OAA) programs highlight the necessity for creating partnerships and linkages among programs that provide information and assistance to older persons. Specific practices to increase collaboration include the following:

- Cross-training of ombudsmen and aging I&R/A program staff and/or volunteers;
- Joint skill-building or other joint training events;
- Sharing resource databases;
- Common intake/shared telephone numbers;
- Co-location in the same agency/unit;
- Joint referral processes; and
- Interagency/inter-program agreements (Miller, 2004).

Aging information & referral/assistance (I&R/A) programs are the primary collectors and maintainers of extensive information databases on a wide array of aging services and are often the first point of contact consumers have when searching for long-term care assistance. Therefore I&R/As play a critical role in accessing the ombudsmen. Ombudsman programs should also be aware of the newly developing 2-1-1 network as another potential access link to the program. The Federal Communications Commission (FCC) has designated 2-1-1 as the abbreviated dialing code for consumer access to community health and human services information. Consumer referral systems, as well as linkage to 2-1-1 activity in the state, will ensure the delivery of accurate information to consumers in a timely fashion. A national goal set by the organizations involved in 2-1-1 was to cover 50 percent of the population by 2005. As more states begin to use 2-1-1, ombudsman programs will want to ensure that information

about, and linkage to, the program is addressed and that staff who initially handle calls for assistance understand when to make referrals to the ombudsman program. Effective coordination between ombudsman programs and aging information and referral systems, as well as linkage to 2-1-1 activity in the state, will ensure the delivery of accurate information to consumers in a timely fashion. To effectively accomplish this requires attention to mutual information sharing and coordination.

**Consumer-Focused and Culturally Competent.** Ombudsman programs' educational efforts should be resident-centered and focused, directed toward the needs of diverse and appropriate audiences, and ensure the program is visible and accessible.

**Protecting Privacy.** Despite the value of coordination with aging I&R/A programs, ombudsman programs must also consider their confidentiality constraints. The Older Americans Act, as amended, specifically prohibits disclosing the identity of complainants or residents who make a complaint. One of the major foundations and guiding principles of ombudsman work is confidentiality as many nursing home residents are frail, vulnerable, and dependent on staff. It is related to every dimension of ombudsman practice including complaint resolution, systemic advocacy, and public education. In 2000, the National Long-term Care Ombudsman Resource Center published a best practices manual for ombudsman programs (Grant, 2000). Fundamentally, a best practice in ombudsman work is upholding strict confidentiality in written, spoken, and electronic files and communication.

#### *What Doesn't Work*

Given the increasing diversity of the older population and their individual and specific needs, senior housing information and referral programs must be culturally competent and not have a "one size fits all" plan of providing information to older adults and their caregivers. Lack of coordination with other information and referral providers results in duplication of efforts and wasted resources.

## IMPACT ON COMMUNITY

Senior housing information and referral programs provide resource referral databases and an inventory of senior housing options for the community. Information and referral statistics reveal gaps in service and help to establish priorities for funding. Programs are uniquely positioned to meet the senior housing information needs of individuals and families as well as agencies, community planners, and funding organizations. Long-term care ombudsman program staff also provides consultation to long-term care facilities staff regarding residents' rights, quality of care and services, and other topics influencing quality of life.

## ACCREDITATIONS/STANDARDS/CERTIFICATIONS

Long-term care ombudsman programs are not required to be accredited or certified by any governmental authority. However, the Older Americans Act in Title 42, Chapter 35, Subchapter XI, Part A, subpart ii, Section 3058g established state long-term care ombudsman programs and outlines the program's mandates, functions, responsibilities, and policies and procedures. Additionally, thorough standards and scales have been developed to measure compliance of health, housing, and other supportive services for older adults, and to support the achievement of quality services. In some states, the long-term care ombudsman is responsible for licensing and certifying nursing homes and other long-term care facilities, but this is not the case in Ohio. The federal government has an important presence in nursing homes and home health

regulation through certification for Medicare and Medicaid. Additionally, the Older Americans Act and the Ohio Ombudsman Enabling Law requires that the state designate regional long-term care ombudsman programs. The State Long-term Care Ombudsman, housed in the Ohio Department of Aging, annually evaluates and designates regional ombudsman programs for the entire state. LTCO is designated as the regional program for its 5-county region (Cuyahoga, Geauga, Lake, Lorain, and Medina).

#### National Long-term Care Ombudsman Resource Center (NLCORC) Self Evaluation and Continuous Quality Improvement Tool

In 2005, the National Long-term Care Ombudsman Resource Center published “A Self-Evaluation and Continuous Quality Improvement Tool for Local Long-term Care Ombudsman Programs” under a grant from the Administration on Aging, Department of Health and Human Services. It is available at the National Long-term Care Ombudsman Resource Center’s website at <http://www.ltcombudsman.org/uploads/LocalPETool-Final.pdf>. This document is for local long-term care ombudsmen and other program representatives to use in identifying strengths and weaknesses in local ombudsman program infrastructures and operations for program planning and development purposes. It is important to note that it is a comprehensive listing of all areas of ombudsman work; and few, if any, local programs will fully meet all of the indicators the report addresses.

The tool consists of 13 global components:

- Program access;
- Program management;
- Complaint handling;
- Education/information and assistance;
- Training;
- Systems advocacy;
- Program integrity;
- Conflict of interest;
- Confidentiality;
- Legal resources;
- Fiscal resources;
- Relationships with agencies/entities/individuals/citizen groups/others; and
- Accountability.

The intended benefits of completing the self-evaluation tool are intended to help the local ombudsman do the following:

- Develop an action plan tailored to address the particular needs of the local program.
- Set priorities for the local program.
- Establish benchmarks for the local program.
- Meet the requirements of the Older Americans Act.
- Identify ombudsman program best practices.
- Identify training needs.
- Gain a greater understanding of the ombudsman program if the local ombudsman is new (Grant, 2005).

### Specialty I&R/A Certification Program

One of the goals of the National Aging I&R Support Center is to enhance the professionalism of aging I&R/A personnel. In 2001, the National Aging I&R Support Center, the Alliance of Information and Referral System (AIRS), leaders in aging I&R/A from state units on aging (SUAs), area agencies on aging (AAAs), and local I&R providers assisted in developing the aging specialty I&R/A certification program. It was designed to build upon the existing AIRS certification program while being customized for the aging field. The first exam was administered in June 2002. Performance-based competencies for certification focus on a) general knowledge of information and referral, b) demonstrated information and referral skills and abilities, and c) attitudes and work related behaviors for aging network information and referral specialists (National Aging I&R Support Center, 2001). A complete copy of certification competencies can be found at <http://www.nasua.org/informationandreferral/pdf/AgingCertificationcompetencies.pdf>. A local agency expert noted that representatives from long-term care ombudsman programs needed to be included in the development of the aging specialty I&R program.

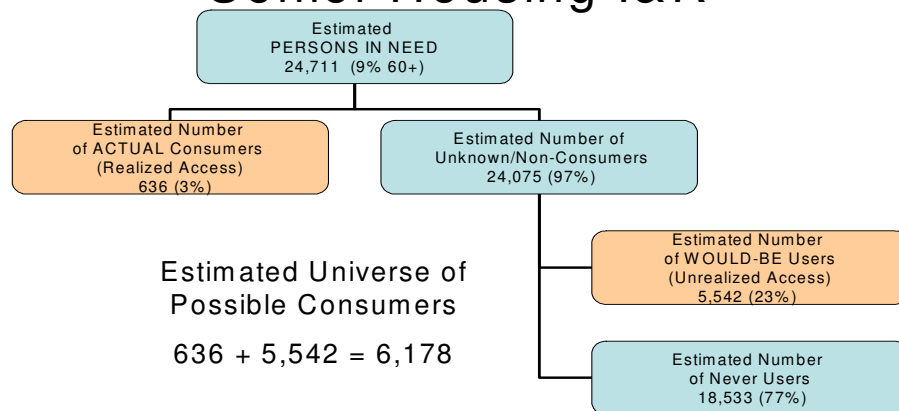
In Ohio, all long-term care ombudsman staff are trained, tested, and certified by the state as representatives of the Office of Long-term Care Ombudsman. Four distinct levels of responsibility are delineated in the law: program directors, certified ombudsman specialist, or ombudsman associates Level I and Level II.

## VI. GAP ANALYSIS

The following is the formula for arriving at the estimated universe of possible consumers for Senior Housing Information and Referral:

- A conservative estimate of 24,711 persons need senior housing information and referral, which is the estimated number of individuals 60 and older with severe disabilities.
- Based on available information about actual consumers, approximately 636 persons have realized access to senior housing information and referral. This is the sum of persons who were consumers of the service from a long-term care ombudsman’s senior housing information and referral program.
- This leaves a net estimate of 24,075 who are either receiving services from unaccounted-for sources or are not receiving senior housing information and referral. (24,711 – 636 = 24,075)
- Based upon the estimate that about 25 percent of disabled elderly live in an institutional setting (Wiener and Stevenson, 1997), the estimated universe of possible consumers is 6,178. (24,711 x 25% = 6,178)
- Subtracting actual consumers from the estimated universe of possible consumers results in 5,542 would be users, i.e., those who would use the service if they knew about it. (6,178 – 636 = 5,542)
- In summary, the estimated universe of possible consumers is 6,178, including both realized (636) and unrealized (5,542) access (See Figure 2.)

### Figure 2 - Consumer Estimates: Senior Housing I&R



#### Service Site Index

Because this is a county wide service (in fact 5-counties), there is no service site index

## VII. SUMMARY

The following are the major findings from the research on senior housing information and referral:

- With the increase in the number of older adults, there will be increased demand for long-term care solutions. Approximately 60 percent of Americans who reach age 65 will need long-term care at some time in their. Senior housing information and referral provides assistance to older adults and their caregivers in finding options that meet their needs for level of care, type of facility, financial considerations, quality, and other issues of concern.
- As federal and state health plan policies shift to allow funding for home- and community-based waiver services, senior housing information and referral programs will need to address the demand for information related to these services.
- The National Association of State Units on Aging's strategic plan "Vision 2010: Toward a Comprehensive Aging Information Resource System" sets forth a vision and call to action to transform the nation's aging I&R/A programs for the 21st century so that all states will have a comprehensive, integrated infrastructure capable of providing consumer-centered, consumer-directed services to meet the information needs of numerous and diverse communities of older adults and their caregivers.
- Per a survey of state long-term care ombudsman programs conducted in 2003 by the National Long-term Care Resource Center in the State of Ohio, federal funding for LTCO programs comes from Older Americans Act Titles III and VII and Victims of Crime Act Funds. State funding comes from ombudsman specific funds, long-term care bed fee or tax, and county/local funds.
- Long-term care ombudsman programs do not only provide senior housing information and referral. As the state budget explains: "This program provides staff and volunteer ombudsmen who file complaints about long-term care services for individuals residing in nursing facilities, assisted living facilities or receiving home care."
- As of May 11, 2006, \$52,332 in revenues for senior housing information and referral has been identified countywide.
- Collaboration is another best practice in senior housing information and referral programs as managed by long-term care ombudsmen.
- Fundamentally, a best practice in ombudsman work is upholding strict confidentiality in written, spoken, and electronic files and communication.
- Given the increasing diversity of the older population and their individual and specific needs, senior housing information and referral programs must be culturally competent and not have a "one size fits all" plan of providing information to older adults and their caregivers.
- The estimated universe of possible consumers is 6,178, including both realized (636) and unrealized (5,542) access.
- Countywide, there are 7 service sites for senior housing information and referral. This is a ratio of 883 possible consumers (estimated 6,178 total) to one service site countywide.

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## ATTACHMENTS

### Attachment 1: Researcher List

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

## Attachment 2: Technical Notes

### Technical Notes: Methodology, Caveats, Limitations of Data

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

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

#### Unit of Analysis

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

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

#### United Way - First Call for Help Data

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

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

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

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

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

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

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

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

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

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

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

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

## Funding Information for Core Services

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

### *Foundation Funding*

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

### *Federated Funding Sources*

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

### *Government Funding*

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

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

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

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

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

*Medicaid Funding*

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

**Entered as Aggregate Total Under Appropriate AIRS Level**

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

**Entered as Aggregate Total Under Third Party Payee/Direct Bill**

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

*United Way of Greater Cleveland Funding*

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

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

*United Way Agency Revenues*

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

**Consumer and Financial Data: Caveats**

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

*All Core Services*

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

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

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

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

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

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

### **Gap Analysis Methodology & Limitations**

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

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

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

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

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

### **Service Site Index**

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

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



## Specific Service Issues

### *Senior Services*

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

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

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

## References

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

### Attachment 3: Actual Consumer Demographics

Core Service: Senior Housing Information & Referral PF-200.800				
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source
	Total Population (%) <sup>*</sup>	Total Population 60+ (%) <sup>**</sup>	Total Population 60+ with Severe Disabilities (%) <sup>***</sup>	UW Program Report Data Cuy Cnty Only (%)
PERIOD	1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004
<b>TOTAL</b>	<b>1,393,978</b>	<b>273,378</b>	<b>24,711</b>	<b>636</b>
<b>Percent</b>		<b>19.6%</b>	<b>9.0%</b>	
<b>GENDER</b>				
Male	47.2%	40.4%	N/A	11.5%
Female	52.8%	59.6%	N/A	26.1%
Unknown Data <sup>*****</sup>				62.3%
Missing Data <sup>*****</sup>				0.0%
<b>RACE<sup>*****</sup></b>				
White alone	67.1%	77.4%	N/A	0.0%
Black or African American alone/combination	27.9%	20.7%	N/A	0.0%
Asian alone/combination	2.1%	1.1%	N/A	0.0%
American Indian and Alaska Native alone/combination	0.7%	0.4%	N/A	0.0%
Native Hawaiian and Other Pacific Islander alone/combination	0.1%	0.0%	N/A	0.0%
Some other race alone/combination	2.1%	0.6%	N/A	0.0%
Unknown Data <sup>*****</sup>				100.0%
Missing Data <sup>*****</sup>				0.0%
<b>HISPANIC<sup>*****</sup></b>	<b>3.3%</b>	<b>1.1%</b>	<b>N/A</b>	<b>0.0%</b>
<b>AGE</b>				
0-4	6.5%			0.0%
5-9	7.3%			0.0%
10-14	7.1%			0.0%
15-19	6.4%			0.0%
20-34	19.1%			0.0%
35-54	29.3%			0.0%
55-64	8.7%	20.6%	N/A	0.0%
65-74	7.8%	39.3%	N/A	15.0%
75+	7.8%	40.2%	N/A	7.2%
Unknown Data <sup>*****</sup>				77.8%
Missing Data <sup>*****</sup>				0.0%
<b>INCOME<sup>*****</sup></b>				
<b>Average Household Size</b>	<b>2.4</b>	<b>N/A</b>	<b>N/A</b>	
\$0-\$9,999	11.3%	N/A	N/A	6.1%
\$10,000-\$14,999	6.9%	N/A	N/A	0.0%
\$15,000-\$19,999	6.7%	N/A	N/A	0.0%
\$20,000-\$29,999	13.6%	N/A	N/A	0.0%
\$30,000 and above	61.5%	N/A	N/A	0.0%
Unknown Data <sup>*****</sup>				93.9%
Missing Data <sup>*****</sup>				0.0%
<b>Totals</b>	<b>100.0%</b>	<b>N/A</b>	<b>0.0%</b>	<b>100.0%</b>

### Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census SF1 (P1); SF4 (PCT 144)
** U.S. Census SF1 (P1); SF3(P52); SF4 (PCT 144)
** Mehdizadeh, S.A., Roman, S.P., Wellin, V.W., Ritchey, P.N. & Kunkel, S. R. (n.d.). Profile and projection of the 60+ population: Cuyahoga County, Ohio. Oxford, OH: Scripps Gerontology Center, Miami University. Severe disability is defined as receiving help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairments.
****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 Housing Information & Referral pf-200.800					
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source *****
	City/Town (% Cleveland)	Total Population (%) <sup>†</sup>	Total Population 60+ (%) <sup>**</sup>	Total Population 60+ with Severe Disabilities (%) <sup>***</sup>	UW Program Report Data (%)
Period		1/1/2000-12/31/2000	1/1/2000-12/31/2000	1/1/2000-12/31/2000	7/1/2003-6/30/2004
<b>TOTAL</b>		<b>1,393,978</b>	<b>273,378</b>	<b>24,711</b>	<b>636</b>
<b>Percent</b>			<b>19.6%</b>	<b>9.0%</b>	
44017	Berea	1.4%	1.3%	N/A	1.1%
44022	Bentleyville	1.3%	1.3%	N/A	1.1%
44040	Gates Mills/Mayfield Village	0.2%	0.3%	N/A	0.0%
44070	North Olmsted	2.4%	2.5%	N/A	1.1%
44101	Cleveland (100%)	0.0%	0.0%	N/A	0.0%
44102	Cleveland/Brooklyn (95%)	3.7%	2.3%	N/A	0.5%
44103	Cleveland (100%)	1.8%	1.5%	N/A	0.6%
44104	Cleveland (100%)	2.1%	1.4%	N/A	0.3%
44105	Cleveland/NewburghHts/GarfieldHts (75%)	3.9%	3.1%	N/A	0.6%
44106	Cleveland/Cleveland Hts (60%)	2.3%	2.3%	N/A	0.6%
44107	Lakewood/Cleveland	4.1%	3.1%	N/A	0.8%
44108	Cleveland/Bratenahl (90%)	2.6%	2.5%	N/A	0.5%
44109	Cleveland/Brooklyn Hts (98%)	3.3%	2.3%	N/A	0.8%
44110	Cleveland/East Cleveland (98%)	1.9%	1.5%	N/A	1.3%
44111	Cleveland (100%)	3.1%	2.5%	N/A	2.4%
44112	East Cleveland/Cleveland	2.4%	2.1%	N/A	1.4%
44113	Cleveland (100%)	1.4%	0.8%	N/A	0.3%
44114	Cleveland (100%)	0.3%	0.3%	N/A	0.3%
44115	Cleveland (100%)	0.6%	0.2%	N/A	0.2%
44116	Rocky River	1.5%	2.2%	N/A	0.5%
44117	Euclid/Cleveland	0.9%	1.4%	N/A	0.5%
44118	ClevelandHts/UniversityHts/ShakerHts	3.2%	2.6%	N/A	3.0%
44119	Cleveland/Euclid (50%)	1.0%	1.1%	N/A	0.2%
44120	Shaker Hts/Cleveland	3.4%	3.1%	N/A	1.6%
44121	University Hts/South Euclid	2.5%	2.2%	N/A	1.3%
44122	Beachwood/Highland Hills/ShakerHts	2.5%	3.7%	N/A	2.2%
44123	Euclid	1.3%	1.4%	N/A	0.8%
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	4.5%	N/A	2.7%
44125	Valley View/Garfield Hts	2.1%	2.5%	N/A	0.8%
44126	Fairview Park/Cleveland	1.2%	1.5%	N/A	0.6%
44127	Cleveland (100%)	0.6%	0.4%	N/A	0.2%
44128	Warrensville Hts/Cleveland	2.4%	2.8%	N/A	0.9%
44129	Brooklyn/Parma/Cleveland	2.1%	2.4%	N/A	1.1%
44130	Parma/Cleveland	3.8%	5.2%	N/A	1.9%
44131	Independence/Seven Hills/BrooklynHts	1.5%	2.2%	N/A	0.9%
44132	Euclid	1.1%	1.1%	N/A	0.8%
44133	North Royalton	2.1%	1.7%	N/A	1.1%
44134	Parma/Cleveland	2.9%	3.7%	N/A	0.5%
44135	Cleveland/Linndale (90%)	2.0%	2.0%	N/A	0.2%
44136	Strongsville	3.1%	2.5%	N/A	2.2%
44137	Maple Hts/Cleveland	1.9%	1.9%	N/A	0.3%
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	N/A	0.9%
44139	Bentleyville/Glenwillow/Solon	1.6%	1.2%	N/A	1.1%
44140	Bay Village	1.2%	1.1%	N/A	0.2%
44141	Brecksville	1.0%	1.1%	N/A	0.6%
44142	Brookpark/Cleveland	1.5%	1.8%	N/A	0.5%
44143	Highland Hts/Richmond Heights	1.7%	2.0%	N/A	1.3%
44144	Brooklyn/Cleveland	1.6%	1.9%	N/A	0.5%
44145	Westlake	2.3%	2.6%	N/A	0.8%
44146	Walton Hills/Oakwood/Bedford	2.3%	2.6%	N/A	1.3%
44147	Broadview Hts	1.1%	1.1%	N/A	0.2%
	Unknown Cuyahoga County Zip Codes*****				54.9%
	Missing*****				0.0%
	Unknown*****				126.7%
	<b>Total Cuyahoga County*****</b>	<b>100.0%</b>	<b>100.0%</b>	<b>N/A</b>	<b>100.0%</b>
	<b>Total Known Cleveland</b>	<b>30.7%</b>	<b>24.2%</b>	<b>N/A</b>	<b>8.8%</b>
	<b>Total Known Suburbs</b>	<b>69.3%</b>	<b>75.8%</b>	<b>N/A</b>	<b>36.3%</b>
	<b>Unknown &amp; Missing</b>				<b>126.7%</b>

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S. Census 2000, SF1 (P1)
** U.S. Census 2000, SF1 (P1)
*** Mehdizadeh, S.A., Roman, S.P., Wellin, V.W., Ritchey, P.N. & Kunkel, S. R. (n.d.). Profile and projection of the 60+ population: Cuyahoga County, Ohio. Oxford, OH: Scripps Gerontology Center, Miami University. Severe disability is defined as receiving help in at least two of the following activities of daily living: eating, transferring in or out of bed or chair, getting to the toilet, dressing, remaining continent, or having cognitive impairments.
**** 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	7	1
Number of Providers by Type		
Nonprofit	1	1
For-profit	-	-
Government	6	-
Other	-	-
Total Number of Sites	7	1
Number of Service Sites per Provider		
1	7	1
2 – 5	-	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 – Berea	-	-
44022 – Bentleyville	-	-
44040 – Gates Mills/Mayfield Village	-	-
44070 – North Olmsted	1	-
44101 – Cleveland	-	-
44102 – Brooklyn/Cleveland	-	-
44103 – Cleveland	-	-
44104 – Cleveland	-	-
44105 – Newburgh Hts/Garfield Hts	-	-
44106 – Cleveland Hts/Cleveland	-	-
44107 – Cleveland/Lakewood	1	-
44108 – Cleveland/East Cleveland	-	-
44109 – Cleveland/Brooklyn Hts	-	-
44110 – Cleveland/Bratenahl	-	-
44111 – Cleveland	-	-
44112 – Cleveland/East Cleveland	-	-
44113 – Cleveland	-	-
44114 – Cleveland	-	-
44115 – Cleveland	1	1
44116 – Rocky River	-	-
44117 – Cleveland/Euclid	-	-
44118 – Euclid/University Hts	-	-
44119 – Cleveland/Euclid	-	-
44120 – Cleveland/Shaker Hts	1	-
44121 – University Hts/South Euclid	-	-
44122 – Orange/Warrensville Hts	-	-
44123 – Euclid	1	-
44124 – Pepper Pike/Mayfield Village	-	-
44125 – Valley View/Garfield Hts	-	-
44126 – Cleveland/Fairview Park	-	-
44127 – Cleveland	-	-
44128 – Cleveland/Warrensville Hts	-	-

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

<b>PROFILE OF CORE SERVICE PROVIDERS - 2005</b>		
<b>Source: United Way - First Call for Help Refer Database February 2005</b>		
	Count	Sub-Count: UW-Affiliated
44129 – Cleveland/Brooklyn/Parma	-	-
44130 – Cleveland/Parma	-	-
44131 – Seven Hills/Brooklyn Hts	-	-
44132 – Euclid	-	-
44133 – North Royalton	-	-
44134 – Parma/Cleveland	-	-
44135 – Cleveland/Linndale	-	-
44136 – Strongsville	-	-
44137 – Maple Hts/Cleveland	-	-
44138 – Olmsted Twp/Olmsted Falls	-	-
44139 – Bentleyville/Glenwillow/Solon	-	-
44140 – Bay Village	1	-
44141 – Brecksville	-	-
44142 – Cleveland/Brookpark	-	-
44143 – Highland Hts/South Euclid	-	-
44144 – Brooklyn/Cleveland	-	-
44145 – Westlake	-	-
44146 – Walton Hills/Oakwood/Bedford	1	-
44147 – Broadview Hts	-	-
44149 – Strongsville	-	-
<b>Total Cuyahoga County</b>	<b>7</b>	<b>1</b>
<b>Total Cleveland</b>	<b>1</b>	<b>1</b>
<b>Total Suburbs</b>	<b>6</b>	<b>0</b>

## Attachment 6: Providers and Functions – 2005

<b>Service Providers &amp; Functions</b>	
<b>Source: United Way - First Call for Help Refer Database February 2005</b>	
<b>Agency</b>	<b>Services</b>
City of Bay Village Department of Community Services	Housing - Housing Search Assistance for Older Adults
City of Bedford Heights	Social Services - Seniors and Disabled
City of Euclid	Senior Center - Senior Housing Information and Referral
City of Lakewood Department of Human Services	Long-term care Planning
<b>Long-term care ombudsman</b>	<b>Long-term care information</b>
City of North Olmsted Department of Human Resources	Senior Information and Referral
City of Shaker Heights	Outreach and Assessment - Older Adults

**Bold** represents agencies funded by United Way for this service.



**United Way of  
Greater Cleveland**

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