

# Core Service Report

## Therapeutic Camps

Consumer Category:  
**Age**

Primary Consumer Group:  
**Children and Youth Needing  
Developmental Opportunities**



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

We are grateful to the multiple public and private funders, provider agencies, experts in the various fields of interest, and staff of United Way of Greater Cleveland for their assistance, support, information, and insight.

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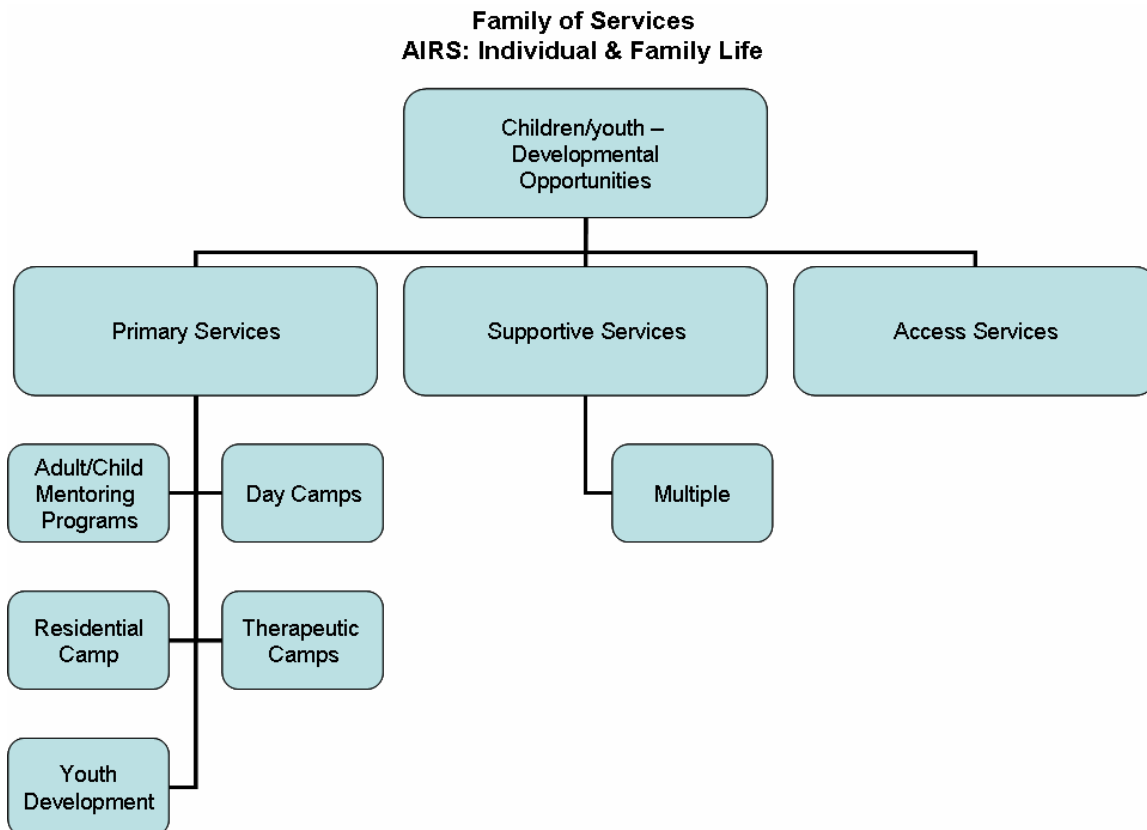
# SNAPSHOT

**AIRS Code Level I: P – Individual & Family Life**  
**AIRS Code Level II: PL – Leisure Activities**  
**Core Service: Therapeutic Camps PL-640.150-85**

**Investment Committee: Strong Families = Successful Children**  
**Cluster: Child & Family Services**

**AIRS Definition:** Residential or day camp facilities that are appropriately staffed and equipped to provide an opportunity for children or adults with developmental disabilities, emotional disturbances, or health impairments, or who have other limitations or problems that require special facilities or programming to enjoy a cooperative indoor or outdoor living experience.

Therapeutic Camp programs are part of a family of services for children and youth needing developmental opportunities. It is one of five services for this consumer group. (See figure below.)



### *Core Service Environment*

Data from the 2000 U.S. Census (2003) indicates that roughly one in five Americans aged five and older has a disability and one in ten has a severe disability. At the same time, one in eight children has a disability (Waldrop & Stern, 2003). There are numerous camping opportunities for the disabled populations. Most of the mainstream camps that serve disabled campers tend to include campers considered to be mildly disabled: attention deficit disorder (90 percent), learning disabilities (71 percent), and mild mental retardation (64 percent). A smaller percentage of camps serve those with more severe disabling conditions: moderate/severe mental retardation (29 percent), deaf/blind (26 percent), autistic (23 percent), and traumatic brain injury (3 percent). In 2003, an American Camp Association study found that up to 15 percent of camps is dedicated to meeting the special needs of campers with physical, emotional, or mental challenges (ACA, 2004).

With the passage of the Americans with Disabilities Act (ADA), the vast majority of outdoor recreation and outdoor education opportunities must now be accessible architecturally, programmatically, and technologically to persons with a disability. Background screening, safety, quality checks, and accessibility are all part of the American Campers Association's (ACA) efforts to provide accredited camps.

Ohio's minimum wage law passed in November of 2006, with 57 percent of the vote raising the minimum wage from \$5.15 to \$6.85. Camp organizations were concerned that this would significantly affect their organizations' budgets as they often rely on youth for camp counselors. On Dec 27, 2006, both the Ohio House of Representatives and the Ohio Senate passed Sub HB 690, which specified a number of exemptions for the higher minimum wage, including workers at youth camps. Governor Taft signed the bill into law on January 2, 2007. However, the constitutionality of the bill may be called into question.

### *Core Service Consumers*

The target population addressed in this core service report is children ages 5 to 15 years with one or more disabilities; however, individuals older than 15 also could benefit from therapeutic camps. These persons could have developmental disabilities, emotional disturbances, health impairments, chronic illness, or other limitations or problems that require special facilities or programming to enjoy a cooperative indoor or outdoor living experience.

In 2000, 14,245 persons 5 to 15 years old had one or more disabilities and are estimated to be in need of therapeutic camps. This number is expected to decrease to 11,290 by 2015 as a result of shifts in population.

### *Core Service Delivery*

The definition of the core service for this report is: residential or day camp facilities that are appropriately staffed and equipped to provide an opportunity for children (and adults) with disabilities or chronic illness to enjoy a cooperative indoor or outdoor living experience.

These camps offer the following services: educational activities, patient assistance, recreation, personal enrichment, occupational therapy and much more. Each camp is operated differently and may either specialize in helping children with a wide variety of disabilities or concentrate on specific conditions, e.g. autism, sickle cell disease, diabetes, etc.

In addition to the increase of children with disabilities being mainstreamed into camps, many new camps have opened to provide services to children with special medical needs. For example, there are over 50 therapeutic wilderness camps across the country represented by the

National Association of Therapeutic Wilderness Camps (NATWC). NATWC cites two kinds of therapeutic wilderness camps: long term and short term. *Long-term* camps last from a few months to more than a year. Campers have primary responsibility for their shelter, food, and activities. Therapy occurs through both the group process experience and through learning personal responsibility. *Short-term* camps typically last from 21 to 90 days and involve groups of peers who are transported into the wilderness with a team of adult leaders.

Based on United Way - First Call for Help's (FCFH) database (2004), there are 12 therapeutic camp program providers operating from 16 different sites, 1 of which is government, and 11 are nonprofit. In FY 2004, United Way did not fund any providers. FCFH call data shows a decrease in the number of total requests for therapeutic camp programs in the county: from 26 in 2000 to 21 in 2004 (19 percent). Over the same five-year period, FCFH had 106 requests for information about therapeutic camps. Of these requests, they were able to make referrals to 92 percent of callers.

Very little government funding is available for therapeutic camps. This same challenge has been true of most programs seen as recreational rather than educational. Recently, many of the dollars contributed to youth development are focused on after-school programming, tutoring, or formal child care.

In the Cleveland area, in 2002, local foundations donated a combined total of \$17,000. In 2003, this rose to \$84,500, and in 2004, donations totaled \$115,500.

As of May 11, 2006, \$128,500 in revenues for therapeutic camps has been identified countywide. Ninety percent of the revenues are from foundations. Another 10 percent is from federated organizations. Currently, United Way of Greater Cleveland does not fund therapeutic camps.

Therapeutic camp fees range from \$75 to \$300 per week for day camps and \$201 to \$400 per week for resident camps. Nearly 65 percent of ACA-accredited camps offer some level of financial aid to over one million children from economically challenged families and who have special medical needs or special situations that might otherwise preclude them from attending camp.

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

The camp counselor is the most important element a child encounters while attending an outdoor education program. No program is successful without counselors who interact positively and productively with children (Brannan, Arick & Fullerton, 1997).

Variables to be considered when grouping children are age; sex; interests; handicapping conditions; personality characteristics; the degree, intensity, and kind of pathology; and group experiences and skills. Camps should favor forming a "balanced" group and avoid extremes in group composition (Brannan, Arick & Fullerton, 1997).

Camp duration may impact whether camping is a successful experience for a child with a disability. Dr. David Austin conducted an evaluative research study of two-week versus six-week camping experiences for handicapped boys. In comparison to the two-week campers, six-week campers demonstrated greater improvement in self-esteem, relationships with others, personal and social behaviors, and general behaviors and attitudes (Austin, 1980)

Constraints to the enjoyment of outdoor or camping activities tend to be either attitudinal or resource based. Attitudinal barriers stem from the attitudes of the camper or the facilitator. Resource barriers include finances, transportation, knowledge and skills, and functioning (Ross, 2005).

The Council on Accreditation (COA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredit some therapeutic wilderness camps. The National Association of Therapeutic Wilderness Camps (NATWC) also offers wilderness counselor certification. NATWC is a nationally recognized credentialing organization for the profession of therapeutic recreation.

*Gap Analysis*

A conservative estimate of 14,245 persons could need therapeutic camps. Due to the lack of available information, it is not possible to conclude a meaningful gap analysis.

## 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

Data from the 2000 U.S. Census (2003) indicates that there are 49.7 million people with some type of long lasting condition or disability in the United States. This equates to roughly one in five Americans aged five and older with a disability and one in ten Americans with a severe disability. At the same time, one in eight children has a disability (Waldrop & Stern, 2003).

A person with a disability is defined as one who has difficulty performing certain physical functions (seeing, walking, talking, etc.), completing daily living activities, or with certain social roles (schoolwork, employment, etc.). This data does not include those with chronic illnesses like diabetes.

Disabilities range in both type and severity. The 2000 Census found the following:

- 21.3 million people aged 16 to 64 with a condition that affected their ability to work at a job or business;
- 21.2 million people (8.2 percent) with a condition limiting basic physical activity, such as walking climbing stairs, reaching, lifting, or carrying;
- 18.2 million people aged 16 and older with a condition that made it difficult to go outside the home to shop or visit the doctor;
- 12.4 million people (4.8 percent) with a physical, mental, or emotional condition causing difficulty in learning, remembering, or concentrating;
- 9.3 million people (3.6 percent) with a sensory disability that involves sight or hearing; and
- 6.8 million people (2.6 percent) with a physical, mental, or emotional condition causing difficulty in dressing, bathing, or getting around inside the home.

In 2000, 8.7 million people with disabilities were poor, a substantially higher proportion (17.6 percent) than among people without disabilities (10.6 percent). The highest poverty rates were found among children aged 5 to 15 which was 25 percent, compared to 15.7 percent for those without disabilities (Waldrop and Stern, 2003).

There are numerous camping opportunities for the disabled populations. Some camping experiences are specifically tailored to be therapeutic, while other mainstream camps include the disabled in their activities. In the summer of 1995, the American Camp Association (ACA), working in conjunction with the Institute for Career and Leisure Development, completed a nationwide survey of all mainstream camps to determine how many included activities for disabled campers. The following information was gleaned from the camps that responded to the survey (Brannan, Arick, Fullerton, & Harris, 1997):

- Thirty-one camps primarily served campers *without* disabilities, but mainstreamed campers with disabilities into their summer residential camp programs.
- Twenty-four camps primarily served campers *with* disabilities. They also reverse mainstreamed campers without disabilities in their summer residential programs.

Most of the mainstream camps that serve disabled campers tend to include campers considered to be mildly disabled: attention deficit disorder (90 percent), learning disabilities (71 percent), and mild mental retardation (64 percent). A smaller percentage of camps serve those with more severe disabling conditions: moderate/severe mental retardation (29 percent), deaf/blind (26 percent), autistic

(23 percent), and traumatic brain injury (3 percent). In 2003, an American Camp Association study found that up to 15 percent of camps are dedicated to meeting the special needs of campers with physical, emotional, or mental challenges (ACA, 2004).

## PUBLIC POLICY ISSUES

### STATE

#### *Ohio's Minimum Wage Law*

Ohio's minimum wage law passed in November of 2006, with 57 percent of the vote raising the minimum wage from \$5.15 to \$6.85. Camp organizations were concerned that this would significantly affect their organizations' budgets as they often rely on youth for camp counselors. On Dec 27, 2006, both the Ohio House of Representatives and the Ohio Senate passed Sub HB 690, which specified a number of exemptions for the higher minimum wage, including workers at youth camps. Governor Taft signed the bill into law on January 2, 2007. This law requires that, if a camp meets the exemption from minimum wage under the Fair Labor Standards Act (FLSA), then it is exempt from paying minimum wage to its employees. If the camp does not meet this exemption, the camp is then required to pay minimum wage to all staff. There are other areas in this bill that also apply to camps (record keeping especially). The constitutionality of this law may be called into question (American Camp Association, 2007).

### III. THE CORE SERVICE CONSUMERS

#### DEFINITION OF TARGET POPULATION

The target population addressed in this core service report is children ages 5 to 15 years with one or more disabilities; however, individuals older than 15 also could benefit from therapeutic camps. These persons could have developmental disabilities, emotional disturbances, health impairments, chronic illness, or other limitations or problems that require special facilities or programming to enjoy a cooperative indoor or outdoor living experience.

#### DEMOGRAPHIC CHARACTERISTICS

Table 1 identifies the specific type of disability by population in Cuyahoga County for potential participants of therapeutic camps.<sup>1</sup>

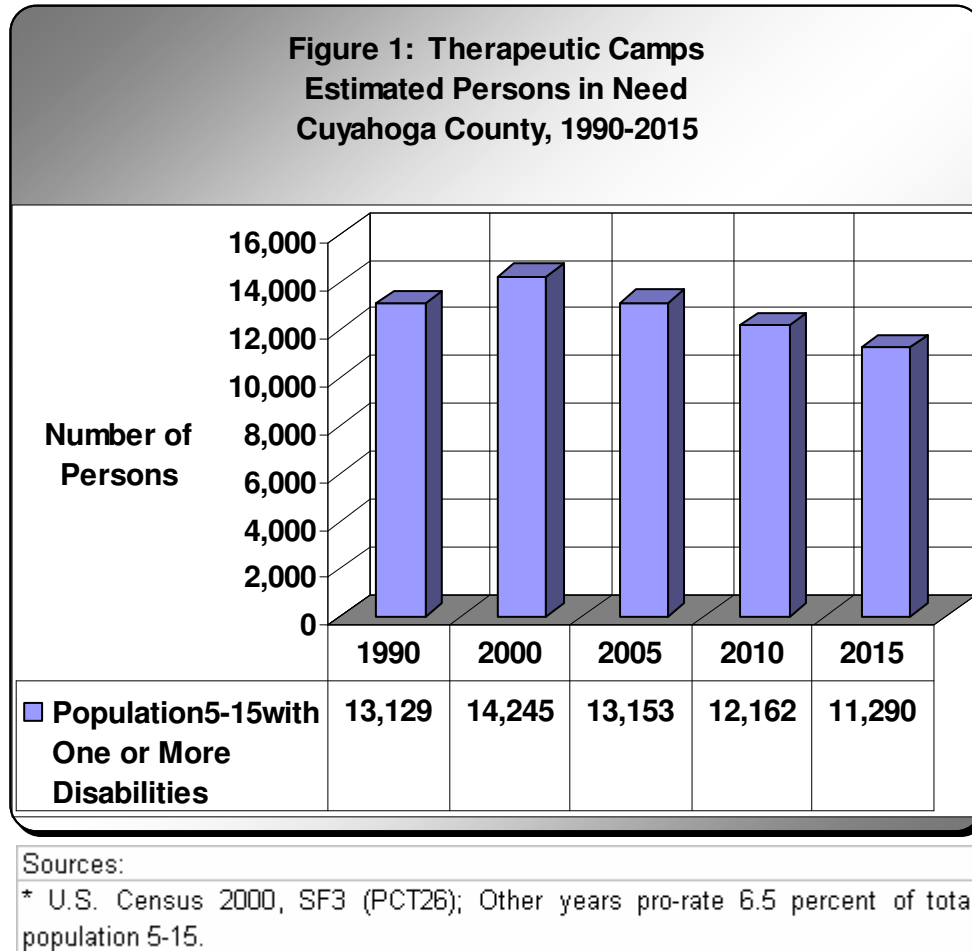
**Table 1: Persons 5-15 Years with Disabilities, by Disability Type, Non-Institutionalized, Cuyahoga County, 2000**

	Total Population	With Disability	Specific Disability	Percent of Age Cohort
<b>5 to 15 years:</b>	<b>219,309</b>	<b>14,245</b>		<b>6.5%</b>
With one type of disability:		<b>11,336</b>		<b>5.2%</b>
Sensory disability			1,111	
Physical disability			949	
Mental disability			8,884	
Self-care disability			392	
With two or more types of disability:		<b>2,909</b>		<b>1.3%</b>
Includes self-care disability			1,749	
Does not include self-care disability			1,160	
* "Disability" is defined by the US Census as a long-lasting physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. This condition can also impede a person from being able to go outside the home alone or to work at a job or business.				
Source: U.S. Census 2000, SF3 (PCT26)				

<sup>1</sup> Individuals with chronic diseases, such as asthma or diabetes, are not necessarily included in this disability count unless these conditions caused them to answer “yes” to specific questions for the U.S. Census. They also can be consumers of therapeutic camps.

*Estimated Persons in Need*

In 2000, 14,245 persons 5 to 15 years old had one or more disabilities and are estimated to be in need of therapeutic camps.<sup>2</sup> This number is expected to decrease to 11,290 by 2015 as a result of population shifts. (See Figure 1.)



It is recognized that this is likely an overestimate of persons in need of therapeutic camps but note that individuals with disabilities older than 15 could also be in need. However, it is a number that begins to offer some clarity about the extent of need in Cuyahoga County.

**REALIZED ACCESS TO SERVICE**

Realized access to service is represented by the numbers of consumers actually served. In FY 2004 United Way did not fund therapeutic camps. There is no data from other funders.

(See Attachments 3 and 4 for demographics.)

<sup>2</sup> The U.S. Census organizes age cohorts for disability (S1801 Disability Characteristics) into the following: 5-15, 16-64, and 65 and older.

## IV. CORE SERVICE DELIVERY

### CORE SERVICE DEFINITION

The definition of the core service for this report is: residential or day camp facilities that are appropriately staffed and equipped to provide an opportunity for children (and adults) with disabilities or chronic illness to enjoy a cooperative indoor or outdoor living experience.

These camps offer the following services: educational activities, patient assistance, recreation, personal enrichment, occupational therapy and much more. Each camp is operated differently and may either specialize in helping children with a wide variety of disabilities or concentrate on specific conditions, e.g. autism, sickle cell disease, diabetes, etc.

### BACKGROUND ON CORE SERVICE

In addition to the increase of children with disabilities being mainstreamed into camps, many new camps have opened to provide specialized services to children with special medical needs. The American Camp Association states:

Therapeutic camps are helping children deal with emotional issues in a safe place. Therapeutic camps specialize in helping children cope with circumstances such as chronic illness, siblings with disabilities, or loss of a loved one. Through the camp experience, children are able to learn the coping skills necessary to face these situations. Some of the critical issues that the camp experience helps children address are:

- Psychological effects of the illness or event;
- How children perceive themselves; and
- How to develop coping abilities.

The safety of the camp environment reduces fear and anxiety in children by providing opportunities where they can interact with other children and learn ways to cope. For most campers, the opportunity to acquire knowledge from other children who are undergoing similar experiences is beneficial. Knowledge of the disease or event is positively related to the child's self-image, and aids in better adjustment for the child attending therapeutic camp...

Therapeutic camps can also provide opportunities for children to be in control of their experiences. By choosing the activities they want to do, children are able to gain a sense of normalcy. When children are given this freedom, they are able to recognize their feelings and gain a greater sense of autonomy. (ACA, 2006)

As noted by one therapeutic camp provider, it is important to parents that the medical team at camp have specialized knowledge in particular diseases or other chronic conditions, which is not always possible in a mainstreamed situation. Specialized camps can offer a networking and disease specific management/coping skills experience not available in general camps which mainstream special

needs children. It is important to campers and their parents to meet other children and staff living effectively with the same condition.

Camps have embraced the concept of whole-child development. Utilizing camping in year-round education and youth development, they are highly effective alternative learning models. As education officials seek ways to provide character education, social development, and solutions to vacation-time learning loss, camps are uniquely positioned to fill the gaps with proven, effective programming. Some examples of this positive development include providing students with the experience of discovery; access to academic enrichment programs that are intellectually stimulating and fun; innovative opportunities to make learning come alive; and removing children from their comfort zones so they will become more open to learning and retain more of what they learn.

There are two basic types of wilderness therapeutic camps according to the National Association of Therapeutic Wilderness Camps (2007). These can be described as long term and short term camps. It must be noted that these are not the typical therapeutic camps for children with disabilities as there are only 50 in the country that are members of the national association. Currently there are none in Ohio. However, this is presented in this section as an option of a camp experience for children with social and emotional disabilities.

### **Long Term Camps**

These programs usually consist of large base camps located on large parcels of wilderness property. Usually these camps consist of a few central, permanent buildings such as schools, offices, dining halls, maintenance facilities, etc. There are also several small campsites in which groups of 8-12 campers live with their counselors on a year 'round basis. The campers build their own tents in these programs. They are responsible for cooking some of their own meals and planning their own activities with guidance from their counselors.

Groups also take various types of adventure trips from these facilities. These trips may include activities such as backpacking, canoeing, rock climbing, ropes course activities, and other adventure activities.

The therapy occurs in these programs through the campers experiencing group process as they take responsibility for their own needs. Usually these programs include group problem solving sessions called circle ups or huddle ups. The traditional therapeutic modality used in these camps is Reality Therapy. Some camps have changed modalities in recent years to Brief Solution Focused Therapy. These programs usually have accredited educational programs. The time campers spend in these programs ranges from a few months to more than one year.

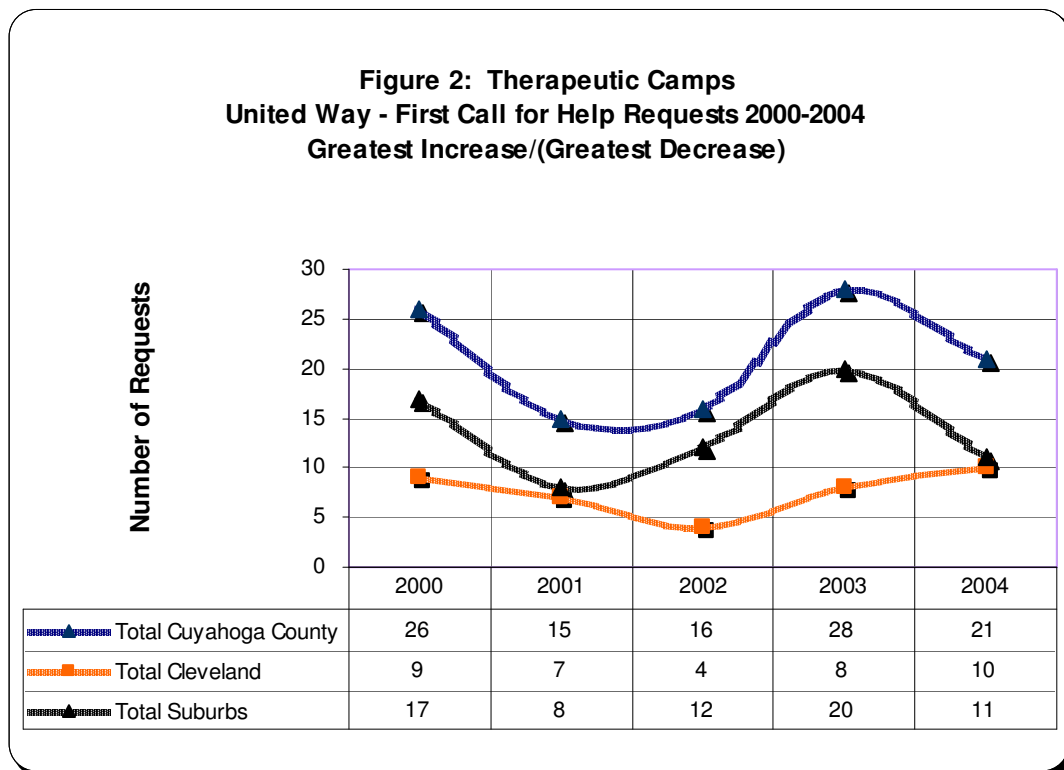
### **Short Term Programs**

Short-term programs usually do not maintain permanent base camps. In these programs, campers are usually evaluated and admitted at a central professional office. After orientation, they are then placed with a group of peers and transported to a wilderness location where they begin a wilderness trek with a team of adult leaders. Similar programming and therapy to those of the long-term camp are used in these programs. Therapy is based on the resolution of group problems by the group, as is the case with the long-term camps. Campers usually stay in these programs from 21 to 90 days.

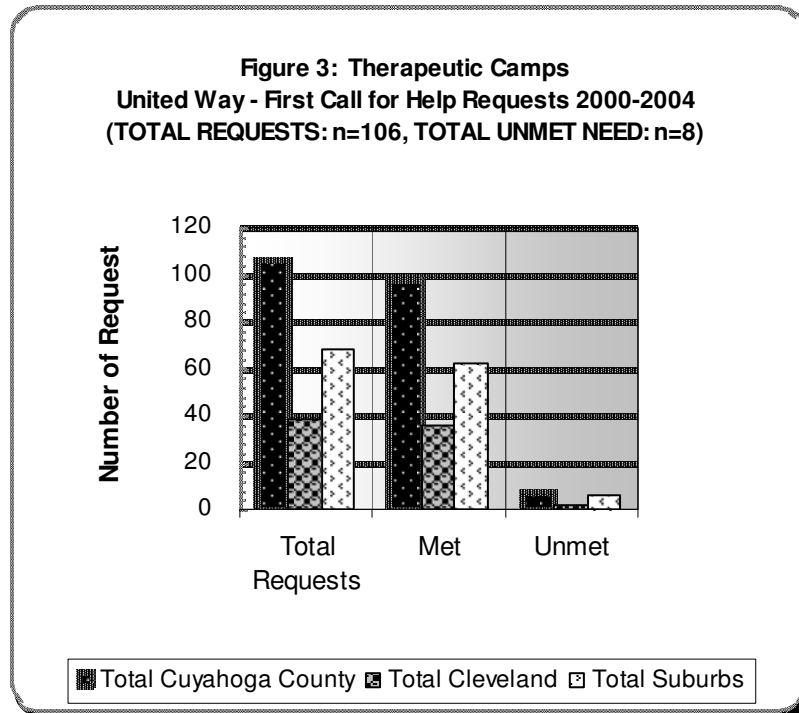
*United Way – First Call for Help Call Data*

Based on United Way - First Call for Help's (FCFH) database (2004), there are 12 therapeutic camp program providers operating from 16 different sites, 1 of which is government and 11 are nonprofit. (See Attachment 5 and 6.)

United Way - First Call for Help call data shows a fluctuation in the number of total requests for therapeutic camp programs in the county, with 26 calls in 2000 down to 21 in 2004—a 19 percent decrease. This decline has been primarily in the suburbs with a decrease of 35 percent. However, there has been an 11 percent increase from the City of Cleveland. (See Figure 2.) (See Attachment 7.)



Over the same five-year period, United Way - First Call for Help had 106 requests for information about therapeutic camps. Of these requests, they were able to make referrals to 92 percent of callers; however, some Cuyahoga County callers (8) had an unmet need, meaning there was no agency to which to refer the caller. Callers from the City of Cleveland had a 5 percent unmet need rate and from the suburbs, 9 percent. (See Figure 3 and Attachment 8.)



It must be noted that camps organized around a particular disease or disability may receive most of their referrals from medical specialists treating the disease.

## FUNDING OF CORE SERVICES

### *Major Government Funders*

Very little government funding is available for therapeutic camps. This same challenge has been true of most programs seen as recreational rather than educational. Recently, much of the funding contributed to youth development is focused on after-school programming, tutoring, or formal child care. Instead, the financial burden tends to fall on families that willingly save for summer camp experiences for their children. Camps may receive some government support services, such as reduced-cost meals for qualifying families, but the majority of the financial burden is borne by the individual or nonprofit organizations. The research for this core service report suggests that IDEA (Individuals with Disabilities Education Act) funding is available for therapeutic camps, but no such funding was specifically identified in Cuyahoga County.

Funding in the Cleveland area generally comes from local private contributions. In 2002, local foundations donated a combined total of \$17,000; in 2003, this rose to \$84,500; and in 2004, donations totaled \$115,500.

## IDENTIFIED REVENUES

As of May 11, 2006, \$128,500 in revenues for therapeutic camps has been identified countywide. Ninety percent of the revenues are from foundations. Another 10 percent is from federated organizations. United Way of Greater Cleveland does not currently fund therapeutic camps. (See Table 2.)

**Table 2: Annual Revenue for Core Services: Countywide and United Way of Greater Cleveland Therapeutic Camps Programs, 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)
Abington Foundation, The		50,000			
Deaconess Community Foundation		19,500			
Other Private Foundations - Not Elsewhere Classified		46,000			
<b>Total - Foundations &amp; Trusts</b>		<b>115,500</b>	<b>89.88%</b>	<b>0</b>	<b>N/A</b>
United Black Fund of Greater Cleveland		13,000			
<b>Total - Federated Fundraising Organizations</b>		<b>13,000</b>	<b>10.12%</b>	<b>0</b>	<b>N/A</b>
<b>Subtotal Non - UWGrCle Support</b>		<b>128,500</b>	<b>100%</b>	<b>0</b>	<b>N/A</b>
<b>Total Support/Revenue</b>		<b>128,500</b>	<b>100%</b>	<b>0</b>	<b>N/A</b>

**REIMBURSEMENT/COST**

Therapeutic camp fees range from \$75 to \$300 per week for day camps and \$201 to \$400 per week for resident camps. Nearly 65 percent of ACA-accredited camps offer some level of financial aid to over one million children from economically challenged families and who have special medical needs or special situations that might preclude them from attending camp.

Some disease specific camps, such as for diabetes, have had success with insurance coverage of camp fees; however, this is not widespread.

## V. WHAT WORKS; WHAT DOESN'T

### IMPACT ON INDIVIDUALS/FAMILIES

#### *What Works*

According to Michalski, et. al. (2003):

Over the past several decades, there has been phenomenal growth in the number and variety of camp programs offered to children and youth (Kelk, 1994; Schwartz, 1960). In addition to regular vacation summer camps, camping programs are used increasingly with specific population groups who have special medical, physical, or psychosocial needs or who are considered to be at risk (Byers, 1979; Kelk, 1994; Langdon & Kelk, 1994). These populations enjoy camping experiences either through camps established for individuals with special needs or, more recently, through integration into regular camps (Blake, 1996). The literature recognizes that summer camp programs offer participants valuable opportunities to grow and develop, as children and youth experience a range of psychological, social, emotional, and physical benefits (Byers, 1979; Kelk, 1994; Schwartz, 1960). The advantages consist of a return to nature and a break from life in the city, increased self-worth, improved relationships with both peers and adults, greater ability to take on responsibility, and better coordination and physical skills (Byers, 1979; Kelk, 1994; Levitt, 1994; Schwartz, 1960; Shasby, Heuchert, & Gansneder, 1984).

Kelk (1994) explains that camping programs designed as psychosocial interventions typically involve participants who have problems in new environments. A central component of these programs involves activities planned by staff to optimally challenge the participants. The process of meeting these challenges helps participants improve their self-esteem, sense of efficacy, social abilities and skills (Kelk, 1994; Kiewa, 1994; Tasse', 1978). The camp counselors utilize the social microcosm of the cabin groups and camp environment to promote beneficial changes (Berkovitz & Sugar, 1986; Vinter, 1965). The camp environment ideally provides the campers with positive and substantially different experiences from those that they typically encounter.

In the scant social work literature on camp and recreation programs, most writers agree both on their value as effective social work interventions and the lack of appreciation for their worth (Breton, 1990; Gentry, 1984; Marx, 1988; Redl, 1966). For example, Kelk (1994) has suggested that camping programs can be effective interventions for many client groups served by social workers. Davis-Berman and Berman (1989, p. 280) have argued that through environmentally based camp approaches, "the uniqueness of the person-in-situation truly comes forth, which serves to define and distinguish the social work profession from other professional groups."

The literature recognizes that some programs for individuals with special needs already exist that utilize outdoor adventure as the primary means through which

therapeutic goals are achieved (Davis-Berman & Berman, 1989; Marx, 1988). Yet systematic evaluations of these programs are elusive. For example, Marx (1988) highlighted the limitations of wilderness programs that do not offer counseling for teenagers with special needs, noting that regression can occur because of the likelihood that these teenagers may fail in traditional recreation programs. More commonly, the social work literature has simply emphasized programmatic approaches rather than systematic research to determine program effectiveness (Davis-Berman & Berman, 1989; Kiewa, 1994).

#### The National Camp Evaluation Project (NCEP)

The National Camp Evaluation Project (NCEP) was a three-year research study sponsored by the U.S. Department of Education and conducted by the Institute for Career and Leisure Development. The study focused on the camper's social/emotional and outdoor recreation skill dimensions (i.e. level of independence). Of the campers studied, the majority was mildly to severely disabled, with a single or combination of intellectual, physical, or sensory impairments, and ranged from ages 7 to 21. Most campers attended a one-week residential summer camping session. The study yielded the following conclusions that suggest that one-week residential camps contribute to the growth and development of children with disabilities (Brannan, Arick & Fullerton, 1997):

- Campers demonstrated high levels of enjoyment and participation in most activities and were affected positively by the camping experience independent of their age, disability, and level of functioning.
- Campers with more severe disabilities were able to perform recreation skills at relatively high levels of independence.
- Positive gains made in various areas of personal development such as communication, independence, and self-esteem carried over from the camp setting to the home and community setting.
- The combined results of all measures revealed that increased independence (or self-reliance) was the predominant outcome for the campers.

#### The National Inclusion Camp Practices Project (NICP)

The National Inclusion Camp Practices project (NICP) followed the NCEP (discussed above) and was conducted between 1997 and 2000 at more than ten accredited camps and two outdoor school sites that operate inclusion programs. Inclusion typically refers to accommodating persons with disabilities who participate in general public activities. Children at these camps represent a wide range of disabling conditions including mild mental retardation, speech impairment, learning disability, or attention deficit disorder (59 percent); autism or emotional disturbance (13.2 percent); physical or orthopedic, health, or brain injury impairment (11.2 percent); vision or hearing impairment (9.6 percent); and moderate to severe mental retardation (6.7 percent) (Brannan, Arick, Fullerton, Harris, 2000).

Like the NCEP, the NICP found that youth with and without disabilities achieved significant growth in both outdoor skills and personal development from attending a one-week residential camp. The inclusionary model was also found to benefit all youth. Youth both with and without disabilities improved their social interactions. Youth with disabilities improved their active interaction with their peers, which is a sign of successful integration, and youth without disabilities developed a greater understanding and respect for persons unlike themselves (Brannan et al., 2000).

Multiple inclusionary practices were employed at the camps studied. The most common practices used to assist children with disabilities were giving encouragement or motivational support (70.7

percent); modeling the activity (49.2 percent); granting the camper more time (40.8 percent); arranging for a peer to provide assistance (36.5 percent); and providing the camper with physical assistance (34.2 percent). These same forms of supports, specifically motivation and modeling, were also given to children without disabilities, although less frequently (Brannan et al., 2000).

Achieving an inclusionary program requires full and shared responsibility from all the program staff, both the general recreation staff and the therapeutic recreation staff. Klitzing (2002) contends that collaboration between these staffs will reduce barriers and yield successful inclusion. Specifically, the author contends that there must be parity among participants so that there is equal power in decision making; there must be a shared common goal, shared responsibility, and shared resources as well as shared accountability for both positive and negative outcomes.

### Therapeutic Methods

- *Reality/Choice Therapy.* The National Association of Therapeutic Wilderness Camps (NATWC) contends that many therapeutic wilderness camps rely on reality therapy (NATWC website). Reality/choice therapy is a therapeutic model developed by William Glasser, a Cleveland-born psychiatrist and founder of The William Glasser Institute (formerly the Institute for Reality Therapy, Control Therapy, and Quality Management). In contrast to Freud, Glasser argues that choice is not unconsciously motivated (Glasser 1965). Rather, Glasser believed that at any moment people are responding to meet one of their basic needs: love, power, fun, freedom, recognition, or survival. Reality therapy guides the patient to develop a well-defined and simple action plan that will improve his/her situation.

Howatt's 2001 article includes sample questions from Glasser's 2000 publication, *Reality Therapy in Action*:

- What do you want or what do you really want?
- What are you doing?
- What is your plan?
- What will happen if you continue to do what you are doing? (Howatt, 2001).

Once people realize that they have complete control over their actions then, Glasser believes, they are able to make the necessary changes (Howatt, 2001).

- *Brief Solution Focused Therapy.* Brief solution focused therapy (BSFT) is an alternative therapy model increasingly used in therapeutic wilderness camp settings. BSFT was pioneered by Steve de Shazer and his colleagues. Its basic tenet is that individuals possess the talents and resources needed to resolve their problems and the task of therapy will help them build on existing attempts to reach a solution (Lethem 2002). BSFT's relies on several components, including (Lethem, 2002):
  - Encouraging the individual or group to see existing signs of solution building so they notice that change is possible;
  - Exploring aspects of life an individual would want to continue regardless of other problems;
  - Ensuring that every stage is goal directed;
  - Acknowledging that there is a problem while the genesis and development of problems may not be analyzed in detail;
  - Eliciting examples of exceptions to the problem; and
  - Creating a picture of a preferred future without a problem.

## Recommended Practices and Policies for Therapeutic Camps

Recommended practices and policies for therapeutic camps include the following:

**Accessibility.** The passage of the Americans with Disabilities Act (ADA) provided broad nondiscrimination protection in employment, public services, public accommodation and services-operated private entities, transportation, and telecommunication for individuals with disabilities (Jones, 2005). With ADA's passage, the vast majority of outdoor recreation and outdoor education opportunities now must be accessible architecturally, programmatically, and technologically to persons with disabilities (Ross, 2000). In addition, the Individuals with Disabilities Education Act requires that all educational activities be accessible to those with disabilities.

Other actions taken by the federal government include a 1992 study conducted by the National Council on Disability to determine the extent to which persons with disabilities engaged and enjoyed National Wilderness Preservation System areas. A 1999 study dealt with access to federal lands for outdoor recreation for persons with disabilities (Ross, 2000).

**Background Screening.** An important aspect of any screening program is biometric-based criminal background checks for all staff and volunteers with access to children, youth, or vulnerable adults. For camps to implement effective biometric-based criminal background checks, a reliable federal program must be in place. ACA supports the establishment of a comprehensive federal biometric-based criminal background checking system that is reasonable in cost, timely in response, uniform in availability to camps across the country regardless of sponsorship, and consistent in the information provided according to identical pre-determined indicators of potentially harmful behavior.

**Safety.** The American Camp Association (ACA) actively promotes and supports camp safety. The Association provides camps and their leaders with well-tested programs and services that advance a continual improvement process that goes well beyond fundamental protection. For assurance of fundamental protection, ACA believes state governments are better able than the federal government to determine levels of care for organized camp operations. Furthermore, it believes that states should collaborate with non-governmental national organizations such as ACA to further advance a higher level of care and well-being during the camp experience.

Systems to assure care and well-being through regulation are most effective when linked to ongoing professional development programs that are continually updated to respond to new outcome-based accountability derived from current industry-specific, relevant research. As the extensive range of camps emerge within the camp industry, states are best equipped to respond to the geographic, environmental, cultural, recreational, and education diversity found across the country.

**Quality Checks.** An ongoing comprehensive improvement process that captures quality and best practice indicators must be integrated in order to truly meet the needs of the camper, camp families, camp professionals, and the camp experience. For a federal program to be viable, the ACA believes that states must mandate timely reporting of information held at the county level, provide both county and state data to the federal program in a timely manner, mandate that checks be done for all staff and volunteers with access to children, youth, and vulnerable adults, and provide assistance to camps in accessing the system in a timely and affordable manner. Furthermore, ACA advocates for the establishment of a coalition of agencies and associations with similar interests and concerns to promote a national response to this critical issue.

The camp counselor is the most important element a child encounters while attending an outdoor education program. No other element has greater potential therapeutic impact than the interpersonal relationship between the counselor and the child. Special programs have operated successfully under

very adverse conditions—lacking adequate facilities, materials and equipment, funds, sufficient numbers of personnel, transportation, and so on. However, no program is successful without counselors who interact positively and productively with children (Brannan, Arick & Fullerton, 1997).

Variables to be considered when grouping children are: age; sex; interests; handicapping conditions; personality characteristics; the degree, intensity, and kind of pathology; and group experiences and skills. Camp staff should consider these and other variables in respect to the individuals in the group. Camps should favor forming a “balanced” group and avoid extremes in group composition (Brannan, Arick & Fullerton, 1997).

Camp duration may impact whether camping is a successful experience for a child with a disability. Austin (1980) conducted an evaluative research study of two-week versus six-week camping experiences for boys with disabilities. In comparison to the two-week campers, six-week campers demonstrated greater improvement in self-esteem, relationships with others, personal and social behaviors, and general behaviors and attitudes.

#### *What Doesn't Work*

Constraints to the enjoyment of outdoor or camping activities tend to be either attitudinal or resource based. Attitudinal barriers stem from the attitudes of the camper or the facilitator. Resource barriers include finances, transportation, knowledge and skills, and functioning (Ross, 2005).

### **IMPACT ON COMMUNITY**

Community impact is difficult to determine for therapeutic camps as there is great variability in the length and frequency of participation. For instance, some therapeutic camps last only one or two days while others last up to ten hours per day for months. Little data is available about degrees of impact specific to the individual child and none for the impact on the community. However, therapeutic camps do often enable parents to continue their jobs while their children are not in school (generally the summer) or may enable them to have some respite from care giving knowing their children are being cared for under the supervision of qualified adults trained to work with children with special needs.

### **ACCREDITATIONS/STANDARDS/CERTIFICATIONS**

The American Camp Association (ACA) established camping standards that are recognized by courts of law and government regulators. The standards are periodically revised pending research in the public, legal, youth development, and camp arenas. ACA also offers accreditation to camps. The ACA will visit a camp at least once every three years so that an outside team of trained professionals can observe the camp while it is in session to verify compliance with ACA standards. The ACA has established over 300 camp standards for the following: site and food service; transportation, health care, management, staffing, and programs. Specifically, the ACA offers standards on staff to camper ratios, first aid facilities, and goals for campers that are developmentally based (ACA, n.d.).

Day camp programs that care for school age children for less than seven hours a day during public school vacations only, and with 50 percent of activities occurring outdoors, must be registered with the Ohio Department of Job and Family Services. If the program receives public funds, it must meet American Camping Association accreditation standards or be approved by the Ohio Department of Job and Family Services. Approximately 250 children's day camps register with the Ohio Department of Jobs and Family Services each year. However, Ohio does not require day camps operated by city or county park districts or recreation departments to register with the State Department of Job and Family Services



The Council on Accreditation (COA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredit some therapeutic wilderness camps. The National Association of Therapeutic Wilderness Camps also offers wilderness counselor certification.

The National Council for Therapeutic Recreation Certification is a nationally recognized credentialing organization for the profession of therapeutic recreation.

## **VI. GAP ANALYSIS**

As discussed in Section III of this report, a conservative estimate of 14,245 persons could need therapeutic camps, which is the estimate of persons between the ages of 5 and 15 with one or more disabilities. No information was available from funders regarding how many consumers between the ages of 5 and 15 have realized access to therapeutic camp programs. Due to the lack of available information, it is not possible to conduct a meaningful analysis.

## VII. SUMMARY

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

- There are numerous camping opportunities for the disabled populations. Most of the mainstream camps that serve disabled campers tend to include campers considered to be mildly disabled. In 2003, an American Camp Association study found that up to 15 percent of camps are dedicated to meeting the special needs of campers with physical, emotional, or mental challenges.
- With the passage of the Americans with Disabilities Act, the vast majority of outdoor recreation and outdoor education opportunities now must be accessible architecturally, programmatically, and technologically to persons with disabilities.
- Ohio's minimum wage law, which passed in November of 2006 and increases the minimum wage from \$5.15 to \$6.85, has been affected by another law, passed in December 2006, which exempts youth workers and camps. However, the constitutionality of the exemption may be challenged which would have significant impact on salary expenses of camps.
- Very little government funding has been made available for therapeutic camps.
- In 2002, local foundations donated a combined total of \$17,000 for therapeutic camps; in 2003, this rose to \$84,500; and in 2004 donations totaled \$115,500.
- As of May 11, 2006, \$128,500 in revenues for therapeutic camps has been identified countywide.
- No program is successful without counselors who interact positively and productively with children.
- Camps should favor forming a "balanced" group and avoid extremes in group composition.
- Camp duration may impact whether camping is a successful experience for a child with disabilities.
- Constraints to the enjoyment of outdoor or camping activities tend to be attitudinal or resource based.
- A conservative estimate of 14,245 persons could need therapeutic camps. Due to the lack of available information, it is not possible to conclude a meaningful gap analysis.

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## ATTACHMENTS

### Attachment 1: Researcher List

# MCS

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## Attachment 2: Technical Notes

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

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

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

#### Unit of Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Funding Information for Core Services**

We collected financial information for each core service on a countywide level from multiple sources including major government funders, foundations, federated fund raising organizations, and United Way of Greater Cleveland. While we were successful in gathering a substantial amount of data, there is much that has not been collected. It must also be noted that even if we had all major public and private funding gathered, this would not create a total picture of health and human service funding in

Cuyahoga County because there are more than 80 core services provided. The following provide highlights of data collected and some of the limitations for each source. It is important to note that funding in each source is changing and represents point in time amounts. The typical period for trend data, when available, is 2002, 2003, and 2004. Note: some services are funded by private insurance or other self-pay arrangements.

#### *Foundation Funding*

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

#### *Federated Funding Sources*

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

#### *Government Funding*

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

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

In other cases, it was not possible to select a specific core service. An example is Medicaid in which Medicaid-defined services crossed over more than four core services in some instances. In cases where Medicaid is a significant source of revenue, the data was entered as an aggregate total at the appropriate AIRS level. These aggregates are footnoted under the appropriate funding table.

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

#### *Medicaid Funding*

A significant portion of Medicaid funding was NOT entered under the countywide total in the core service reports for two reasons: first, because many of the Medicaid services are not a one-to-one match with United Way core services, and second because some Medicaid services fall into more

than one AIRS Level 1 categories. In the first instance, Medicaid funding was entered as an aggregate total at the AIRS 1 level, and in the second instance Medicaid funding was entered as an aggregate total under Third Party Payee/Direct Bill in the combined Master Revenue file of funding across all nine AIRS Levels. They are as follows:

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

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

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

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

*United Way of Greater Cleveland Funding*

Financial data for core services funded by United Way of Greater Cleveland was for FY 2004 (July 2003 to June 2004). It included allocations through the community investment committees and donor designations that United Way funded agencies applied to the respective core services. It is important to note that not all United Way funded agencies applied donor designated gifts, which are unrestricted, to the core service for which they receive United Way funding. It did not include donor designations that non-United Way funded agencies used for any of the 80 core services.

*United Way Agency Revenues*

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

### **Consumer and Financial Data: Caveats**

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

#### *All Core Services*

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

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

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

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

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

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

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

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

- *Estimate of persons in need of the service:* Unless local research was conducted to determine need for a given service, this estimate was obtained by either using U.S. Census data for

Cuyahoga County or applying percentages from national studies and reports to the census data. All references and percentages are footnoted in the respective graphs or tables. In most cases this percentage was also applied to actual 1990 Census figures and population projections 2005 through 2015 that were done by the Ohio Department of Development.

- *Estimate of number of ACTUAL consumers in the public systems (realized access):* Data submitted to United Way by funded agencies was aggregated to determine the number of consumers for each core service. The period was FY 2004, which is July 2003 through July 2004.
  - In some cases data was “unknown,” defined as data not collected by agency because no tracking system was available or the type of service delivered made it difficult (i.e., group presentations, telephone information and referral, and drop-ins). This also represents data not completed by consumers either deliberately or inadvertently on intake forms.
  - In other cases, data was missing that, for United Way data, represented computational errors or incorrect completion of online reports. For all other data, “missing” represents data funders/providers were unable to provide.
  - There was no check of the accuracy of data submitted by agencies.
  - Major government funders were asked to provide information about the number of consumers for the respective core services that they funded. In most cases, services were not defined in the same way as the United Way core services which are based on the Alliance for Information and Referral Systems (AIRS) taxonomy. To accommodate these differences, customized crosswalks were developed.
  - We assumed that the numbers of consumers across funding sources were not unduplicated and thus made a judgment about which numbers would be the best estimate of an unduplicated number.
  - The estimate of consumers is not inclusive since it does not include numbers of consumers who use their personal resources to pay for services, nor for other private resources such as insurance or agency fundraising. In addition, it was not always possible to obtain information from some government funders.
- *Estimate of number of “unknown/non-consumers”:* This is the difference between the estimated number of actual consumers and the estimate of persons in need.
- *Estimate of number of “would-be users” (unrealized access):* This is the estimate of persons who would use a service if it were available, typically based on research.
- *Estimate of number of “never users”:* This is the difference between the estimated number of unknown/non-consumers and would-be users.
- *Estimate of “universe of possible consumers”:* This is the total of those actually receiving the service (realized access) and those would-be users (unrealized access).

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

The numbers we provided are on a countywide level. We recognize that there could be, and often are, differences by demographics and geographical area. In the Actual Consumer Demographics attachment, we have identified the profile of the base consumer group from census, but have little on the estimated persons in need. Occasionally, there is information from other research that describes differences among different racial, ethnic, gender, age, or income groups that is discussed in the narrative. There is also inconsistent information for consumers funded by various governmental

bodies. In other words, some funders provided demographic data and others did not. In the Actual Consumer Zip Codes attachment, we have also attempted to identify the geographic profile of the estimated persons in need and actual consumers. However, this information has the same limitations as the demographics.

### **Service Site Index**

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

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

### **Specific Service Issues**

#### *Senior Services*

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

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

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

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## 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: Therapeutic Camps PL-640.150-85				
			Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****
	Total Population (%)*	Total Population 5-15 (%)**	Population 5-15 with One or More Disabilities (%)***	UW Program Report Data Cuy Cnty Only N/A% (%)
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>219,525</b>	<b>14,245</b>	<b>N/A</b>
<b>Percent</b>		<b>15.7%</b>	<b>6.5%</b>	
<b>GENDER</b>				
Male	47.2%	51.3%	61.7%	N/A
Female	52.8%	48.7%	38.3%	N/A
Unknown Data*****				N/A
Missing Data*****				N/A
<b>RACE*****</b>				
White alone	67.1%	57.7%	49.9%	N/A
Black or African American alone/combo	27.9%	36.8%	43.9%	N/A
Asian alone/combo	2.1%	1.8%	0.8%	N/A
American Indian and Alaska Native alone/combo	0.7%	0.8%	1.5%	N/A
Native Hawaiian and Other Pacific Islander alone/combo	0.1%	0.0%	0.0%	N/A
Some other race alone/combo	2.1%	2.9%	3.8%	N/A
Unknown Data*****				N/A
Missing Data*****				N/A
<b>HISPANIC*****</b>	3.3%	4.7%	7.4%	N/A
<b>AGE</b>				
0-4	6.5%			N/A
5-9	7.3%	46.3%	N/A	N/A
10-14	7.1%	45.2%	N/A	N/A
15-19	6.4%	8.5%	N/A	N/A
20-34	19.1%			N/A
35-54	29.3%			N/A
55-64	8.7%			N/A
65-74	7.8%			N/A
75+	7.8%			N/A
Unknown Data*****				N/A
Missing Data*****				N/A
<b>INCOME*****</b>				
<b>Average Household Size</b>	<b>2.4</b>	<b>N/A</b>	<b>N/A</b>	
\$0-\$9,999	11.3%	11.3%	11.3%	N/A
\$10,000-\$14,999	6.9%	6.9%	6.9%	N/A
\$15,000-\$19,999	6.7%	6.7%	6.7%	N/A
\$20,000-\$29,999	13.6%	13.6%	13.6%	N/A
\$30,000 and above	61.5%	61.5%	61.5%	N/A
Unknown Data*****				N/A
Missing Data*****				N/A
<b>Totals</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>N/A</b>

Attachment 3: Actual Consumer Demographics (continued)

* U.S. Census SF1 (P1); SF4 (PCT 144)
** U.S. Census 2000 SF3 (P8); SF4 (PCT3); SF4 (PCT144)
*** U.S. Census 2000, SF1 (PCT26), SF4 (PCT69)
****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: Therapeutic Camps PL-640.150-85					
				Estimated Persons in Need	Actual Number/Percent of Consumers by Funding Source ****
	City/Town (% Cleveland)	Total Population (%)*	Total Population 5-15 (%)**	Population 5-15 with One or More Disabilities (%)***	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>219,525</b>	<b>14,245</b>	<b>N/A</b>
			<b>15.7%</b>	<b>6.5%</b>	
44017	Berea	1.4%	1.1%	1.4%	N/A
44022	Bentleyville	1.3%	0.8%	0.7%	N/A
44040	Gates Mills/Mayfield Village	0.2%	0.2%	0.1%	N/A
44070	North Olmsted	2.4%	2.3%	1.7%	N/A
44101	Cleveland (100%)	0.0%	0.0%	0.0%	N/A
44102	Cleveland/Brooklyn (95%)	3.7%	4.4%	8.2%	N/A
44103	Cleveland (100%)	1.8%	2.4%	3.0%	N/A
44104	Cleveland (100%)	2.1%	3.1%	3.9%	N/A
44105	Cleveland/NewburghHts/ GarfieldHts	3.9%	4.9%	6.1%	N/A
44106	Cleveland/Cleveland Hts (60%)	2.3%	1.8%	2.2%	N/A
44107	Lakewood/Cleveland	4.0%	3.3%	3.1%	N/A
44108	Cleveland/Bratenahl (90%)	2.6%	3.4%	4.4%	N/A
44109	Cleveland/Brooklyn Hts (98%)	3.3%	3.5%	6.1%	N/A
44110	Cleveland/East Cleveland (98%)	1.9%	2.3%	2.2%	N/A
44111	Cleveland (100%)	3.1%	2.9%	2.5%	N/A
44112	East Cleveland/Cleveland	2.4%	2.9%	2.7%	N/A
44113	Cleveland (100%)	1.4%	1.2%	1.9%	N/A
44114	Cleveland (100%)	0.3%	0.1%	0.2%	N/A
44115	Cleveland (100%)	0.6%	0.7%	0.7%	N/A
44116	Rocky River	1.5%	1.3%	0.7%	N/A
44117	Euclid/Cleveland	0.9%	0.7%	0.8%	N/A
44118	ClevelandHts/UniversityHts/	3.2%	3.1%	2.8%	N/A
44119	Cleveland/Euclid (50%)	1.0%	0.8%	0.5%	N/A
44120	Shaker Hts/Cleveland	3.4%	3.8%	4.1%	N/A
44121	University Hts/South Euclid	2.5%	2.5%	2.7%	N/A
44122	Beachwood/Highland	2.5%	2.5%	1.7%	N/A
44123	Euclid	1.3%	1.2%	0.6%	N/A
44124	Pepper Pike/MayfieldHts/Lyndhurst	2.9%	2.1%	1.6%	N/A
44125	Valley View/Garfield Hts	2.1%	2.0%	1.4%	N/A
44126	Fairview Park/Cleveland	1.2%	1.1%	0.2%	N/A
44127	Cleveland (100%)	0.6%	0.9%	1.9%	N/A
44128	Warrensville Hts/Cleveland	2.4%	2.4%	2.3%	N/A
44129	Brooklyn/Parma/Cleveland	2.1%	1.9%	2.0%	N/A
44130	Parma/Cleveland	3.8%	2.9%	2.1%	N/A
44131	Independence/Seven	1.5%	1.2%	0.7%	N/A
44132	Euclid	1.1%	1.0%	1.0%	N/A
44133	North Royalton	2.0%	2.1%	1.3%	N/A
44134	Parma/Cleveland	2.9%	2.6%	2.1%	N/A
44135	Cleveland/Linndale (90%)	2.0%	2.0%	2.5%	N/A
44136	Strongsville	3.1%	3.4%	2.4%	N/A
44137	Maple Hts/Cleveland	1.9%	2.0%	1.9%	N/A
44138	Olmsted Twp/Olmsted Falls	1.3%	1.3%	0.8%	N/A
44139	Bentleyville/Glenwillow/Solon	1.6%	2.1%	1.3%	N/A
44140	Bay Village	1.1%	1.2%	0.8%	N/A
44141	Brecksville	1.0%	0.9%	0.5%	N/A
44142	Brookpark/Cleveland	1.5%	1.4%	1.3%	N/A
44143	Highland Hts/Richmond Heights	1.7%	1.6%	0.8%	N/A
44144	Brooklyn/Cleveland	1.6%	1.2%	1.1%	N/A
44145	Westlake	2.3%	2.2%	1.7%	N/A
44146	Walton Hills/Oakwood/Bedford	2.3%	2.0%	2.9%	N/A
44147	Broadview Hts	1.1%	1.1%	0.3%	N/A
44149	Strongsville	0.0%			N/A
	Unknown Cuyahoga County Zip Codes*****				N/A
	Missing*****				N/A
	Unknown *****				N/A
	<b>Total Cuyahoga County*****</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>N/A</b>
	<b>Total Known Cleveland</b>	<b>30.5%</b>	<b>34.6%</b>	<b>46.4%</b>	<b>N/A</b>
	<b>Total Known Suburbs</b>	<b>69.5%</b>	<b>65.4%</b>	<b>53.6%</b>	<b>N/A</b>
	<b>Unknown &amp; Missing</b>				<b>N/A</b>

Attachment 4: Actual Consumer Zip Codes (continued)

* U.S.Census 2000, SF1 (P1)
** U.S.Census 2000, SF3 (P8)
*** U.S. Census 2000, SF3 (PCT26)
**** 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**

<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
Total Number of Providers	12	-
Number of Providers by Type		
Nonprofit	11	-
For-profit	-	-
Government	1	-
Other	-	-
Total Number of Sites	16	-
Number of Service Sites per Provider		
1	10	-
2 – 5	2	-
6 – 10	-	-
11+	-	-
Geographical Location of Service Sites, by ZIP Code		
44017 - Berea	1	-
44022 - Bentleyville	-	-
44040 - Gates Mills/Mayfield Village	-	-
44070 - North Olmsted	-	-
44101 - Cleveland	-	-
44102 - Cleveland/Brooklyn	1	-
44103 - Cleveland	-	-
44104 - Cleveland	1	-
44105 - Cleveland/Newburgh Hts/Garfield Hts	-	-
44106 - Cleveland/Cleveland Hts	2	-
44107 - Lakewood/Cleveland	1	-
44108 - Cleveland/Bratenahl	-	-
44109 - Cleveland/Brooklyn Hts	-	-
44110 - Cleveland/East Cleveland	-	-
44111 - Cleveland	-	-
44112 - East Cleveland/Cleveland	-	-
44113 - Cleveland	1	-
44114 - Cleveland	-	-
44115 - Cleveland	2	-
44116 - Rocky River	-	-
44117 - Euclid/Cleveland	-	-
44118 - ClevelandHts/UniversityHts/ShakerHts	-	-
44119 - Cleveland/Euclid	-	-
44120 - Shaker Hts/Cleveland	-	-
44121 - University Hts/South Euclid	-	-
44122 - Beachwood/Highland Hills/Shaker Hts.	2	-
44123 - Euclid	-	-
44124 - Pepper Pike/Mayfield Hts./Lyndhurst	1	-
44125 - Valley View/Garfield Hts	-	-
44126 - Fairview Park/Cleveland	-	-
44127 - Cleveland	-	-

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
44128 - Warrensville Hts/Cleveland	-	-
44129 - Brooklyn/Parma/Cleveland	-	-
44130 - Parma/Cleveland	1	-
44131 - Independence/Seven Hills/Brooklyn Hts	-	-
44132 - Euclid	-	-
44133 - North Royalton	-	-
44134 - Parma/Cleveland	-	-
44135 - Cleveland/Linndale	-	-
44136 - Strongsville	3	-
44137 - Maple Hts/Cleveland	-	-
44138 - Olmsted Twp/Olmsted Falls	-	-
44139 - Bentleyville/Glenwillow/Solon	-	-
44140 - Bay Village	-	-
44141 - Brecksville	-	-
44142 - Brookpark/Cleveland	-	-
44143 - Highland Hts/Richmond Heights	-	-
44144 - Brooklyn/Cleveland	-	-
44145 - Westlake	-	-
44146 - Walton Hills/Oakwood/Bedford	-	-
44147 - Broadview Hts	-	-
44149 - Strongsville	-	-

**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>
Achievement Centers For Children	Full-Day Camp For Children With Disabilities, Residential Camp - Children With Autism, PDD-NOS, Asperger's, Day Camp/Occupational Therapy For Children, Residential Camp For Disabilities
American Sickle Cell Anemia Assn.	Camping - Youth With Sickle Cell Disease
Berea Children's Home And Family Services	Summer Day Camp Respite
Catholic Charities Health And Human Services - Disability Services	Day Camps For Children With Mental Retardation
Cleveland Clinic Children's Hospital For Rehabilitation	Camping Program
Diabetes Assn. Of Greater Cleveland	Residential Camp, Mini Day Camp For Children With Diabetes
Help Foundation	Educational Activities For Mr/Dd Youth - Summer Program
Kidney Foundation Of Ohio	Patient Assistance
Muscular Dystrophy Assn. National Headquarters	Summer Camp
Orange City School District	Recreation - Camping Programs
Professional Flair/Dancing Wheels	Personal Enrichment Classes - Dance/Theater
United Cerebral Palsy Assn. Of Greater Cleveland	Summer Day Camp

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

**Attachment 7: United Way - First Call for Help Therapeutic Camps Requests – 2000-2004:  
Greatest Increase/Greatest Decrease**

<b>PL-640.150-85 Therapeutic Camps</b>								
<b>United Way - First Call for Help Requests 2000-2004</b>								
<b>Greatest Increase/(Greatest Decrease)</b>								
Zip Code		TOTAL REQUESTS					%Change* 00&04	Avg. # Calls 00-04
		2000	2001	2002	2003	2004		
44108	Cleveland/Bratenahl	1	5	0	4	3	200%	3
44135	Cleveland/Linndale	0	0	0	1	3	N/A	1
44123	Euclid	0	0	1	1	2	N/A	1
44117	Euclid/Cleveland	0	0	0	0	2	N/A	N/A
44070	North Olmsted	0	0	0	0	1	N/A	N/A
44124	Pepper Pike/MayfieldHts/Lyndhurst	0	0	0	0	1	N/A	N/A
44120	Shaker Hts/Cleveland	0	0	1	1	1	N/A	1
44136	Strongsville	0	0	1	0	1	N/A	N/A
44145	Westlake	0	0	0	0	1	N/A	N/A
44122	Beachwood/Highland Hills/ShakerHts	2	0	0	5	0	(100%)	1
44022	Bentleyville	1	0	0	0	0	(100%)	N/A
44129	Brooklyn/Parma/Cleveland	1	0	0	0	0	(100%)	N/A
44111	Cleveland	1	1	1	0	0	(100%)	1
44115	Cleveland	1	0	0	0	0	(100%)	N/A
44109	Cleveland/Brooklyn Hts	1	0	0	0	0	(100%)	N/A
44118	ClevelandHts/UniversityHts/ShakerHts	3	0	0	1	0	(100%)	1
44131	Independence/Seven Hills/BrooklynHts	3	0	0	0	0	(100%)	1
44134	Parma/Cleveland	1	0	0	0	0	(100%)	N/A
44125	Valley View/Garfield Hts	3	0	0	0	0	(100%)	1
44128	Warrensville Hts/Cleveland	1	0	3	0	0	(100%)	1
44110	Cleveland/East Cleveland	2	0	1	0	1	(50%)	1
	<b>**Total Cuyahoga County</b>	<b>26</b>	<b>15</b>	<b>16</b>	<b>28</b>	<b>21</b>	<b>(19%)</b>	<b>21</b>
	<b>**Total Cleveland</b>	<b>9</b>	<b>7</b>	<b>4</b>	<b>8</b>	<b>10</b>	<b>11%</b>	<b>8</b>
	<b>**Total Suburbs</b>	<b>17</b>	<b>8</b>	<b>12</b>	<b>20</b>	<b>11</b>	<b>(35%)</b>	<b>14</b>
* Extremely high percentages are due to low numbers.								
** These totals do not reflect the sum of the numbers above which are the zip codes reflecting the greatest increase or decrease. Rather, they are the total of calls from ALL zip codes many of which do not appear on this table.								

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

<b>PL-640.150-85 Therapeutic Camps</b>					
<b>United Way - First Call for Help Requests 2000-2004</b>					
<b>Unmet Need</b>					
<b>Zip Code</b>		<b>TOTALS 00-04</b>			<b>%</b>
		<b>Requests</b>	<b>Met</b>	<b>Unmet</b>	<b>Unmet</b>
44106	Cleveland/Cleveland Hts	1	0	1	100%
44144	Brooklyn/Cleveland	3	2	1	33%
44122	Beachwood/Highland Hills/ShakerHts	7	5	2	29%
44110	Cleveland/East Cleveland	4	3	1	25%
44123	Euclid	4	3	1	25%
44107	Lakewood/Cleveland	5	4	1	20%
44121	University Hts/South Euclid	7	6	1	14%
<b>* Total Cuyahoga County</b>		<b>106</b>	<b>98</b>	<b>8</b>	<b>8%</b>
<b>* Total Cleveland</b>		<b>38</b>	<b>36</b>	<b>2</b>	<b>5%</b>
<b>* Total Suburbs</b>		<b>68</b>	<b>62</b>	<b>6</b>	<b>9%</b>
<b>FCFH DATA NOTES</b>					
<p><b>Met</b> = service request resulting in referral to an organization. (Does not mean agency was able to provide the service.)</p> <p><b>Unmet</b> = service request for which there was no referral.</p> <p><b>Note:</b> Zip Codes shared by Cleveland and surrounding suburbs whose boundaries fall 50% and greater within the city of Cleveland are highlighted and totaled as Cleveland. Others are totaled as Suburbs.</p> <p>* These totals do not reflect the sum of the numbers above which are the zip codes reflecting unmet need in 2004. Rather, they are the total of calls from ALL zip codes some of which do not appear on this table.</p>					



**United Way of  
Greater Cleveland**

1331 Euclid Avenue  
Cleveland, Ohio 44115

[uws.org/CoreServicesPlanning](https://uws.org/CoreServicesPlanning)