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National Eldercare System Project: A National Study Comparing Successful Community-based Systems of Care for Older People

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Human Services Development Institute

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Graduate Program in Public Policy and Management

Human Services Development Institute

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The National Eldercare Systems Project:
A National Study Comparing Successful
Community-Based Systems of Care for Older People

Final Report

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Project Abstract

The purpose of this project was to compare three different models of building and strengthening community-based systems of care for older adults. Models were distinguished by the type of organization that took the lead in developing the system of services: Area Agency on Aging, acute care hospital, and residential facility. Specific questions addressed in this project were: (1) What conditions in a local community give rise to a community-based system of care (CBSC) for older adults? (2) What are the necessary steps in planning and designing CBSCs? (3) How are successful CBSCs established and maintained? (4) How does the type of lead organization influence a CBSC's accessibility, responsiveness, and effectiveness? (5) To what extent and under what conditions can successful CBSCs be replicated? Answers to these questions were meant to assist leaders in new communities wishing to develop CBSCs for older adults in their own locales.

Organizations were selected through a screening process involving mailed questionnaires completed by candidates referred to the project team because of their reputations as successful CBSCs. Questionnaires were designed to measure accessibility (provision of services to all types of older adults), responsiveness (development of new services in response to community needs), and effectiveness (capacity to monitor service impact on client well-being). A total of 15 organizations from as many states were selected for three-day site visits, including five of each type of lead organization.

Regardless of geographic location or type of lead organization, key ingredients that gave rise to CBSCs were: individuals with strong visions of a "continuum of care" for older adults; service gaps or fragmentation; local political support for service expansion; and availability of funding from public or private sectors. Planning and design processes were found to be influenced much more by intuition and opportunism than by elaborate data collection and analysis. Successful CBSCs were established and maintained by: retaining key staff for long periods of time; diversifying funding sources; continuing to introduce new services, especially case management; sustaining political support; and effectively managing the expanding range of services. Service decentralization was the strategy used most often by lead organizations to maximize accessibility of their CBSCs. AAAs used public hearings and Advisory Councils to elicit unmet needs for enhancing responsiveness, while hospitals and residential CBSCs responded to needs expressed by individuals desiring alternatives to their core services. To maximize effectiveness, AAAs relied most on contracting protocols while hospitals and residential CBSCs relied most on record reviews. Client feedback was commonly obtained, but automated client tracking systems were not highly developed.

Implications of findings focused on conditions facilitating replication of successful CBSCs, and seven recommendations described steps the Aging Network should take to encourage development of CBSCs at the local level.

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EXECUTIVE SUMMARY

I.   INTRODUCTION

Comprehensive and coordinated community based systems of care for older adults have been established in many areas of the United States in recent years. These systems seek to assure the delivery of accessible, responsive and effective health and social services in ways that enhance opportunities for older persons to live independent and dignified lives in their own communities.

Until now little has been known about how these systems of community based care are initiated, developed, and maintained. While various aspects of service improvement and coordination for local older populations have been studied in the recent past--the National Long-Term Care Channeling Demonstration and its evaluation, the Medicaid 2176 waiver programs now operating in 41 states, together with the Section 222 and Section 1115 Medicaid waiver demonstrations of the 1970s-- no comprehensive systematic inquiry into the methods and mechanics of community-wide system development has been conducted on a national scale.

This two year comparative case study, the National Eldercare Systems Project, examined how successful community based systems of care are developed and maintained. The goal of this research was to inform the introduction or enhancement of eldercare systems in other locales. The unique perspective adopted by this project was a clear focus on service and planning organizations which took the initiative in their communities to build a service system for older adults. Three different types of lead organizations were selected for study because of their propensity to serve older adults -- Area Agencies on Aging (AAAs), hospitals, and residential facilities. By detailing the evolution of three specific types of successfully-developed systems, findings should have direct relevance to nearly any local community wishing to build its own system or systems of care for older Americans. Findings can also help the Aging Network--the U.S. Administration on Aging, State Units on Aging, Area Agencies on Aging--establish policies and take appropriate action to foster replication on a broad scale.

Specific questions addressed in this project include:

o What conditions, factors, and arrangements in a community give rise to a community-based system of care (CBSC) for older adults?

o What are the necessary steps in planning and design?

o How are successful CBSCs established and maintained?

o How does the type of lead organization influence and reflect a system's accessibility, responsiveness and effectiveness?

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o To what extent and under what conditions can CBSCs be replicated?

Some of the systems selected for study are located entirely within single organizations. Others consist of many separate organizations operating in tightly or loosely orchestrated relation to one another, with some degree of accountability to the lead organization. Variation in the means used to create and manage many service components by a single organization is was a matter of considerable interest in this research.

Systems selected for study offer the promise of serving as models for replication. The project team developed "success criteria" as guidelines to the selection of AAAs, hospitals, and residential facilities. Systems were chosen because the screening process indicated they were:

o <u>Accessible</u>--services are available to all kinds of older persons, based on need and level of functional independence. People from a broad range of income levels are served. Where poor, minority or rural area populations are included in the catchment area, vigorous efforts are made to reach and serve them.

o <u>Responsive</u>--a broad array of services, accommodating variations in the nature and degree of functional independence among older adults and changes in their functional capacity over time.

o <u>Effective</u>--attention to client outcomes and commitment to quality assurance enjoy high priority among leaders and decisionmakers.

For purposes of this study, therefore, successful community-based systems are those that provided a broad array of health and social services to older people regardless of socioeconomic background or setting of care. Further, these systems exhibited a commitment to effectiveness in the delivery of these services--a well defined approach to quality assurance as well as an effort to track clients across a range of services they may use over time.

II. METHODOLOGY

The unit of analysis for this research was an organization located in a local community which has built a system of care for older adults. While many influences outside the community affect the development of comprehensive systems, in the end services are delivered by organizations within communities.

Three major steps were followed in our study methodology in order to answer the specific research questions:

Step 1.   Identify successful community-based systems of care.

Once a typology of systems based on lead organization was established, the task was to select strong candidates from each system type. National associations representing AAAs, hospitals, and residential facilities, and other experts in the field were invited to nominate potential study-sites. Nominated sites were contacted and asked to complete questionnaires defining and describing their histories, range and volume of services, funding sources, geographical and socioeconomic contexts, and management systems. These screening questionnaires included items used to measure accessibility, responsiveness, and effectiveness of service systems in a standardized fashion. Sites returning questionnaires were subsequently contacted by telephone, and additional documents were assembled and analyzed from each candidate system. The project team developed draft recommendations for a field of 15 study-sites--five from each type. Final decisions were reached with the aid of a National Advisory Panel.

The final field of 15 study sites emerged from this process. Their selection was based on evidence of their accessibility, responsiveness, and effectiveness. These study sites were:

AAA Agency on Aging (AAA) sites:

Aroostook AAA, Presque Isle, Maine
Atlanta Regional Commission and AAA, Atlanta, Georgia
Region IV AAA, St. Joseph, Michigan
First Tennessee AAA, Johnson City, Tennessee
Monterey County AAA, Salinas, California

Hospital sites:

Greater Southeast Community Center for the Aging, Washington, D.C.
Parkside Senior Services, Lutheran General Hospital, Arlington Heights,
    Illinois
Good Samaritan Hospital, Portland, Oregon
Parkland Memorial Hospital, Dallas, Texas
Craven Regional Medical Center, New Bern, North Carolina

Residential sites:

Miami Jewish Home and Hospital for the Aged, Miami, Florida
Eddy Memorial Geriatric Center, Troy, New York
Otterbein Homes, Lebanon, Ohio
Ebenezer Community Services, Minneapolis, Minnesota
Handmaker Jewish Geriatric Services, Inc., Tucson, Arizona

Step 2:   Identify the features and characteristics associated with the
           development and operations of successful systems.

Members of the project teams visited each study site for a three-day period to conduct semi-structured interviews with key informants within and outside the AAA, hospital, or residential facility. The project team also reviewed documents and additional data supplied by study sites. Based on results from field research and document review, site reports and case reports were written to enable the project team to describe each study-site and make systematic cross-site comparisons.

Step 3:   Develop findings and conclusions concerning the replicability of
           successful programs and propose recommendations regarding
           nationwide dissemination.

At three distinct stages during the project, the team analyzed site and case reports to develop draft findings, which were then tested during subsequent stages in the research. The team's preliminary findings were reviewed by the National Advisory Panel, which also offered many useful suggestions for the content, organization, and presentation of findings in the final report.

III. STUDY FINDINGS

Results of systematic comparisons across study sites are arranged according to the five research questions guiding this inquiry. The sequence of the first three research questions parallels the evolution of CBSCs from origin through maintenance and continued growth, while the fourth considers strategies for success used by each type of lead organization. The fifth question, dealing with replication elsewhere, is addressed in the section of this report highlighting implications of findings.

1.   What conditions, factors, and arrangements in a community give rise to
      CBSCs for older adults?

The 15 study sites included AAAs, hospitals, and residential facilities located in a wide range of communities--including inner city, suburban, and rural--in all geographic regions of the United States. Regardless of location or socioeconomic profile of older adults in the community, certain key ingredients were present when lead organizations began building their CBSCs for older adults. These ingredients included:

o one or a few individuals with a highly developed vision of a "continuum of care" for the older population, and a strong sense of their organization's role in the continuum;

o either a service vacuum or service fragmentation, indicating several missing services or unrelated organizations delivering single services to older adults without communicating with one another;

o local political support for development/expansion of services to the older population; and

o access to new sources of funding from either the public or private sector, or both.

In the five **AAAs** studied, persons with the visions of a continuum of care were either the first or second Executive Directors hired in the mid 1970s or early 1980s. All but one of these Executive Directors were still at the helm during this study, which demonstrates the importance of tenure in CBSC building and strengthening. AAAs serving mostly rural areas were faced primarily with service vacuums, while urban AAAs viewed service fragmentation as a barrier to system building. Free-standing AAAs gained local support by carefully establishing Boards of Directors and Advisory Councils to help implement the organization's mission, while county or district-supervised AAAs maintained or secured political support by strongly advocating for aging issues with pragmatic strategies before elected officials. The most common new funding source for early system building among AAAs was the State Unit on Aging, especially to begin case management programs which gave AAAs the important service coordination function in their locales.

In the five **hospital** study sites, early CBSC planners had a desire to develop services which could assist older adults before and after hospital episodes. Acute care was seen as but a step in the much longer career of service needs and utilization associated with aging and chronic disability. For hospitals, early political support for geriatric care was often reflected by commitment of internal funds for early service development. Persons responsible for these ventures realized the necessity of demonstrating the importance of eldercare issues as part of the hospital's long-range service development strategy. External funding most often came from private foundations for new service development, which ranged from geriatric assessment teams to adult day care.

The five **residential** models were most likely to have an individual at the start who worked in the institutional component and realized the importance of developing services which would delay or avoid nursing home placement for older adults. Four of the five sites are affiliated with religious denominations, so that political support involved demonstrating the fit between service expansion and the philosophy and mission of the residential facility. Early influential individuals in these sites have also had long tenure. Access to new funds ranged from a large personal endowment to securing federal research and demonstration funds for innovative service design.

2. <u>What are the necessary steps in planning and design?</u>

The most important finding here was that decisions about CBSC planning and design were influenced much more by practical experience, personal intuition, professional interests, political instinct, the chance to experiment, and funding opportunities than by elaborate data gathering and analysis or other formal planning processes. Mechanisms such as needs assessments and public hearings often generated

evidence and support for planning and design decisions that already had been proposed by organizational leaders. Regardless of the lead organization, a crucial design element for CBSCs was the sensitivity of system builders to the political and interorganizational climate in the community regarding service expansion for the older population.

AAAs were much more likely than hospitals or residential models to initiate community-wide planning processes, given their mandate to submit detailed area plans every two to three years. Public input was solicited by most AAAs at formal public hearings, but study sites wisely used members of their Advisory Councils to obtain informal public feedback when considering adding major new services to build their CBSCs. AAAs also discussed their system plans with service providers in the community, especially when designing new case management programs. This was an important strategy for minimizing friction encountered after case management services were in place, particularly from home health agencies which often viewed AAA case management as an unnecessarily duplicative service in their communities.

Individuals planning CBSCs for older adults in **hospital** and **residential** environments focused their planning efforts on winning agreement among various internal constituencies rather than in the larger community. Major challenges they faced were related to convincing superiors that expanding services for older adults was a financially viable proposition. Their common rationale was that older adults will come to regard that health care institution as a comprehensive care provider to which they will continue to turn as their needs change. As found in this study, however, even the best laid plans for developing eldercare programs may be threatened if competing organizational priorities assume greater importance among key decision makers.

3. How are successful CBSCs established and maintained?

This study found several organizational characteristics and strategies which enabled the study sites to establish and maintain their CBSCs after they were designed and planned. This phase of system development clearly separates efforts which look good on paper or survive for short periods from those which can be sustained for longer periods as a result of continued commitment to service expansion, coordination, and refinement.

Findings from the 15 study sites indicate that establishing and maintaining successful CBSCs required:

o retaining key staff as systems develop;

o expanding the funding mix;

o continuing to introduce new services, especially case management;

o sustaining political support; and

o   sustaining political support; and

o   effectively managing the developing system.

Low turnover among top leadership was a very consistent organizational pattern in these study sites. In many instances, the original visionary was still in charge at the time of the site visit, while in most others the present leader was only the second in the history of the CBSC. Many of these leaders hired associates from within the organization to handle the daily operations of the service system. This strategy has allowed CBSC leaders to continue building for the future based on trends observed in the older population locally or nationally. Another result of this trend is that organizational missions become internalized by lower level staff, which contributes to lower turnover throughout the organization. Successful CBSCs can be best maintained if staff remain committed to the cause of the linchpin organization.

Nearly all study sites successfully tapped significant new financial resources in order to establish their CBSCs for older adults. The key to maintaining their systems has been to continue **diversifying funding sources** through solicited and unsolicited channels.

AAAs expanded their access to resources beyond Older Americans Act funds to include Social Service Block Grant, Medicaid waiver, and state general revenue funds. These funds were usually attracted through development of case management programs. Some AAAs in this study have also tapped private sector funds through fee-for-service case management options and contracts with local employers to educate employees about eldercare issues.

Hospitals most often secured private foundation funds to establish non-traditional services for their older patients, and then gained administrative support for continued funding from internal budgets. Private sector initiatives by hospitals have included senior membership programs which help underwrite costs of other eldercare services.

Residential facilities used the most diverse financing strategies, ranging from internal resources to fund service expansion, to grants from federal and private foundation sources, to offering private long-term care insurance to residents. .This latter strategy was used in the retirement community included in this study, and was viewed as a way to assure funds are available when residents transfer from independent to more dependent living situations. Revenues may also be used to underwrite new services offered to the older population residing outside the boundaries of the residential campus.

The single most important service introduced by study sites to establish and maintain their CBSCs was case management. A variety of case management styles was revealed in this study. All five AAAs practiced comprehensive case management for older adults eligible for publicly-funded home and community-based services. Activities included comprehensive assessment, care plan construction,

linkage of services with public funding sources, service monitoring, and periodic reassessment and care plan modification. Two hospital CBSCs and one residential study site also practiced comprehensive case management. More limited case management styles found among hospitals and residential study sites focused on linking older adults with their own spectrum of services, with no systematic link to public funding sources.

Many approaches were used by leaders of CBSCs to sustain **political support**, both within their organizational structures and with other service providers in the community. AAA Executive Directors must interact with a wide variety of actors as they attempt to maintain and expand services, including Boards and Advisory Councils, local elected officials, local consumer groups, service providers such as home health agencies and senior centers, and State Units on Aging. AAAs in this study were characterized by very active Advisory Councils, who were assigned such tasks as reviewing service provider contracts and advocating on behalf of older adults in state legislatures. Staff were assigned clear responsibility for communicating with other service providers, while Directors ultimately handled conflicts arising in the community. A major challenge for AAAs functioning within county or district government was to keep aging issues in the minds of elected local supervisors.

Major political issues facing **hospitals** involved changing priorities expressed by top administrators or Boards. Regardless of whether older adult services were physically separated from hospital grounds, they programs were regularly scrutinized by more senior hospital officials for fiscal integrity. All but one hospital-based service system have so far successfully justified their existence in fiscal terms, but leaders of these systems realize the necessity of continuing to impress their superiors with new cost-effective strategies.

Political considerations for **residential** systems focus on the tension between those within the organization who define its mission as solely institutional care, and those advocating for a much broader definition of care. Systems operating in areas where long-standing shortages of nursing home beds are the rule generally have had an easier time sustaining Board support for noninstitutional service expansion.

Finally, **effective management** was characterized in study sites by CBSC leaders focusing energy and attention to emerging trends in eldercare, contending with political issues, funders, policymakers at state and federal levels, and the media. Leaders accomplished these tasks by delegating responsibility for daily operations to a trusted deputy or associate, who was competent in staff supervision and very knowledgeable about all service program functions.

4. <u>How does the nature of the lead organization influence and reflect a system's accessibility, responsiveness, and effectiveness?</u>

Accessibility refers to the service system's ability to care for all kinds of older persons based on level of need, regardless of ability to pay, ethnic/racial background,

and rural/urban residence. In most study sites, lead organizations worked vigorously to make services accessible to all types of older adults. Major challenges were isolated, rural community residents, and those whose finances placed them above the eligibility level for publicly-funded services but prevented them from paying out-of-pocket for services. Although sliding-fee scales were common, many older persons were reluctant to use limited resources for required co-payments. Transportation problems prevented the most isolated elders from being served in many area, although some study sites employed creative strategies to reach them.

AAAs decentralized outreach and meal services by allowing outreach workers to operate out of their own homes and cover a designated part of the service area, and by using extensive volunteer networks to deliver in-home meals to isolated elders. To improve transportation more broadly, one AAA site worked with organizations serving other disabled groups to develop aa area-wide transportation system for all such groups. The AAA contracting mechanism was used judiciously to maximize accessibility, assuring that service providers met population quotas specified in area plans. Pooling diverse sources of public funds was the common strategy used by AAA case management programs to minimize co-payments required of financially limited elders.

Hospitals enhanced service accessibility by decentralizing eldercare services beyond the hospital campus, such as adult day care. Some study sites designed their own transportation service to on-campus services, which include geriatric clinics, health promotion programs, and multi-purpose senior centers. For hospitalized older adults who need in-home services upon discharge, study sites have worked to strengthen links between discharge planners and community agencies to minimize the number of elders who are lost to followup.

The two major strategies used by **residential** model study sites to enhance service accessibility were: establishing clearly visible home and community-based service divisions separate from their institutional components; and developing joint planning and/or service ventures with other community agencies serving older adults. The first strategy enabled division leaders to determine how best to reach older adults in their own homes. The second strategy resulted in a retirement community lending its planning expertise and subsidized office space to a rural subsidiary of the multi-county AAA, which in turn led to more resources available to serve older adults in their own homes.

Responsiveness: AAAs maximized the use of public hearings and needs assessments to develop consensus in their communities for developing new services over time. These study sites also used Advisory Councils as community sounding boards in order to capture needs through more informal channels. Since new service development was often a function of availability of new funds, AAAs in this study responded regularly to initiatives offered by their State Units on Aging and other funders for demonstration projects.

Hospital study sites were more likely to base new service development on the special interests of the system visionaries, such as comprehensive geriatric services or home health services. Hospitals' versions of needs assessments were commonly services requested by older persons and their families during hospitalization episodes. New service development was also triggered by availability of demonstration funds from private foundations or state Medicaid agencies.

Residential study sites were least likely to conduct formal needs assessments to guide new service development. Rather, they responded to excessive demand for institutional care by developing alternative services for older adults and their families to delay or avoid nursing home placement. In choosing new services, they studied other providers in the community for service gaps and listened to suggestions from consumers inquiring about institutionalization. As with AAAs and hospitals, residential study sites also pursued funding for demonstration projects offered by external sources.

Effectiveness refers to the attention given by the lead organization to quality assurance strategies and client tracking procedures. This study found that effectiveness was the area reported by study sites as most in need of attention and improvement. Although every site collects voluminous data about program activity, few use data routinely to examine how services affect clients.

Whether the lead organization was a hospital, AAA, or residential facility, the most common effectiveness strategies were client record reviews and client satisfaction surveys. AAAs used service contracting protocols and case managers to review performance of direct service providers. These reviews were often a source of tension, and few enforcement procedures were in place to address deficient service patterns. Hospitals and residential facilities relied on the institutional version of medical record review for most eldercare services outside the institutional setting. Client feedback through surveys was considered an important check on effectiveness by most sites, yet few examples of service improvement as a result of such feedback were observed or reported.

Finally, the use of automated data systems for tracking clients over services and time was rare in these study sites. Many interviewees expressed a desire to develop or even purchase computer software which would allow them to monitor changes in client health status and observe effects of different services in their systems on client outcomes. It appears that such innovations in enhancing service effectiveness represent a continuing challenge as CBSCs for older adults unfold in the next several years.

IV. IMPLICATIONS AND RECOMMENDATIONS

Findings from this study are intended to have immediate, practical applicability to organizations interested in building CBSCs in their own communities, as well as to policymakers who could encourage the development of eldercare systems.

Implications and recommendations are directed at both of these audiences. First, implications for system replication are discussed at the organizational level; second, recommendations for the Aging Network are summarized.

Several system elements were identified as variables which could determine the climate for CBSC replication elsewhere. These elements, as well as the conditions of each which facilitate replication, include:

o **Leadership:** Clear vision about continuum of care for older adults; knowledge of community politics; capacity to articulate and persuade others; sensitivity to constraints and opportunities; practical experience in service areas.

Administrative structure: Strong, committed Board of Directors regarding service expansion for older adults; executive leaders clearly identified to carry out the mission of the system; lines of authority clear between lead organization and components of service system.

o **Operating systems:** Effective supervision and accountability within lead organization; unambiguous contracting arrangements; automated fiscal control systems; clear standards for quality assurance across services.

o **Planning and information systems:** Flexibility to move outside planning process to exploit unforeseen opportunity; frequent communication among system leaders; written plan with measurable goals and participatory planning.

o **Financing:** Ability to secure multiple funding sources in both public and private sectors; sufficient ownership over service budgets to exert influence over deployment of funds across programs and services.

o **Interorganizational linkages:** Agreement on scope and role of lead organization; control or influence by lead organization on client pathways; written agreements on client referral mechanisms; capacity by lead organization to review records of other providers; regular communication about service goals.

o **Relationships with competitors and other systems:** Lack of strong competitors in community; agreement about turf issues and possible areas of cooperation.

o **Community characteristics:** support for older adult services among elected officials; clear service gaps or expressed unmet needs among older adults; support from key state agencies for system development.

Regardless of the climate in local organizations and communities, much can be done by the traditional members of the Aging Network at federal and state levels--the U.S. Administration on Aging (AoA) and the State Units on Aging (SUAs)--to encourage development of community-based systems of care at the local level. The major challenge is to take specific actions which would steer AAAs and other health

and social service providers into collaborative ventures that will benefit older adults as their needs change over time. Recommendations include:

o **Clarify Aging Network goals to promote system building:** At the Federal level, AoA should work with national provider associations to produce guidelines legitimizing cooperation at the local level to overcome service gaps and fragmentation. At state levels, SUAs and provider associations should identify organizations to participate in system building in each AAA region.

o **Build flexibility into AAA functions:** AAAs should be encouraged to help develop or deliver comprehensive case management services, to pursue access to services funded by other public sources, and to initiate alliances with private sector organizations to explore pooled funding arrangements and new service development.

o **Support development of systems led by alternative organizations:** AAAs need not always be system leaders, but they can use Title III or other funds, as well as their expertise as advocates and brokers for older adults, to stimulate other providers to assume lead organization positions in their communities. AoA and SUAs should issue policy directives for AAAs to forge systems even when they are not leaders.

o **Encourage innovative financing strategies:** Public resources will always be scarce relative to service needs of local older populations. This study revealed many strategies used by AAAs, hospitals, and residential facilities to attract private sector resources. AoA and SUAs should actively promote development of private long-term care insurance products and provide training to AAAs so they can become local experts in innovative financing and delivery strategies (e.g., Social Health Maintenance Organizations) for adoption in their communities.

o **Recognize the alternative utility of loc planning and needs assessment procedures:** AoA and SUAs should recognize th value of community needs assessments as tools for building consensus and political support for service expansion. They should encourage AAAs to recognize these alternative uses of formal, mechanistic area plan formulations.

o **Support mentorship programs as technology transfer mechanisms:** This study has identified many successful system builders who are willing t serve as mentors in other communities because of their commitment to strengthening links among existing service providers for the benefit of older adults. AoA should sponsor mentorship programs with the goal of building new eldercare systems using technical assistance from these experts.

o **Support capacity to monitor service effectiveness in existing and emergent systems:** Guidelines are needed which spell out for AAAs and others a step-by-step approach for building capacity to measure service effectiveness. Stages should move from establishing client feedback mechanisms through developing client

outcome measures and designing automated data reports which would be routinely reviewed by peer teams from participating organizations in the service system.

These recommendations recognize the increasing interdependence among health and social service organizations helping older Americans at the local level. More focused efforts to facilitate system development will benefit older adults across the country where they actually demand and use services--in their own communities.

I. INTRODUCTION

A. Purpose and Research Questions

Communities throughout the United States face a common challenge -- how best to expand and improve service delivery to growing numbers of older adults. The major purpose of this study was to identify and compare different types of organizations in local communities throughout the United States that have successfully built comprehensive, coordinated systems of services for this population. Three different types of lead organization were selected because of their propensity to serve older adults -- Area Agencies on Aging (AAAs), hospitals, and residential facilities. From the start, we wanted this research to have direct application to local organizations and communities struggling to develop health and social services for an ever-increasing older population. By detailing the evolution of three specific types of successfully-developed systems, our findings are meant to have direct relevance to nearly any local community wishing to build its own system or systems of care for older Americans.

In this research, we targeted community-based systems that provide a broad array of services to older people regardless of socioeconomic background or setting of care. Further, these systems needed to exhibit a commitment to effectiveness in the delivery of these services--a well defined approach to quality assurance as well as an effort to track clients across a range of services they may use over time. Once we identified these systems of care, our goal was to compare and contrast their development and management in order to inform the introduction or enhancement of eldercare systems in other locales. We present our findings with the aims of stimulating innovation and increasing the likelihood of success in new communities.

Specific questions addressed in this project include:

o   What conditions, factors, and arrangements in a community give rise to a community-based system of care (CBSC) for older adults?

o   What are the necessary steps in planning and design?

o   How are successful CBSCs established and maintained?

o   How does the type of lead organization -- AAA, hospital, or residential facility --influence and reflect a system's accessibility, responsiveness and effectiveness?

o   To what extent and under what conditions can CBSCs be replicated?

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B. Key Definitions

1. Community-Based Systems of Care (CBSCs)

For purposes of this study, "system" refers to clusters of critical health and social services, coordinated and organized to achieve clearly delineated and commonly held service objectives, linked together within an accountable framework. The term "community" refers to a geographic area, always smaller than a state, identified as the service area of the system. The terms "system" and "CBSC" are used interchangeably in this report.

This report also uses the term "linchpin" or "lead organization" to refer to the specific sponsoring and administering organization responsible for system operations and management. The essential characteristic of a CBSC is the presence of several service-providing elements whose functions are influenced or controlled by the linchpin. In addition, the range of services must, at a minimum, address the needs of older adults with some degree of disability.

The system may be located entirely within a single organization. It may consist of many separate organizations operating in tightly or loosely orchestrated relation to one another, with some degree of accountability to the linchpin organization. It may exhibit features of both--a host organization providing certain services under its own auspices and coordinating others through any combination of contractual arrangements, agreements, and understandings. For our purposes, therefore, care systems for older adults require a linchpin organization in a community capable of exerting significant continuing influence over the volume, character, or objectives of direct service programs in its local geographic area. Variation in the means used to create and manage many service components by a single organization is a matter of considerable interest in this research. Finally, from the older adult's viewpoint, the service system should be easily navigable regardless of the type or level of care needed.

This report also uses the term "study site" to refer to particular systems in specific communities, and "study site program" or "program" to refer to specific system components.

2. Types of Care Systems

This study examined three distinct types of community based systems of care, distinguished by the organization most central to the coordination of services for older adults (i.e., the linchpin organization):

o   Area Agency on Aging (AAA) model. The emphasis is on a mix of contracted and/or directly provided social and health services, with the AAA assuming responsibility for service coordination and exerting considerable influence over service delivery. AAA ownership or control of case management is a key feature of this type of system.

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o   Hospital model. A major provider of acute care services in the locale expands its array of services to the older population. Typically, the hospital creates its own group of services which together offer a continuum of care for hospitalized and non-hospitalized older adults in the community. The hospital may also enter into cooperative ventures with other health and service providers in this type of system.

o   Residential model. These systems develop around the capabilities of residential care facilities for older persons. The host facility provides housing or nursing home care, but also offers noninstitutional services -- sometimes under its own administrative and corporate rubric, other times according to formal and informal agreements with other service organizations. Services must be offered to older adults living outside the residential facility through clear efforts by that organization to qualify as a system in our study.[1]

3. System Selection Criteria.

Our search was for systems offering promise of serving as models for replication elsewhere. We developed "success criteria" which helped us screen and select AAAs, hospitals, and residential facilities for in-depth study. We targeted systems that were:

o   Accessible. This means that services are available to all kinds of older persons, based on need and level of functional independence. Programs serve people from a broad range of income levels. Where poor, minority or rural area populations are included in the catchment area, vigorous efforts are made to reach and serve them.

o   Responsive. This means that a broad array of services is available, accommodating variations in the nature and degree of functional independence among older adults and changes in their functional capacity over time. Of particular interest is the degree to which expressed community needs have resulted in the development of services over time.

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[1] It is important to point out that these are not the only types of linchpin organizations that could or, indeed, have successfully built CBSC for older adults. Home health agencies in particular have been known to initiate development of CBSCs in some locales, assuming leadership in expanding services for their clients and building interorganizational linkages. We have been reminded of this several times in the course of this project. Multipurpose senior centers may also serve as linchpins in some large rural areas. The three types chosen for this study are the most common linchpin organizations known at this early stage of CBSC development in the United States.

o   Effective. This means that attention to client outcomes and commitment to
    quality assurance enjoy high priority among leaders and decisionmakers.
    Service standards are rigorously maintained. Client service utilization data
    are collected and used by system leaders to monitor service activity and
    consider the introduction of new services.

An original premise of our research was that we would find one major "system
of care" in each community we studied. We assumed that one of the three types of
systems defined above would always define and characterize service coordination and
delivery for older adults in the community as a whole. We learned, however, that
within a single community (i.e., large city, multi-county rural area) more than one --
even several -- systems of care may be operating simultaneously. We learned the
prime importance of examining how a linchpin organization's efforts at system
development was hindered and enhanced by political, economic, and social factors
both internal and external to that organization. A major implication of our research is
that communities, however defined, should not automatically expect to build a single
system of care for older adults. Two or more systems working in formal or informal
confederation may be more realistic. This means that organizations -- AAAs,
hospitals, residential facilities, and others-- rather than communities as a whole are
prime audiences for our findings.

C. Context of Study

This study builds upon a rich literature which has evaluated coordinated home
and community-based service demonstration projects for older adults, including the
National Channeling Demonstration Project (Kemper, et al., 1988) and many state or
substate demonstrations (Capitman, 1986; Weissert, et. al., 1988). The primary focus
of this literature has been the cost-effectiveness of the demonstrations, with the unit of
analysis typically being the individual client. Our study takes a different approach
than these earlier demonstrations by focusing at organizational and the community
levels to identify features and strategies of successful systems of care which may be
replicable in other settings.

Recently, several authors have provided insightful expositions related to
successful systems of care for an aging population. Koff (1988) posited that
smooth-functioning chronic care systems depend on three characteristics: single-point
of entry into the system, patient assessment, and care coordination. He then
described several organizational models for such systems, including vertically
integrated, brokered, and federated approaches which resemble the arrangements
encountered in our research. Kaluzny and Fried (1985) explored interorganizational
decision-making approaches surrounding older adult service coordination. Dychtwald
and his colleagues reviewed what is known about current and projected demographic,
socioeconomic, and health and functional characteristics of the elderly; sources of
financing and settings for care; and characteristics of emerging systems of care
(1990a). Based on this exposition, these authors offered suggestions for health care
organizations in selecting which service components to include and how to plan,

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market, and finance these services (1990b). Model programs and case studies were then presented which illustrate these suggestions.

The Koff and Dychtwald approaches are very useful in integrating much of what is known about discrete geriatric service components and proposing how they might be best configured within systems of care. Kaluzny and Fried focus on factors which hinder or enhance the capabilities of coordinating organizations to design and manage multiple services. Real programs are used as examples to show that such systems are possible, at least in part.

In contrast to the conceptual model approach taken by these authors, our study began by selecting local eldercare systems sponsored by three specific types of health and social service organizations, nominated by experts and rigorously screened against the criteria of accessibility, responsiveness and effectiveness. We then proceeded to observe empirically and systematically how and why these systems developed, transformed and, in some cases, deteriorated over time. The result, we believe, is a more pragmatic and evolutionary approach to community-based system analysis than those presented by previous authors. Our focus on successful strategies implemented by organizations as they built systems of care for their local older populations will assist others as they move to coordinate and develop services in their own communities. This empirical approach to identifying and comparing successful eldercare systems complements very well the conceptual approach taken by Koff, Dychtwald, and Kaluzny and Fried, as well as the theoretical model of community-based systems of service for older persons developed by Savant, Inc. (1988).

Specific components of our study have benefitted from, and extend, the findings of other recent studies. The National Governors' Association study of State Long Term Care Reform (Justice, 1988) provides important comparative data about the role of six State Units on Aging (SUAs) in influencing community-based systems of care for older adults. Our study complements this state level focus with a local community-focused inquiry. Not surprisingly, the views of community level actors sometimes differ markedly from state level actors. In some states the SUA is crucial to the development of successful AAA-led systems of care; in other states they are not. A study of differences in planning and service delivery between rural and urban AAAs, funded by the Retirement Research Foundation (Krout, 1989), provides an important profile of the current capacity of AAAs to provide comprehensive services for older Americans. Our study describes how five specific AAAs developed an array of health and social services, and compares their strategies to those of hospitals and residential settings.

The Robert Wood Johnson Foundation (RWJ) Hospital Long Term Care Initiative provided four-year grants for 24 general-care hospitals to develop geriatric services. Capitman and his colleagues (1988a) developed a framework describing the goals these hospitals reported in developing geriatric services (market share, efficient use of resources, and new product lines), the service approaches taken (geriatric medicine, post-acute care, transition management, chronic care, and geriatric

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information), and the organizational strategies adopted (vertical integration and diversification). Two of the five hospitals in our study received grants under this Foundation initiative, providing an interesting source of comparison to determine the importance of external funding for eldercare system development.

In contrast to the relatively rich literature on the role of AAAs and hospitals in developing and coordinating services for older adults, there are virtually no studies on the role of residential facilities in building community-based systems of care. We avoided selecting Continuing Care Retirement Communities (CCRCs) in our study which did not link with public sector organizations to assist older adults outside the CCRC. These CCRCs, about which detailed descriptive information is readily available (American Association of Homes for the Aging and Ernst & Young, 1988), did not meet our criteria of accessibility and responsiveness as defined above. No systematic analyses have been done on systems of care that have grown from nursing homes to offer an expanded array of home and community-based services to older adults in the surrounding community. Consequently, our study's findings are particularly illuminating with regard to this area.

Finally our study's examination of the importance of case management and at what stage it should be implemented in the development of community-based systems of care, makes an important contribution to this rapidly growing literature. Capitman and colleagues (1986) have described case management approaches used in twelve service coordination demonstration projects funded by Medicaid or Medicare waivers. Their analysis did not focus on the types of sponsoring organizations nor their links with other providers, as we do in this study. More recently, Capitman and colleagues (1988b) categorized case management approaches adopted by the hospitals in the RWJ Foundation initiative discussed above. Austin and Applebaum (1989) provide an important public policy perspective to the role of case management (or care management) in long-term care for frail older adults. Our analysis of case management and its implications for system development should provide a deeper understanding of options for financing and organizing this coordinating service in local communities.

II.   METHODOLOGY

A. Overview

Our approach incorporated a mix of qualitative and quantitative research methods. The unit of analysis was the organization located in a local community which has built a system of care for older adults. While many influences outside the community affect the development of comprehensive systems--federal policies and funding mechanisms, state health and aging agency priorities, interagency agreements across and between governments at all levels--in the end services are delivered by organizations within communities. Our study anticipated these influences and incorporated them into our design.

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Three major steps were followed in our study methodology.

Step 1.   Select successful community-based systems of care.

The first task was to establish a typology of community based systems and develop criteria for successful systems. These have already been described. The next task was to gather candidates from each systems type, inviting national associations representing AAAs, hospitals, and residential facilities, as well as experts in the field to offer suggestions. Then we developed and implemented mechanisms for verifying the presence or absence of success criteria at each nominated site. From this information we selected five organizations from each system type for in-depth analysis, which are presented in Section B below.

Step 2:   Identify the features and characteristics associated with the development and operations of successful systems.

The tasks included:

o   Review organizational documents and data, including budgets, organizational charts, contracts and agreements, and demographic data;

o   Interview key informants on site--those playing critical roles in creating and managing strong systems as well as policymakers, local leaders, advocates, expert observers and service providers;

o   Prepare site reports and case summaries that synthesize field findings and present information in a manner that supports cross-site comparison;

o   Compare sites within type and across types to identify characteristics associated with relative degrees of success.

Step 3:   Develop findings and conclusions concerning the replicability of successful programs and propose recommendations regarding nationwide dissemination.

The tasks included:

o   At three distinct stages, analyze case summaries and site reports to develop draft findings concerning replicability of strategies, generation of critical resources, administrative structures and processes, and operational features of strong programs. Test draft findings at subsequent stages of the research;

o   Review and refine preliminary findings with assistance of a National Advisory Panel;

o   Identify key audiences, practical products, dissemination mechanisms and strategies. Incorporate dissemination recommendations into final report.

The remainder of this section details our methodology.

B. Site Selection

A total of fifteen (15) sites were selected for in-depth analysis, five representing each of the three types of linchpin organizations in community-based system of care for older adults:

AAA Agency on Aging (AAA) sites:

o   Aroostook AAA, Presque Isle, Maine
o   Atlanta Regional Commission and AAA, Atlanta, Georgia
o   First Tennessee AAA, Johnson City, Tennessee
p   Monterey County AAA, Salinas, California
o   Region IV AAA, St. Joseph, Michigan

Hospital sites:

o   Craven Regional Medical Center, New Bern, North Carolina
o   Good Samaritan Hospital, Portland, Oregon
o   Greater Southeast Community Center for the Aging, Washington, D.C.
o   Parkland Memorial Hospital, Dallas, Texas
o   Parkside Senior Services, Lutheran General Hospital, Arlington Heights, Illinois

Residential sites:

o   Ebenezer Community Services, Minneapolis, Minnesota
o   Eddy Memorial Geriatric Center, Troy, New York
o   Handmaker Jewish Geriatric Services, Inc., Tucson, Arizona
o   Miami Jewish Home and Hospital for the Aged, Miami, Florida
o   Otterbein Homes, Lebanon, Ohio

These sites were selected through a process of nomination and screening which occurred throughout the first project year. Candidates were nominated by members of our National Advisory Panel, which includes representatives from the major national associations of AAAs, the National Association of State Units on Aging, hospitals, and residential facilities, and by other nationally-known experts on services for older adults. A total of 53 of candidates were considered in the screening phase of the project, including 13 AAAs, 15 hospitals, and 25 residential facilities.

Screening questionnaires were designed to gather self-reported data which we used to measure the degree of accessibility, responsiveness, and effectiveness in the nominated systems. Sociodemographic profiles of the client population were

compared with those of the older population in the system's service area to measure degree of **accessibility**. A service matrix provided summary information on the evolution and current array of services offered in each system. Information was also obtained concerning the nature and formality of linkages between lead organizations and other providers in the community. This information combined with open-ended responses about how community needs are determined allowed us to measure **responsiveness**. Finally, **effectiveness** was determined by open-ended responses about how client well-being is monitored by the lead organization and how such data were used. We were most interested in quality assurance strategies and the degree to which client-level data were used to improve programs. A copy of our screening questionnaire is attached to this report (See Appendix 1). We received a total of 35 completed questionnaires (for a 66 percent response rate), including 11 AAAs, 10 hospitals, and 14 residential facilities.

Telephone interviews were then conducted with key informants from all candidates returning questionnaires. This enabled us to verify information and to explore more deeply those issues related to accessibility, responsiveness, and effectiveness.

Written summaries were prepared in a standard format for all candidates based on questionnaire and telephone interview data. Each candidate received a ranking from 1 to 5 on accessibility, responsiveness, and effectiveness by project staff. Summaries of nominated AAA and hospital systems were mailed to members of the project's National Advisory Panel in preparation for an April 1989 meeting in Washington, D.C. We had not completed screening of programs sponsored by residential facilities at this stage, so materials on these candidates were not reviewed.

The panel discussion was productive and illuminating, leading the project team to modify its selection of the fifteen study sites in several instances. The team also adopted the panel's recommendations to increase the number of sites selected in each type from four to five and to include a rural hospital in the group, offering a wider diversity of systems for study. Five AAAs and four hospitals were chosen soon after the meeting, and individual panelists subsequently assisted the project team in nominating additional hospital and residential model candidates for screening. The screening methods and procedures used to select AAAs and the first four hospitals were also used to choose the rest of the study sites.

C. Planning Field Visits

Our in-depth field visits were scheduled for three days of personal interviews with key informants at the selected study sites. At each study site, the primary informant interviewed by telephone during screening also served as the contact person for coordinating our interviews (and planning special events in many cases). We sent congratulatory letters to these individuals when their systems were selected, arranged site visit dates by telephone and sent followup letters confirming our visit dates and specifying the types of people with whom we wished to speak. We also requested

additional documents that might improve our understanding of the system prior to our arrival (see Appendix 2 for samples of both letters).

We worried that the burdens of time and effort we imposed on the systems -- the extensive interviews with senior officials and other busy people, the planning needed to structure the field visits and schedule and coordinate interviews -- would discourage nominated sites from participating. Only one nominated program withdrew during screening on these grounds. Indeed, it seems to us that the thoroughness of our early surveying and telephone screening efforts enhanced our credibility and the willingness of local leaders and program staff to participate in the field research phase.

In preparation for the field visits, we spent considerable time designing structured interview protocols for the various types of interview subjects with whom we planned to speak. Specific types of respondents for whom we designed interview schedules were:

o   Executive Director (AAA)/Care System Administrator/Manager
        (residential/hospital)
o   Board Member
o   Fiscal Manager
o   Program Service Department Head
o   Program Data/MIS Director
o   Direct Service Provider
o   Critic/Historian/Local Politician

The most comprehensive interviews were planned with the AAA Executive Director, the ranking hospital administrator for older adult services, and the residential facility representative most knowledgeable about community-based services. Interview topics and questions were modified to reflect the unique organizational aspects of individual systems as much as possible (see Appendix 3 for a sample of this more comprehensive interview protocol).

D. Field Visits

Sites were visited between June 1989 and May 1990. Each site was visited by two members of the project team, although the specific field assignments varied from site to site. The tasks of selecting informants, assembling documents and scheduling interviews were handled with great enthusiasm, thoroughness and care by staff in the communities we visited. Many participants told us that their inclusion in the field research phase of our study built morale and pride, and generated considerable local interest.

The interviews themselves were lively, searching, candid, and generally pleasant, although every site had its critic(s). Some critics were insiders; board or advisory board members, physicians, or other program administrators. Outsider critics often represented "provider" organizations such as home health agencies and

multipurpose senior centers, who often raised competitive or contractual issues about the linchpin organization. Their perspectives helped us understand challenges and tensions inherent in building or maintaining interorganizational relationships.

Many systems included us in social activities, some of which had little or nothing officially to do with our inquiry. One organization held its annual staff picnic during our visit and we were invited to participate. Another visit included participation in a retreat for the agency and staff of its contracting provider organizations. These events enabled us to interview more people and casually observe interactions more closely than would otherwise have been possible. More frequently, lunch or dinner meetings with staff of the lead organization were convened during which we gained a deeper understanding of and appreciation for system leaders' characters and personal styles.

Most on-site interviews were conducted with both project team members present. We used interview protocols both as guides and points of departure in structuring the discussions. None of the interviews was tape recorded.

E. Data Reduction and Analysis

1. Site Reports and Case Reports

Standard formats were designed for **site reports**, which were completed by site visitors as soon as possible after visits were completed. Site reports included sections on:

o History/Chronology of System Development, including major milestones;

o Current Administration and Management, including administrative structure, use of needs assessment, quality assurance, and data management strategies;

o Service arrangements within the lead organization and between the lead and other organizations;

o External influences on the program;

o Current problems and barriers;

o Future plans and directions;

o Final replicability.

These site reports were primarily descriptive, intended to distill from the voluminous data in interview schedules those system attributes and strategies which helped us answer the major research questions. Since site reports were meant to be descriptive, their major function was that of a standardized factual reference document; source

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interviews contain much additional information which served as evidence to support or refute comparative hypotheses.

Case reports built on the descriptive site reports by taking a more analytical approach to the site as a community-based system of care for older adults. The case report served as the basis for comparing data across systems to determine similarities and differences in system attributes, evolution, performance, and feasibility of replication. Case reports included sections on:

o The system verified and described, including how its various components are interrelated and whether the system is owned, controlled, and/or negotiated;

o Site selection criteria revisited, including whether the system was found to be accessible, responsive, and effective as believed before the site visit;

o System strengths and weaknesses, including the basis for its exemplary reputation in the field, its strongest or most distinct administrative and programmatic features, weakest administrative and programmatic features;

o The service environment; whether the community was rich in services or whether major deficiencies were identified, and the extent to which the climate was competitive or collaborative;

o System milestones, including rationale for establishing the system at the lead organization, influential and charismatic individuals at the start, major grants or contracts leading to service expansion;

o Replicable features given the system's location in a rural or urban area, and given the type of lead organization in the system.

2. Team Meetings

The first of two special team meetings was held on October 13, 1989 to summarize results of the initial five field visits and begin generating hypotheses about key ingredients for successful community based systems of care. The five sites included two AAAs, two hospitals, and one residential model study site. This meeting was attended by core project staff and our project consultant. The first five site reports were reviewed in advance of this meeting.

At this meeting, we conducted a site-by-site review using the case report format described above. This process generated initial drafts of the first five case reports, as well as several preliminary hypotheses about common features of the successful systems we visited.

One significant observation was discussed in great detail: that one selected hospital had not fully implemented the system we expected to find. In fact, many of the elements -- structural, programmatic, and administrative -- we viewed as essential to defining a system were missing. This prompted the methodological question: "What happens when a system in the field does not fulfill this basic expectation?" In the end, we concluded that the opportunity to compare this hospital's experience with more fully developed hospital based systems deepened our understanding of the barriers confronting hospital sponsors and ultimately enriched the study.

Ideas and hypotheses generated at the team meeting, with supporting evidence, were recorded in our December 15, 1989 quarterly report to AoA. In the Findings section below, we elaborate on these ideas based on the following five visits.

The second special team meeting was held January 25 and 26, 1990, after the second group of 5 sites was visited. The objectives of that meeting were:

o   Review original research questions for the project, revising
    as necessary, based on 10 field visits;

o   Generate propositions which answer the revised research questions;

o   Examine evidence from site reports and available case reports which
    supports propositions;

o   Identify issues to explore in more depth during the final 5 field visits;

o   Identify scope of community demographic information to obtain
    beyond the questionnaire data;

o   Outline interim report;

o   Schedule and develop timetable for products needed for second
    meeting of the National Advisory Panel.

We generated several propositions about key ingredients influencing community-based system development, and placed the ten sites on a continuum ranging from "ingredient present" to "ingredient absent". When the ten sites were also ranked from strongest to weakest (for internal purposes only), we developed a series of matrices showing where each site fit in terms of strength and presence/absence of specific ingredients.

The team developed a number of ways of analyzing and sorting case and site information and other documents during meetings. Many working papers, such as the matrix presented below, were assembled to help sort and evaluate study site information. This matrix was created to shed light on whether the strengths of the systems at the time of our visits were related to the presence or absence of new funding when they were started. In this instance, the team went through a quick

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process of ranking the systems according to their strengths and then examined the extent of new money available at the beginning. The matrix and the rankings were created entirely for the purposes of discussion at this particular point during the progress of the research. No formal ranking of the fifteen study sties was ever carried out.

Infusion of Money at the Start

	A Lot	Moderate	No Funds
Strength of System			
++			
+			
+/-			

We then placed the ten sites in cells according to these two variables and reviewed evidence supporting our decisions. This exercise helped us identify and analyze key factors that contribute to the relative success of systems. We elaborate on many of these ingredients in our findings section.

We resolved at this meeting to focus on two major issues at the remaining five sites in conducting our standard interview protocols: (1) gather information comparing the system at the start with the present system, to provide the evolutionary perspective on system development; and (2) pursue in detail the role of the board of directors/trustees in the daily decision - making process of the lead organization. The latter issue is important for executives in other organizations who may have concerns about the optimal functioning of such a board when system development is a priority item for executives. We also decided at this meeting to computerize screening questionnaire data from all respondent sites, and to conduct telephone interviews with State Units on Aging in the states represented by our 15 systems.

Based on our conclusions to date, we then drafted an interim report which we circulated to members of our National Advisory Panel in advance of a second panel meeting in Washington, D.C. This report contained preliminary findings to our five research questions, including evidence generated from our first ten site visits.

At the second panel meeting, held June 19, 1990, attending members provided insightful feedback to our interim report and practical suggestions about how best to present data in our final report. We also discussed how findings presented in the interim report were verified or revised based on our last five site visits. The present document represents the result of input received since we wrote our interim report.

III. RESULTS

This section of the report summarizes our findings. We begin by providing a profile of each community-based system of care, classified by the type of lead organization. Profiles include sociodemographic information about the community and client populations of older adults in each locale, as well as organizational information about the Area Agency on Aging (AAA), hospital, or residential setting serving as the system leader for our study. Following these profiles, we present answers to our research questions based on comparative analysis across all 15 sites.

A critical issue was whether or not to identify sites by name in this report. We elected to limit specific site identification to the profile section immediately following, and to omit references to specific sites when answering research questions. Our decision was based on a desire to be as thorough as possible in discussing strengths and weaknesses of system development. We concluded that this goal could be best accomplished by excluding names in the section of our report describing how systems evolved over time.

A. Site Profiles

Figures 1 and 2 provide comparative data on each study site's key organizational and client characteristics. Figure 1 shows the range of organizational affiliations among AAAs, hospitals, and residential models in this study. Both free-standing and government-affiliated AAAs were selected, residential sites were affiliated primarily with religious groups, and hospitals represented public sector, private sector, and religious affiliations.

The service summary in Figure 1 indicates that AAAs faced coordination of an interorganizational nature due to the large number of service contracts they administered.   On the other hand, hospitals and residential sites were more likely to be preoccupied with intraorganizational coordination. All three types of lead organizations reported numerous informal service arrangements as part of their community-based systems of care as well.

Figure 2 illustrates the diversity of older adult populations served by the 15 study sites. Although client data reported by study sites were not always complete, most provided data on age groups, urban/suburban/rural residence, income groups, percent receiving Medicard, and impairment level. Results show that AAAs and residential model systems were more likely than hospital systems to serve a majority of clients aged 75 or older. Since a definition of rural was not provided in the Screening Questionnaire, study sites used their own interpretation, resulting in a probable underestimate by at least one AAA and one hospital site in this Figure. Study site-specific profiles below highlight in more detail the geographic areas served by each CBSC. Figure 2 also indicates that AAAs and hospitals served a relatively poor older population as measured by annual household income, although this did not always translate into large proportions of clients receiving Medicaid as a source of

FIGURE 1

COMPARATIVE PROFILE OF ORGANIZATIONAL AND SERVICE CHARACTERISTICS, SITES IN NATIONAL ELDERCARE SYSTEMS PROJECT*

	Lead Organizational Affiliation			Service Summary - Number Provided:			
	Government/ Public Sector	Private Sector	Religious Group	Directly	By Contract	By Collaborative Agreement	By Informal Referral
AAAs							
1 Aroostook		X		9	6	5	4
2 Atlanta					15	9	20
3 Region IV		X		8	9	-	-
4 First Tenn	X			-	10	1	7
5 Monterey	X			8	16	7	9
Hospitals							
1 Greater SE		X		11	-	6	3
2 Parkside			X	12	-	4	4
3 Good Sam			X	8	3	-	16
4 Parkland	X			7	-	16	-
5 Craven	X			7	1	-	-
Residential							
1 Miami Jewish			X	13	6	4	1
2 Otterbein			X	12	-	2	3
3 Eddy		X		13	-	-	7
4 Handmaker			X	10	-	-	-
5 Ebenezer			X	12	-	-	-

*Source of data: Screening Questionnaire completed by staff at each site; 1988-89. See Appendix I for service matrix in Screening Questionnaire.

FIGURE 2

SELECTED CLIENT CHARACTERISTICS,

SITES IN NATIONAL ELDERCARE SYSTEMS PROJECT

	Percent 75 Years +	Percent Rural	Percent Household Income <$10,000	Percent Medicaid Clients	Percent Impaired
AAAs					
1 Aroostook	52	80	60	4	45
2 Atlanta	60	0	90	7	_a
3 Region IV	52	50	57	_a	90
4 First Tenn	40	33	70	7	_a
Monterey	65	5	70	80	85
Hospitals					
Greater SE	55	5	80	80	90
Parkside	65	0	_a	5	90
Good Samaritan	30	20	15	3	40
Parkland	41	1	_a	6	80
Craven	18	20	30	20	30
Residential					
Miami Jewish	75	0	85	50	90
Otterbein	90	34	35	15	44
Eddy	62	10	38	32	96
Handmaker	68	_a	_a	3	100
Ebenezer	10	0	75	5	20

a not reported by site; Source: Screening Questionnaire

payment for services. Finally, most study sites reported significant proportions of impaired older adults among their older client populations. Most also reported, however, that they were attempting to attract healthier older adults through such serves as health promotion and education.

1. Area Agencies on Aging

a. Aroostook Area Agency on Aging
Presque Isle, Maine

The Aroostook Area Agency on Aging (AAAA) is the designated AAA for Maine's northernmost county. This vast service area is rural, remote, sparsely populated and bordered on three sides by Canada.

Aroostook AAA directly provides an extensive array of services to the area's elderly, and contracts for other services with various providers within the community. The AAAA directly provides personal care services, homemaker/ chore services, in-home meals, congregate meals, adult day care, respite care, case management, social and recreational services, health promotion, education, and congregate housing. This is, in part, a reflection of the scarcity of service providers and the general lack of alternative services in the region. AAAA serves over a quarter of the region's elderly population. Of these clients, 52 percent are over 75 years of age. The client population is made up of low-income, healthy to moderately impaired elderly. Sixty percent of clients have yearly household incomes of less than $10,000 and ten percent of the client population is substantially impaired.

AAAA evolved from a pre-existing program created in 1968-69 when the Committee for Maine's Elderly mandated the creation of the Aroostook Task Force on Aging. After completing its early work, the Task Force continued to meet to consider the county's needs; consequently, an established framework for a county-wide agency was in place when the Older Americans Act was passed in 1973. A 1980 pilot project funded by the Bureau of Maine's Elderly created AAAA's case management system.

b. Atlanta Regional Commission Area Agency on Aging
Atlanta, Georgia

Atlanta (Georgia) Regional AAA is the linchpin agency for a service area that includes Fulton County, which includes Atlanta, and six adjacent counties encompassing a mix of urban, suburban and rural populations. Each county is served by a single, comprehensive aging services agency with which the Atlanta Regional AAA exclusively contracts for the delivery of funded services. A total of 47 munic-ipalities fall within the catchment area.

The agency identifies 20 services provided under its auspices, although the specific array available depends on the county in question. All county agencies

provide case management according to a regionwide system and protocol. The agency has recently begun implementing private pay case management and has begun marketing the program to major employer groups in the region. Programs coordinated regionwide by the AAA are funded variously under Title III, Medicaid, Title XX, JTPA, the Food and Agricultural Act, state appropriated funds, and private donations.

In the aggregate, Atlanta Regional AAA serves about six percent of the area's older population. Of these clients, approximately 60 percent are 75 years of age and older. Ninety percent of clients have yearly household incomes of less than $10,000.

The AAA was created and located within the framework of the Atlanta Regional Commission in 1974. It emerged from an AoA-funded demonstration and developed from a base of social and nutrition services and a case management system funded initially by the Robert Wood Johnson Foundation.

c. First Tennessee Development District Area Agency on Aging
Johnson City, Tennessee

First Tennessee Development District Area Agency on Aging (FTAAA) serves eight rural counties of northeastern Tennessee. The population is widely scattered throughout a catchment area of 2,886 square miles, bounded on the east by the Blue Ridge Mountains.

The agency is one of three programmatically unrelated departments of the development district. It contracts or subcontracts for twelve services and directly administers a senior guardianship program. A Robert Wood Johnson grant enabled the agency to develop case management. The AAA operated its case management system under its own auspices until the Tennessee Commission on Aging denied a request to extend a waiver that had set aside the prohibition against AAAs providing services directly. Case management was subsequently incorporated into a private, non-profit organization that initiated private-pay case management, and counseling and monitoring services for individuals and private industry.

First Tennessee AAA serves almost 14 percent of the region's elderly population. Of these, approximately seven percent receive services funded by Medicaid. Clients are low-income and almost one third are substantially impaired.

FTAAA was designated as the regional agency in 1973, and most of the services provided under its auspices were developed subsequently. The case management program was introduced in 1980.

d. Region IV AAA
St. Joseph, Michigan

Region IV AAA serves a three county area in southwestern Michigan (Van Buren, Berrien and Cass counties). The western boundary of its service area is the

eastern shore of Lake Michigan. The area includes a substantial black community, located in the city of Benton Harbor; an urban white population located in St. Joseph; and several suburban towns and isolated rural areas.

Twelve services are provided under Region IV's umbrella. Three of these-- legal services, case management, senior employment and JTPA-Title V--are admin- istered directly by the agency, while the others are contracted to provider organizations. The agency has also established a growing number of direct purchase contractual arrangements with other providers under which reimbursement is on a unit of service basis. The introduction of case management--funded under a state demonstration in 1983--enabled Region IV to reach an informal working agreement with a large local hospital to receive clients referred routinely by the hospital's discharge planning unit. The arrangement provides the system's link to the acute care end of the continuum. In two counties, services are contracted by Region IV through an array of individual provider entities. In the third, a comprehensive county council on aging coordinates and delivers the major proportion of nonacute care.

Services coordinated or provided by the AAA reach approximately 10 percent of the area's elderly population. Most clients are low income and almost 90% have some form of health impairment.

Region IV is a 501(c)3 nonprofit organization whose board is made up of persons appointed by county governments. One alternative board member is a county commissioner. Its present executive director was instrumental in founding the agency in 1974, bringing elder services under a multi-county umbrella, and shifting the emphasis of care from social, recreational and nutritional programs to services directed to frailer older persons.

e. Monterey County AAA
Salinas, CA

Monterey County is approximately 30 miles wide and 100 miles long and encompasses 3,324 square miles. The county includes 24 different communities of which 13 are incorporated cities or towns. It is broken into four major geographical areas that include both urban and rural sections. It is one of only two county agencies in California to control funds for both populations. The state has a county- administered human services system.

The AAA is administratively located within the Monterey County Department of Social Services, and is responsible for coordinating services to both disabled persons 18 and over and older adults. It is known as the Office for Aging and Adult Programs. The Department is one of only two county agencies in California to control funds for both populations. The state has a county-administered human services system. It delivers services that would otherwise be separately provided by a designated county welfare department, including a number of in- home services directed to the disabled and to income-eligible elderly. The agency uses its Title III monies to contract with local providers for congregate and home delivered nutrition

services, senior employment, transportation, adult day care, homemaker and attendant care, legal services, ombudsman services, companionship and telephone reassurance, and stroke rehabilitation services. It also directly delivers case management services to older persons under the LINKAGES designation.

The agency directly serves approximately 4,400 people, not including clients served by Title III contract providers; 90 percent have family incomes under $20,000. Fifty percent suffered substantial functional impairment. Medicaid paid for care for 80 percent of clients served.

The California Department of Aging designated the Monterey County Board of Supervisors as the Area Agency on Aging in 1980. The County Department of Social Services became the parent organization and the AAA's founding executive still directs aging services for the county.

2. Hospitals

a. Craven Regional Medical Center
   New Bern, NC

Craven Regional Medical Center is a 350 bed hospital serving the rural four county New Bern, North Carolina region. It is the only hospital within a 50 mile radius of the city. The proximity of the area to the Carolina shore has attracted increasing numbers of retired older persons in recent years, who supplement the indigenous, largely poor and black, population.

In addition to acute care, the medical center delivers home health care, personal care, social and recreational programs, health promotion and case management. Case management is directed to Medicaid-eligible elderly and to paying members of the medical center's "Gold Card" senior membership program. The program is located within a Patient and Family Services unit alongside the utilization review and discharge planning groups, enabling Craven to anticipate patient needs for community-based care early during their hospital stay. The case management group is also able to coordinate transportation, nutrition, and in-home services delivered by county agencies and other provider organizations. A nursing home is scheduled to open in the fall.

The program serves approximately nine percent of the region's elderly population. About 20% of clients receive services funded by Medicaid. Twenty-eight percent of clients are moderately or substantially impaired. Seventeen percent have household incomes under $20,000 and 51 percent are in the $20,000 to $29,000 range.

The Patient and Family Services unit began in 1984 with Robert Wood Johnson funding for case coordination and community planning. Almost simultaneously, the medical center received Cap-Medicaid approval for community based care for SNF and ICF-eligible Medicaid clients and obtained a transportation grant

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from the Public Welfare Foundation (passed through to the Red Cross). Two years ago, the medical center was reorganized as a municipal corporation, whose seven member board is appointed by the Craven County Board of Commissioners. Previously, the center was a unit of county government.

b. Good Samaritan Hospital Senior Health Services
Portland, Oregon

Good Samaritan Hospital Senior Health Services serves the northwest area of Portland, Oregon. However, certain programs reach a tri-county area encompassing Multnomah, Clakamas, and Washington Counties. The surrounding urban community is a diverse multi-ethnic, prosperous, middle class neighborhood.

The Senior Health Services program began in 1980 as a cluster of related screening, assessment and treatment clinic programs, directed specifically to older adults. In 1985, Good Samaritan Hospital created a new subsidiary organization, known as "Health Services", and placed the existing "Senior Health Services" cluster within it. This multi-level care initiative was intended to establish a full continuum of community-based and residential care for older adults, with "Senior Health Services" serving as the clinical component of a new entity, related to the hospital but separate from it, offering what was intended to be a full continuum of social, educational, and medical care to older persons.

At that point, Senior Health Services included gerontology and Alzheimer's assessment clinics, foot care clinics, continence services, and mental healthy services. Research, consultation services, senior membership, and community and professional education programs were also provided by the Senior Health Services components. A nursing home, a congregate living facility, and in-home nursing services were added as new components under the rapidly developing Health Services subsidiary corporate umbrella.

In 1989, Good Samaritan Hospital merged with four other hospitals to create a new corporation known as The Legacy Health System. The Healthy Services subsidiary corporation was dissolved. Senior Health Services was bought back within the administrative framework of Good Samaritan Hospital, where it still provides clinical care and conducts related senior membership, research, educational, and consultation programs. It also provides services to the hospital's affiliated nursing home as it gradually converts to skilled nursing beds. A number of other services for older adults are provided by other Legacy hospital affiliates and by the VNA, which is also part of the new corporation. However, the distinct, unified continuum of community based services envisioned in the 1985 initiative was not fully implemented as planned.

The Senior Health Services program serves about four percent of the region's elderly population; two to three percent of those clients receive services funded by Medicaid. The majority of the clients are the "young elderly" and most have no severe health impairments.

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c. Greater Southeast Community Center for the Aging
   Washington, D.C.

Greater Southeast Community Center for the Aging in Washington, D.C. serves a predominantly black, densely populated, low-income section of the city. It also serves southern Prince Georges County, Maryland.

The system directly provides congregate meals, adult day care, respite care, case management, skilled nursing and intermediate care, and several other services. It contracts for home health, homemaker care, mental health services, and in-home meals.

Eighty percent of clients are black. Ninety-five percent have household incomes under $20,000. Sixty percent are substantially impaired, and eighty percent received services funded by Medicaid.

With support from an AoA planning grant, the program was founded by Greater Southeast Hospital in 1978 as a separate, but related, nonprofit organization. Community-wide participation in the early planning process was extensive. A skilled and intermediate care facility was developed and is now a teaching nursing home site. A multi-service senior center, constructed on the campus of the facility, opened in 1981 and houses several of the program's core services. Expansion into Maryland came in 1983.

d. Parkland Memorial Hospital
   Dallas, Texas

Parkland Memorial Hospital's Geriatric Services Program serves Dallas County, which includes Dallas and 22 other urban and suburban cities and towns. Parkland is the county hospital and shares its campus with the University of Texas/Southwestern Medical School.

The program provides inpatient, discharge planning, screening and multi-disciplinary assessment, and case management services. It administers the Access Center for the Elderly (ACE), a network of 45 affiliated organizations providing services to older adults living at home in high risk circumstances. A broad array of services is offered by the organizations participating in the ACE network.

The program reaches about one percent of the elderly population of the area. Six percent of clients receive services funded by Medicaid. Fifty-two percent are black; ninety percent are residents of the city proper. Nearly 50 percent have household incomes under $20,000. Eighty percent are moderately or substantially impaired.

The Geriatric Services Program is the product of a "Center of Medical Excellence Concept" initiative launched by the hospital's CEO in the early 1980's. His interest in geriatric medicine (he is a board-certified internist and geriatrician)

triggered development of the system of care sponsored by the hospital. The hospital received a Robert Wood Johnson Foundation grant to develop long term care services in 1984, targeting indigent older persons primarily. The Geriatric Clinic was expanded in 1987 to provide a primary care experience for residents in internal medicine, and a Geriatric Nursing Clinic now allows area physicians to refer complex geriatric cases to a multi-disciplinary geriatric assessment team.

e. Parkside Senior Services
Arlington Heights, Illinois

Parkside Senior Services/Older Adult Services serves the northwest side of Chicago and the northwest suburbs of Arlington Heights, Des Plaines, Mount Prospect, Park Ridge, Rosemont, and other towns in the vicinity of O'Hare Airport. It is a predominantly middle income area.

The program offers adult day health care, rehabilitation services, home delivered meals, geriatric assessment, information and referral, emergency response, and family education and support. The acute care services of Lutheran General Hospital, the founder, are not immediately linked, as this system is administratively located outside the hospital's corporate structure. Older Adults Service also delivered case management services, but spun them off when the Illinois Department of Aging decided that the arrangement raised the issue of potential conflict of interest.

Four percent of the area's older population receive services from the program. Ninety-nine percent of clients are white. Five percent receive services funded by Medicaid. Ninety percent are moderately or substantially impaired.

Older Adult Services began in 1978 as a program of the hospital with a planning and geriatric assessment grant from the Retirement Research Foundation. It developed around a core program component of adult day care and geriatric assessment. Lutheran General's CEO at the time had also served in that capacity at Greater Southeast Hospital when that program was initiated. His interest in hospital-sponsored programs for older persons was instrumental here, as well. During his tenure, the Lutheran General System has become a nationwide confederation of health and human service providers, and Older Adults Services current operates within the framework of a "Parkside Senior Services" corporate subsidiary.

3. Residential Model Study Sites

a. Ebenezer Society
Minneapolis, Minnesota

Ebenezer Society defines its service area as the seven county metropolitan area encompassing the Minneapolis and St. Paul areas. Most community services clients live in Minneapolis (Hennepin County). The program array of the community services component includes home health care, personal care, homemaker services,

adult day care, respite care, outreach, case management, health promotion, protective services, and caregiver support. All services are provided directly by the organization. Ebenezer provides long term care insurance through a social health maintenance organization known as Seniors Plus, under which participating medical centers and Ebenezer become the exclusive Medicare providers for members. Benefits for Seniors Plus include case management and 80 percent coverage of many non-Medicare covered home care and nursing home services. The community services program is administratively and programmatically linked to the Society's traditional residential array of services.

Sixty percent of the community services program's clients live within the city limits. Ninety percent are white. Seventy-five percent have household incomes less that $10,000, and eighty percent have some substantial functional impairment. Five percent receive services funded by Medicaid.

The Ebenezer Society was founded in 1917 and has continuing ties to the Lutheran Church. The community services arm was established in the early 1970's to address the needs of older persons waiting for nursing home placement. Early financing for community-based services was provided in part by pass-through Title III funds. In 1987 the Society became an affiliate of the Lutheran General Health Care System, a national confederation of health and human service organizations developed under the leadership of the CEO responsible for founding Greater Southeast Community Center for the Aging (Washington, D.C.) and Parkside Older Adult Services (Illinois). Within that confederation, Parkside Older Adult Services and Ebenezer are both part of what is currently known as Parkside Senior Services.

b. **The Eddy Family of Services**
   Troy New York

The Eddy Family of Services serves the Greater Capital Region of New York State, which includes Albany, Rensselaer, Schendectady, Saratoga, Columbia and Greene Counties.

The group of organizations known collectively as "the Eddy" are separate corporations clustered around a core "Eddy" parent that sells management services to the affiliates and coordinates their activities and programs. The Eddy Memorial Geriatric Center provides skilled nursing and intermediate care, adult residential care, congregate living, adult day care, and respite care. Senior Care Connection provides information and referral and case management services to the community. The Alzheimer's Disease Center offers education and diagnostic services to Alzheimer's patients and their families. Durable medical equipment and transportation services are offered by other related corporations. The Capital Region Geriatric Center offers geriatric acute and skilled levels of rehabilitation, Alzheimer's day care, home care, screening and evaluation services, and outpatient clinic care. The Capital Region Ford Nursing Home is a skilled nursing facility. Beechwood, Inc. is a retirement community. Construction is proceeding on "Heritage", a skilled nursing facility.

Three home care corporations provide a broad array of in home health, chore, nursing, personal care, nutrition counseling, and emergency response services.

Five percent of older persons in the service area are served by the Eddy Family. Ninety-six percent of clients are moderately or substantially impaired. Thirty-two percent receive services reimbursed by Medicaid. Almost eighty percent have family incomes under $20,000.

The system began as a small skilled nursing facility in 1925. The present system developed when the facility's major benefactress died and left the organization with an unanticipated substantial bequest. A core group of planners developed the systemic framework for what is now known as the Eddy Family. The configuration has developed through affiliation with existing services and through the direct introduction of programs within the Eddy framework.

c. Handmaker Jewish Geriatric Services, Inc.
Tucson, Arizona

Handmaker Jewish Geriatric Services, Inc. serves Pima County (Tucson and environs), Arizona. The multi-level nursing home is known as Handmaker Jewish Geriatric Center, while the array of community-based services is known as Handmaker Senior Services. The system began by offering intermediate and skilled nursing care and an assisted living, residential community. Community-based services are organized within a distinct administrative framework and include home health care, in-home meals, congregate meals, adult day care, respite care, rehabilitative services, and in-house pharmacy services. Outreach, case management, health promotion and education services are planned. All services are provided directly by the organization, and its meals are prepared in a Kosher kitchen.

Less than one percent of the region's 122,850 older persons are served by Handmaker Senior Services. Although the original target population was the elderly Jewish community, the program is presently non-sectarian and reaches out to disabled younger populations, as well. One hundred percent of clients are moderately or substantially impaired, and approximately three percent of noninstitutionalized clients receive services funded by Medicaid. Sixty-eight percent are 75 years old or older.

Handmaker Jewish Geriatric Center was known as Handmaker Jewish Nursing Home at its founding in 1963, with substantial early participation by the Jewish Federation of Southern Arizona. It was originally a 40-bed skilled nursing facility. Its name was changed when community-based care was introduced in 1977, reflecting the developing multi-faceted character of the organization.

d. Miami Jewish Home and Hospital for the Aged
Miami, Florida

Miami Jewish Home and Hospital for the Aged (MJHHA) serves the elderly

population of Dade and South Broward counties, Florida. The area encompasses nearly two million people, of whom about 580,000 are over the age of 65.

The array of in-home and community-based services includes home health care, personal care, homemaker services, in-home and congregate meals and other nutrition services, adult day and respite care, case management, mental health services, and health promotion. These are delivered in a number of ways -- directly by the organization and through a range of contractual arrangements with related and independent providers.

Although the core residential programs are directed to the area's Jewish population, 38 percent of community and in-home clients are hispanic or black. Eighty-five percent have household incomes under $10,000, and 50 percent receive services reimbursed by Medicaid. Ninety percent are substantially impaired.

MJHHA began in 1947 as a 12 bed nursing home funded by Jewish philanthropy. Rapid increases in the number of nursing home beds could not keep pace with demand, bringing the organization to begin considering community-based care alternatives in the 1970's. The initial community program, begun in 1976, was adult day care, which expanded to several area sites with the financial support of the City of Miami, the Department of Health and Rehabilitative Services the United Way. MJHHA was designated as a Channeling Demonstration site. This site was subsequently approved for 2196 Medicaid Waiver funding after the demonstration ended. The Stein Gerontological Institute was founded in 1981 to develop a body of clinical, behavioral, economic and systems research leading to enhancements in the ability of older persons to lead independent, useful lives. Its special focus has been evaluation and transfer of technology in services to older persons through its Technology Center for Independent Living.

e. Otterbein Homes
Lebanon, Ohio

Otterbein Homes is a comprehensive retirement community providing three types of independent housing (cottage, duplex, congregate) and three levels of care (personal, intermediate, and skilled) from five residential campuses in Ohio. The largest of these, with 720 residents, is in Lebanon, where this site visit took place.

Formally, services provided by the organization are directed exclusively to residents of Otterbein's residential and nursing home facilities. However, the Lebanon campus has a variety of working agreements and understandings with county agencies, and Warren County Community Services provides a range of programs from a location immediately adjacent to the campus in a building owned by Otterbein.

One of three present Warren County Commissioners also heads Special Services for Otterbein. These arrangements give the organization important influence in delivery of services for older persons in Warren County.

In the Lebanon study site, 71 percent of clients have household incomes under $20,000, and approximately 15 percent receive services reimbursed by Medicaid. Forty-four percent are moderately or substantially impaired. Ninety percent are 75 years old or older.

The Lebanon site was initially a Shaker Community, settled in the early 1800s. The United Methodist Church acquired the site and developed an orphanage and home for the elderly. These were formally separated in the 1960s. The Otterbein Gerontology Center was established in 1975 to provide educational and training services.

B. Study Findings

Our proposal to AoA posed five basic questions as the framework for this study. They are presented below.

Research Question #1: What conditions, factors, and arrangements in a community give rise to a CBSC for older adults?

Research Question #2: What are the necessary steps in planning and design?

Research Question #3: How are successful CBSCs established and maintained?

Research Question #4: How does the type of the lead organization influence and reflect a system's accessibility, responsiveness and effectiveness?

Research Question #5: To what extent and under what circumstances can CBSCs be replicated?

Our findings are organized to address each of these questions. Findings for questions 1 through 4 are presented in this chapter. Answering Question #5 requires that we reconsider these findings in light of their implications for replication in new communities, so this discussion is presented under "Discussion and Implications of Results" in Section IV.

In order to standardize responses to these study questions as much as possible, our general format is to first discuss findings about all types of CBSCs, and then to compare and contrast each type of lead organization; AAA, hospital, and residential setting.

1. <u>What conditions, factors, and arrangements in a community give rise to CBSCs for older adults?</u>

This question refers to what key ingredients were present in the lead organizations and local communities at the time the organizations began building their systems of care. To answer this question, we looked back to the start of the AAAs to examine the individuals and community needs identified as influential in the emergence of the AAA. For hospitals and residential model study sites, we examined the factors that led to expansion beyond their core service (i.e., acute care or nursing home care).

Our major source of data for this research question was personal interviews on-site with current system leaders and/or previous influential individuals who were involved at the start of service system development and expansion. We asked identical questions of these individuals at all sites to gather consistent information.

Findings from this research indicate that CBSC's can be developed in any type of community, as long as there is an organization committed to serving the diverse needs of the older population. This generalization applies whether a locale is rural, suburban, or urban and regardless of the socioeconomic characteristics of older adults in the community. Certain key ingredients were always present in the study site communities:

o one or a few local individuals with a highly developed vision of a "continuum of care" for the older population, and a strong sense of their organization's role in the continuum;

o a "service vacuum" -- one or several badly needed missing services; and/or "service fragmentation" -- unrelated organizations delivering single services to older adults without communicating with each other;

o local political support for development/expansion of services to the older population; and

o access to new funds and/or new sources of funds, together with the ability to manage, allocate and control the uses of these monies to achieve system objectives;

These key ingredients were found at nearly all of the 15 sites when the service system for older adults was first established by the lead organization.

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In most communities the local visionaries were already affiliated with their lead organizations, but in a few communities they were hired to implement a plan established by a group of advocates or health professionals who predated the organization. In the latter communities, the hired visionaries were clearly responsible for the successful implementation of a system of services for the local older population. Nearly all visionaries have had very long tenure at their lead organizations.

The term visionary describes individuals who can look beyond current crises or long-standing problems, set goals for the development of services that will meet the social and health needs of the local older population and propose the ways in which the delivery of services might be organized. Two types of approaches were taken by such individuals to formalize their visions: area-wide needs assessments and long-range planning based on past service experience. The former approach involved the local older population in expressing social and health service needs, while the latter approach was based on intuition about needs stemming from demands for a core service (e.g., nursing home care).

Serious gaps in service existed in many communities prior to introduction of the new systems. This was particularly true in rural locales. Several inner city communities suffered from the same problem, but they were also frequently burdened by fragmentation of existing services. Needs assessments and/or intuition usually led to identification of specific service vacuums and fragmentation.

Local political support for the lead organization at the start of the system took different forms, depending on the type of lead organization, but was a key ingredient in all cases. Individuals at the helm of lead organizations often found this to be the greatest challenge in establishing themselves as service system leaders. Among AAAs, those which were free-standing had to negotiate continually with service providers over turf for specific service control or influence, while simultaneously organizing Boards of Directors and Advisory Councils to help implement the organization's mission. Both study site AAAs located in regional commissions were able to persuade local leaders to assign high priority to older adult services at the start. This occurred when regional commission executives and their AAA directors held common views of aging issues and worked together to win the support of their boards.

Hospital-based interviewees in our study consistently reported that geriatric care issues would not have achieved prominence without the support of lead administrators. Even after being given the initial go-ahead to expand services to older adults, leaders of hospital-based eldercare systems often need to periodically advocate for and justify them anew, a reflection of the fact that geriatric services are not as clearly established or universally valued as other, more traditional hospital programs.

Among residential model study sites, political support usually focused on convincing Boards of Directors about the value of expanding beyond institutional care. These organizations and hospitals also reported the importance of gaining

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political support among service providers whose turf could be threatened by their service expansion.

Finally, access to new funds was a key ingredient at the start of most systems we studied. Specific funding sources are described below, but generally, the lead organizations were opportunistic in identifying and securing resources to realize their missions from the beginning. AAAs received new monies by virtue of their selection by State Units, but often pursued additional resources soon thereafter to expand services in their communities. Hospitals and residential model study sites either provided internal funds for early development of eldercare services, or pursued external funding for service expansion. Those organizations which took both approaches at the start have clearly visible programs or divisions that serve older adults in the community exclusively.

When the AAA was the lead organization, we found several similar conditions and/or arrangements at the start of their systems (four AAAs were designated by the State Unit on Aging in 1973 or 1974 and the fifth in 1980):

o lack of health and social services for the elder population;

o initial or early "visionary" Executive Directors who saw advantages in working closely with health and social service providers in their communities, which were defined by their State-designated planning areas and ranged from one county to eight counties. These Executive Directors would prove to have long-lasting tenures at their AAAs;

o desire by AAA to reach elderly in all parts of its service area through standard arrangements (e.g., same lead service providers in each county);

o commitment by sponsoring planning body (e.g., county officials) to aging issues.

Differences in conditions or arrangements at the start included:

o sponsorship of AAAs ranged from single or multi-county planning body subsidiary to autonomous, non-profit organization;

o availability of "seed money" for service demonstration before State designation: one AAA had federal (Administration on Aging) money for regional nutritional and social service delivery system. Other sites had no such funds to supplement Title III or pre-Title XX funds for social services to older adults at their inception.

When the hospital was the lead organization, we found the following similarities at the start of their service system development:

o presence of visionary who saw development of a CBSC for older adults as a way of generating new revenues (especially Medicare) for the hospital from this undeserved population;

o desire by original planners to develop specific services which would assist older adults before and after hospital episodes. The "continuum of care" concept drove service development, whereby acute care for older adults was but an episode in a much longer career of service needs due to chronic disabilities;

o access to external funding sources, with four of the five hospitals receiving external funding either for direct services or service planning at the start of system expansion.

There were also several differences among these hospitals in pre-existing conditions, including:

o sponsorship of hospitals: two were designated county hospitals, one was a community general hospital and two were private, non-profit hospitals at the start of their eldercare systems;

o degree of medical predominance in initial planning efforts, with two focusing on the medical model, a third following a more holistic health mission, and two embarking on a more ambitious social/medical model;

o resource "richness" of community, with two hospitals operating in a resource-rich community, and the others starting in communities where services for older adults were scarce or non-existent.

Finally, among the Residential study sites, we found more similarities than differences. Similarities included:

o lack of home and community-based service alternatives to nursing home placement;

o willingness of lead organization to develop linkages with public sector agencies and educational institutions to expand influence in community;

o AAAs in service area which were focused on more traditional AAA functions to complement health care orientation of residential models. In four of the five communities, AAAs are not directly involved in health and social service delivery, but provide funding, information, and referral services;

o sponsorship: four of the five sites are affiliated with a religious denomination which has influenced its mission and philosophy to serve older adults regardless of needs;

o expansion from residential facility. Only one residential model study site established an integrated multi-level continuum linking residential and off-campus programs and services as distinct components, to which residential care is programmatically unrelated.

Differences included:

o infusion of funding for expansion, with one receiving a large personal endowment, two turning to internal endowment funds, and two receiving both internal and federal research and demonstration funds;

o resource richness of the community, with two residential model study sites expanding in resource poor communities and the others expanding where levels of existing services are moderate or very rich. Competition among service providers is especially acute in the latter two communities.

These patterns of similarities and differences allow the conclusion that most communities today have in place organizations which could take the lead in building CBSCs for older adults. Necessary key ingredients to launch new CBSCs include leaders with vision about how to coordinate services, political support behind service expansion, and financing opportunities for innovative service ideas.

2. What are the necessary steps in planning and design?

The terms "planning" and "design" are often used synonymously. For this discussion to have meaning, a distinction must be drawn between them. As used here, planning refers to information gathering, and analytical processes -- assessing community needs; conducting inventories of resources, organizations, skills and services; organizing and displaying information; conducting meetings and public hearings; establishing agreements and building consensus.

"Design" refers to the decisions that are expected to emerge from these activities -- stated system goals, objectives and strategies; working agreements and responsibilities of key actors and organizations; completion timetables and milestones; financing schemes; and administrative structures and procedures.

In the real world, planning and design often overlap as design drafts are developed, considered and modified in light of shifting and emerging planning considerations.

a. The Roles of Planning and Design for Community Based Systems of Care

The question, "What are the necessary steps in planning and design?" when applied to community based systems of care for older people, conjures up images of community meetings, needs assessments, public hearings, formal planning sessions; all leading ultimately to the detailed design of systems whose characteristics emerge

as the rational expression of careful analysis and extended discussion. We found that while planning did occur early in the development of the systems described here, the fact that the systems were shaped by one or a few people had a far more significant impact on their actual designs. These key actors did not stop at triggering the development of systems in communities. They also took the lead in designing them. Their decisions were influenced more by intuition and opportunism than by elaborate data gathering or formal planning processes. In other words, designing actually preceded planning or developed in loose relation to it. The founders' early visions shaped the designs, while rational planning processes validated and ratified their design decisions. These processes generated evidence and support for what the systems' builders already knew or believed.

It is not surprising that community-wide planning processes were more frequently associated with AAA-driven programs than those sponsored by hospitals or residential facilities. In these latter study sites, efforts were generally directed more to winning agreement among various internal constituencies than in the community at large. In all cases, a crucial design element was the sensitivity of systems builders to the climate--institutional, political, inter-organizational, socioeconomic, financial, and cultural.

b. Factors Influencing Planning and Design Decisions

Certain planning and design considerations applied across all types of systems in our study, while others were specific to the nature of the lead agency.

Program design considerations for all types included the extent to which programs and services were already present in the community at the start; the extent to which existing programs and services were already controlled, and by whom; and the extent to which critical services were absent or inadequate. These issues are closely related from a design perspective.

For all study sites, the systems' founders sought to extend the linchpin organizations' influence over what was already in place, improve coordination and integration throughout the community, and find ways to create new services where they were insufficient or unavailable.

All the programs in our study moved to fill gaps in service. One hospital sponsor built its cluster of programs around adult day and respite care. Another hospital used geriatric screening and community education programs as programmatic springboards. Where services were already present, the objective of the system builder was to gain influence over and access to them. One AAA in our study helped create a new nutrition services organization; but it also gained a high degree of influence and control over existing in-home health and social services through development and control of the case management function.

We also found that it was generally easier to develop care networks in resource poor environments. The new undertaking generally brought new resources

to the community, and competition from existing institutions and systems was less likely to impede the effort. In resource rich environments, competition and resistance to centralized control were more commonplace. Hospital and residential sponsored programs in resource rich environments were likely to be smaller and more self-contained. In these circumstances, organizations designed small clusters of critical services such as adult day and respite care, senior membership, and lifeline, with informal agreements and referral arrangements to providers in the wider community.

The relationship between types of linchpin organizations and system design considerations revealed more detailed findings and implications.

(1) AAA systems: AAAs are the aging network's official instrument for service coordination at the community level. The coordination and development of community based programs is so central to the AAA mission that its immediate task is to find ways to generate services or to link them together. However, we found that the capacity of AAAs to influence services and providers beyond the traditional constellation of social and nutritional programs varied greatly from community to community. For AAAs, the barriers included limits on resources, a general prohibition against direct delivery of services, and lack of influence over providers of acute and nursing home care.

The five AAAs in our study addressed these problems and constraints by pursuing funding from many sources in addition to Title III, using these expanded resources to increase influence and leverage, and creating comprehensive case management systems that centralized AAA control over the client pathway to services. These delivery and financing design strategies shaped AAA system development in every community studied. One metropolitan AAA gained control over Title XIX and Title XX funds directed to the region. Other AAAs built their programs directly on foundation-funded or state-funded case management demonstrations.

Regarding service delivery, three of the five AAAs we studied chose to provide case management services in order to influence client pathways to service delivery. One of these used its new case management capability to strike a "handshake agreement" with a local hospital's discharge planning unit; thereby linking acute care, in-home services, and social programs. The remaining AAAs chose a contracting design for their systems' case management services. These design decisions were based on political constraints from state and regional governmental agencies.

(2) Hospital-based systems present different challenges to program designers. They also enjoy certain advantages. Often, the impetus to establish community programs is a perceived market opportunity to capture older persons, to encourage them to use services while they are still essentially healthy. The expectation is that healthy older persons come to regard the hospital as a comprehensive care provider to which they will continue to turn as their needs

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change. The advantage to the hospital is that the claim of these programs on institutional resources is generally not great in comparison to other, more traditional hospital program components.

The hospital is not prohibited from delivering services on its own; in fact, the impulse to extend its capacity to manage the care received by hospital patients and offer discharge planners immediate access to community-based options is often a critical consideration. The availability of hospital sponsored community-based care can ease the discharge planner's burdens and permit physicians to "stage" patient care based on level of need more appropriately. Levels of care can be designed to address patients' needs more appropriately and cost-effectively.

Hospitals often possess more resources than any other local provider organization. One inner city hospital system developed for just this reason. The hospital's leadership realized that critical resources were simply not available in the surrounding low income neighborhood. It was the only local institution capable of mounting a significant response. Here, perceptions of immediate compelling need, as well as a commitment to the hospital's mission as comprehensive care provider, triggered system development.

Barriers spring from the fact that the hospital is not intrinsically in the business of providing care to older persons outside the acute care setting. Changing regulations and reimbursement mechanisms can quickly alter a hospital's perception of the market. Furthermore, physicians and home health agencies often view screening, community education, and in-home care programs sponsored by hospitals as competitive to their own function, motivating them to work against the creation of the service array or refuse to support its full development.

Factors beyond the immediate scope of elderly services may also threaten the undertaking. One hospital in this study approached the development of a comprehensive care system by creating a senior services subsidiary. The program array developed rapidly for a time, but the subsidiary corporation was dissolved after the parent hospital merged with four competitors. The priorities of the newly created hospital confederation did not accommodate a senior services subsidiary arrangement. Certain community programs were spun off to various traditional hospital program departments or were sold off. Senior membership, community education, and a cluster of clinical screening programs are the essential remaining components in what was at one point a more extensive continuum. This is an illustration of the problems planners face in fitting a lateral array of elderly services and programs within the vertical chain of command structure of most modern hospitals.

The question of where to locate a hospital program is a major design consideration. One metropolitan hospital has begun developing a nationwide network of acute care, outpatient, and elder services programs, expanding rapidly from its traditional suburban base. Its local elder adult services component is now administratively located within a separate subsidiary senior services organization linked to the parent entity through a complex interorganizational chain of command

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structure. However, the system continues to reorganize, searching for a way to control and link its growing constellation of program components. The final administrative location of the community care system we studied is very much unknown. In the interim, separation from the hospital parent seems to have weakened the program's linkage to the hospital's discharge planning unit. The routinely collaborative mechanisms of discharge planning and referral generally expected from programs sponsored by hospitals have not been fully developed here.

(3) <u>Residential systems</u>: Residential facilities seem to be particularly promising linchpin organizations for community-based systems. They have the advantage over AAAs of being able to create and administer programs and services directly. They are more centrally focused on serving older people than hospitals. The major design consideration here appears to be the availability of resources. These organizations are not as likely as acute care facilities to be able to claim or shift monies and manpower. The availability of new dollars or access to nontraditional sources of funding seems to be a critical prerequisite. One of the very strong programs in our study developed from a core 18 bed skilled nursing facility only as the result of a substantial bequest. Another was able to self-finance expansion while two others aggressively pursued grant funds and contracts. Two of these systems began in institutions whose size and range of resources at the start rivaled those of a well developed hospital.

Residential sponsorship often provides these systems easier access to discharge planning units of hospitals than is generally available to AAAs. The social service emphasis of AAAs may be perceived by physicians and hospital administrators as remote and irrelevant to the medical model of care. By contrast, many retirement communities and all nursing homes provide medical services or monitor the physical health of their residents. However, residential sponsors seem to have difficulty integrating noninstitutional community-based services. In four of the five residential model study sites, these components operated semi-autonomously.

3. How are successful CBSCs established and maintained?

We have examined the circumstances that give rise to community-wide systems of care and explored the factors that influence their design and development. This section discusses what we learned about how strong systems are managed and maintained.

Findings from the 15 study sites indicate that maintaining strong programs required:

o   retaining key staff as systems develop;

o   expanding the funding mix;

o   continuing to introduce new programs and services, especially case management;

o   sustaining political support, and;

o   effectively managing the developing system.

a. Retaining Key Staff

(1) <u>AAA systems'</u> ability to retain key staff was particularly impressive, given the fiscal constraints associated with living and working within the aging network. Rural AAAs appeared to benefit from being among the major human service employers in their regions. Other AAAs tapped local universities for help in designing client tracking systems, conducting needs assessments, and developing nutritional and health educational programs.

(2) <u>Hospital systems</u> were triggered by visionary administrators and key clinicians working together. The hospital CEO's support for community-based programming was crucial, whether or not that individual actually participated directly in planning and development. These collaborations were vital in overcoming physician resistance, building bridges among hospital operating units, and maintaining the pace of development within tradition-bound acute care settings.

(3) <u>Residential systems</u> benefitted from a focus on aging clients from the start. They were in the position to locate and hire individuals with specific skills -- financial, planning, technical, service delivery. Their knowledge of geriatric issues and programs helped them recruit high quality staff for their noninstitutional service divisions. Residential systems also appeared to be more able to hire talented people outside narrowly defined geriatric disciplines.

b. Expanding the Funding Mix

Nearly all study sites successfully tapped significant new financial resources early in their programs' history. Often these resources were captured opportunistically, by identifying and exploiting once-in-a-lifetime funding opportunities. Successful programs also managed to continue diversification of funding sources, although "second stage" development occurred more cautiously and systematically.

(1) <u>AAA systems</u> expanded their access to resources beyond Title III and the Older Americans Act to include Titles XIX and XX; legislatively appropriated state funds; and foundation, corporation, and United Way support. A crisis sometimes developed when critical seed monies began drying up and new sources had to be located to sustain the newly created services. One AAA headquartered within a county public welfare department successfully drew upon public welfare dollars, which were directed to the needs of financially dependent older persons.

Case management demonstration funds are excellent ways to gain influence over a clients' pathway to care. A critical stage occurs when those funds end and replacement funds need to be captured. For example, one AAA obtained time-limited

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foundation funding for design and development of its case management system. The system is now fully operational, but the phasing out of demonstration funds weakened the AAA's position with certain providers.

(2) Hospitals systems exhibited a high degree of variation in the extent to which resources were available at the beginning of the planning and development phase. One hospital program began with a planning and service development grant from the Retirement Research Foundation. Two hospitals in the study financed system development from unallocated operating funds. Although these programs do not produce sufficient revenues to cover their costs, their claim on hospital resources is relatively modest. The lack of visibility of these "hidden" programs often protects them from controversy. However, they are also vulnerable to changes in hospital-wide priorities. They exert little or no control over their financial resources, and their destiny is in the hands of other administrators further up the chain of command.

One public hospital in this study targeted the elderly because of their Medicare eligibility. The hospital treats many indigent clients; consequently Medicare revenues were seen as an attractive source of funding despite the revenue limitations of Medicare's prospective payment system. A subsequent Robert Wood Johnson Foundation long term care grant enabled the hospital to further develop geriatric services. Then the hospital affiliated with a medical school; the two entities created a regional "Center of Excellence" in geriatrics. Most recently, the hospital supplemented revenues by initiating a Senior "Gold Card" Membership program.

(3) Residential systems were innovative in locating new revenues for community-based care. Financing was obtained through Title III pass-through funding arrangements, from fund raising efforts, from United Way funding, and from foundation awards. One residential model study site promoted long term care insurance by requiring everyone on its waiting list and all older persons in residence below a certain age to purchase it. Another facility acquired a local Visiting Nurse Association home health program and purchased a rehabilitation hospital to diversify funding and gain control over the cost of treating clients.

c. Continuing to Introduce New Programs and Services

All study sites have steadily expanded their mix of services, a factor immediately related to their capacity to diversify funding. Core clusters of services often developed in response to founders' visions and compelling needs. Subsequent development reflected a more systematic appraisal of needs, funding opportunities, and program-wide development priorities. As during early developmental stages, the appearance on an unforseen funding opportunity may trigger an opportunistic response. However, several systems consciously decided to constrain further growth, out of concern for the long range financial viability of the proposed programs or because the new services would represent entering fields already occupied by competitors.

The single most important service added by linchpin organizations to firmly establish or sustain their CBSC was case management, or care management as many AAAs refer to this service. Most organizations saw case management as the opportunity to coordinate multiple services for older adults, as well as to access new funding sources for their growing service systems. Figure 3 summarizes several aspects of case management services established by the 15 study sites. Names of sites were included in Figure 3 so that interested readers could contact any site whose profile was particularly relevant to their own circumstances.

One of the most striking features of Figure 3 is that the style of case management delivered by AAAs, hospitals, and residential models varies considerably. This variation illustrates the lack of standardization in the long-term care nomenclature regarding case management. All five AAAs in this study practice what is referred to in Figure 3 as "comprehensive" case management. Comprehensive case management means that older adults living in their own homes receive a detailed health assessment from a case manager to determine eligibility for publicly-funded home and community-based services. If eligible, case managers construct a care plan to address the client's needs, determine what funding source(s) will pay for services, and contact appropriate service providers to arrange service delivery. Once services are in place, case managers periodically reassess the client and adjust the care plan accordingly. Finally, in the comprehensive model, case managers also must carefully monitor their budget, because public funding for their caseload is usually capped and monitored by their supervisors. Two hospital CBSCs and one residential study site also practice comprehensive case management as defined in this project.

Other case management styles practiced by study sites are more limited in scope. Among hospitals, one site provides assessment and referral services for older adults with Alzheimer's Disease if the client and family visit the hospital for diagnostic evaluation. Although case managers are responsible for helping arrange services, their involvement does not include pooling funding sources or periodic reassessment on a systematic basis. Another hospital provides assessment services for older adults through referrals from service organizations in the community, but their involvement ends after recommending a supplementary care plan to the referring organization. These case managers do not manage their own service budgets as in the comprehensive style.

Among residential models, two study sites offer case management services which differ from the comprehensive style. One site, however, has practiced case management since 1972 for its clients by assessing and referring them to services offered within its own system of services. This approach has continued for older adults enrolled in the social health maintenance component of the system, which has operated since 1985. Compared to the comprehensive style, case managers at this site do not have access to public funds for service payment, nor do they interact very

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FIGURE 3

**COMPARATIVE PROFILE OF CASE MANAGEMENT (CM) SERVICES DELIVERY,
SITES IN NATIONAL ELDERCARE SYSTEMS PROJECT***

	Yr.Started	CM Style	How Provided		Funding Sources for CM Service					
			Direct	Contract	Client	Medi-caid	State	SSBG	AoA Title III	Other
AAAs										
Aroostook	1981	compreh.	X		X	X	X	X		Found.
Atlanta	1983	compreh.		X	X	X	X		X	Found.
Region IV	1983	compreh.	X			X	X			
First Tennessee	1980	compreh.		X	X	X			X	Found.
Monterey	1985	compreh.	X				X			

* Source: Screening Questionnaire: telephone conversation with site staff; field notes.
See text for more detail about abbreviations used in this table.

FIGURE 3 (contd)

**COMPARATIVE PROFILE OF CASE MANAGEMENT (CM) SERVICES DELIVERY,
SITES IN NATIONAL ELDERCARE SYSTEMS PROJECT**

	Yr.Started	CM Style	How Provided		Funding Sources for CM Service					
			Direct	Contract	Client	Medicaid	State	SSBG	AoA Title III	Other
Hospitals										
Greater SE	1982	compreh.	X					X (from AAA)		
Parkside	--	none (I&R)								
Good Samaritan	1989	limited to hospital	X		X					HCFA Alzheim ers demo
Parkland	1983	assessment & referral	X						X (from AAA)	
Craven	1984	compreh.	X		X	X				

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FIGURE 3 (contd)

COMPARATIVE PROFILE OF CASE MANAGEMENT (CM) SERVICES DELIVERY, SITES IN NATIONAL ELDERCARE SYSTEMS PROJECT

	Yr.Started	CM Style	How Provided		Funding Sources for CM Service					
			Direct	Contract	Client	Medicaid	State	SSBG	AoA Tile III	Other
Residential										
Miami Jewish	1918	compreh.	X		X	X	X	X	X	Found.
Otterbein	-	none								
Eddy	1988	limited	X		X					
Handmaker	-	none								
Ebenezer	1972	limited	X		X					Found.

much with other service providers in the community. The other residential site has just introduced case management, which is a fee-for-service arrangement with clients and focuses on linking clients with services offered within the lead organization's service system.

Figure 3 also indicates that when case management is introduced as a new service in CBSCs, lead organizations usually provide the service directly rather than contract to others. Even among AAAs, three of the five sites provide case management directly. Finally, a diverse set of funding sources helps pay for case management, especially under the comprehensive style. Private foundations are shown as funding sources for case management in several sites as well.

In summary, case management has been introduced in most study sites as a strategy for continuing to sustain their growing CBSCs for older adults. AAAs have adopted a style allowing them to access and pool public funding sources, while communicating with other service providers to carry out individual care plans. Residential models have adopted a style which links clients with services already offered within the organization. Hospitals have adopted both styles of case management. Finally, one of the residential sites is now considering adding a case management program in conjunction with another community agency. Case management is clearly a critical service in the eyes of all types of organizations wishing to establish and maintain CBSCs for older adults.

d. Sustaining Political Support

Continued political support is necessary for maintaining successful eldercare systems. As used here, the term "political support" applies not only to the realm of government but also to the whole range of institutional arrangements between programs for older persons and other departments within the same organizational settings.

(1) Political considerations for AAA systems: When AAAs "stand alone" -- that is, function autonomously, coordinating services for older person -- they may be vulnerable to the shifting and colliding priorities of local political officials who frequently serve on AAA boards of directors. One AAA director neutralized conflict of this kind at the board level by bringing policymaking functions into the range of decisions made by executive staff. Simultaneously, the AAA advisory board was given broader powers to contract with providers and gather data on community needs, giving the agency continued visibility and credibility in the community. This arrangement appears to be stable, at least for the duration of the current executive's term of service.

AAAs functioning within regional development districts and as departments of larger public human service organizations confront different problems and opportunities. One AAA developed rapidly as a department within a regional agency. However, abrupt changes in board and executive leadership reduced aging programs'

priority in the agency. The system remains intact, but has lost visibility and political capital and is more vulnerable to abrupt changes in policy than in the past.

Another AAA administratively located within a seven-county urban development district clearly benefits from its autonomous position among other unrelated departments. Ranking executive staff of this district support the AAA director's effort and intervene only to help head off problems. However, a change in this district's executive leadership could trigger a sudden reversal in the AAA's fortunes.

(2) Political considerations for hospital systems: Hospital-based systems are potentially susceptible to organization-wide changes in priorities and goals. Many hospitals that entered the community-care field in the early 1980s have retrenched as reimbursement formulae make it harder to recover costs. One hospital in this study originally conceptualized its program as a quasi-independent subsidiary that would offer a range of nonacute care services -- screening, outreach, community and professional education, in-home nursing, senior membership. When the hospital merged with four others, its priorities and service strategy changed. The subsidiary idea was discarded, many programs were spun off, and several others were repositioned in various departments within the hospital. The core of clinical screening, diagnostic and treatment services that preceded the development of the system remains in place. Two other study sites operate entirely outside the administrative rubric of their founding hospitals, within related senior services organizations. However, the parent corporation of one has gone through an almost continuous process of corporate restructuring, making the administrative future of the program hard to predict. Furthermore, its administrative separation from the hospital has weakened its referral linkage with the hospital's discharge planning unit.

Conceiving hospital-based community care as a way to control costs and coordinate services may help to assure the permanency of the system in a hospital setting. One rural public hospital site developed a case managed system on this basis and has neutralized physician resistance, in large part, by presenting it as a way to provide various levels of care for patients not requiring hospitalization.

(3) Political considerations for residential systems focus essentially on the tension between those within the institution who define its mission more narrowly, as primarily residential in character, and those advocating for a broader definition of care. Systems operating where long-standing shortages of nursing home beds are the rule generally have an easier time developing and sustaining community-based alternative services. The ability to sustain political support for community-based care is vital to this system's survival, since the tendency of Board members is to retrench toward the institutional component during times of fiscal uncertainty.

e. Effectively Managing the Developing System

In almost every site we studied, the founding executive of an established program focused energy and attention on the external world, delegating responsibility

for daily operations to a trusted deputy while contending with political issues, funders, policymakers, and the media. Specialization of leadership functions generally occurred in the very early stages of system development, regardless of system type.

(1) Management issues for AAA systems: We expected to find that case management is a critical component in all systems. We learned that it is a powerful management tool by which AAAs coordinate client access to care and manage their contractual relationships with provider agencies in the community. It is less vital as a primary control mechanism in other types of systems, reflecting the fact that most AAAs contract and subcontract the systems they control, rather than deliver services directly themselves. Four of the five AAAs in this study fit this description. Their capacity to use Title III and other public funds creatively in case managed environments is the key to their success.

(2) Management issues for hospital systems: It bears repeating that hospitals often experience difficulty fitting laterally configured eldercare systems within the vertical chain of command structure of the modern hospital. One hospital in the study resolved the problem by placing administrative responsibility for aging services in the same administrative unit as utilization review and discharge planning. Others placed their programs in related, but distinctly different organizations. The major maintenance issues in these settings included overcoming the opposition of physicians, who often see the programs as competing with them for patients, and sustaining the high level support of hospital boards and CEOs, who may require re-education concerning the place eldercare services occupy in the hospital environment.

(3) Management issues for residential systems: Most residential facilities placed community services within a distinct administrative unit, accountable to CEOs. Many function essentially autonomously, pursing their own funding and making their own decisions. It is generally more important that community service components approach or achieve balanced budget outcomes in residential programs, since parent organizations generally have fewer places to hide program deficits than hospitals.

For programs of all types we expected to find needs assessment, case monitoring, and formalized service evaluations as primary management tools. Similarly, we anticipated that computerized data systems would be closely associated with strong management. In fact, the extent to which these actually inform and support strong management varied widely from system to system. Many systems used "handshake" agreements of various kinds among linchpin organizations and providers limiting the capacity to monitor and enforce management decisions. Nevertheless, this appeared to work well when all parties viewed collaboration and commitment to quality services as intrinsic to their own interests.

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4. How does the type of lead organization influence and reflect a system's accessibility, responsiveness and effectiveness?

Sites were selected for our study because they ranked favorably on accessibility, responsiveness, and effectiveness compared to other candidates. The focus in this section is on these criteria and the strategies study-sites used to achieve them. Findings from this study shed light on the ways lead organizations opened their existing services to all types of older adults throughout their communities (accessibility); their strategies for developing new services to meet emergent needs in the community (responsiveness); and their mecha   ns established to assess how well they serve their older populations (effectiveness). Considerable variability in strategies was discovered among the three types of linchpin organizations, due primarily to differences in the missions of AAAs, hospitals, and residential sponsors. We also found approaches common to all types of lead organizations which have direct utility to any organization service older adults. Sources of data for this section of findings include our screening questionnaire, documents supplied by sites, and personal interviews conducted on-site. Figure 4 presents major strategies in matrix form.

a. Accessibility

Accessibility refers to the service system's ability to care for all kinds of older persons based on level of need, regardless of ability to pay, ethnic/racial background, and rural-urban residence. In most study sites, lead organizations worked vigorously to make their services accessible to all types of older persons. The biggest challenges were the isolated, rural elderly and the group with assets too high to qualify for publicly funded services but too low to pay out-of-pocket for services. Although sliding-fee scales were common, many older persons were reluctant to use limited financial resources for required co-payments. Transportation problems prevented the most isolated elders from being served in many areas, although some study-sites employed creative strategies for reaching them.

(1). AAA systems: Accessibility is at the core of the AAA mission as expressed in the language of the Older Americans Act, which mandates service to socially and economically disadvantaged elders. Study-site AAAs used several strategies to maximize accessibility. They were creative in decentralizing outreach and meal services, by allowing outreach workers to work out of their own homes to cover a designated part of the service area, and by using extensive volunteer networks to deliver in-home meals to isolated elders. Outreach workers in rural areas serve as the "eyes and ears" of the AAA when allowed to use their homes as offices, while volunteers use their own vehicles beyond the service area of AAA or other agencies.

The AAA contracting mechanism was seen as a more structural way to maximize accessibility, by providing AAAs with the leverage to assure their service providers meet population quotas. Successful AAAs carefully monitored contractors to assure services to targeted subgroups, even though service providers sometimes resented it. A major point of tension between AAAs and meals program contractors,

FIGURE 4

STRATEGIES FOR MAXIMIZING ACCESSIBILITY, RESPONSIVENESS, AND EFFECTIVENESS BY TYPE OF LEAD ORGANIZATION

	AAA	Hospital	Residential
Accessibility	Decentralize outreach and meal services	Decentralize older adult services beyond hospital campus and design transportation service to on-campus services	Decentralize by establishing home and community-based service programs or divisions
	Pool multiple funding sources and offer sliding fee co-payments	Develop on-campus services for poorer and self-paying older adults in geographic area (e.g., geriatric clinics, health promotion programs)	Develop join service and/or planning ventures with existing community agencies as fund-pooling strategy
	Monitor contractors to assure hard-to-reach subgroups served	Strengthen links between discharge planners and community agencies	

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FIGURE 4 (contd)

STRATEGIES FOR MAXIMIZING ACCESSIBILITY, RESPONSIVENESS, AND EFFECTIVENESS BY TYPE OF LEAD ORGANIZATION

	AAA	Hospital	Residential
Responsiveness	Maximize use of public hearings and needs assessments to develop consensus for expanding services	Conduct community needs assessment to establish service priorities	Respond to excessive demand for institutional care by developing alternative services
	Use Advisory Councils as community sounding boards	Base service development on special interests of visionaries	Study other providers in community for service gaps
	Respond to initiatives from State Unit on Aging and other funders for demonstration projects	Respond to services requested by patients and their families	Respond to initiatives from funders for demonstration projects
		Respond to initiatives from funders for demonstration projects	

FIGURE 4 (contd)

STRATEGIES FOR MAXIMIZING ACCESSIBILITY, RESPONSIVENESS, AND EFFECTIVENESS BY TYPE OF LEAD ORGANIZATION

	AAA	Hospital	Residential
Effectiveness	Use contracting protocols and case managers to monitor service effectiveness	Rely primarily on record review and standard setting	Rely primarily on record review and standard setting
	Obtain client feedback about quality of services through satisfaction surveys	Use client/family surveys for feedback	Obtain client feedback through informal serveys
	Use automated data systems for cross-sectional client profiles only	Use of client tracking system from acute care to community services emerging slowly	Use automated data in more established systems

for example, was the watchdog function AAAs played in assuring that the appropriate proportion of older adult subgroups were served each reporting period. In areas where there was only one such contractor, AAAs faced the dilemma of forcing quotas at the risk of losing this contractor. Study-site AAAs lived with that tension, balancing maximum accessibility against total withdrawal of services.

All five study site AAAs provide case management services to older adults and their families, either directly by agency staff or through contracts (see Figure 3 above). Case management allowed the AAAs to link a wide range of existing services with the frail older population, based primarily on level of functional disability. Case managers were available to older adults throughout the entire service area of the AAAs in our study, although in practice they did not always serve the entire area equally well. Most often, either the inner city minority groups or the most rural older adults were not served as well as others.

Accessibility to in-home services through case management was compromised to the extent that AAAs controlled only Medicaid waiver and state funds to pay for these services. Medicaid waiver program and most state (general revenue)-funded long-term care programs employed income means tests for eligibility, and if clients did not qualify or cannot afford co-payments, case management through AAAs was not available to them. Paradoxically, then, the poorer elderly often had greater access to AAA case management services. Two study site AAAs now offer private pay case management through contractors and one has begun to provide this service directly, which may enhance accessibility of this coordination service to a wider group of older adults. Thus, while case management allowed AAAs to finance and coordinate long-term care services available through their systems, not all older adults can benefit from the service.

AAA control over case management was also met with considerable resistance by home health agencies and multiservice agencies for older adults who provide direct services. Put simply, providers often regarded AAA-directed case management as a function they are far better able to carry out themselves. Indeed, many of them argued that they were already providing this service to their clients, rendering AAA case management duplicative and unnecessary. This is an obstacle AAAs should expect if they enter the case management business. Study-site AAAs handled this tension and resistance most often by conferring about specific cases with home health agencies on a regular basis to minimize duplication of effort. Another strategy they used was to limit case manager involvement in areas of their communities where especially vocal agencies provide services.

AAAs also used pooled funding sources to maximize service accessibility for older adults. One example from this study was an AAA that administered funds from its county for in-home and other disability-related services, Social Service Block Grant funds, state general revenue funds for case management, and traditional Title III funds for healthy and disabled older adults. All study-site AAAs described their never-ending search for new sources of funds to increase the number of older adults who can benefit from existing services in the community.

(2). Hospital systems: Hospitals are not bound to serve older people regardless of income or residential location in the community. Hospitals that decide to develop geriatric services have diverse goals in mind, take different service approaches, and adopt different organizational strategies (Capitman, et. al., 1988a). These differences, we found, were based primarily on the mission of the hospital and its geographic location.

Regarding mission, two study-site hospitals are directly accountable to the public due to county or municipal affiliation, one is part of a hospital chain, one is a non-profit, non-denominational community hospital, and the fifth has a religious group affiliation. Locations range from poor, inner city communities to middle class suburban and urban communities to a largely rural mixed economic community.

All study-site hospitals made deliberate decisions about which target groups of older adults best fit their missions and locations. They maximized accessibility by making services available to their chosen target groups. For example, the two public hospitals offer services that attract the poor older population, including comprehensive ambulatory medical services and AAA-funded case management in one site, and strong discharge planning with Medicaid-funded case management in the other. The poor inner city community hospital has its own transportation service which brings older adults to its on-campus multipurpose senior center and adult day care program, as well as a AAA-funded case management program. On the other hand, the two hospitals in middle class communities consciously targeted the self-pay older adult population and work hard to make services available to them. They channel poorer elders to local AAA-sponsored programs which the hospitals do not influence or control. One of these hospitals also offers a Senior Membership program with associated service discounts to older adults who can afford the membership fee and the non-discounted portion of services not covered by Medicare. The other hospital decentralized adult day care programs throughout its community, offering geographic accessibility to those able to pay for the service.

Study site hospitals also set their sights on new target groups of older adults and are expanding accessibility to their services accordingly. The rural public hospital began offering a Senior Membership program to the more well-to-do segment of older adults in its community to complement its Medicaid case management program. The urban public hospital is developing a sophisticated Community Oriented Primary Care system in several neighborhoods which will offer comprehensive ambulatory care to older adults, among other services. Finally, the urban community hospital set its sights on an adjacent suburban area and plans to offer its on-campus services to self-pay clientele at decentralized sites.

In general, hospitals placed more emphasis than AAAs on disabled older adults, since their core service is acute care. The sites in this study were very creative in maximizing accessibility to these primarily health-related services for carefully chosen subgroups of the older population in their communities.

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(3). <u>Residential systems</u>: Like hospitals, residential facilities had considerable latitude in choosing approaches to expand beyond their institutional service base and make services accessible to older adults living in their own homes. Although four of the five residential sites in our study have religious affiliations, none restrict their services to elders because of religious background. Residential sites also vary according to geographic location, with three in large cities, one in a medium-sized city, and one in a rural community. Those in cities, like hospitals, chose which target groups they wished to serve and organized themselves accordingly. They also targeted primarily disabled elders in order to develop home-based services which complement their long-term care expertise.

The two major strategies residential model study sites used to make noninstitutional services accessible in their communities were: establish clearly visible home and community-based service divisions or programs separate from their institutional services; and develop joint planning and/or service ventures with existing community agencies. While some hospital study sites have also established separate older adult divisions, we found that in residential models these divisions have more independent decision-making authority within the organization.

Two of the residential sites received large federal research and demonstration project funds to make home and community based services more accessible to older adults in their communities through coordination and financing innovations. One of these sites focused on serving poor elders through noninstitutional programs while the other targeted insured and self paying older adults. Both have case management services, although they serve different target groups as well (public vs. self pay). Their noninstitutional programs have existed for more than ten years and they are well established in their communities.

Two other residential sites much more recently established formal divisions and programs in their organizational structures, although one of these has offered decentralized adult day care services for more than ten years. One of these sites is establishing home-based care subsidiaries which accept Medicaid clients, while the other is targeting self-pay older adult groups with its home-based services. The residential site located in a medium sized city borders on a large suburban and rural area, and has begun making its services available to older adults in those areas as well.

We found creative uses of joint planning/service ventures at residential study sites to maximize accessibility. The rural residential site is a retirement community, which makes its own services quite inaccessible to older adults who cannot afford entrance fees and monthly rates. However, organizational leaders have provided significant assistance in the forms of heavily subsidized office space and technical assistance for service planning to the county community service agency located in an adjacent building. Since this agency is a rural subsidiary of the multi-county AAA as well as the county planning and service body for younger populations, its staff has relied on the expertise of the retirement community leaders in planning and designing services for rural older adults throughout the county. We found this to be a creative

way for an otherwise "closed" retirement community to influence service accessibility for the rest of the area's older population.

Finally, a joint venture just being planned by one residential site includes a fee for service case management program with an organization which already receives county funds to provide case management to poorer older adults. This is an example of offering an existing service to a group for whom it is not currently available, without the residential organization claiming sole ownership of the program.

b. Responsiveness

This section describes strategies used by study-site linchpin organizations to develop new services in their communities. We are most interested in the degree to which services are added to eldercare systems based on formal community needs assessments and other consumer input processes, versus intuition and direct experiences of service providers. In most communities studied, lead organizations had clearly developed or were developing the full array of services reflecting a continuum of care, from residential services to in-home services. Not all services in the array were intended to be owned by lead organizations, but their rationale for introducing new services in the community stemmed from a variety of sources.

(1). AAA systems: Since AAAs are mandated to hold public hearings, they have a built-in mechanism for documenting community needs. While all AAAs used their Advisory Councils to convene these hearings, we found that study site AAAs also used their Advisory Councils very actively throughout the year to keep in touch with the emerging needs of their neighbors. Advisory Council members routinely reported service needs through this informal process, and executive staff kept their planning process flexible enough to accommodate new needs throughout the year.

Another strategy used to develop services in response to community needs was for AAAs to work with service providers representing other populations. For example, one rural AAA worked with mental health and developmental disability service providers to develop a county-wide transportation system serving all disabled and disadvantaged populations. Rather than fragmenting transportation to different needy groups based on age or health problems, this strategy resulted in a much more efficient, visible transportation system.

Some study-site AAAs conducted formal community-wide needs assessments with assistance from nearby universities. More commonly, however, targeted needs assessments were done in response to a proposal request for a new service from the state agency on aging. Therefore, all study-site AAAs have histories of developing services incrementally in response to needs expressed by their communities, as well as by being opportunistic. Case management was begun in four AAAs in response to external funding availability, while special initiatives such as subsidized housing and homeless shelters are operational components in selected areas based on local opportunities recognized by AAA executive directors.

(2). <u>Hospital systems</u>: Two of the five hospitals conducted formal community-wide needs assessments ten years ago as first steps in developing their systems of care for older adults. This strategy stemmed from the vision of system architects, who wished their hospitals to have a central position in a continuum of care for older adults. As a result of their needs assessment results both hospitals set in motion a multi-year service development plan. Although one hospital is in an inner city and the other is in a rural area, both included a publicly-funded case management program and a nursing home as part of their system of services. Hospitals in relatively resource poor areas could learn from these examples the value of starting with a vision, taking stock of community needs, and following through with a service development plan.

Two other hospitals, located in more resource rich communities, made intuitive decisions about service expansion rather than conducing a formal needs assessment. They elected to specialize in health and social services for older adults which other hospitals in their areas had not yet developed. Examples are adult day care, Alzheimer's Disease programs, and outpatient clinics for podiatry. Consumers who have used the hospital are an informal source of information to planners of these services, and these hospitals have succeeded in attracting users. From a system perspective, however, this strategy has not resulted in the degree of coordination with acute care services that the other two hospitals enjoy, especially the rural hospital.

The fifth hospital clearly illustrates the influences of the system visionary on service development. This hospital focused on multidisciplinary geriatric assessment team care in the inpatient and ambulatory settings. The hospital is the centerpiece of chronic care, and the philosophy of comprehensive care extends to discharge planning, especially for older patients returning home. The hospital-sponsored case management program carries this philosophy into the community, where case managers work with a large consortium of service providers by assessing older adults in their own homes upon request and then discussing their multiple needs in weekly consortium meetings. Referring agencies benefit from the multidisciplinary assessment and planning process, and more services are available to older adults.

(3). <u>Residential systems</u>: We found that when nursing homes were the original lead organization, they developed services beyond institutional walls without conducting formal needs assessments. Rather, they sensed the need for alternatives to nursing home care when they saw their waiting lists growing; demand outstripped supply in their core service. When nursing home staff discussed needs of clients on waiting lists with their family members, staff realized that some older adults could remain home if support services were available to family members. Two residential model study sites began adult day care for precisely this reason, and now offer them "off campus" to reach as many families as possible. The adult day care program provided by the retirement community is available to non-residents as well, due to this need being expressed by county residents inquiring about the nursing home.

The other major strategy followed by residential model study sites was to determine what additional services were not being offered by other providers in the

community, or were being offered at what they considered to be high-cost or low-quality. This strategy is similar to hospitals which decide to specialize in certain geriatric services, in that they do not involve formal needs assessment.

c. Effectiveness

This criterion refers to the attention given by the lead organization to client outcomes and quality assurance. We searched for examples of client-tracking strategies whereby movement from one service in the system to another was monitored. We were particularly interested in how study sites use routinely-collected data -- either client-specific or service-specific -- to monitor the effectiveness of their programs.

We found that effectiveness was approached in a variety of ways, but that most sites reported this as the area in need of attention and improvement. Although every study-site collected voluminous data about program activity, few used data routinely to examine how services affect clients. We did, however, find that some sites used data for many important purposes related to program effectiveness, and that several sites were planning to purchase or design their own client-tracking data systems.

(1). _AAA systems_: AAAs generally contracted with service organizations rather than provide services directly themselves. Study-site AAAs used contract specifications as a monitoring tool to measure and verify the effectiveness of services delivered by providers. In most cases, however, these specifications did not require examining how service delivery actually affects the well-being of older adults. In other words, contracts measured structural and process aspects of service quality, but not outcomes.

AAAs also used a variety of feedback techniques to monitor service effectiveness. These ranged from client satisfaction surveys, to riding on the home-delivered meals routes and talking to clients, to employing a part-time nutrition consultant who set standards for home delivered and congregate meals which are more stringent than state guidelines. Annual contracts for meal services were often dependent on positive results from these feedback mechanisms.

For health and personal care services, all study-site AAAs used case managers to review client records and conduct other quality assurance activities. Automated data systems which contained health profiles of clients at intake (often for State reporting purposes) were not updated with subsequent health profiles to determine changes over time. Rather, record reviews commonly resulted in a review of the appropriateness of services delivered. Client satisfaction surveys were used by some AAAs to examine the effectiveness of their case management programs.

(2). _Hospital systems_: All hospital study sites implemented, at a minimum, reviews of client records for some of the eldercare services offered outside the acute care setting. Since so much attention was paid to quality of inpatient care,

this traditional "medical model" of chart review to monitor quality was their logical first stage of system effectiveness.

A few hospitals went beyond this minimum in their quality assurance activities. One hospital study site maintained influence over home health agencies to which it refers patients by requiring that agencies sign an agreement stating that if their care does not meet the hospital's standards, the hospital will remove the patient from their care. This hospital also employed older adult and family feedback mechanisms through informal and formal surveys. Its ambulatory record review was also fairly sophisticated due to the multidisciplinary approach taken to geriatric care, and the involvement of medical school faculty in hospital clinics. Another hospital developed a detailed quality assurance procedure for each of its services, including adult day care, case management, and multipurpose senior center. One person was the system-wide quality assurance director for all aging services including the nursing home (but not the hospital itself), providing a centralized strategy for monitoring service effectiveness of eldercare services in the system.

Finally, one hospital began to track client participation in all services provided through its public and private case management programs using an automated data system. Of all the sites studied, this hospital progressed the most in linking acute and post acute services received by older adults in an automated, interactive system. This capability did not extend to services received by non-contracted providers at this point.

(3). Residential systems: We found a wide variety of strategies for monitoring system effectiveness among residential model study sites. The most common approaches, as with other system types, were review of client records as a formal quality assurance technique and client/family feedback as an informal quality assurance strategy. Facilities that established separate divisions for noninstitutional services had the more sophisticated approaches to monitoring service effectiveness. For example, one site automated client data for each community-based program to meet funding requirements, and staff used these data for program management and planning purposes. The original impetus for this monitoring system was a federal research and demonstration project, so this is the exception rather than the rule. This site's division of community services acted like a AAA in its monitoring of service contractors as well.

Finally, considerable attention was paid to financial aspects of service delivery in residential systems. System effectiveness was often measured against the yardstick of fiscal solvency. One site ranked this business model of effectiveness along with reputation as the best ways to assure high quality services.

This variety of strategies used to achieve effectiveness by all three system types left us grappling with the best way to suggest strategies to others. Later in this report, we present a preliminary scheme of stages of system effectiveness which could serve as a standard for organizations serving older adults.

IV. DISCUSSION AND IMPLICATIONS OF RESULTS

A. Implications for System Replication

This study is intended to have immediate, practical applicability--to provide information about the features of system development and management that will encourage and guide their introduction into new communities. This section summarizes implications arising from our research in light of that intention. First, we highlight those elements of strong systems that provide lessons for would-be systems builders in other communities. Then we examine the policy implications of our research for the Aging Network by offering recommendations to the federal government and the states regarding how they can foster the development of community-based systems of care elsewhere.

Nearly everyone we interviewed at the 15 study sites initially expressed the view that their systems could be replicated. When we probed beyond these answers, we found that respondents usually did not mean that the specific administrative, programmatic and contractual features of specific systems could be picked up and placed down intact in another locale. Rather, they generally meant that the processes they followed in building their own systems offered lessons others could learn from in developing systems elsewhere. When asked, "If you were to start from scratch in a new community, what would you do?" respondents' replies came in the form of advice such as "find out where political power lies"; "figure out what services are missing and fill the gaps;" "find out what's being done particularly well and build from that base," and so on.

Often, respondents advised that a good preliminary step is to conduct a thorough community-wide needs assessment and step-by-step organizational planning process, even though respondents usually had not developed their own programs in this way. This is not as paradoxical as it might seem. Most systems builders we interviewed knew their communities well before they got started. Their visions developed from extensive personal and professional knowledge. Had they been hired to develop systems in communities they knew less well they would very probably have proceeded alone the lines they recommended.

We have seen that the specific configurations, administrative procedures, and working agreements of the systems in this study arose out of the existing political, cultural, and inter-institution environments extant in each community at the start. Systems builders capitalized on what was already there, and built on established ways of getting things done. There are no blueprints that lend themselves automatically to system development elsewhere.

If replication is not a matter of copying, then how is it accomplished? Our analysis shows that each of several elements of a successful system can be replicated more easily under some conditions than under others. These conditions can be arrayed on a continuum ranging from those that can actually inhibit the development of a successful system, to those that facilitate it, to those that are crucial to its

development. Figure 5 is a synthesis of our findings, presented in terms of the essential elements of system development and the inhibiting, facilitating, important and crucial actions and circumstances that influence the result. The following discussion examines these elements in light of these actions and circumstances.

1. Administrative Structures

A variety of administrative arrangements were observed among the fifteen organizations we studied. Two of the AAAs we examined are "free standing" organizations; one of these serves a single county and one serves a multicounty catchment area. Two others are departments of regional commissions, and another is a unit of a county social services department. Three hospitals spun off their community programs under the rubric of related subsidiary senior services corporations, while the others place them within the hospital chain of command structure. Four of the five residential sponsors operate their programs as administrative departments of the parent, while the fifth has created a constellation of service-specific corporations linked in a tight confederation to a parent coordinating entity.

All the strong programs exhibited forceful, unambiguous leadership, clear lines of accountability, and links to legitimating organizations or authority. A strong, committed group of volunteers was often helpful, although this did not always mean awareness or commitment from the official board of the parent. Advisory boards often provided the continuity and broad community linkages these programs enjoyed. Among residential systems, those with clearly visible noninstitutional divisions were most able to build accessible, responsive and effective systems.

We have already observed that fitting community programs into the vertical chain of command structures of hospitals is problematic, in part because the program is so distanced from the policymaking function that organizational priorities sometimes fail to take services for older people into account. This can also happen to AAAs within departmentalized bureaucracies in which they compete with other programs and services for visibility and high level support.

One way to link hospital-based systems to discharge planning is to place case managed community based care in the same operating department as discharge planning and utilization review. This administrative linkage offers one sensible way to relate discharge planning to community based long term care within a traditional hospital chain of command structure. The fact that utilization review is also administratively and programmatically related means that case management for older persons can effectively begin when the patient is admitted to the hospital, with assessment of client needs and care requirements routinely reassessed throughout the hospital stay and after discharge.

FIGURE 5
FACTORS INFLUENCING REPLICATION DEVELOPMENT

System Elements	Inhibiting	Facilitating	Crucial
1. Administrative Structure	-be embedded in hierarchy	-strong, committed board of directors	-leaders clearly identified -lines of authority clear -linkage to a legitimating organization or authority
2. Operating Systems (fiscal and program controls)	-conflicting/confusing reporting requirements	-automated systems -performance contracts -quality assurance	-effective supervision -accountability
3. Planning and information systems	-lack of information regarding target population -lack of knowledge about service landscape	-automated info systems -established formal planning process -written plan with measurable goals, formal needs assessment participatory planning	-flexibility -capacity to move outside planning process to exploit unforseen opportunity -frequent communication among principals in system
4. Financing	-inability to access new funds -insufficient financial leverage over providers	-flexibility in deploying funds across programs and services	-multiple sources of funding -ability to access "new" funding sources -sufficient "ownership" of provider agency program budgets to exert control
5. Inter-organizational linkages	-presence of non-cooperating competitors	-written contracts -capacity to audit	-agreement on linchpin scope and role -control over client pathway
6. Relationships with competitors and other systems	-unresolved turf issues	-lack of strong competitors	-at least informal agreements on turf issues and linkages

FIGURE 5 (contd)
FACTORS INFLUENCING REPLICATION DEVELOPMENT

System Elements	Inhibiting	Facilitating	Crucial
7. Leadership	-leader lacks visibility, credibility -leader's vision fails to reflect priorities of other key actors	-practical experience in key service areas -"charismatic personality"	-knows community well -possess clear vision of needs, possibilities capacity to articulate and persuade others -sensitivity to cultural and political opportunities and constraints
8. Political, environmental and economic community characteristics	-resource rich, with many participants in a heavily competitive environment -hostile organizational or political climate	-a few system elements established, but none dominant -community already committed to coordinated comprehensive care -support of state policymakers	-elders with unmet needs -existing untapped funds or new funding opportunities -support of political, civic, community leaders

2. Operating Systems

All AAA systems exhibited highly developed contracting and reporting relationships with provider organizations, the byproduct of the aging network's prohibition on AAAs providing services directly and the need to achieve accountability within systems involving two or more organizations in tandem. However well designed and managed these contractual arrangements may be, it is nevertheless easier to manage programs you operate yourself than those operated by someone else.

Levels of technological sophistication in automated program management and financial reporting vary widely. It appears that while automated systems are useful, they are not crucial to the effective implementation of fiscal and program controls. Good supervision within an accountable framework is vital, whether the linchpin entity delivers services itself or contracts for them, or both. All the strong systems in the study place day-to-day management responsibility in the hands of a single individual, whose scope of authority is widely understood. Sometimes the linchpin executive director or program director plays this role; more frequently it is assigned to a trusted deputy who handles day-to-day operations and frees the executive to focus on external relationships with politicians, policymakers, other institutions and funders.

Similarly, the development of highly elaborated quality assurance procedures varied widely from site to site. One residential site places most of its emphasis upon strong administration, taking the position that in a well-run businesslike setting service quality and adherence to high standards are inevitable byproducts. Other systems evidenced a real commitment to formal quality assurance, including close case monitoring and record review, client satisfaction surveys, commitment to recognized performance standards. Most systems fell somewhere in between these two approaches. Hospitals and nursing homes relied most heavily on patient record reviews, while AAAs count on periodic on-site audits to achieve the same result.

3. Planning and Information Systems

The role formal communitywide and organizational planning plays in the early stages of system development has been shown to be subordinated to the entrepreneurial, opportunistic spirit in most of the programs we studied. Needs assessments, formal plans, and highly developed approaches to the uses of objective data in decisionmaking are useful, but they are not as important as the capacity to move quickly to exploit opportunities as they develop. Frequent interaction among key actors is also crucial.

We expected to find that highly sophisticated data systems would be an essential characteristic of strong systems. In fact, the levels of technological innovation were often fairly primitive. We observed a highly interactive activity reporting system in one rural AAA-driven system, and the fact that case management is a powerful mechanism for control in all AAA sites means that data concerning

client outcomes is more routinely gathered and analyzed in these settings than in systems less committed to case management.

4. Financing

As we have seen, the capacity to access several sources of funding and to increase the levels of funds under the control of the linchpin organization is crucial, particularly at the outset. The lead organization need not own or control all the dollars flowing to the providers; indeed, there may be cooperating organizations which it does not fund at all. However, it must channel sufficient financial support in a sufficient number of directions that it is able to exert influence over the way services are delivered in the community, and to whom. An AAA attempting to impose accountability on a senior center when its contribution to the center's operating budget is marginal is likely to run into difficulty unless some other incentive or constraint is present in the interaction between the two organizations.

The ability to access new sources of funds generally implies the capacity to support new services, increasing system responsiveness and enhancing the leverage of the lead organization. Several were able to attract local philanthropic support and United Way funding. The dollar contributions from these local sources generally do not represent a high percentage of revenue and support, but they increase the visibility and reputation of the linchpin entity. It is also helpful if the linchpin organization has a degree of flexibility in moving funds across services as needs and priorities shift.

5. Inter-organizational Linkages

The significance of these linkages to the lead organization depends on the number of provider organizations in the community and the scope, range and volume of services provided under the lead organization's auspices. Obviously, interorganizational arrangements will always be important to AAAs. Mini-systems operated by hospitals and residential facilities are less dependent on the array of programs offered under AAA sponsorship and by other local providers, although the well-being of clients will always be influenced by the system's capacity to refer to needed services outside its own array and receive referrals from outside sources.

Organizations serving the same target populations need to agree on the scope of the linchpin entity's influence and ability to influence the nature and volume of care, and the linchpin must be able to control or profoundly influence the client pathway to services. It is helpful if it is in a position to monitor and audit program activities and hold providers to specific performance standards. However, "handshake agreements", in which formal auditing mechanisms are absent, are commonplace in the communities we selected for in-depth study. Informal partnerships between hospitals, public and private providers of social, nutritional, and in-home services work where the partners' ability to do what they already do very well is enhanced by the relationship and all parties share complementary goals and a commitment to high standards.

6. Relationships with Competitors and Other Systems

From an organizational perspective, the fewer competitors in the community the easier system building becomes. Some ability to reach agreement on turf issues in critical in all environments, resource rich and resource poor alike.

7. Leadership

This may be the most critical element of all. Strong leaders must know their communities and be able to persuade other key actors that their vision reflects community priorities and political reality. They must be sensitive to cultural opportunities and constraints. They must be fully committed to the systems they envision, but they must be able to tailor their expectations to reflect opportunities and constraints. Failure to anticipate larger organizational or community priorities will cripple the effort.

8. Political, Environmental, and Economic Community Characteristics

We have already observed that any community with a population of older persons is a candidate for system development. Success depends on support from political and civic leadership, and the opportunity to address critical gaps in existing services at the start. Guidance and support from state policymaking and regulatory bodies is often very helpful and may in some cases be absolutely crucial to a favorable outcome. The presence of a sufficient array of programs on which to build facilitates the introduction and coordination of complementary services.

B. Policy Implications for the Aging Network

The previous section highlighted specific organizational features which must be considered when building community-based systems of care, drawing from the experience of successful systems to guide local leaders as they design and implement their own plans. This section focuses on public policy directions that should be taken at state and federal levels to encourage locales to create community-based systems of care for older adults.

A major premise underlying recommendations in this section is that the meaning of the term "Aging Network" has undergone a gradual metamorphosis in the past decade which is consistent with the development of community-based systems of care. This alteration in meaning provides an important opportunity for the original members of the "Aging Network" to exert influence on health and social service providers with the aim of expanding and coordinating service systems for older adults at the local level.

In its traditional sense, the "Aging Network" refers to the tri-level array of federal, state and local agencies specifically charged with administering resources and programs under the Older Americans Act. This narrow definition reflects the fact that in the early years of this Act, the primary emphasis of these agencies was

planning and funding social and nutritional services for relatively healthy older adults. Services such as in-home health care, acute care, and nursing home care were not viewed within the scope of the Aging Network, which meant that more disabled older persons were not usually included in the planning process of local AAAs.

This study has shown, however, that not only AAAs but also hospitals and residential facilities in many communities have taken major steps to link together multiple services older adults may need as their health and social conditions change over time. AAAs have expanded their service arrays to include health services, while hospitals and residential facilities have added social and recreational services to their spectrums. Lines have blurred between social and health services for older adults from the organization's perspective. In these communities, the Aging Network is no longer defined simply by the AAAs formal, hierarchical relationships with State Units on Aging and the U.S. Administration on Aging. Rather, the definition has grown to encompass all the cooperating organizations in a community serving older persons, regardless of their core mission. These trends will inevitably spread to new communities throughout the country, placing the traditional notion of the Aging Network into a state of permanent transition. The broader meaning of Aging Network has found its way into recent amendments of the Older Americans Act which encourage AAAs to provide Title III monies for more health-related services.

An emerging major challenge for the traditional Aging Network, as the term itself has taken on a broader meaning, is to find ways to encourage other service organizations to get into the community care business for older adults and remain there. In fully developed, successful community-based systems of care, all the organizational types studied here must participate. Although nursing homes and retirement communities may be primarily in the "aging business", they may not always see the links with noninstitutional services. While hospitals may develop plans to expand services to older persons in their communities, they may withdraw as organizational priorities change.

The following recommendations, therefore, are aimed at the traditional Aging Network--particularly the U.S. Administration on Aging (AoA)and State Units on Aging (SUAs)--and suggest policy strategies they should pursue to encourage AAAs and other service organizations to develop community-based systems of care in local communities throughout the United States.

1. Clarify Aging Network Goals to Promote System Building

Among AoA's goals for 1990 and beyond are strengthening systems of care and encouraging public-private sector partnerships. These goals should explicitly acknowledge the broader meaning of the Aging Network. At the federal level, the AoA should work with national associations representing hospitals, residential facilities, home health/homemaker agencies, and other key service providers to suggest blueprints for interorganizational cooperation at the local level based on known successes. Jointly-developed guidelines by these national organizations would legitimize cooperation among disparate service organizations and address the problem

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of service fragmentation facing older Americans in most communities. At the state level, SUAs and provider associations should work together to identify rosters of organizational players in each AAA service area whose participation is crucial to system building. Where AAAs are in positions to assume the lead in assembling systems themselves, they should be encouraged to do so. State and area-level planning and reporting protocols should be modified to require SUAs and AAAs to establish and work toward system-building objectives.

2. Build Flexibility into AAA Functions

AoA and SUAs should encourage AAAs to develop and/or deliver case management services in their communities, since case management clearly advances AAA capacity to influence and coordinate services for disabled older adults. Case management greatly assists AAAs in assuming a linchpin organization role in their communities, as this study found in all five AAA study sites. AAAs should also be strongly encouraged to pursue access to services funded by other public sources such as Social Service Block Grants, general revenues, and Medicaid waiver monies. Seeking alliances with the private sector should be required of all AAAs, not only those pursuing discretionary AoA funding, to explore prospects for pooled funding arrangements and new service development. Large employers and corporate donors are obvious examples here. Under certain circumstances, AoA and SUAs should encourage AAAs to develop and deliver unavailable services directly, if only for limited developmental periods of time.

3. Support Development of Alternative Linchpin Organizations

As this study found, it is not always possible for AAAs to assume the linchpin role. Sometimes barriers to their accumulating sufficient influence and resources are too great. However, AAAs can strengthen other organizations better positioned to assume leadership by using Title III funds allowing them to establish key services under their own auspices. Two hospitals and one residential model study sites, for example, used Title III funds to develop case management services of their own. Such arrangements should be explicitly encouraged and widely replicated.

AAAs should also be encouraged through policy directives to act as brokers and referral agents among providers with whom they contract. For example, they can encourage multi-purpose senior centers to establish referral agreements with hospitals and residential facilities so that older adults discharged from these institutional settings can be linked with community-based social and recreational opportunities. An equally important role for AAAs can be convener and mobilizer of public opinion in support of service systems for older adults being developed by others. Their mandate to develop area plans and gather community needs data should be channeled to generate consensus and guide development of systems administered by other organizations. AAAs should also be urged to foster local funding partnerships and assist other organizations design and obtain financing for needed services.

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4. Encourage Innovative Financing Strategies

A critical component of any policy blueprint delivered from national associations is innovative approaches to financing and delivering health and social services for older adults. In the public sector, the major strategy at this time is pooling Title III funds with other public funds available at the local level, as already described. Public resources alone, however, will always be scarce relative to the service needs of local older populations. Major innovations, therefore, will involve creative options for infusing service systems with private sector monies. AAAs should bec____ __al experts in private sector options, which would clearly demonstra__ ___ __les as effective advocates for older adults in their service areas.

Major _____ used by AAAs in this study to attract private sector financing include offering fee-for-service case management services to older adults and their families, and soliciting funding from private foundations and local businesses to provide case management or educational services to local employees with disabled older relatives. Hospitals offer many variations of "senior membership" services to older adults, which are increasingly used to offer health education programs. While still primarily marketing devices, these programs have great potential for underwriting needed services in communities. Residential facilities are also beginning to offer case management through subsidiaries or corporate divisions on a fee-for-service basis. AoA and SUAs should direct AAAs to take active roles in assuring that these initiatives by provider organizations offer meaningful services to older adults, and link consumers with other services funded through the public sector whenever possible.

AoA and SUAs should also promote the development of private long-term care (LTC) insurance products, as well as variations of Social Health Maintenance Organizations (SHMOs) and On Lok service programs in local communities. There may be unstudied advantages to developing SHMOs in rural areas, for example, because of the relatively few service providers whose care for older adults could be shared and better coordinated. None of the existing SHMO demonstration sites or On Lok replication sites are in exclusively rural areas at this time. Regarding private LTC insurance, one trend to build on is the multi-state public-private financing partnerships sponsored by the Robert Wood Johnson Foundation. These state-level initiatives will hopefully lead to affordable LTC insurance for a broad cross-section of the population, with private insurers and state governments (Medicaid programs) sharing the financial risk. Local-level innovations could conceivably be designed in these states using optional premium surcharges for new services.

A final trend to learn from is the group-focused UNUM approach to LTC insurance, which has recently expanded from retirement communities to employer-based models (e.g., Huntington Memorial Hospital's new program with UNUM). At the local community level, employee groups and their retirees should be examined as potential candidates for group LTC insurance as a means for financing coordinated care systems. AAAs could work with insurers to identify such promising subscriber groups, and take the lead in planning and developing more coordinated service

systems in order to hold down the costs of premiums for LTC insurance policyholders.

5. Recognize Alternative Utilities of Local Planning and Needs Assessment Procedures

This study found that assessments of unmet need and formal deliberative area planning rarely trigger system development. Instead, these activities frequently help create consensus and support the identification of service priorities during later periods of system development. Often the real value of community needs assessments is their ability to build political support and neutralize competition. AoA and SUAs should explicitly recognize this function and encourage AAAs to consider these alternative uses as they formulate their planning agendas.

6. Support Technology Transfer through Mentorship Programs

AoA and SUAs should establish forums and information exchange mechanisms that teach community organizations how to improve service coordination for older adults. These forums should be regularly sponsored by AoA and/or SUAs and held at annual meetings of health and social service provider associations. In addition, AoA should sponsor mentorship programs in which successful system builders travel to other locales and provide technical assistance with the goal of building new care systems. This study has identified several individuals who are willing to serve as mentors because of their commitment to strengthening links among existing health and social service providers for the benefit of older adults.

7. Support Capacity to Monitor Service Effectiveness

Finally, this study found that although voluminous data are routinely collected to document service utilization, few service systems use these data to monitor the impact of services on their client populations. Traditional chart audits and client satisfaction surveys represented the vast majority of efforts to determine service effectiveness.

AoA and SUAs should promote more systematic and creative uses of routinely collected data to broaden approaches for measuring service effectiveness. Guidelines should be developed and disseminated to all AAAs, encouraging and supporting them to work with other service providers to implement a service effectiveness strategy for the entire system. Specific stages that organizations proceed through to improve their capacity to monitor service effectiveness may include:

o   establishing client feedback mechanisms for each service in the system, such as brief telephone or self-administered surveys;

o   establishing service standards acceptable to all organizations involved in the delivery of each service, incorporating client responses about service adequacy from feedback mechanisms;

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o   establishing peer review teams from participating organizations to compare actual service delivery to service standards through chart audit or formal presentation methodologies;

o   developing client outcome measures or benchmarks, based on routinely collected data over time for each client. These may include such benchmarks as inappropriate institutionalization, unusual deterioration in health or functional status, or unusual voluntary service termination rates;

o   designing automated data reports highlighting outcome measures or benchmarks, which would be disseminated to peer review teams from participating organizations in the service system;

o   customizing computer software to facilitate generation of automate data reports based on client tracking techniques to monitor service effectiveness.

These are meant to be stages in the sense that systems should develop earlier strategies before moving to subsequent steps.

The purpose of these suggested guidelines would be to enable community-based systems of care to move in a similar fashion toward self-control over service effectiveness. They are not meant to replace existing federally and state-mandated quality assurance reviews. Rather, these local initiatives would help providers to continuously refine their own service goals and work in a coordinated fashion toward those goals as needs of their local older populations change over time.

In conclusion, these seven major recommendations for the Aging Network recognize the increasing interdependence among health and social service organizations helping older adults at the local level. More focused efforts at federal and state levels to facilitate system development along these lines will benefit older adults across the country where they actually demand and use services--at the local community level.

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The National Eldercare Systems Project:
A National Study Comparing Successful
Community-Based Systems of Care for Older People
Policy/Program Implications Paper

The purpose of this project was to compare three different models of building and strengthening community-based systems of care (CBSCs) for older adults. Models were distinguished by the type of organization that took the lead in developing the CBSC: Area Agency on Aging (AAA), acute care hospital, and residential facility. Findings, implications and recommendations were intended to have immediate, practical applicability to organizations interested in building CBSCs in their own communities, as well as to policymakers who could encourage the development of CBSCs.

Organizational elements identified as variables which determine the climate for replicability of successful CBSCs included leadership, administrative structure, operating systems, planning and information systems, financing, interorganizational linkages, relationships with competitors, and community characteristics. Leaders must have clear vision about continuum of care for older adults, capacity to articulate vision, and sensitivity to constraints and opportunities. Boards must support service expansion, and accountability and flexibility must be present in operating and planning systems. Creativity must be used to diversify funding sources and to deploy existing funds across programs for initiating new services. Communication with others is crucial to develop formal and informal client referral procedures, as well as to agree on protocols to review service performance. Turf issues must be addressed directly and frequently. Support for older adult services must be solicited from local elected officials and service gaps must be clearly identified.

The major challenge to the Aging Network--led by the U.S. Administration on Aging (AoA) and State Units on Aging (SUAs)--is to take specific actions which steer AAAs and other service providers toward development of CBSCs. Seven recommendations were set forth to meet this challenge:

1. Clarify Aging Network goals to promote system building at local levels, by working with national provider associations to provide explicit guidelines to overcome service gaps and fragmentation;

2. Build flexibility into AAA functions, by encouraging them to develop or deliver case management services and actively explore pooled funding arrangements to start new services;

3. Support development of CBSCs led by alternative organizations;

4. Encourage innovative financing strategies, by requiring AAAs to become familiar with and promote long-term care insurance options and Social Health Maintenance Organization variations;

5. Recognize alternative utilities of AAA area plan activities, by promoting their use as tools for building political support for service expansion and coordination;

6. Support mentorship programs as technology transfer mechanisms; a full proposal to establish a CBSC mentorship program was written as part of this project.

7. Support capacity to monitor service effectiveness by disseminating specific guidelines for developing quality monitoring systems.

DISSEMINATION AND UTILIZATION PAPER

Our final report will stand as our major product to the Administration on Aging (AoA). We have composed a thirteen (13) page executive summary which will serve as our major written synopsis of study purpose, methods, findings, implications and recommendations. This summary document will be made available to the following individuals and organizations immediately upon submission of our final report to AoA:

o   all members of our National Advisory Panel, who represent major national associations concerned with older Americans:

o   all fifteen (15) organizations which served as sites for our research project; and

o   Senators George Mitchell and William Cohen, and Representatives Olympia Snowe and Tom Andrews, all congressional representatives from Maine who are very involved with policy issues concerning older Americans.

In addition, the American Association of Retired Persons (AARP) has expressed interest in having us prepare an Issue Brief based on our executive summary, which they may disseminate through their national distribution channels. Finally, the American Health Care Association expressed interest in assisting us with a proactive media relations strategy, to encapsulate our project and its implications as a press release for major newspapers throughout the United States.

Besides these immediate written dissemination plans, we have already begun a more interactive dissemination strategy. We participated in a pre-conference workshop at the 1990 meeting of the National Association of Area Agencies on Aging in August, along with other AoA grant recipients. Our project was also featured in a workshop with other AoA grantees during the 1990 Gerontological Society of America meetings. We also plan to present study findings at the 1991 meeting of the American Society on Aging.

Finally, we plan to publish all or parts of our final report, either as a book or a series of articles in gerontological journals. We will assess our publishing options after receiving more feedback from reviewers about appropriate audiences.

APPENDIX 1

UNIVERSITY OF SOUTHERN MAINE

Human Services Development
Institute

96 Falmouth Street
Portland, Maine 04103
207 780-4430

Project ID#_____

National Eldercare Systems Project
Screening Questionnaire

For purposes of this questionnaire, the term *"Program"* means the *entire range* of Eldercare services for which you are administratively responsible.

For example, if yours is a hospital-based eldercare program, you may be administratively responsible for acute care, home care, and skilled nursing facility care. All these services would be part of your *"program"* for our purposes.

Also, by *"older persons or population"* we mean individuals *aged 60 years or older*.

Please call us at **207-780-4430** if you have questions as you complete this form.

Please complete and return by *December 30, 1988*.

Thank you.

**Name(s) of Person(s) Completing
This Questionnaire:**

Position/Title:

_____   _____

_____   _____

_____   _____

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DEMOGRAPHICS OF COMMUNITY SERVED AND CLIENT INFORMATION

We are interested in some basic information about the community and clients you serve. In Section I, we ask about the geographic area your program serves, the estimated size of the older population within this area, the age distribution of this population, and their socio-economic and health characteristics. In Section II, we ask about the total number of older persons your program has served over the past year, and then ask several questions about their socio-economic and health status. Please answer the questions to the best of your knowledge. *If you don't have "exact" figures readily available, "approximate" figures will be fine.*

I. DEMOGRAPHICS OF COMMUNITY SERVED

1. Please describe the specific geographic area(s) which your program serves. Please include a map if available.

2. How many older people (aged 60 or older) reside in your program's service area?

3. What *percentage* of this older population falls into each of the following age groups?

a. 60-64	_____ %	
b. 65-74	_____ %	
c. 75-84	_____ %	
d. 85+	_____ %	
	Total	100%

4. What is the ethnic composition, residence, income and health status of the older population in your service area? Please answer by filling in the percentage of total for each of the following categories.

a. ETHNIC COMPOSITION

WHITE	_____ %
BLACK	_____ %
NATIVE AMERICAN	_____ %
ASIAN AMERICAN	_____ %
HISPANIC	_____ %
OTHER (*Please specify*)	_____ %
_____ Total	100%

b. RESIDENCE

INNER CITY	_____ %
SUBURBAN	_____ %
RURAL/FARM	_____ %
Total	100%

c. HOUSEHOLD INCOME

UNDER $10,000	_____ %
$10,000-$19,999	_____ %
$20,000-$29,999	_____ %
$30,000-$39,999	_____ %
$40,000-49,999	_____ %
OVER $50,000	_____ %
Total	100%

d. HEALTH STATUS

HEALTHY/NOT IMPAIRED	_____ %
MODERATELY IMPAIRED	_____ %
SUBSTANTIALLY IMPAIRED	_____ %
Total	100%

II. CLIENT INFORMATION

Please think about all the older people your program has served *over the past year.*

1. What is the total number of older persons served? _____

2. What *percentage* of your older clients in the past year falls into each of the following age groups?

        a. 60-64   _____%

        b. 65-74   _____%

        c. 75-84   _____%

        d. 85+   _____%

           Total   100%

3. What is the ethnic composition, residence, income, and health status of these people? Please answer by filling in the percentage of total for each of the following categories.

a. ETHNIC COMPOSITION

WHITE   _____%

BLACK   _____%

NATIVE AMERICAN   _____%

ASIAN AMERICAN   _____%

HISPANIC   _____%

OTHER (*Please specify*) _____%

_____ Total   100%

b. RESIDENCE

INNER CITY   _____%

SUBURBAN   _____%

RURAL/FARM   _____%

    Total   100%

c. HOUSEHOLD INCOME

UNDER $10,000   _____%

$10,000-$19,999   _____%

$20,000-$29,999   _____%

$30,000-$39,999   _____%

$40,000-49,999   _____%

OVER $50,000   _____%

      Total   100%

d. HEALTH STATUS

HEALTHY/NOT IMPAIRED   _____%

MODERATELY IMPAIRED   _____%

SUBSTANTIALLY IMPAIRED   _____%

      Total   100%

4. For what percentage of your clients over the past year did Medicaid pay for services? _____%

III. SERVICE MATRIX

We are interested in which services your program provides, how these services are provided in your community, whether there is a waiting list of clients to receive them, and how the services are funded. To avoid asking a long series of questions, we have combined our questions concerning services into a matrix format. Instructions for completing the matrix are presented below.

Column 1: Check each service *your program* provides to older persons.
(Please remember our definition of program — see cover page.)

Column 2: Please indicate how each service is provided *in your community*.

    a. Provided directly by a division or subsidiary of your program
    b. Subcontract to an organization outside your program.
    c. Offered through collaborative agreement with other organizations (i.e., no formal subcontract).
    d. Refer clients to other organizations without working agreements.
    e. Service not provided within community to your knowledge.
    f. Other *(Please describe in Column 6 and continue on back if necessary.)*

Column 3: Please indicate, to the best of your knowledge, the year each service was initiated. *Complete only for services offered by your program.*

Column 4: Please indicate the approximate number of older persons typically waiting to receive this service *from your program*. If no waiting list, please enter "0". If not applicable, leave blank.

Column 5: Funding sources: for each service, check as many boxes as apply. *Complete only for services offered by your program.*

    a. Client (self-pay)
    b. Medicare
    c. Medicaid
    d. Social services block grant (Title XX)
    e. State-appropriated funding
    f. Private foundation (local or national)
    g. Other *(Please specify in Column 6 and continue on back if necessary.)*

Column 6: Use this Column for any additional remarks that will help us better understand your eldercare program or your relationship with other service organizations in your community.
Please continue on the back if necessary.

	1. Check if Provided	2. How Services are Provided						3. Year Initiated	4. # of Persons Typically Waiting	5. Funding Sources							6. Additional Remarks
		a	b	c	d	e	f			a	b	c	d	e	f	g	
Acute Care																	
Home Health Care																	
Personal Care Services																	
Homemaker/Chore Services																	
In-home Meals																	
Congregate Meals																	
Other Nutrition Services																	
Adult Day Care																	
Respite Care																	
Outreach Services																	
Case Management																	
Mental Health																	
Social/Recreational Services																	
Health Promotion & Education																	
Congregate Housing																	
Skilled Nursing Facility																	
Intermediate Care Facility																	
Residential Community																	
Other (*Please specify*)																	

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IV. ADMINISTRATIVE

The questions below refer to the administrative organization and process of your program. We are interested in the administrative levels and positions (board, executive director, case manager, supervisor, etc.) responsible for planning, overseeing, and evaluating your program. Please answer the questions briefly, and include an organizational chart, if available, with your returned questionnaire.

1. Where in your program is the responsibility for establishing policy located? _____

_____

_____

_____

_____

2. Where in your program is the responsibility for fiscal control/budgeting located? _____

_____

_____

_____

_____

3. Where in your program is the responsibility for long-range planning located? _____

_____

_____

_____

_____

4. Where in your program is the responsibility for service monitoring and evaluation located? _____

_____

_____

_____

_____

5. Where in your program is the responsibility for overseeing day-to-day operations located? _____

_____

_____

_____

_____

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V. ASSESSMENT OF NEEDS AND STAFFING OF SERVICES

Finally, we would like to find out about how you determine whether older persons in your program, and in your community at-large, are receiving the services they need. We would also like to know the extent to which older clients and their families are included in planning the services they receive and whether staff are used to ensure outreach of services.

1. How do you determine whether older persons *in your community* are receiving the services they need? _____

_____

_____

_____

2. How do you determine whether *older clients served by your program* are receiving the services they need? _____

_____

_____

_____

3. How do you determine what effect the services you provide are having on the well-being of older persons served by your program? _____

_____

_____

_____

4. How do you involve older clients and their families in planning, monitoring, and evaluating (1) their specific care and service plans; and (2) your overall program? _____

_____

_____

_____

5. Does your program employ staff who have been hired because of their ability to speak the language of some of the persons you serve, or because of a common cultural heritage? If yes, please indicate how many staff and what they do. _____

_____

_____

_____

6. Finally, do you use standardized data collection instruments in assessing clients and providing services to them? Please enclose copies with your returned questionnaire if they are immediately available. Please comment on their adequacy for your program's purposes. _____

_____

_____

_____

Thank you very much for your cooperation. Please return this questionnaire and other materials requested in the envelope provided. If you wish to send us additional materials under separate cover, we will reimburse copying and mailing costs.

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APPENDIX 2

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Human Services Development
Institute

April 27, 1989

Dear   :

We are pleased to let you know that the Eldercare Systems Project has
selected (site name) as an exemplary program -- one that incorporates those
elements of accessibility, responsiveness and effectiveness that characterize
excellent systems of care for older persons. We are grateful for your
cooperation throughout our screening process, and we look forward to gaining a
more detailed understanding of the elements of your success.

We plan to visit each of the communities we have selected, to examine the
elements associated with creating and managing strong programs. We will
explore developmental histories, examine the way resources are coordinated and
expanded, and study program management systems. We are particularly
interested in identifying the impetus for creating these programs, charting
their step-by-step development, determining the roles of key individuals,
organizations, and institutions, and learning the processes and locations of
systemwide decision-making.

Two members of our project team will visit your community for a three day
period. We will interview you and other key informants -- those working
within your organization as well as representatives of service providers and
cooperating entities, advocates and spokespersons for older persons, and
others who can shed light on the historic development of your system.

One of our team members will telephone you within the next several days to
set up a time for us to visit and to work with you to identify the people in
your community we should interview. We will also work with you to identify
those additional documents and materials that will contribute to a detailed
and accurate understanding of your program's development, current operations,
prospects and problems, and long range direction.

We are delighted that your program has been selected. Thank you once again for your help in reaching this critical stage in the development of the project.

Sincerely,

Richard H. Fortinsky, Ph.D.
Principal Investigator

David Karraker
Project Director

/mc

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UNIVERSITY OF SOUTHERN MAINE

Human Services Development
Institute

Dear   :

As I promised during our recent telephone conversation, this letter
confirms our plan to visit your community over the three day period
beginning _____, and ending _____. I will be traveling
with _____, another member of the Eldercare Systems Project team, and
both of us look forward to meeting you and learning more about your program.

I also want to provide a clearer understanding of the kinds of people we
hope to interview during our stay, and to arrange to obtain certain documents
that will provide a deeper understanding of your work.

Areas of inquiry. We will examine your program from a number of
perspectives: its origins and development; its current organizational and
administrative system; its service array and interorganizational
arrangements. We also want to explore your program's interactions with other
systems, such as state funding and policymaking bodies, local government,
advocacy groups, and professional associations. We need to understand how you
monitor, evaluate and plan. And we hope to gain a good grasp of your plans
and future direction, as well as the obstacles, problems and barriers with
which you presently contend.

Interview subjects. Different people shed light on different aspects of
this inquiry. These may be defined variously as follows:

1. Administrators (you, ranking department heads, planners, operations
   and data managers;

2. Program Managers (people who perform service functions within your
   organization);

3. Provider Service Managers (people who manage service delivery for
   other organizations in the community;

4. Historians (people who participated in or witnessed the development of
   your program from its inception);

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5. <u>Local Political Leaders</u>;

6. <u>Local Civic Leaders</u> (business people, volunteer leadership, influential citizens);

7. <u>Board/Advisory Board Members</u>:

8. <u>Critics/Gadflies</u> (the people who keep reminding you how much better you could be doing);

9. <u>Members of Professional Associations</u>.

We expect that certain key individuals will perform several of these functions at the same time. For example, a local civic leader may also have held political office, have participated in the creation and development of your program, and currently serve on the board. We may need to spend more time with people who can discuss your work from these several perspectives than with someone whose relationship to you is more limited or specialized. While the normal length of a single interview is approximately one hour, we will want to allow additional time to talk with people who can speak to several issues in one sitting.

Where possible we will conduct interviews together. However, we are prepared to separate where time, location, and limits of availability require it. The most important consideration for us is that we talk to the people who understand your program best, and that we respect competing demands on their time and energy. This is why we must rely on you to decide who can best provide the information and background we need, and to help us schedule the interviews. We expect that it will sometimes be best to interview two or more people at once, while in other cases we will need to interview people alone. We will discuss these concerns with you before the final schedule is set, and we will rely on your good judgment throughout. If it is not inconvenient, we would like to set time aside at the very end of our stay to talk with you and ask whatever questions may remain.

<u>Documents</u>. We would very much like to prepare for our visit by reviewing documents that will improve our understanding and help us generate better questions for our visit. These might include (depending on availability and relevance) your current budget and financial statements from the previous two fiscal years; organizational planning documents; the area plan; guidelines from state funding and policymaking bodies; demographic summaries and/or marketing reports; program reports; internal policies, evaluation reports, decision memoranda. Again, we will rely on your judgment concerning the utility and availability of these materials for our review, and whether we should wait to examine them until after we arrive. Please be assured that we will respect any request to hold such information in confidence.

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I will telephone you within the next few days to discuss the plan for the visit and answer your questions. We expect to learn much that is instructive and useful during our stay, and we are very much looking forward to it.

Sincerely,

David Karraker
Project Team Member

DK/mc

enclosure

APPENDIX 3

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AAA MODEL

EXECUTIVE DIRECTOR

C O N F I D E N T I A L

NATIONAL ELDERCARE SYSTEMS PROJECT

The National Eldercare Systems Project, funded by the U.S. Administration on Aging, is devoted to helping local communities determine how to build successful systems of care for older persons using their own resources and talents. We are comparing three models of care, distinguished by the type of organization that has taken the lead in building the system: (1) Area Agency on Aging, (2) acute care hospital, and (3) residential facility for the elderly. Five systems representing each model will be studied to determine: what conditions must be present to enable development of a successful system; what steps are necessary in designing a successful system; how is systemwide coordination established and maintained; and what are the effects of successful systems on the array of services available and on the well-being of the elderly.

This site is one of the Area Agencies on Aging we are visiting for this study. The questions we will ask are semi-structured, and will cover the following topics _____,

_____, _____, _____, _____.

All answers are confidential and will not be attributed to any individual.

1. Name of Respondent_____

2. Position/Title_____

3. Role of Respondent in Organization_____

4. Institution/Organization Name_____

5. Address_____

6. Phone_____

7. Date_____ Time Interview Began_____ Time Interview Ended_____

8. Interviewer(s)_____

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NOTES

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NOTES

0.1

EXECUTIVE DIRECTOR INTERVIEW: AAA MODEL

TOPIC I: ORIGIN AND DEVELOPMENT OF THE ORGANIZATION

1. How long have you worked with this program? How long have you been in your current position? What other positions have you held within this program?

   First, we would like to ask about the history of Monterey County Area Agency on Aging.

2. In what year was it founded?

3. By whom was it founded (e.g., broad community coalition, institutional sponsor, political leader)? Was a single individual, or small group of individuals, particularily important in getting your program started? (NAME, TITLE, RELATIONSHIP TO PROGRAM)

4. Why was Monterey County Area Agency on Aging founded (e.g., compelling community need, result of advocacy effort, charismatic leader, political issue, funding opportunity)? (IF CHARISMATIC LEADER MENTIONED, COULD ANOTHER INDIVIDUAL(S) HAVE ACCOMPLISHED SIMILAR RESULTS?)

5. Were any existing organizations doing the same thing?

6. What was the original mission of Monterey County Area Agency on Aging? Has this mission changed over time?

7. Were significant portions of the elderly population unserved or underserved at the start of the program (e.g., in terms of income, geography, ethnicity, special needs)?

-1-

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8. How adequate was the availability of services at the start? What services were missing or in short supply (e.g., acute care, housing, social/recreational, in-home, etc.)?

9. How would you describe the quality of the services to older persons at the start (IN GENERAL: WITH RESPECT TO SPECIFIC SERVICES)?

10. What were the most significant assets or resources available to your program at the time it started (e.g., funding, political support, community support)?

11. What were the most significant barriers and problems inhibiting the development of your program?

12. How did you overcome these initial barriers?

13. Are any of these early barriers still present today?

14. Have there been major growth spurts in your program since it started? What factors or conditions contributed to these growth spurts? What were the major milestones in your program's development?

15. The term AGING NETWORK is used all the time, and usually means somewhat different things to different people. How would you describe the AGING SERVICE DELIVERY NETWORK in the Monterey County California area?

TOPIC II: CURRENT ORGANIZATIONAL AND ADMINISTRATIVE ARRANGEMENTS

1. Where does decision-making occur in each of the following administrative
   areas? How centralized is the decision-making process?

OVERALL POLICY DEVELOPMENT:

                           Centralized   In-between   Decentralized

FISCAL CONTROL/BUDGETING:

                           Centralized   In-between   Decentralized

LONG-RANGE PLANNING:

                           Centralized   In-between   Decentralized

DAY-TO-DAY OPERATIONS:

                           Centralized   In-between   Decentralized

2. Have any of these tasks become more or less important to you over time? In
   what ways?

OVERALL POLICY DEVELOPMENT:

FISCAL CONTROL/BUDGETING:

LONG-RANGE PLANNING:

DAY-TO-DAY OPERATIONS:

3. Is there anything unusual, or innovative, in how these tasks are conducted?

OVERALL POLICY DEVELOPMENT:

FISCAL CONTROL/BUDGETING:

LONG-RANGE PLANNING:

DAY-TO-DAY OPERATIONS:

4. What decision-making bodies are involved in your program?

5. Have any decision-making bodies assumed more or less importance over time? [PROBE ABOUT ADVISORY BOARD]

TOPIC III: CURRENT SERVICES AND INTERAGENCY ARRANGEMENTS

1. In addition to the formal service arrangements indicated in this matrix, (SHOW MATRIX) does your program have informal "handshake arrangements" with other agencies, providers, or individuals for direct provision of services to the elderly?

   IF YES: Could you briefly describe these arrangements?
   [WITH WHOM, TO DO WHAT, SCOPE OF SERVICES] ASK FOR COPY
   OF ARRANGEMENTS IF WRITTEN DOWN & AVAILABLE

2. How do you advertise your services to and communicate with older persons in your community (e.g., media, newsletter, civic groups, religious groups)?

3. Considering those services you provide directly, why did you decide to provide them yourself?

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4. Next, considering those services you do **not provide directly yourself:**

   a. **How** do you determine **who** will provide the service? Do you apply specific criteria in selecting a provider?

   b. What **type(s) of contract** do you usually have with providers (e.g., subcontract, fee-for-service; performance based)? Does the type of contract vary according to the type of service provided?

5. What information **must** you provide to your Board of Directors and Advisory Council regarding the services you provide (e.g., written reports, oral presentations)? What information do you voluntarily provide to your Board of Directors and Advisory Council? Are these advisory bodies adequately informed about the services your program provides?

TOPIC IV: EVALUATION AND PLANNING

1. Please describe how you determine the needs of older persons in your community, in general, and of those older persons served by your program, in particular. What data is collected? How is it used?

2. Please describe what activities you undertake for QUALITY ASSURANCE (e.g., to assess the impact of services on quality)? What data is collected? How is it used?

3. Please describe what activities you undertake for LONG-RANGE PLANNING? What data are collected? How is it used?

4. Do you collect any other data to evaluate or monitor your program? What data are collected? How is it used?

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5. Does your program have a computerized data system?
   IF YES, what can the system do ? Can the system track patients across services; to what extent? How has the system helped you develop, deliver, and manage services to older persons? Has the system hindered your program in any ways? ASK FOR COPIES OF REPORTS GENERATED BY COMPUTERIZED DATA SYSTEM.

6. How do you use financial information in daily operations, do you...

   a) - use it in all services?

      - which ones and why?

   b) Modify your program plans based on interim financial results?

   c) Establish priorities and plans for future years?

      Fiscal progress? Why or why not?

7. Who is responsible for financial plan and fiscal control? Where is financial decision making located?

TOPIC V: EXTERNAL INFLUENCES ON PROGRAM

We would like to ask you about external influences on your program.

1. Which of the following groups on this list (SHOW CARD) influence program activities for which you are responsible? Has the influence of each of these groups been **VERY IMPORTANT, SOMEWHAT IMPORTANT,** or **NOT IMPORTANT.** If **VERY OR SOMEWHAT IMPORTANT,** please describe this influence.

	Very Important	Somewhat Important	Not Important
Local officials and agencies			
State policymakers and agencies			
Advocacy groups			
Professional associations			
Voluntary associations (e.g., churches)			
Other individuals or groups_____			
_____			

DESCRIPTION OF IMPORTANCE

Local officials and agencies

State policymakers and agencies

Advocacy groups

Professional associations

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Voluntary
associations
(e.g., churches)

Other individuals
or groups _ _____
_____

2. Have you been able to influence the policies of any of these groups in a
    way that has benefited your program? Please describe.

Local officials
and agencies

State policymakers
and agencies

Advocacy groups

Professional
associations

Voluntary
associations
(e.g., churches)

Other individuals
or groups_____
_____

TOPIC VI: PROBLEMS AND BARRIERS

1. Are you currently experiencing problems with service providers? What is the nature of the problem(s)? How serious is the problem(s)? What have you done, what can be done, to address this problem(s)?

2. If we were to ask service providers what the major problems are with your program, do you know or can you guess what they would answer?

3. Are you currently experiencing problems with clients, advocates, or other consumer groups? What is the nature of the problem(s)? How serious is the problem(s)? What have you done, what can be done, to address this problem(s)?

4. Are you currently experiencing significant problems with your program staff? What is the nature of the problem(s)? How serious is the problem(s)? What have you done, what can be done, to address this problem(s)?

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TOPIC VII: FUTURE PLANS AND DIRECTIONS

1. Are your program revenues likely to change over the next two years? If yes, please describe.

2. Are your program costs likely to change over the next two years? If yes, please describe. Will there be sufficient revenue to meet these costs? If not, what do you plan to do?

3. Do you plan to change significantly the current array of services provided by your program? If yes, please describe.

4. Do you plan to make any major changes in your work with other organizations?

5. Do you plan to change the major goals and objectives of your program? If yes, please describe.

6. Do you plan any major changes in the management or operation of your program? If yes, please describe.

TOPIC VIII: ISSUES OF REPLICABILITY OF PROGRAM

1. Could your program be replicated, in part or in total, in other locations? Urban locations? Rural locations?

2. What parts of your program are most replicable?

3. What parts of your program are least replicable?

4. If you were starting your program in another location, what would you do first? Which parts of your program would you be sure to include? Which parts would you exclude? What would you not do?

THANK YOU. THESE ARE ALL THE QUESTIONS WE HAVE, EXCEPT ONE.

Is there any question that you expected us to ask you, that we didn't ask, but should have? What is that question? [ANSWER]