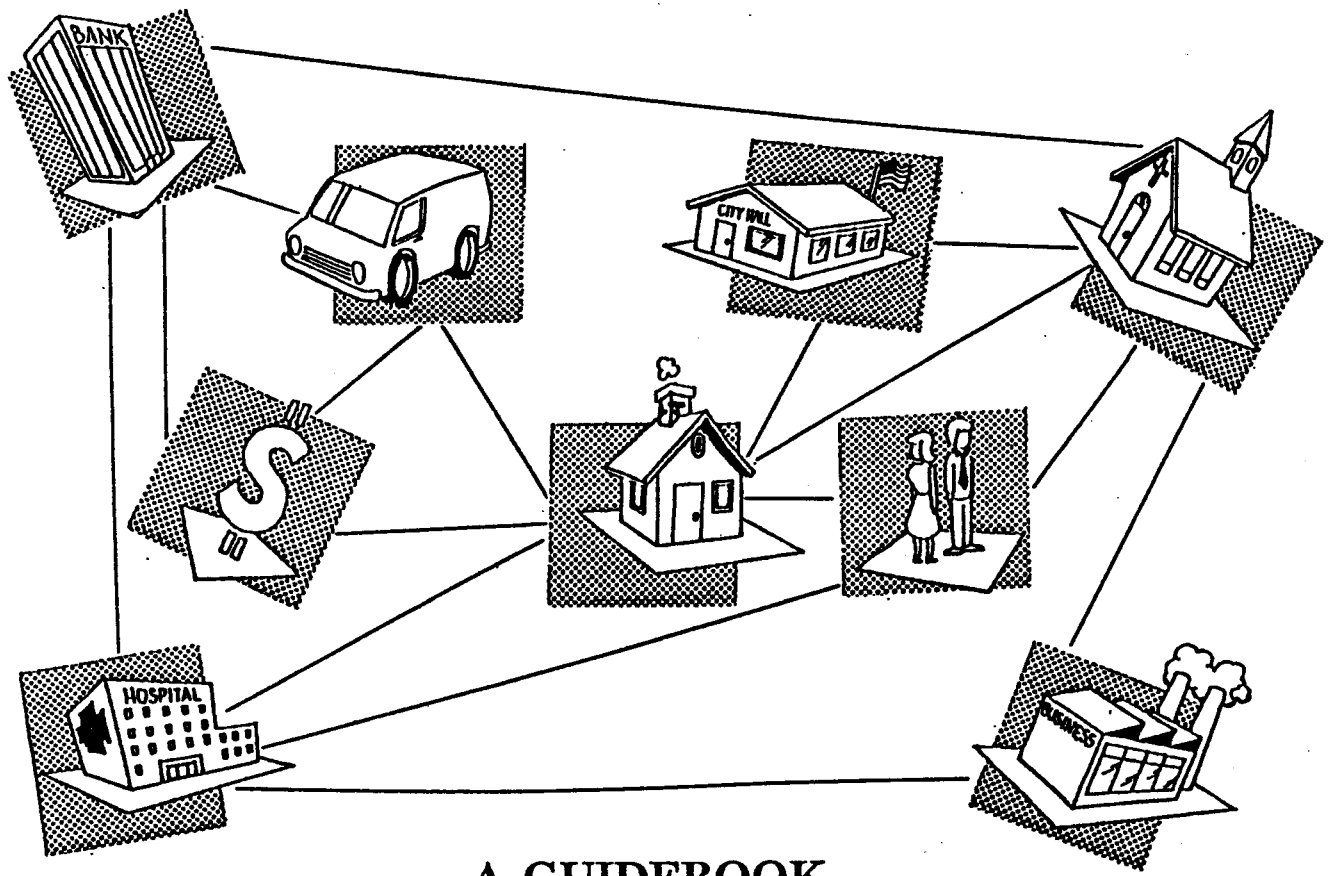
DEVELOPING COMMUNITY BASED SYSTEMS OF CARE



A GUIDEBOOK
FOR
AREA AGENCIES ON AGING
1991

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Developed by
The University of Southern California
The Andrus Gerontology Center
and
The California Department of Aging

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PREFACE

Over the years, a compelling scene consisting of a simple act -

> *the extension of a helping hand to an older person in need of assistance -*

has motivated those who have supported and shaped the Older Americans Act. This caring scene is one which most older persons, their families, friends and others in the community hope will be a reality for themselves or a loved one, should they ever need assistance. It is a scene which epitomizes the objectives of the National Eldercare Cronpaign, a multi-year, nation-wide effort recently launched by the Administration on Aging to mobilize resources for older persons at risk of losing their independence.

Pulling together the supporting players and structure needed to ensure that eldercare services are available and accessible in communities throughout the nation is the work of those charged under the Older Americans Act with providing leadership in the development of community based systems of care.

While this Guidebook focuses on "behind the scene" activities important to the development of community based systems of care, it is dedicated to ensuring that helping hands are extended to those older persons who need assistance.

v~ ere.

Joyce T. Berry, Ph.D.
U.S. Commissioner on Aging

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The Guidebook is based, in part, on three years of observation, evaluation and research focused on 14 communities in California engaged in developing community based systems of care for older persons. We wish to thank the many individuals in California who participated in interviews and filled out numerous questionnaires as part of those research efforts.'

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INTRODUCTION TO THE GUIDEBOOK

"...the area agency shall proactively carry out, under the leadership and direction of the State agency, a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, each community in the planning and service area." Regulations, Administration on Aging, Federal Register, August 31, 1988.

This Guidebook is Designed to Help Area Agencies on Aging with a Difficult Task

This guidebook is designed to help Area Agencies on Aging, and other interested community organizations working with them, tackle the difficult task of developing community based systems of care (CBSC) for older persons at the local level. The guidebook also outlines ways that State Units on Aging can support and assist Area Agencies in carrying out their systems development role.

Although developing a comprehensive and coordinated system of services has been an important goal for the aging network since the Older Americans Act was amended in 1973, many Area Agencies are struggling with how to implement the broader "systems development" role mandated by the 1988 Regulations. They confront two basic questions:

- ► What is systems development?
- ► How do we "do" systems development in our community?

Therefore, the purposes of this guidebook are to:

- ► provide a conceptual context within which communities can raise and discuss the "what" and "how" of systems development;
- ► provide an action framework to help communities initiate and sustain systems development efforts;
- ► provide examples of successful and unsuccessful attempts at systems development in other communities and states; and
- ► identify actions for State Units on Aging which help promote and sustain systems development efforts of Area Agencies on Aging at the community level.

Systems Development Leadership Status Varies

The Older Americans Act charges Area Agencies on Aging with a broad mandate to develop community based systems of services. We realize that for a wide variety of reasons Area Agencies have embraced this responsibility with different levels of commitment and enthusiasm. As a result, Area Agencies are in different stages of development vis-a-vis their CBSC leadership role. These stages include:

- ► Leading: Area Agencies in this stage are well underway with systems development efforts. They are the recognized entity for leading systems development efforts in the community.
- ► Facilitating: Area Agencies in this stage are actively supporting systems development efforts which are being lead by another organization(s) in the community.
- ► Initiating: Area Agencies in this stage are the "wanna-bes" of systems development. They accept their systems development mandate and are eager to "get going".
- ► Deliberating: Area Agencies in this stage are contemplating an active systems development role but are holding back either because they feel overwhelmed by grantsmanship responsibilities and staffing limitations or have been discouraged *on* the basis of earlier, unsuccessful efforts.

This Guidebook is aimed primarily at those Area Agencies and communities in the "Initiating" and "Deliberating" stages of systems development. But because systems are rarely static and development is rarely complete, we believe those Area Agencies in the "Leading" and "Facilitating" stages will also find something useful in the pages that follow.

State/Local Partnership is Essential for Successful Systems Development Efforts

It is important to point out at the beginning a theme that runs throughout the Guidebook: *We believe systems development efforts will be most successful where there is a viable partnership between leaders at the state and local levels. Communities cannot build systems without the guidance and help of key parties at the state level By the same token, state leaders cannot impose "systems" on local communities and expect them to be successful Cooperation and consideration must flow both ways.*

Guidebook is Not a Magic Bullet

This Guidebook will help you move forward with developing the community-based system of care in your communities, but it is not a magic bullet. It can point the way by outlining processes and providing examples of what has worked (or not worked) in other communities, but it cannot substitute for your own knowledge of your communities and your own hard work. Systems development is not easy or painless; nor is it "free". Time, money, leadership and, perhaps most of all, perseverance will be required. It also requires a "personal and organizational view.. .which involves risk taking, flexibility and the opportunity to learn and grow from the change process."[2]

How to Use the Guidebook

While we have presented the material in the Guidebook in what we believe is a logical sequence, we realize that (at least on a first reading) some readers may want to skip the "preliminaries" and move directly to the "how to's." Accordingly, the chapters are grouped into general headings and described briefly below. If you do choose to turn directly to Chapter Three, we urge you to come back to Chapter Two when you've finished as some of the key concepts used in Chapter Three are further elaborated in Chapter Two. The remainder of the Guidebook is organized as follows:

Background: Chapters One and Two

- ► Chapter One describes the problems that have led to the call for systems development, identifies barriers to systems development, documents the legislative mandate for developing a CBSC and identifies and discusses the leadership styles of State Units on Aging.
- ► Chapter Two provides a conceptual context for considering systems development issues; key concepts are defined and discussed.

How To's for Area Agencies on Aging: Chapters Three and Four

- ► Chapter Three outlines a step-by-step framework for initiating and sustaining systems development efforts.
- ► Chapter Four identifies key characteristics of a community based system of care.

How To's for State Units on Aging: Chapter Five

- ► Chapter Five discusses steps that State Units on Aging can take to help Area Agencies successfully carry out their systems development mandate.

Wrap-Up: Chapter Six

- ► Chapter Six offers a final few words of advice regarding the maintenance of systems development efforts.

Appendix

- ► The Appendix discusses in greater detail some of the data-gathering techniques described briefly in Chapter Three.

CHAPTER ONE

THE CONTEXT OF SYSTEMS DEVELOPMENT .

In this chapter we briefly explore the context within which Area Agencies carry out their systems development mandate. Topics include: 1) the forces and problems that have led to the push for systems development, 2) bathers to systems development, 3) federal and state legislative mandates vis-a-vis systems development; and 4) State Unit on Aging (SUA) leadership styles.

The Push for Systems Development Comes From All Levels

While the Older Americans Act and its Rules and Regulations are a strong mandate for action, the push for systems development is coming from state and local levels as well. A growing older population coupled with static or shrinking public resources has prompted many states to turn to systems development as part of a strategy to slow the growth of nursing home costs and to "rationalize" fragmented services. At the local level, Area Agencies, hospitals, and other community organizations are looking to systems development as a way of making it easier for service providers, older people and their families to navigate an increasingly complex maze of social and health care services. Leaders at all three levels believe systems development can help improve the effectiveness and efficiency of services delivered to older persons in their communities.

Systems Development Addresses Service Delivery Problems

Systems development seeks to address four major problems associated with the delivery of services in the community. These include:

- difficulty in accessing or using services, especially if multiple services are required
- fragmentation of services
- duplication of services
- gaps in services.

Access: Perhaps most importantly, systems development is viewed as a strategy for improving the accessibility and useability of services. Improved communication and coordination can help ensure that clients and service providers are knowledgeable about services and can help identify physical, social and psychological barriers that impede service utilization.

Fragmentation: Except in rare circumstances, most agencies are unable to provide the entire range of services needed by older clients, particularly those who are frail and/or chronically ill. Consequently, it is often necessary to refer and link clients with other agencies, something that can be costly in terms of time and money. And even if staff have the time and knowledge to make referrals, clients may be refused because they do not meet age or income eligibility criteria. Thus, systems development seeks to increase knowledge among service providers in order: to improve the referral and transfer process.

Duplication: Systems development is also viewed as a "solution" when duplicate services exist in a community, something that may be less common today as resources for health and social services become increasingly scarce. While some duplication may be necessary to ensure that services are accessible, excessive duplication reduces service efficiency and effectiveness. Coordinated decision making among providers "offers one approach to reducing excessive duplication and enhancing efficient resource allocation."'

Gap-filling: The elimination of gaps in services is another goal of systems development. By sharing information about community services, providers can identify gaps and develop collective strategies for initiating new services or expanding existing programs.

Barriers and Disincentives to Systems Development are Numerous

Although it has potential pay-offs for both clients and service providers, systems development is not "free". It involves tangible costs in terms of staff time and other resources as well as opportunity costs, other things that go "un-done." Thus, before embarking on systems development efforts, it is important to consider the benefits and costs of coordination/systems development and the incentives and disincentives organizations face as they

contemplate participation in such efforts.

Indeed, the bafflers to systems development are numerous. Programs am often categorical in terms of their financing and administration. Programs have different eligibility criteria. Agencies have different allegiances and values which guide their approaches to serving clients. In short, basic differences in operations and philosophy may make organizations feel threatened or challenged by collaborative efforts and may make it difficult to create a "vision" of what a system of care should accomplish. Yet without a "vision" or clear sense of direction, organizations are often unable to assess the impact of their efforts and some become frustrated when systems development appears to be synonymous with means, such as the development of assessment tools, rather than ends, such as improving opportunities for frail elders to remain in the community.

Another barrier to systems - development is its voluntary nature. Unfortunately, Area Agencies on Aging often do not have the authority to "require" other agencies or organizations to participate in systems development efforts. Indeed, other organizations in the system of care may not even be aware of the Area Agency's systems development role! Although organizations may participate in systems development activities to meet their own needs for resources (clients, information, etc.) this participation is not mandatory nor does it necessarily result in an effective system; "that is, the degree of interaction or coordination among organizations may be optimal for specific organizations, yet suboptimal for the system as a whole."`

Why are managers sonietimes reluctant to participate in systems development efforts? Much of the answer lies in the fact that managers am preoccupied with fulfilling their own program requirements and am wary of changes that may make that task more difficult. Managers are also interested in maintaining consensus in the community about their organization's domain—its goals, role, service, target population, etc. Coordination and systems development activities call necessary domains into question and can generate conflict and competition among organizations.

In addition, "...organizations are by design change avoiders. One of the fundamental factors influencing organizational efficiency is predictability in processes and procedures."[5] Because managers prefer an orderly, reliable flow of resources, the uncertainty that is a by-product of many systems development efforts discourages managers from engaging in collaboration. It simply "goes against the grain." And finally, "most people have a vested interest in the functioning of the system as it currently exists."[6] Thus, managers "promote the application and defense of the agency's perspective and defend the organization's way of doing things." Not surprisingly, systems development efforts that require organizations to change their approach to clients or their methods of operation are likely to be resisted.

Finally, even managers who wish to participate in systems development are often constrained by the level of their own authority. Changes in executive leadership or changes in policy and posture at the top may be needed before collaborative activities supported by mid-level managers can move forward.

In sum, there are numerous barriers and disincentives that must be overcome before systems development efforts are likely to be successful. These obstacles are not insurmountable, but they do point to the need for careful planning and a considered response to the Area Agency's systems development mandate.

Legislative Mandates Provide the Context for Systems Development

Systems development does not take place in a vacuum. Rather, it unfolds within a context of laws, regulations, organizational arrangements and expectations created and shaped at federal, state and local levels.

At the federal level, the Older Americans Act and its regulations provide the legislative context within which Area Agencies am to carry out their systems development role. Four sections of the Act/regulations are important for understanding that role. First, Part A of Title III, Grants for State and Community Programs on Aging, sets out the broad purpose of the Title III grant programs, an important source of funding for home and community based services:

> It is the purpose of this title to encourage and assist State and Area Agencies to concentrate resources in order to develop greater capacity

and foster the development and implementation of comprehensive and coordinated service systems to serve older individuals ...in order to:

(1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care with appropriate supportive services;

(2) remove individual and social barriers to economic and personal independence for older individuals; and

(3) provide a continuum of care for the vulnerable elderly. (Older Americans Act of 1965 as *amended.)*

In sum, this language identifies the ultimate goal of Area Agencies' systems development efforts, the opportunity for older persons to remain independent in their homes and community as long as possible.

Second, the definitions section of Title III Part A outlines the purpose of a comprehensive and coordinated system:

(1) The term, "comprehensive and coordinated system" means a system for providing all necessary supportive services, including nutrition services, in a manner designed to –

(A) facilitate accessibility to, and utilization of, all supportive services and nutrition services provided within the geographic area served by such system by any public or private agency or organization;

(B) develop and make the most efficient use of supportive services and nutrition services in meeting the needs of older individuals; and

(C) use available resources efficiently and with a minimum of duplication.

This language makes it clear that systems development efforts are to extend beyond Title III funded services to include all supportive services provided by both public and private entities. This part of the act also emphasizes the need for attention to efficiency in the organization of the service delivery system.

Third, the Rules and Regulations Subpart C, Area Agency Responsibilities issued in the Federal Register on August 31, 1988, dearly sets forth the systems development mission of the Area Agency on Aging:

1321.53 Mission of the area agency.

(a) The Older Americans Act intends that the area agency on aging shall be the leader relative to all aging issues on behalf of older persons in the planning and service area. This means that the area agency shall proactively carry out, under the leadership and direction of the State agency, a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, each community in the planning and service area. These systems shall be designed to assist older persons in leading independent, meaningful and dignified lives in their own homes and communities as long as possible.

This language from the Rules and Regulations governing the Older Americans Act plainly mandates Area Agencies to carry out a proactive leadership role vis-a-vis systems development in each community in the PSA

And fourth, this section of the Rules and Regulations (based on AoA's "Blueprint for Community Action in Aging") goes on to describe the characteristics of the comprehensive and coordinated system mandated above:

(b) A comprehensive and coordinated community based system described in paragraph (a) of this section shall:

(1) Have a visible focal point of contact where anyone can go or call for help, information or referral on any aging issue;

(2) Provide a range of options;

(3) Assure that these options are readily accessible to all older persons: The independent, semi-dependent and totally dependent, no matter what their income;

(4) Include a commitment of public, private, voluntary and personal resources committed to supporting the system;

(5) Involve collaborative decision-making among public, private, voluntary, religious and fraternal organizations and older people in the community;

(6) Offer special help or targeted resources for the most vulnerable older persons, those in danger of losing their independence;

(7) Provide effective referral from agency to agency to assure that information or assistance is received, no matter how or where contact is made in the community;

(8) Evidence sufficient flexibility to respond with appropriate individualized assistance, especially for the vulnerable older person;

(9) Have a unique character which is tailored to the specific nature of the community; and

(10) Be directed by leaders in the community who have the respect, capacity and authority necessary to convene all interested persons, assess needs, design solutions, track overall success, stimulate change and plan community responses for the present and for the future.

With this section, AoA has begun to identify the processes, services and characteristics of a community based system of care, as well as to lay out criteria for evaluating the performance of the system.

Together, these legislative mandates send a clear signal that Area Agencies on Aging are to become actively engaged in developing community based systems of care in their communities. The goal of such efforts should be to ensure that older persons have choices in their communities which allow them to remain as independent as possible.

State Level Policies and Structures also Define Mandates

While the Older Americans Act provides the overarching mandate for Area Agencies to become actively engaged in systems development efforts, state-level policies and structures also define the Area Agency's systems development role. Particularly important are policies which determine the structure of the service delivery systems as well as explicit legislative mandates for systems development.

With regard to the service delivery system, some states, for example, have adopted program designation and funding strategies which have concentrated administrative and fiscal authority over aging program and services (particularly those related to long term care) in one organization at the state and/or local levels. At the local level, Area Agencies on Aging are often the designated entity to administer these resources. Other states have taken the opposite tack with the result that a number of different organizations fund and administer key aging services and resources such as OAA funds, Social Security Title XX dollars and Social Security Title XIX funds. Clearly, these state-level decisions produce different configurations of service delivery networks at the local level which in turn can make a difference in how an Area Agency carries out its systems development role. For example, the amount of external coordination an Area Agency needs to undertake is likely to vary depending on whether the state has pursued a consolidated or multi-organization strategy for funding and administering aging services.

Similarly, some state legislatures have explicitly charged the State Unit on Aging with the responsibility to develop the system of care and/or have sanctioned interagency task forces, committees, or other similar structures

as vehicles for coordinating the efforts of state-level departments that serve older persons. Again, the presence of these structures as well as the expectations they create may, depending on the organization of the service delivery system, facilitate systems development efforts at the local leveL On the other hand, the absence of such arrangements at the state level and/or animosity among state departments may create barriers to coordination and systems development at the local level.

State Unit on Aging Leadership Style Another Important Contextual Factor

Mother important factor at the state level that can influence systems development efforts at the local level is the leadership style of the State Unit. According to the National Association of State Units on Aging (NASUA), State Units have developed different leadership styles which are broadly reflected in the way staff interpret the agency's mission as well as the scope and nature of the State Unit's interorganizational relationships. NASUA has identified six basic leadership styles pursued by State Units:

- The Preservationist Style: Agencies who act primarily as a trustee or steward over an existing pool of funds. These agencies devote the majority of their time assuring the basic requirements of the programs they administer are met in an accurate, timely fashion. The content and structure of the Program being administered are largely defined by others through legislation and the like. Their orientation is to maintain what exists, minimize problems and reduce unnecessary risks. Agency relationships are sought out or maintained only to the extent required by the administrative duties.

- The Problem Response Style: Agencies who spend most of their time responding to the thy-to-day problems which arise from internal operations or their relationships with other organizations. Management attention shifts from one problem to another, leaving little time to "get ahead" of the problems and focus on opportunities for the aging programs or the State Unit itself. Some would call this the siege mentality.

- The Technician Style: Agencies who endeavor to improve what currently exists. These agencies tend to accept the current structure of programs and responsibilities as given. Their primary interest is in making the programs and organizations more efficient. For example, these agencies tend to focus on management improvements, skills development and the like. Their agency relationships tend to be limited to those perceived as necessary to the job at hand. These agencies are often characterized as "well run."

- The Incrementalist Style: Agencies who seek out new projects but only those which are a natural extension to what is already in place. They want change to occur but not at the price of too much disruption or risk. Their agency relationships are- usually more extensive than the fast two styles, but are not guided by an overall strategy for systems building.

- The New Project Style: Agencies who are continually involved in new initiatives. Their identity is largely shaped by a constant stream of new ideas, a willingness to try something new and accept certain risks in venturing into the unknown. Most often new ideas grow out of what already exists. These agencies sometimes sacrifice administrative or managerial efficiency for the opportunity to become involved in new project activities. These agencies also tend to develop extensive agency relationships. They use these relationships as a source of new ideas or as a venue for pursuing new ideas which the State Unit originates.

- The Visionary Style: Agencies who develop a vision or blueprint of an overall Program which they seek to implement on a comprehensive scale. The blue-print typically reacts to perceived deficiencies in the current Program operations and seeks to define a new future. Agency priorities are driven by the vision and the type of changes it requires. Often-times this involves reorganization and new legislation which will underpin the vision. Agency relationships are often recast reflecting a different role and orientation to the mandates of the agencies. It is not unusual for the blueprint to address in some fashion the basic mandates of the agency itself!

As NASUA points out, "...no single style defines a State Unit agency completely. Traits of various styles can. . .be observed. Yet one style tends to prevail and defme the "culture" of the organization for a defined period of time."'

Although SUM are charged with a basic set of responsibilities and undertake a fairly well defined set of activities to execute those responsibilities, their specific actions and interactions with other organizations are highly influenced by the agency's leadership style. While the classification scheme outlined above may not exactly describe the behavior of your SUA vis-a-vis systems development, it can help you identify and understand the broader context within which your own efforts are taking place. Ideally, of course, we would hope that State Units adopt a "visionary" style vis-a-vis systems development.

Despite Legislative Mandates, Systems Development is Still Poorly Understood

Despite the legislative mandates laid out in the Older Americans Act and, in some states, state legislation, many Area Agencies on Aging are still unclear about what is meant by "systems development." For the purposes of this guidebook, we defme systems development as the set of activities and processes used by the Area Agency and other organizations to envision, plan, manage, : coordinate, integrate, evaluate, refine and improve the quality of a community's constellation of services. We believe the goal of such . efforts is to maximize client functioning by providing essential services in a cost effective manner compatible with the preferences and capabilities of the client.

Systems development activities include:

- developing a shared "vision" for the system of care in the community which includes goals and objectives,
- developing a community-wide plan which includes operational and political strategies for achieving or making progress toward the vision,
- garnering the commitment of key organizations and individuals to implement the plan, and developing a community-wide problem solving capacity,
- initiating and sustaining the actions needed to implement the plan, including evaluating the effectiveness of the CBSC.

As this list suggests, the systems development mandate places important new demands on Area Agencies and encompasses a much broader set of activities than the coordination role Area Agencies have been pursuing since their creation in 1973. Indeed, systems development implies concern for "the big picture" and for developing decision making processes and structures that allow individuals and organizations in the community to work together on creating "the big picture."

While the primary goal of systems development is to ensure that the elements of the system of care are in place and functioning well together in order to maximize client functioning in a cost effective manner, systems development may also be concerned with increasing productivity in the delivery of services, reducing uncertain or arbitrary behavior on the part of service providers and/or promoting equity in the delivery and use of services. In sum, the purpose of systems development is to establish goals for the system of care in the community and to "promote the effective and efficient delivery of services through the collaboration of a number of different organizations."'

CHAPTER TWO

CBSC DEVELOPMENT: CONCEPTS TO CONSIDER

In this chapter we identify and discuss a number of concepts which we believe are useful for thinking about systems development efforts. These concepts/ideas include:

- scope of a CBSC
- organizational arrangements and structures
- community
- vision
- leadership

Each is explored in greater detail below.

What is the Scope of the System?

One of the first questions that Area Agencies must ask is "What is the scope of the system that is envisioned?" Does "the system of community based care" include only those services targeted to older people, or does it also include generic services for other age groups? Does it include only social services or should it encompass social, long term care and acute *health* care services. What about the police department? Is it part of "the system of services?"

To some degree, the scope of the system is something that each community must define. Most communities would include all Title III services as well as key community based long term care services and acute services such as discharge planning. The scope of the system can, of course, be expanded incrementally as communities have the time, energy, inclination and resources to bring additional services into the CBSC.

The scope of a health and human service system can be measured along various dimensions including:

- persons which the system serves and/or targets, particularly in regard to their age, functional level, income and minority/non-minority status (persons served);
- services the system incorporates and provides (services);
- the "catchment" area the system serves (service area); and
- organizations involved in providing services (organizations).

Each of the dimensions associated with a system has implications for the system as a whole.

The general dimensions of the CBSC model illustrated in Figure 1 and some major assumptions and implications related to these dimensions are discussed below?

Persons Served

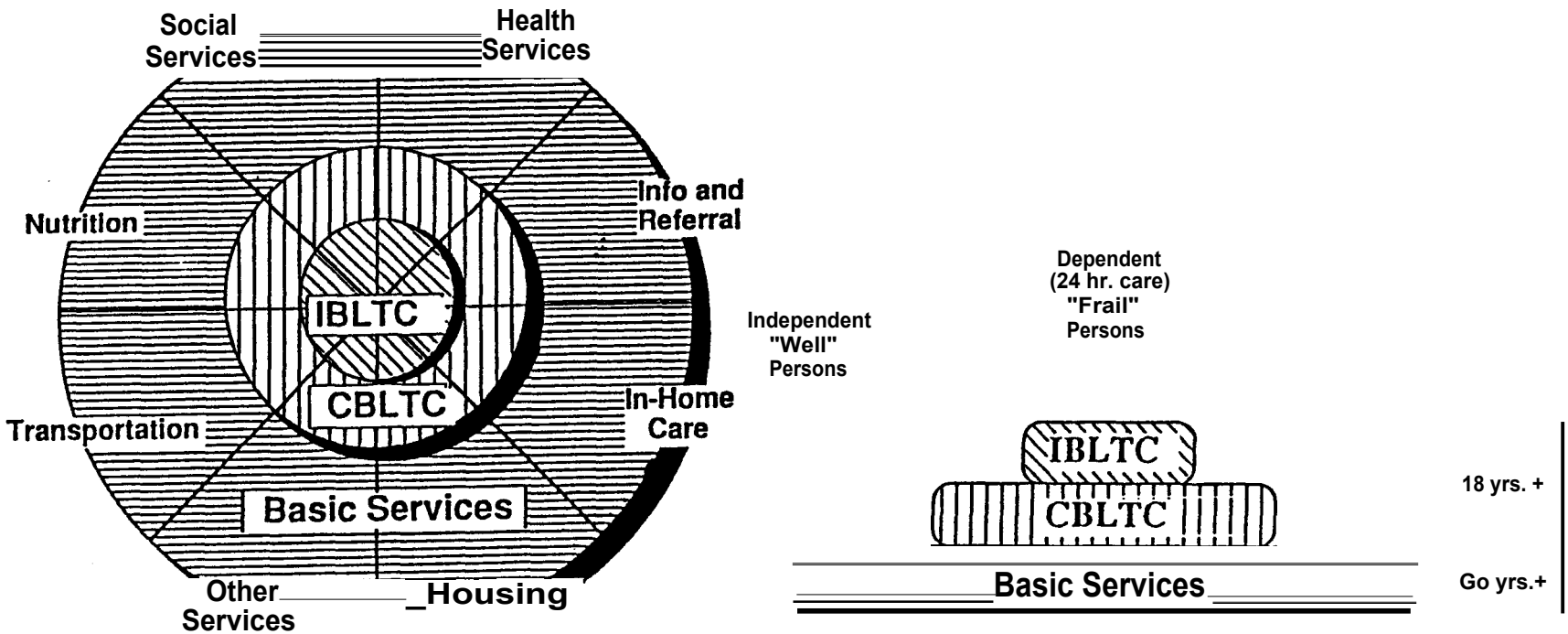
The community-based system of care concept is based on the assumption that the system needs to be individual participant oriented. In all aspects of systems development it is important to focus on how, and how well, the system will serve individuals who have a variety of service needs which may change over time. While some individuals may be very independent others, because of functional impairment," may be increasingly dependent and frail. Therefore, a community-based system of care, as a whole, is designed to respond to the current functional ability (which can range from independent to dependent) of each individual.

Whether, and to what degree, a person's independence is currently limited by functional impairment is a major factor in differentiating levels of service within the system:

Figure 1

COMMUNITY BASED SYSTEM OF CARE (CBSC)

Promotes *coordination* between community organizations to establish the network of programs and services required to provide effective and efficient *service integration* for persons in accordance with their functional ability.



This *CBSC* Model *was* developed by *the California* Department *of Aging*

Non-Functionally Impaired Persons

- Older persons (typically age 60 and over) whose current needs are not predominantly determined by problems associated with functional impairment are served at Level 1 - Basic Services.

Functionally Impaired Persons

- Older persons (typically age 60 and over), as well as some persons 18 and over, whose current needs are predominantly determined by problems associated with functional impairment, which place them at risk of entering an institutional-based long team care facility and/or loss of independence are served at Level 2 - Community-Based Long Term Care (CBLTC).

- Persons who currently reside in an institutional-based long term care facility are served at Level 3 - Institutional-Based Long Term Care (IBLTC).'[2]

A CBSC model can respond to the emphasis of the OAA to target older persons with special needs (greatest economic need and/or greatest social need) with emphasis on low income minority older persons. The needs of many of these persons are not necessarily based on functional impairment. Their needs equate more to prevention, delay, or decrease of future functional impairment. Therefore, it is especially important to maintain the basic services level as an integral part of the system and respond to the needs of target populations who are not functionally impaired.

While most OAA programs are for persons age 60 or older, other funding sources are available to provide services for younger functionally impaired adults. A CBSC can support coordination and integration of OAA services in a way that is beneficial for all concerned.

Services

California's CBSC model reflects the close relationship of the three service levels discussed above: basic services (many of which are provided for or coordinated under OAA Title Ill), CBLTC services; and IBLTC services for persons in institutional based long term health care facilities.

A single service (e.g., information and- referral) may be an 'essential component of one or more sets of services or levels. However, the nature of a service provided within a generic category (e.g., transportation) may well differ according to the service level. At the basic services level it may include bus rides or taxi vouchers, etc. At the CBLTC level, it may include dial-a-ride, escort service, and/or medical transportation. At the IBLTC level, it may include specialized transportation. (e.g., ambulance) to receive required acute medical care.

The model illustrates how each set of services can be viewed as one level of a more responsive system of care which is accessible through a request for information and referral and/or other services.

The CBSC consists of an extensive array of health, social, and other services that are available within a community. Over time it could encompass most, if not all, of the services included in a community's information and referral resource file. The services provided through a CBSC could potentially include all publicly and privately funded programs.

Community Service Areas

The CBSC model focuses on the community as a place to provide for access to the services needed by its residents. Therefore the service area of a CBSC is the community."

The CBSC model recognizes economic, geographic, and ethnic diversity. It provides for the designation of various communities on the basis of criteria developed within each respective PSA. It then allows these local communities to develop a CBSC appropriate to their needs.

It also encourages communities to use their unique resources, sense of identity, and traditional ways of relating to address the needs of its citizenry (e.g., building on the long standing interest of religious, fraternal and other organ»adions and groups to contribute toward the welfare of members of

their own community; or, by developing fundraising themes and service approaches that have special significance for that community).

Similarly, it encourages communities to test other ways to work toward building a CBSC when certain resources are not available (e.g., by, at least temporarily, building around or substituting for a needed service).

Lastly, the CBSC model recognizes the importance of community focal points to various aspects of CBSC development and implementation.

Organizations

Implementation of a CBSC relies on the participation of a wide number of public and private organizations responsible for the services included within a CBSC. The CBSC model allows for an incremental approach to gaining their participation in the system development process.

Most importantly, the model provides a common focus for these various agencies by offering an overall framework within *which* each agency can better identify individual roles and ways it can participate in and contribute to the development and maintenance of a CBSC. Bringing these agencies together to participate in this process should, over time, lead to the establishment of a more formal intemrganizational relationship with sufficient structure to ensure mechanisms for making decisions compatible to the overall development of CBSC. Given the broad extent and nature of CBS C, this approach, rather than the administrative consolidation approach (e.g., the consolidation of -Title III, Title XIX and Title XX funding and administrative authority used in some states to build a CBLTC system) may be an initial basis for a CBSC's organizational structure.

Organizational Arrangements/Structures DIffer Across Communities

Although communities will differ in the details of their service systems, these differences are likely to be trivial in comparison to the differences in the organizational structures and arrangements that exist to fund and administer services. Yet, these differences may have profound consequences for systems development. For example, in some communities, funds for all public community based long term care services are administered by the same organizational unit; in others, responsibilities are scattered among a number of organizations, compounding coordination problems. In some communities, the Area Agency on Agency is clearly recognized as the "lead agency" for developing the community based system of care. In others, a hospital or other community organization may be the recognized leader for coordinating a portion of the CBSC, such as community based long term care services. As yet, research has not answered the question of whether one set of organizational arrangements is more effective than another.

Because organizational arnmgements and relationships are an important aspect of systems development, both in terms of setting a framework within which efforts take place and facilitating or impeding the implementation of the "system" that results from development efforts, we believe it is useful to briefly examine some of the structural dimensions that characterize these relationships."

Systems Can Be Described by the Degree of Formalization, Centralization and Complexity

Systems are often described along three dimensions: formalization, centralization and complexity. Each of these dimensions is discussed below.

Formalization

Formalization refers to the extent to which agreements and relationships between organizations are governed by rules, policies and procedures. In most communities, the nature of relationships between many organizations providing services to the elderly would be characterized as highly informal. That is, there are no formal, written agreements which specify referral patterns and the nature of referrals themselves are informal, usually taking place by phone or through the exchange of agency-specific documents. In sharp contrast, some organizations maintain a highly formal relationship via purchase-of-service agreements and/or memoranda of understanding (MOUs) which codify referral procedures and patterns.

Similarly, at a systems development level, some communities have informal processes for bringing organizations together to exchange information and plan for change. Others have more formalized structures which are clearly charged with systems development responsibilities.

While larger, more mature, "systems" are often characterized by greater degrees of formalization than their smaller, younger counterparts, there is little evidence that formal systems are per se better than informal ones. Indeed, Kaluzny and Fried note that

> There is no rule that informal relationships are less effective than formalized arrangements, although certainly the formal approach has greater stability. In some cases informal - coordinative initiatives are the only possible options. Furthermore, interorganizational networks are dynamic entities, easily subject to deterioration, but also capable of growth and development. What begins as an incidental, informal mechanism of coordination may in fact evolve into a formal, stable relationship.

Centralization

Centralization refers to the extent to which organizations in the system have delegated decision making authority to one or more organizations/individuals. For example, in highly centralized systems, a lead agency performs a formal coordinating role, usually facilitated through the control of resources. Collaborating organizations subordinated some of their decision making authority to the lead agency or small group of organizations.

In a less centralized system, there may be a facilitating organization which convenes a consortia of community agencies for a common purpose, but which does not assume decision making authority. In fact, the convening agency many rotate among the participating members of the consortia. Decision making authority vis-a-vis consortia activities continues to reside with the *individual* organizations who make up the consortium.

In still other communities, decision making authority resides in individual organizations, but a lead agency is designated to implement the decisions of the group. Some functions may be delegated entirely to the lead agency within the policy parameters established by the group as a whole.

Complexity

A third dimension along which systems can be described is complexity. Complexity is determined by the number of organizations who are part of the system and the number of issues or activities confronting the system. Obviously, the larger the number of organizations and/or the number of issues, the more complex the system. Generally, the more complex the system, the more difficult it is to manage. (This is not to say that "simple" systems are always easy to manage; a decision by a key organization not to "play ball" can wreak havoc in the systems development efforts of even the most simple system.)

Summary

These three dimensions, formalization, centralization and complexity--are useful for characterizing the relationships among organizations in the CBSC as well as thinking about how to structure or re-structure relationships as part of a community's systems development efforts. For example, some communities will fmd it useful to formalize previously informal relationships, procedures or processes. Formalized referral procedures or MOUs regarding grant applications/fund raising help communicate a set of expectations about how organizations will relate to each other.

The locus of decision making is another important consideration in systems development. On the one hand, centralized structures threaten the autonomy of organizations and may discourage participation in collaborative efforts. On the other hand, decentralized structures can lead to avoidance of important issues that face the community as a whole, or even paralysis.

As we pointed out above, each community will need to decide how inclusive to be in defining the scope of its "system" in terms of the three levels described earlier (i.e., Basic Services, CBLTC, IBLTC). The broader or

more inclusive the definition, the more likely the community will need to be concerned about the complexity dimension both in terms of the number of organizations involved and the number of issues to be addressed. Some communities may opt to minimize complexity initially by defining the scope of the system rather narrowly.

The Term "Community" Takes on New Meaning for Systems Development Efforts

The 1988 Older Americans Act Regulations gave increasing emphasis to the term "community" and its role in the development of a community based system of care. The amendments also gave Area Agencies the responsibility of defining the term "community" for the purpose of implementing a community based system of care. The language in the OAA states: "the Area Agency shall work with elected community officials in the planning and service area to designate one or more focal points on aging in each community, as appropriate." The language further states that the Area Agency shall assure that services financed under the OAA in or on behalf of, the community will be either based at, linked to or coordinated with the designated community focal points. Because of the emphasis placed on the importance of this concept in CBSC development, it is important to define and understand what is meant by "community."

For years "community" has been in the term "community-based" to highlight the need for service alternatives to a nursing home placement. Community-based in this context referred to a combination and range of services and programs provided in the community to help older persons remain independent and in their own homes. In addition, prior to the 1988 regulations, it was generally viewed by the Area Agencies that the whole planning and service area was the service area to be developed and served by the "comprehensive and coordinated system of services." However, the 1988 regulations emphasized the narrowing of the service area focus to a community which represents a significant departure from the previous interpretation of "community."

In the current context of CBSC, the term "community" is being used to clarify where the primary responsibility for development and improvement of services and supports to older persons should reside. It also emphasizes -that community level participation and leadership is critical to ensuring the development of the most effective and appropriate services and opportunities to help older persons and their families."

What then should constitute the criteria to determine a "community" since the term is somewhat general and may be interpreted differently in different areas? A "community" may be perceived as a township or a city, a group of small towns that are close together, two or three small suburban cities or rural multi-county PSA, or individual counties. Communities may also be defined on the basis of cultural or ethnic groupings. Given the variability of the interpretation of "community", it is appropriate that each Area Agency take such factors as the following into account in establishing its own criteria for defining community service areas: geography, political subdivisions and jurisdictions, demographics, cultural and ethnic groups, service catchment areas, community designations established for other programs, etc.[16]

Finally, the definition of "community" must address the concept of being "locally accessible." Key congregate services considered essential to a system of services need to be within reasonable distance to the participants to allow for frequent use. This concept is especially important given the 1988 OAA regulations' emphasis on focal points. The focal point concept provides for a tangible, visible mechanism by which services, opportunities and protections can be made locally accessible."

A "Vision" of Success Provides a Framework for Systems Development

Most organizations are familiar with the concept of a mission statement: a written description of organizational purposes. A vision, while including mission, goes beyond it to "describe how the organization should look when it is working well "" While the concept of vision is usually discussed in the context of a specific organization, we believe it is equally applicable to a community based system of care; without a vision of the CBSC--what it should look like, how it should work for clients–organizations who participate in systems development efforts have little or no way to judge the efficacy of their efforts.

According to Warren Bennis and Burt Nanus, a "vision articulates a view of a realistic, credible, attractive future for the organization, a condition that is better in some important ways than what now exists. A vision is a target that beckons."[19]

Writing about non-profit organizations, but equally applicable to communities engaged in systems development, Bryson suggests that a vision of success should include:

1. Mission
2. Basic philosophy and core values
3. Goals, if they are established.
4. Basic strategies.
5. Performance criteria.
6. Important decision rules.
7. Ethical standards expected of all employees.

The benefits of creating a vision are numerous:

1. Organizational members are given specific, reasonable, and supportive guidance about what is expected of them and why.

2. A vision of success provides the conception that people need to discriminate among preferred and undesirable actions and outcomes, to produce more of what is preferred, and to fashion expectations and reward systems in line with what is preferred.

3. Less time will be expended on debating what to do, how to do it, and why, and more time can be devoted to simply getting on with it.

4. If the future is what we make it, then a vision outlines the future we want to have and forces us to live it--create it, realize it —in the present.

5. A well-tuned vision of success can motivate the organization's members to pursue excellence.

6. If a vision of success becomes a calling, an enormous amount of individual energy and dedication can be released in pursuit of a forceful vision focused on a better future.

7. A well-articulated vision of success will at least implicitly help people recognize the bathers to realization of the vision and thereby assist in overcoming them.

8. A clear vision of success provides an effective substitute for leadership. People are able to lead and manage themselves if they are given clear guidance about directions and behavioral expectations.

9. An agreed-upon vision may contribute to a significant reduction in the level of organizational conflict if the vision establishes a set of superordmate goals than can rechannel conflict in useful directions.

10. A vision of success provides important permission, justification, and legitimacy to the actions and decisions that accord with the vision, at the same time that it establishes boundaries of permitted behavior.'

In sum,

> A shared vision of the future suggests measures of effectiveness for the organization and for all its parts. It helps individuals distinguish between what's good and what's bad for the organization, and what it's worthwhile to want to achieve. And Most important, it makes it possible to distribute decision making widely. People can make difficult decisions without having to appeal to higher levels in the organization each time because *they* know what end results are desired. Thus, in a very real sense, individual behavior can be shaped, directed, and coordinated by a shared and empowering vision of the futures

Within the context of developing a community based system of care, the vision becomes the glue that holds systems development efforts together.

The process for creating a CBSC vision in your communities is discussed in greater detail in the next chapter.

Leadership is a Key Ingredient for Success

Identifying and using community leaders in appropriate ways is a key part of any systems development process. Without an organization to take charge of or lead the process, systems development will probably simply not occur. "You need a process champion. This person should believe in the process and see his or her role as facilitating the effective thinking, deciding, and acting of key decision makers.[7]

But equally important, without the support and commitment of individuals who can provide needed and appropriate leadership at various stages of the process, systems development is likely to become a hollow exercise. "Unless the process is sponsored (ultimately, if not initially) by important and powerful leaders and decision makers, it is likely to fail. Only key decision makers who are also effective leaders will be able to motivate and guide their organizations through a successful strategic thinking and acting process."[24]

Most experts in the field of management agree that leaden are more than people who hold top jobs. According to Bennis and Nanus, leaders "...can move organizations from current to future states, create visions of potential opportunities for organizations, instill within employees commitment to change and instill new cultures and strategies in organizations that mobilize and focus energy and resources."[2s] Leadership and visions are closely linked: "Leadership is what *gives* an organization its vision and its ability to translate that vision into reality."[26]

While both will be needed to ensure an effective and efficient system of care, management and leadership should not be confused. "Managers are people who do things right and leaders are people who do the right thing. The difference may be summarized as activities of vision and judgment—effectiveness versus activities of mastering routines--efficiency.[u77] Leaders have an agenda and are concerned with outcomes; they create a focus for the organization and thus "manage attention through vision."

Our reading of the management literature and our experiences observing systems development efforts suggests that leadership of the type described by Bennis and Nanus is crucial to the success of systems development efforts. Good managers are needed too, but without leaders who provide vision, systems development is likely to result in little more than marginal adjustments to existing policies, procedures and activities.

Conclusion

This chapter has identified a number of concepts which we believe are useful for understanding the context within which Area Agencies are expected to carry out their systems development roles. As the discussion of barriers to systems development suggests, many Area Agencies face a difficult task in fulfilling their systems development mandate. By their very nature, organizations are likely to resist systems development initiatives. In addition, many Area Agencies lack the resources and authority to require other organizations to participate in systems development efforts. Nevertheless, we believe that those Area Agencies who are serious about systems development can overcome many of these obstacles and move their communities forward toward developing a system of care. Part of the key to success will be the identification and enlistment of leaders who can provide a vision of the CBSC. Without leadership and vision, the results of systems development are likely to be disappointing.

In the next chapter we outline a process designed to help Area Agencies who wish to take the next step toward developing community based systems of care.

CHAPTER THREE

CBSC DEVELOPMENT: A FRAMEWORK.FOR ACTION

Developing a CBSC requires restraint. There is considerable temptation to rush in and do what can be readily achieved without thinking much about how the effort contributes to an overall plan for developing a community based system of care. While planning cannot ensure success, we believe that it can help prevent failure. Thus, the purpose of this chapter is to outline a process which Area Agencies can follow to approach systems development in a planned and purposeful fashion.°

Just Follow the Yellow Brick Road

Like Dorothy and Toto in the Wizard of Oz, you probably don't have a magic broom stick to take you to the Emerald City, a fully developed system of care. Unfortunately, neither do we. But in this chapter we've tried to provide the next best thing, a "yellow brick road" or path to follow for planning, initiating and sustaining systems development efforts.

Our yellow brick road is comprised of ten steps. Below, each step is described in some detail and is accompanied by examples from California and elsewhere that illustrate successful, and occasionally unsuccessful, applications of the step. Although the steps have been presented in a linear fashion for the sake of clarity and simplicity, we recognize that this approach "tends to de-emphasize the organic nature of the planning-implementation process."[z'] Indeed, we believe that many Area Agencies will experience the process in an iterative rather than linear fashion. That is, completion of one step will lead back to the prior step and so forth.

Also for the sake of simplicity, we describe the steps below as if they were being taken by one organization, namely the Area Agency on Aging. Again, we realize that in some communities these steps will be carried out collaboratively by a small set of organizations, a CBSC Leadership Group. Each community will differ in terms of who initiates the process and how many organizations are involved. If a CBSC Leadership Group is established, however, we believe membership should be limited in order to keep the process manageable and the tasks focused.

Old Information Will Be Analyzed in New Ways

In completing the steps outlined below, we ask you to answer what may seem to be some fairly basic questions about your PSA and its communities. You may be tempted to skip an early step or two thinking, "Oh, we already know that." Indeed, we assume that you do in fact already have a fairly good inventory of the health and social services available in the PSA, are knowledgeable about the key organizations and individuals who fund, provide and control services, and are familiar with the characteristics of the older persons residing in the PSA/community. While this information may be quite familiar, we ask you to consider it in what we hope will be new ways. Indeed, by the end of the process, we hope you will have made "the strange familiar and the familiar strange!"

Implementation Timelines Will Vary

We have not provided a timeline for the completion of the ten steps because we believe that depending on a variety of factors, Area Agencies and communities will vary considerably in terms of how long such a process might take. Some will be able to progress to Step 6 in a matter of a few months; others make take a year or two to reach this stage. In complex communities in particular, Step Nine is likely to be measured in years rather than months; Step Ten is on-going. In short, systems development does not proceed according to some pre-determined schedule applicable in all locations and all situations, but varies depending on state and local conditions, needs, resources and preferences.

Discussion Includes Suggested Techniques and "Do's & Don'ts"

In addition to outlining the content of each step, we have made suggestions, where appropriate, about the techniques, such as brainstorming and nominal group, that you might use to gather data needed to carry out the step. We

have also included Do's and Don'ts -approaches to try and things to avoid. It is important to remember throughout, however, that our suggestions are presented as guides: we urge you to discard those that do not apply given your situation, to embellish those that seem particularly useful, and to make adaptations that improve the implementability of specific steps. Our purpose is not to present a lock-step absolute formula, but rather to outline a general framework that can be modified and adapted to meet the unique needs of Area Agencies across the country. (Brief descriptions of the more common data gathering techniques are provided in the Appendix.)

Systems Development Process Includes Ten Steps

Ten steps are included in the process outlined below. We believe it is important that Area Agencies complete all ten *steps in* roughly the sequence outlined, realizing, of course, that some steps may be iterative and some may take place simultaneously. Each is described in greater detail below:

Step One:	Determine Where You Are Now
Step Two:	Review Past Collaborative Experiences
Step Three:	Diagnose Your Community's Characteristics & Capacities
Step Four:	Create .& Communicate a Vision of the CBSC
Step Five:	Identify Current Capacity of CBSC
Step Six:	Identify CBSC Stakeholders
Step Seven:	Assess Ability to Implement Vision
Step Eight:	Develop Strategy to Achieve Vision
Step Nine:	Develop Appropriate Structures/Processes
Step Ten:	Monitor, Evaluate and Re-vision

STEP ONE: DETERMINE WHERE YOU ARE NOW

This step deals with what some have called the "fifth point of the compass", where you are now as opposed to where you want to go. Below, we provide a series of check lists that will help you determine where you are now vis-a-vis a number of the contextual/conceptual variables discussed in Chapters One and Two. You may wish to refer back to these chapters as needed.

State Unit on Aging Leadership Style

What is the leadership style of your State Unit on Aging? Is it

1. Preservationist
2. Problem Response
3. Technician
4. Incrementalist
5. New Project
6. Visionary

Legislative Mandate

To what extent is a state-level legislative mandate for developing community based systems of care present?

1. Not present
2. Modest mandate(s)
3. Major mandate(s)
4. Comprehensive Mandate

If mandate is present, how exactly does it affect the SUA and Area Agency?

To what extent is the mandate **being carried out?**

Administrative/Fiscal Consolidation

To what extent does **the State Unit on Aging and the Area Agency on Aging have administrative and fiscal responsibility for key resources that fund aging services?**

SUA AAA

1. OAA Title III **only**

2. OAA Title III and
   Social Security Title XIX or
   OAA Title III **and**
   Social Security Title XX

3. OAA Title III/Social Security
   Title XIX and
   Social Security Title XX

4. State dollars for **Aging and Long** Term Care

State Fiscal Support for CBSC

What is the level of state funding for the community based system of care beyond that required to meet federal matching requirements?

1. None
2. Small
3. Moderate
4. Significant

AAA CBSC Leadership Role Status

Where is the Area Agency in terms of assuming leadership for developing community based systems of care?

1. **Deliberating**
2. **Anticipating**
3. **Facilitating**
4. **Leading**

Service Type and Eligibility

Who is eligible to receive health and social services provided or funded by you?

	Social Services	**Health Services**
Persons age 60 or older		
.Persons age 65 or older		
Adults age 18 or older		
Other_____		

Level of CBSC Integration

To what extent is your current community based system of care characterized by.

1. **Minimum Integration**

   ▶ Multiple entry points
   ▶ Occasionally shared assessments
   ▶ Workable referral mechanisms
   ▶ Relatively easy transfer of clients between services
   ▶ Information sharing among service provider
   ▶ Limited planning for the community

2. **Moderate Integration**

   ▶ Multiple entry points
   ▶ Shared assessments *among* all service providers
   ▶ Workable referral mechanisms
   ▶ Easy transfer of clients between services
   ▶ Regular communication between service providers regarding CBSC goals and objectives

3. **Significant Integration**

   ▶ One stop shopping for clients
   ▶ Single comprehensive assessment with appropriate services arranged by a single care manager
   ▶ Centralized client monitoring and tracking
   ▶ Formal decision making process for determining CBSC goals and objectives

.CBSC Leadership

To what extent 'are leaders with "vision" present in the community?

1. Present in non-aging organizations/agencies
2. Present in other aging-related organizations/agencies
3. Present in Area Agency on Aging

CBSC Vision

To what extent has a "vision" of the CBSC been developed for the community?

1. *No vision* articulated/discussed.
2. Beginning discussions have taken place._
3. Vision has been articulated, communicated and accepted by participants in the CBSC.

The point of completing Step One has been to 1) help you identify where you are now vis-a-vis some of the key aspects of systems development and, in so doing, 2) raise questions about where you might want to be sometime in the future. With this general picture of "where you are", we now ask you to begin to look more closely as past collaborative experiences in Step Two.

STEP TWO: REVIEW PAST COLLABORATIVE EXPERIENCES

This step builds on Step One and might be thought of as "planning for planning." Its purpose is to collect specific information about the past which can be helpful for structuring the current process and tasks. It involves stepping back and looking at the successes and failures of past collaborative efforts among members of the aging network. Does the community have a successful track record of working together? If so, what have been the key elements associated with past successes? In completing the review, questions to ask include:

- What kinds of collaborative efforts were tried in the past? What *worked?* What didn't? Why?
- What organizations and individuals provided leadership for past collaborative efforts?
- What issues have been the focus of collaboration? How and why did these particular issues emerge?
- What kinds of issues have been addressed successfully? Unsuccessfully?
- What kinds of resources were available to address the issue? Was the availability of resources a key ingredient in ensuring success?
- What was the nature and level of political support for past efforts? What role did political support, or its absence, play in ensuring success/failure?
- What was the nature and level of support from constituents? What role did the presence or absence of constituent support play?
- What was the nature and level of support from professional staff? What role did the presence or absence of staff support play?
- What unique characteristics of the community, its leaders or constituents were associated with success or failure.

In short, this review should focus on what can be learned from successful and unsuccessful collaborative efforts of the past. This "scanning" allows you to identify both opportunities and pitfalls before new activities are initiated. It also allows you to identify what factors or conditions have changed since the last successful effort. These changes may have important implications for how the current effort is organized. Indeed, it will be important to keep the results of Step Two in mind throughout the remaining steps.

The successful implementation of Step Two requires knowledge about the past. If Area Agency staff have been in the area fora long time or the CBSC Leadership Group has worked together successfully in the past, it might be possible to do Step Two internally through a group meeting or interviews with key staff and members of the governing board and/or advisory council. Brainstorming or a nominal group technique are two possible approaches for conducting the review. If Area Agency staff are not familiar with past efforts or the CBSC Leadership Group is new or has not worked well together, it may be necessary to individually interview or conduct a group process with key community "historians", individuals who are knowledgeable about past collaborative efforts.

Do's and Don'ts

Whatever data gathering techniques are used, it is important to avoid "group think", the situation that arises when members of a group "selectively seek out supportive information to bolster a prefetired position and defensively avoid contradictory or unfavorable information."[30] Also be wary of the "halo and horn" effect, perceiving a situation as either all good or all bad. The purpose of this step is not to reach unanimity or consensus. Indeed, learning that participants see the same set of events differently is important! Similarly, if "historians" are used, it will be important to assess the credibility of each individual chosen and to include individuals with different points of view to help keep biases in *check*. Finally, we urge you to carefully consider the composition of your own internal planning team or the CBSC Leadership Group. We believe diversity in terms of the ethnic and cultural backgrounds of participants is desirable and will help ensure that the processes that follow take into account the views and needs of all segments of the community.

STEP THREE: DIAGNOSE YOUR COMMUNITY'S CHARACTERISTICS & CAPACITIES

Keeping the results of Step Two firmly in mind, Step Three asks you to diagnosis the current conditions in your community. Areas for "diagnosis" include:

- collaborative experiences
- leadership for CBSC
- degree of community homogeneity/heterogeneity
- presence of compelling issues or problems
- community history, context and political fabric
- state-level policies and leadership

Collaborative Experiences: Although some assessment of past collaborative experiences will have been completed in Step Two, Step Three asks you to more closely examine and diagnose these experiences in terms of their success and failure. Here you are interested in finding out what made a similar effort work. Specifically, you should try *to* identify any established community protocols or norms that may need to be followed (or at least not violated) in systems development. Strategies for carrying out this part of Step Three include asking individuals who participated in Step Two to review the results of Step Two and identify "lessons to be learned" from past collaborative experiences. Individual interviews or a group process exercise could be used *to* elicit this information.

Leadership: Perhaps the most important aspect of Step Three involves assessing the locus and nature of leadership in the community. You will need to consider which individuals and organizations in the community provide (or could provide) leadership vis-a-vis:

- programs and program development
- policy formulation
- community decision making
- management of the CBSC
- the CBSC vision

As this listing suggests, leadership is not a singular quality or characteristic .that is likely to reside in one organization or individual. Indeed, it is quite common to find one organization providing leadership in developing new programs, another taking charge vis-a-vis policy and advocacy issues and still another initiating a process to pull the community together to work on common problems. In addition, most communities have one or more key individuals who are recognized as providing "visionary" leadership of the type discussed in Chapter Two around a particular issue or cause. And of course, elected officials may exert political leadership vis-a-vis a particular policy issue.

We believe it is important *to* consider and identify individual and organization leaders early on because you will need to tap different sources of leadership throughout the systems development process. More immediately, this information will be important for making decisions about who should "lead" your community's systems development effort. Some communities may adopt a "group" or committee approach *to* leading systems development efforts; others may identify one organization as the "lead agency." The latter approach may be appropriate when one organization has clearly been identified and accepted by the community as the leader for developing the CBSC." Alternatively, this analysis might suggest that it will be more effective to designate two or more organizations to assume leadership for CBSC in a collaborative fashion. Again, past experiences (assessed in Step Two and above) will help determine whether or not shared leadership is appropriate.

In considering the lead agency versus collaborative approach to systems development leadership, important questions *to* ask include the following:

- Which individuals and organizations have a commitment to developing CBSC?
- Which individuals have a leadership style *which* others respect and respond to positively?
- Which organizations have legal mandates to promote coordination?
- Which organizations and individuals are accepted by others in the community as legitimate leaders for developing CBSC?
- Which organizations have the resources to "staff" systems development efforts?

- Which organizations and individuals can block or disrupt systems development efforts?
- Which organizations and individuals can sanction, support or give a broad base of "legitimacy" to individual and/or collective efforts for systems development?

AAA staff and/or members of the leadership group will usually be able to answer the questions posed above. Based on your knowledge of the community, you will need to decide whether these questions can be answered honestly and in an informed, knowledgeable fashion in a group brainstorming session or whether they should be addressed through individual interviews.

A Consortium/Focal Point Approach

In recognition of its large, geographically and ethnically diverse population, an urban Area Agency believed it was important to build a broad base of organizational support for systems development efforts. Consequently, the Area Agency organized the Long Term Care Consortium with representatives from key county departments, Medicaid and community based service providers. While the Area Agency assumed the official lead agency role, the Consortium was used as a forum to discuss common problems and identify areas for reform. A major long term care provider was also designated as the coordinating agency in each of four sub-areas of the county targeted for concerted systems development efforts. For a variety of reasons, including possible role conflicts and limited direction and management from the lead agency, these agencies did not play the coordination role originally envisioned by the lead agency. As result of this experience, the lead agency has now developed formal criteria for designating community focal points. In addition, the Area Agency has identified specific functions each focal point is to carry out as well as responsibilities of the Area Agency to community service areas and focal points.

A Tri-Partite Leadership Model

Another model of shared leadership for systems development is reflected in a small rural county in northern California. The Area I Agency on Aging (a private non-profit entity) was the "official" lead agency for systems development. The community's plan was designed by a tri-partite group composed of the Area Agency, a consortium of service providers and a single service provider who controlled the major long term care services in the community. The systems development plan specified roles for each member of the three-way partnership. For example, the Area Agency acted as the facilitator and implementor of the plan; responsibility for participating in the development of a uniform assessment instrument and other service related procedures and policies for LTC programs was delegated to the single service provider. The members of the consortium, a long . term care committee representing all agencies concerned with LTC systems building, agreed to "work as a peer group to develop and implement" the systems development plan. This delegation and sharing of responsibility both reflected and took advantage of the community's existing leadership structure.

Caution: In reaching a decision regarding single or multiple agency leadership for systems development, it will be important to keep in mind that there will be significant costs—both in terms of real dollars and lost opportunities—for the organization(s) that assumes this role. If possible, the lead agency should assign responsibility for managing the systems development process to one staff member, preferably on a full-time basis, particularly in large communities or PSAs. At a minimum, the lead agency should be able to provide sufficient staff time to regularly convene meetings, distribute agendas and minutes, and "ride herd" on committees and task forces. While the lead agency can reap significant "rewards" from systems development in terms of legitimacy and stature in the community, it cannot do so without using some of its resources. If a delegation approach is used, it will be helpful to consider the delegation checklist provided below. [32]

Degree of Community Heterogeneity: Assessing the degree of homogeneity/heterogeneity in a community is important in two areas: the population to be served and the agencies providing services. Communities with ethnically or racially diverse populations will need to take these differences into account both in terms of implementing the systems development process and actually structuring the CBSC. Other elements of diversity that should be assessed include the following:

- rural/urban dimension
- characteristics of the older population (e.g. income, frailty, culture, living conditions, support systems)
- neighborhood, community or social demographic sense of identity
- natural or ethnic/cultural population "clusterings".

The degree of homogeneity among community agencies and organizations can also affect the systems development process. Systems development may proceed more smoothly, for example, in communities where organizations share similar goals, clients, norms, languages and structures. Elements of organizational diversity/similarity to be assessed include:

- characteristics of clients served
- organizational goals and mandates
- professional orientations and values that affect how clients are assessed and served
- public/private; profit/non-profit status
- source and use of program funds
- governing board structure including overlaps and interlocks

Again, knowledge of the community and its organizations will be important for completing this step. Staff of the Area Agency will probably be able to answer most of the questions posed above. Gaps can be filled by contacting agencies directly or reviewing their promotional materials. It is probably a good idea to check your initial assessments with someone who is very familiar with the *service* delivery network in the community.

Caution! In considering differences within the community, it is important to be sure that "what you know is what exists." You must guard against perceptual/conceptual blocks and biases that do not acknowledge changes that have taken place in the community. We found one community in a large metropolitan area, for example, that had a well developed service delivery system for the white majority population but which virtually ignored Blacks, Hispanics and recent Asian immigrants. This delivery system was reinforced by geographic features that tended to separate the minority and majority populations. Service providers in this system appeared to be defining "need" based on who they had historically served, rather than on an analysis of who was actually residing in the community.

Targeting Private-Sector Participation

While most communities have a mix of public and private sector service providers, this split is accentuated in some communities and may even pose barriers to systems development. Individuals leading systems development efforts in a rural county for example, were aware of a "good ole boy/girl" mentality among county employees involved in long term care programs which tended to stifle participation among private providers. As a result, *the* lead agency specifically made increased participation of private sector providers a goal of systems development efforts.

Identification of Compelling Issue(s): The literature on the coordination of human services suggests that collaborative efforts are more likely to be successful when they revolve around shared issues or problems. Although most people believe community services would be more effective if they were better. coordinated, coordination for coordination's sake is usually not compelling enough to get communities to make major changes in the way *they* plan and provide services. Indeed, past experience suggests that communities that "coordinate" due to external pressures often find that nothing happens. Not surprisingly, the opportunity to solve a "real", shared problem is likely to be a more compelling reason for engaging in systems development than a vague idea that systems development is a good thing. Thus, the identification of shared problems that can be addressed through group action is important for focusing systems development efforts and "buying in" participants. We stress that problems must be participant based

and generated—the selection of a "problem" that does not actually affect participants can eventually lead to apathy and disengagement in the systems development process. It is also important to select issues or problems that stand some chance of being successfully addressed given the community's resources. A small, successful effort is likely to pave the way for more difficult undertakings. Failure, however, can sour enthusiasm for any further activity.

Brainstorming or nominal group technique sessions with managers and service providers am effective ways of identifying common problems. While individual interviews can also be used, the group sessions provide a forum for building consensus about which issues are most important and for engaging in initial problem solving. Needs assessment data can also be useful for identifying common problems.

Do's and Don'ts

We urge you to resist the temptation to select one very narrow problem as the focus for collaborative efforts. Experience suggests that finding one common issue to meet the interests/needs of a diverse group of participants is usually unsuccessfuL Amulti-problem, multi-task force managed by an executive planning group to integrate and coordinate efforts is more likely to build interest and a critical mass for effective change.

Multiple Issue Focus for Systems Development

In its systems development plan, the lead agency identified a limited number of problems that would be addressed by the community during the first phase of systems development. These problems included multiple and conflicting defmitions of services and units of service; lack of centralized information about clients and their use of services, and multiple assessments of clients. Service providers in this community believed these problems made it difficult for older persons to use long teen care services and wasted program resources. To address these problems, the lead agency proposed to develop uniform definitions of services and units of service, develop a uniform release of information form and create a central computerized Client Index, and develop and implement a uniform intake/assessment form with information to be shared among service providers as appropriate.

Single Issue As Rallying Point

The effective use of a single issue as a rallying point for systems development is illustrated in an urban community's decision to focus on victims of elder abuse. As a result of a hearing on elder abuse, the Board of Supervisors passed a motion instructing key county departments to develop and implement a pilot project to serve as a program model for providing better coordination, linkages and integration of services targeted to abused and neglected older persons in need of short-term crisis intervention and assessment services. The model project used a multidisciplinary, interdepartmental, mobile team to conduct evaluations and make client referrals. Based in part on the results of the model project, the Board of Supervisors adopted a Master Plan for Long-Term Care and Adult Services for the county.

Conununity History, Context and Political Fabric: Systems development efforts do not take place within a vacuum but rather within an existing community context shaped by past history and the current political fabric. Thus, we believe it is important to briefly assess the community's history for events and/or trends that may have some bearing on systems development efforts. In the example just discussed, the decision was made to organize systems development efforts around serving a particular target group because the county's board of supervisors was keenly interested in improving services to abused elders and was willing to experiment to find ways in which county services could be delivered more effectively.

In considering community history and context, however, it is important to keep an open mind. Making use of existing organizational leadership, for example, can be advantageous as long as the organization in question is capable of bringing together all segments of the CBSC community. Using organization X because "we've always done it that way" can be a serious blunder, however, if organization X has routinely ignored the needs of part of the older population. Regardless, it's easier to "buck tradition" if you know what the traditions are in your community and have assessed their usefulness for shaping current systems development endeavors!

State-Level Policies and Leadership: As we pointed out in Chapter One, the development of a CBSC takes place within a context of State policies and leadership. A clearly articulated "vision" of CBSC at the State level, for example, provides an important framework for systems development efforts at the local level. Logically, your assessment should begin with the State Unit on Aging. In evaluating the SUA's policies and leadership, it is important to examine not only stated policies; but also the mandates, rules and sanctions, both formal and informal, under which the SUA operates. At the same time, it is important to look at how the SUA's "vision" of CBSC (if present) is supported by organizational structures, resources and policies. Key questions might include:

- Does the SUA operate under a state legislative mandate to develop CBSC?
- Does the SUA have the authority, support and resources to carry out its mandate?
- What, if any sanctions, can be imposed on the SUA if it fails to carry out its mandate?
- Does the SUA have a clearly articulated vision of CBSC?
- If so, do organizational structures, policies and resources support or impede the SUA's ability to implement its vision?
- Is the SUA regarded by the Legislature and other State departments as the appropriate leader for systems development at the State level?
- Does the Director of the SUA demonstrate leadership for and commitment to systems development?
- Does the SUA operate autonomously in developing policies and programs or does it work collaboratively with other state departments/agencies? What is the nature of working relationships?
- Is developing systems of care at the local level a priority of the Governor and/or the Legislature?

In assessing the environment at the State level, Area Agencies need to take into account not only the current policies and "vision" of the State Unit on Aging, but also those of other State departments that control key services in the system. This will be particularly important if systems development responsibility has been delegated or assumed by a Department other than the SUA.

Ideally, SUAs and other State Departments will be committed to systems development and will provide the support and leadership needed to overcome barriers at the local leveL Unfortunately, the ideal is unlikely to prevail in every state. Area Agencies can, of course, work to change actions and attitudes at the State level (a strategy to be discussed later in Step Eight). In the meantime, however, a careful assessment of the State's vision and how it is supported at the beginning of systems development efforts can help minimize frustration and disappointment down the line.

Conclusion

Step Three involves important diagnostic work that helps you assess conditions at both the local and State level that may influence systems development efforts. While some aspects of this Step, such as determining the extent of heterogeneity, can be completed by a single individual, we believe that most of the diagnosing required in this step is best carried out by a small group of individuals who are very familiar with the community, its players and its past experiences. Whether or not this step can be accomplished solely by individuals within the Area Agency on Aging will depend on their tenure and experiences in the community and their familiarity with individuals and events at the State level.

Do's and Don'ts

Because assessments are likely to be biased, both intentionally and unintentionally, we recommend that multiple views be sought in carrying out this step. Multiple views from different vantage points will uncover "core" areas of knowledge along with speculative hunches which can be analyzed further.

STEP FOUR: CREATE AND COMMUNICATE A VISION OF THE CBSC

Now comes the bard part. By creating a vision or "sense of direction" of the CBSC, we mean coming to grips with the question of what the CBSC should achieve for older persons in the community. Although structures can help or hinder a community's ability to implement a desired vision, it is important not to confuse this step with Step Nine which explicitly addresses the issue of the structure and processes needed to carry out the vision. Rather, here you must deal with questions of who will be served, bow they will be served, when they will be served, what kinds of services they will receive, how clients will be assessed and how services will be delivered and evaluated.

In answering these questions, we believe the most logical place to start is with the needs of clients rather than with the needs of the Area Agency or service providers. As in the old adage "the solution is inherent in the definition of the problem," we believe the "system" is inherent *in* the clients' problems. If we can figure out what needs to be done to solve clients' problems and meet their needs, we can devise a structure or set of organizational arrangements and relationships that will allow us to address those problems, meet those needs. For example, Diane Justice takes a client's perspective when she argues that in a successful system "...the elderly will have access to appropriate care without having to contact multiple agencies to receive services for which they are eligible.""

Where do you begin in crafting your community's vision of the CBSC? Borrowing again from the management literature," there are three sources of guidance for developing a vision:

- the past,
- the present, and
- alternative images of future possibilities:

The Past

Much information about the past should already be well in hand as a result of completing Step Two. This information should be reviewed again with the specific purpose of identifying what, if any, vision has guided collaborative efforts in the past. If a vision can be identified, it is important to ask how well it has worked and why? Does the "old" vision have relevance for the current *effort?* Can it be revised or does it need to be scrapped? Because "past decisions and actions often are the record of a consensus about what the organization is and should do,"" do not be too quick to abandon a previous vision. "Basing a vision on a preexisting consensus avoids unnecessary conflict."" In short, it pays to carefully consider the past as a starting place for current efforts.

In reviewing the past, you will also want to consider systems development efforts that have taken place in analogous or similar service delivery systems. Systems development efforts in service delivery systems for

children or the developmentally disabled, for example, may provide useful guidance.

The Present

The "present provides a first approximation of the human, organizational and material resources out of which the future will be formed."'[7]

Again, Steps One, Two and Three have helped you assess the present in terms of the nature and structure of your community. You also probably have a sense of what forces are at work in your community, at the state level or even the federal level that might impinge on systems development efforts. An impending reorganization of state government, for example, would be an important event in "the present" that will influence your vision of the CBSC.

The Future

Creating scenarios of the future is a useful exercise for thinking about how possible future events may affect your vision. Using assumptions about trends (e.g., funding levels, demographics, new and unmet needs, etc.) and events (e.g., restructuring, development of new programs, OAA reauthorization etc.), a worst case, best case and "status quo" scenario of the future can be written to illustrate the range of possible futures the community may confront. Because "much of the future can be invented or designed,:" actions can be taken to help ensure or prevent a particular scenario from materializing!

Synthesizing a Vision of the Future

Bennis and Nanus point out that the leader's challenge is to synthesize information about the past, present and future into a vision of the future. They suggest that many dimensions of vision may be required in this process:

> Leaders require foresight so that they can judge how the vision fits into the way the environment *of* the organization may evolve; hindsight, so that the vision does not violate the traditions and culture of the organization; a world view, within which to interpret the impact of possible new developments and trends; depth perception, so that the whole picture can be seen in appropriate detail and perspective; peripheral vision, so that the possible responses of competitors and other stakeholders to the new direction can be comprehended; and a process of revision, so that all visions previously synthesized are constantly reviewed as the environment changes.'

Although Bennis and Nanus are writing about leaders of individual organizations, their advice seems equally appropriate for leaders of community-based systems development endeavors.

Let us be clear at the outset that there is no one ideal CBSC vision, nor will all visions be precise. Your vision of CBSC will undoubtedly be shaped in large part by the characteristics of your own community. Communities with only the barest minimum of services, for example, will probably have a different vision than those that are "resource rich." Similarly, communities with heterogeneous populations may see their ideal CBSC differently than those with relatively homogeneous populations.

The degree of precision with which a community can construct its vision will also vary. Some, particularly those who are relatively far along in systems development, may be able to articulate a very well defined vision. Others may be at a stage where the development of "guiding principles" is more manageable and perhaps, for some communities, even preferable. Indeed, some degree of "fuzziness" may be useful in the early stages of developing a vision of the CBS C.

Although its content will vary from community to community, the vision provides the framework for all systems development efforts. Even if implementation proceeds incrementally, and it will in most communities, activities become planned rather than ad hoc and can always be checked to see how they contribute to the overall vision.

Because visions usually involve an element of change, this step will not be an easy one. For all the reasons outlined in Chapter Two, managers and organizations are likely to resist change that threatens their autonomy, independence and domain. Issues of power and turf, competition and conflict most probably will surface and even if they do not, they may be present but not visible! That is why we believe it is extremely important to devote sufficient time and energy to this step, it lays the groundwork for everything that follows.

Communicating the Vision is Essential

Once the vision has been created, it must be communicated. It should be written (preferably no more than 10 double spaced pages) in language that is clear and easily understood by policy makers, service providers and clients. Remember, the vision is the glue that holds systems development efforts together. If it is vague, fuzzy, subject to misinterpretation, or couched in bureaucratic jargon, confusion and conflict are likely to ensue and systems development efforts may fall apart. In this regard, it's worth quoting at some length Douglas Nelson's comments about Wisconsin's decision to use "plain language" to describe their long term care Community Options Program (COP):

> A third contributor to the success of COP has been a semiconscious decision that we made about language. In our written and verbal discussions we tried to use anecdotal and unscientific language. We taught ourselves to say, "getting to know the person in trouble" when we were tempted *to* talk about assessment and screening. We talked about "getting the right people to show up at the right time" when we were really describing case management... Our decision to eschew jargon may seem trivial, but I really do not think it was. For one thing, it fostered clearer than usual thinking among those of us who were the bureaucratic and professional advocates of reform. And, in general, I have come *to* think that our reliance upon the quasiscientific vocabulary of human services is more often than not a device to disguise our policy confusion than it is a helpful tool for precision. But, more important, our commitment to plain language has had an immense political significance. It enabled older people in Wisconsin to understand the plain language of COP proposals; made it easy for Wisconsin legislators to understand it, and so far has made it hard for them to oppose it."'

Your vision must not only be successfully communicated throughout the community, but it must also be "institutionalized as a guiding principle?" The Area Agency, service providers, volunteers–in short, anyone involved in the system of care–must "enact" the vision in the course of making decisions and delivering services on a day-to-day basis. In this regard, it may be *helpful* to develop a metaphor, model or symbol that captures the essence of the vision and communicates it in a phrase or at a glance. "In fact, the right metaphor. . .' feels right', it appeals at the gut level, it resonates with the listener's own emotional needs, it somehow 'clicks'.?"

A metaphor or symbol can also be used as part of a campaign to communicate the vision through more "creative" media such as videos, a one-act play or other dramatic effort, songs, posters, inexpensive give-aways, etc.

> **Communicating a CBSC Vision**
>
> The network of 43 senior agencies in Humboldt County in northern California has made effective use of both slogans and visual media in communicating its vision. According to Patty Berg, Executive Director of the Area I Agency on Aging, the network's vision is embodied in its slogan "We are an aging network that works", and the shared goal of "being in business to make life better for those we serve." The network also developed a 20 minute video which focuses on conveying the network's vision/values.

Although developing a formal statement of the community's vision is important, it is important to remember that a vision is never truly "final." For some communities, achieving the "vision" becomes a time for creating

a "new" vision that takes into account changes in the environment as well as the experiences and learning associated with reaching the first vision.

Do's and Don'ts

Up to this point, we have described each Step as if it is being undertaken by the Area Agency on Aging or a small Leadership Group of key organizations. While the Area Agency or Leadership Group can take the first cut at developing the "vision", it will probably be necessary to expand the scope of organizations and individuals who provide input at this phase. These organizations may come with new or additional insights and can help test the reality of your emergent vision.

Illustrations of how two different states–Texas and Wisconsin--have approached the issue of "vision" vis-a-vis their systems of long term care are provided below, followed by an example of how an Area Agency on Aging reoriented its "vision":43 [44 4s]

Developing a CBSC Vision in Texas

Faced with rapidly escalating nursing home costs, the Texas Department of Human Services decided to reform its long term care system by providing a continuum of services while at the same time reducing the overlap between institutional and homebased care. That is, Texas rejected the idea behind Medicaid 2176 Waivers–that individuals whose physical functioning qualified them for nursing home placement could be cared for in the community. Instead, Texas chose to make institutional care available "only to those whose level of care needs really indicated care in that type of setting" but also not to provide home-based care to individuals "who meet the level of care criteria for nursing homes unless the client has an unusally strong informal network."

Developing a CBSC Vision in Wisconsin

Wisconsin provides an example of how one state grappled with creating a "vision" of its long term care system. Officials in Wisconsin began by informally asking the state's older residents what kind of help they would like, what kinds of services or programs they would seek if they could no longer care for themselves. The responses were varied but "shared a primary and paramount concern for preserving dignity, identity, independence, participation and the familiar." Officials also found that the vast majority of older citizens believed they would not be able to get the help they needed. With this information, the planning team concluded that "we needed to create a long term care system that enabled, allowed, and funded individuals to get the help they needed in the form and the place they chose.

> Put another way, we decided early on that the priority objective to long term care reform ought to be to empower the client and the family–not to build a structure, a system, or a program." (Emphasis added)

The focus on client preferences significantly influenced the design of "the system." For example, "we defined assessment not only as the process for objectively identifying client needs, but much more critically, as the way of fmding out how they *and* their families wished to meet those needs. We defined case planning as the process of describing and arranging those supports and services that correspond most closely with clients' own goals and preferences. Finally, we made the individual client case plan the unit of funding. Instead of funding :counties or agencies or specified services, we reimbursed for the costs of individually designed case plans up to the amount the state would have paid had the client become a Medicaid recipient in a nursing home."

Reorienting a Vision: An Area Agency Example

Highland Valley Elder Services, *Inc.*, a private, not-for-profit Area Agency on Aging serves twenty four communities in Western Massachusetts. When the current executive director joined the organization he felt a need to reposition the agency to be more effective in meeting the needs of the elders in the region. To meet these needs, while being sensitive to the economic and cultural diversity of the communities being served, a new focus and mission orientation seemed clearly indicated.

Two concerns were paramount. The first was *to* move the agency from a position of "fund seeking" to that of "income generation." The second was to change the relationship between elders and the options available to them. This, he felt, could be accomplished by changing from a traditional orientation which viewed older persons as an "object of charity" to one which was designed to provide them with "empowerment to influence or control their lives and communities."

This required a shift from a "social service agency" philosophy and orientation which involved "doing something *to* or for people" *to* that of an "empowering" agency which "helps people do something they want for themselves." Doing so meant "standing the agency on its head" and restructuring and reorienting roles and functions to support this very different posture. Municipal Councils on Aging were created, and members from these were chosen *to* serve on Highland Valley's Board of Directors. While this external devolution took place, internal restructuring also took place. A "bottom to top" orientation was developed to complement the changes in community agency relationships that were being planned. Concepts of empowerment, participation, ownership and personal development and growth were made part of the organizational philosophy and corporate culture.

STOP!

Completing Step Four is a big accomplishment! Now it's time to stop for just a moment and take stock. Our experience with intense planning efforts of this type suggests that now is a good time to look at the effectiveness of the group that has been leading the planning process, the Area Agency internal planning team or the CBSC Leadership Group. "Like a car, a group needs maintenance. If feelings am not taken into account, creativity is stifled and problem-solving is adversely affected."'[b]

We suggest that you have each participant complete the 9 questions in Figure 2" and then discuss the results using specific examples if possible. If everyone perceives the group to be working well together, fine. If not, you will need to consider ways to improve your group's effectiveness.

Figure 2: Analyze Planning-Team Effectiveness

Please circle the appropriate number which most closely identifies your opinion.

1. Degree of Representativeness:
   Are different constituencies and their views represented?
   Lack of representativeness — High representativeness
   1 2 3 4 5

2 Degree of mutual trust:
   High suspicion — High trust
   1 2 3 4 5

3. Degree of mutual support:
   Every person for himself — Genuine concern for each other
   1 2 3 4 5

4. Conununications:
   Guarded, cautious — Open, authentic
   1 2 3 4 5

5. Listening:
   Members do not listen to one another. Ideas are ignored: members make speeches to impress rather than to solve problems. — Members do listen to each other. Every idea is given a heating.
   1 2 3 4 5

6. Objectives:
   Not understood by team — Clearly understood
   1 2 3 4 5

7. Commitment toward objectives:
   No commitment — Team is committed to objectives
   1 2 3 4 5

& Handling conflicts within team:
   We deny, avoid, or suppress conflicts — We accept conflicts and weds them through
   1 2 3 4 5

9. Utilization of member resources:
   Our abilities, knowledge & experiences are not fully utilized by the team — Our abilities, knowledge & experiences are fury utilized by the team
   1 2 3 4 5

STEP FIVE: ASSESS CURRENT CAPACITY of CBSC

In Step Five you will need to examine the community's capacity to actually achieve the vision that emerged in Step Four: Three aspects of capacity are particularly important: the availability and quality of CBSC services; the nature of organizational linkages and relationships; and the presence of visionary leaders.

The importance of the first aspect—services—is fairly obvious. Implementing a vision that relies on the availability of high quality of services will be next to impossible if these services do not exist or they are of poor quality. The second aspect—organizational relationships—is perhaps less obvious, but equally important. Since most visions are likely to address issues related to client assessment and service delivery, the relationships between and among organizations are likely to influence how easily the vision can be implemented. For example, if organizations in the community routinely cooperate with each other and share client information as appropriate, then implementing a centralized client tracking system may be relatively easy. The reverse is likely to be true, however, when organizations operate autonomously and do not share routine information. Thus, organizational relationships become part of the "capacity" of the exiting CBSC. Finally, as discussed in Chapter Two, strong leadership is key to the successful implementation of a community's "vision." If visionary leadership is not present in the community, it will need to be developed.

Assess Service Availability and Quality

The assessment of existing services is relatively straightforward. An inventory of services, both direct and access, available in the community may already be available; if not, you will need to compile this information. In reviewing the resource inventory, key questions include:

- Are key services missing? If so, what is the likelihood that they can be developed in 1 to 3 years?
- Can existing services meet current and projected needs?

- Are any service providers "in trouble"; are any services at risk of being discontinued?
- Is there inefficient duplication?
- What is the quality of existing resources? If some services are of poor quality, what is the likelihood that quality can be improved? At what cost?

In answering these questions, it is important to keep in mind the target groups) to be served by the system. Some services may appear to be in ample supply for the community as a whole, but totally lacking for particular segments of the older population or specific geographic regions. Or the quality of services provided to a particular group or region may be substandard.

To help answer the questions posed above, it will be useful to convene a group of case managers, discharge planners and other service providers who are familiar with the service delivery network in the community. Members of the Advisory Council may also be able to provide valuable information about the quality of services.

Assess Organizational Relationships

To assess the capacity of the CBSC in terms of organizational relationships, we believe it will be useful to begin by looking at the relationship of your own organization, the Area Agency, to other key organizations, agencies and programs that comprise the CBSC. One way to begin is to prepare a diagram similar to the one in Figure 3.

Then, for each organization, program, etc., consider the nature and importance of the relationship vis-a-vis your organization. The symbols (+,-,o,H,L,N) can be placed on the spokes to provide a quick visual tally of your assessment.

First, consider the nature of the relationship between your organization and each organization in your CBSC. Is the current relationship supportive, conflictual or non-existent. Next, consider how important each organization is in terms of helping your organization achieve its goals and objectives. Is the organization's importance high, low or neutral?

Nature of Relationship	Importance of Relationship
supportive (+)	High (H)
conflictual (-)	Low (L)
non-existent (o)	Neutral (N)

Ideally, a similar assessment should be performed for each key organization or program in the CBSC, assessing each organization's relationships with others in the CBSC. Alternatively, you might wish to "map" the service delivery system using a client perspective (entry, assessment, service provision, etc.) and use this "map" to consider the nature and importance of existing organizational relationships.

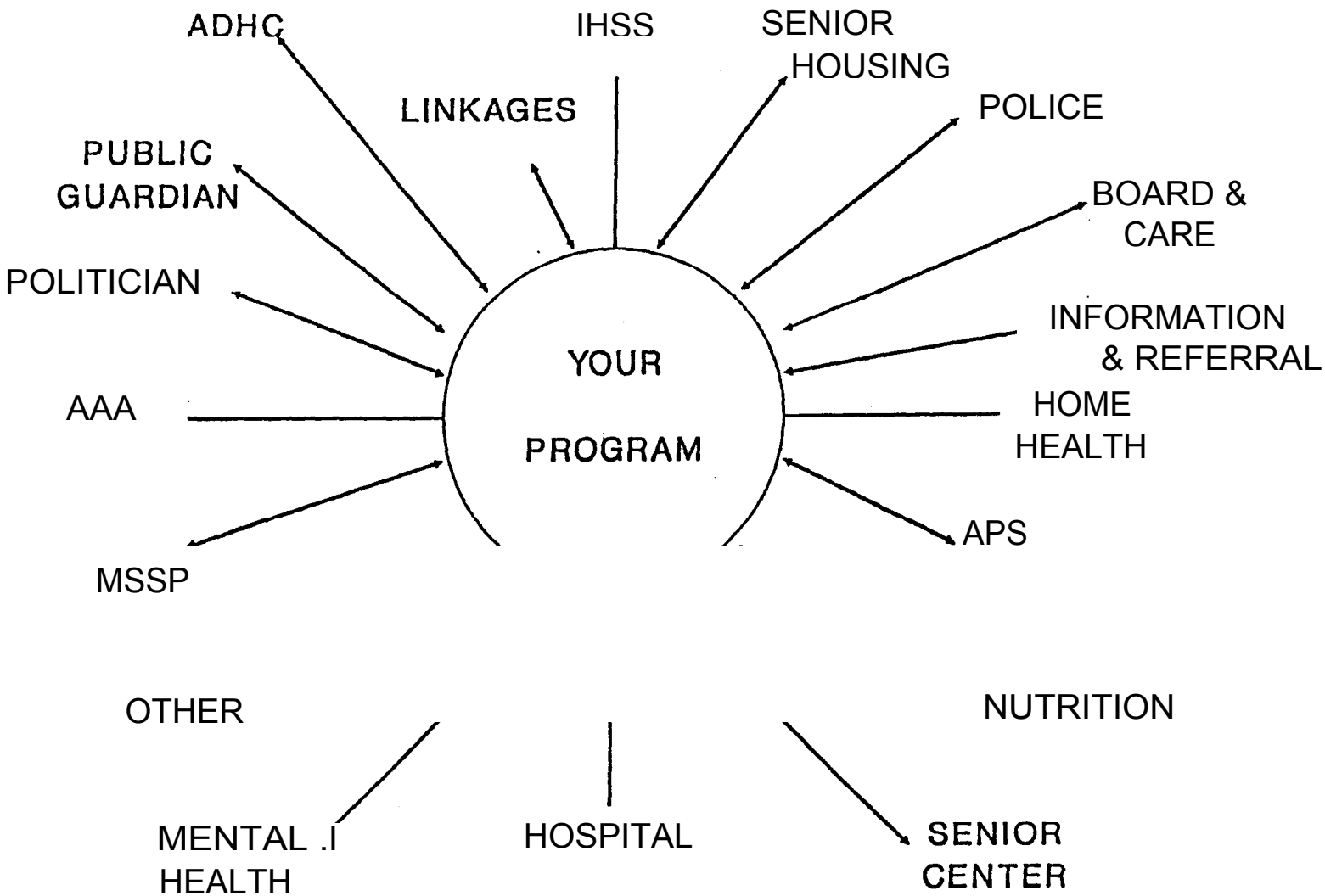
Although this step may be somewhat time consuming to complete, it is important because it allows you to see both strengths and weaknesses in the existing organizational network and pinpoint targets of opportunity as well as sources of potential trouble. For example, if an organization is important in terms of attaining your own organization's goals but the current relationship is conflictual, you will probably want to think carefully about ways to reduce tensions.

Assess Presence of Visionary Leadership

In completing Step Three: Diagnose Your Community's Characteristics and Capacities you have already taken a preliminary look at which individuals and organizations in the community currently provide leadership in a variety of areas such as program development and community decision making. Here it is important to focus specifically on leadership for articulating the CBSC vision.

While it is important to be able to identify an individual who is willing and able to assume the leadership role, it is also important to develop depth of

Figure 3: Organizational Relationship Assessment Diagram



leadership within the community. If for example, the CBSC "visionary" is the director of the Area Agency on Aging, it is helpful to have as members of the Board of Directors and/or Advisory Council individuals who share the vision and who are regarded as leaders in the community. To ensure such leadership, it may be necessary to recruit new members to the Board or Council. In considering new members, it will be important to include as possible candidates individuals who may not be part of the traditional aging network such as business leaders or community "celebrities," influentials. These individuals must, of course, be committed to the vision and willing to work for its implementation.

Research on developing community based systems of care conducted by the University of Southern Maine also suggests that it is important for the "visionary" to have a strong deputy or "second in command" who takes charge of much of the day-to-day operation of the organization.'

STEP SIX: IDENTIFY CBSC STAKEHOLDERS

Effective implementation of the CBSC vision of the future will require the support and participation of key organizations, agencies, individuals and groups in the community, the CBSC stakeholders. By identifying stakeholders at this stage and assessing their likely positions vis-a-vis implementation of the vision, as well as their importance to the implementation process, you will be better able to develop effective implementation strategies.

Who are the CBSC stakeholders? One way to begin generating a list of stakeholders is to think of the community and identify all "the key parties that affect or are affected by the problem being addressed"", in this case developing a community based system of care for older persons. Questions to ask include:

1. *Who* has an interest in the problem and its resolution?

2. *Who* can affect the adoption, implementation, and execution of any plan to resolve the problem by virtue of their political influence, resources or mandated responsibilities?

3. Because of demographics or other factors, who ought to care or might care about the problem?"

To get you started, a list of CBSC stakeholders will probably include:

older persons and/or other target groups,
organizations providing aging services (e.g. Title III, Title XIX, Title XX, Medicare, state funds),
hospitals,
physicians,
board and care facilities,
nursing homes,
congregate housing,
police,
public guardian,
politicians (local/state/possibly federal),
State Unit on Aging/other state depts,
AAA Advisory Council,
AAA Board of directors,
Aging advocacy/consumer groups (AARP, Grey Panthers, etc.),
Senior Legislature (or equivalent),
Provider groups/coalitions,
Businesses/business coalitions,
Foundations,
etc.

Once stakeholders have been identified, you will need to assess their likely position—support, neutral or oppose—and their relative importance or influence, least to most, vis-a-vis the CBSC vision and systems development efforts. It may be useful to use the matrix in Figure 4 to categorize stakeholders.

Figure 4: Stakeholder Classification Matrix

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Problematic | Antagonistic

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Low Priority | Supporters

+5

1 5 10

Least Important | Most Important

Source: *J. M. Bryson, Strategic Planning for Public and Nonprofit Organizations,* San *Francisco: lossey-Bass, 1988.*

Although the matrix was developed to help individual organizations identify stakeholders that may have an impact on strategic planning, it is equally suited to our purposes. The types of stakeholders and strategies for dealing with them are discussed briefly below.

Antagonistic Stakeholders: These individuals are very important to the organization but are likely to oppose the plan of action. Strategies for dealing with antagonistic stakeholders include engaging them in negotiations and developing counterarguments in anticipation of their opposition. If these individuals hold veto power, it will be very important to overcome their opposition.

Supporters: These stakeholders are also important to the organization and support the proposed course of action. It is important to maintain and reinforce their support and to keep them involved in the planning process. They can be helpful in influencing those who are neutral. .

Problematic Stakeholders: These individuals oppose the plan of action but are relatively unimportant to the organization. Education and lobbying efforts may help overcome the opposition of problematic stakeholders.

Low Priority Stakeholders: These stakeholders support the proposed course of action, but are realtively unimportant to the organization. The support of these individuals should be maintained through low-cost education and involvement.

Stakeholder analysis is useful because it forces you to think about the implementation steps that follow in stakeholder terms. That is, you will be more likely to develop workable strategies for implementing the CBSC if you have already identified the sources of support and opposition in the community.

Do's and Don'ts

In identifying stakeholders, we urge you to be as inclusive as possible. Avoid the tendency to limit your thinking about stakeholders to individuals and organizations in the established aging network. Otherwise you are likely to overlook important individuals and organizations who can actively oppose or support your efforts.

Mother consideration is whether or not to make the results of your stakeholder analysis public. Depending on the political climate and traditions of your community, you may even choose not to commit your analysis to paper and to confine discussions of stakeholders and stakeholder strategies to meetings of key Area Agency and/or Leadership Group staff.

While much of the information needed to complete the first part of this step may already be available as a result of needs assessments and area plan development activities, you will probably need to enlist the help of your internal planning team or the Leadership *Group* to identify stakeholders and their likely positions.

> Stakeholder Analysis in Oregon
>
> The importance of doing a stakeholder analysis became apparent to those involved in reforming Oregon's long term care system. Recounting the history cif Oregon's reform process in Buildinc Affordable Long Term Care Alternatives, Richard Ladd noted that, "The department I worked for then developed a paper on how to create a state agency for the elderly and long term care. We made only one mistake. We did not involve anybody outside the department. This error caused a major political upheaval in Oregon. The senior advocates who were really interested in the program felt left out, they wanted to be a part of it. The local area agencies were active, they wanted to be part of it. And so on."

STEP SEVEN: ASSESS ABILITY TO IMPLEMENT THE VISION

Armed with information about the current capacity of the CBSC in terms of the availability and accessibility of services, and community stakeholders, you are now ready to compare the CBSC "vision" to current "reality". If discrepancies emerge, and they will in nearly every community, what changes will need to occur to bring reality closer to the vision? Do new services need to be created? Do processes need adjusting? Do linkages need .to be developed or strengthened? Do roles need to be clarified? Etc.

Once you have an idea of what needs to change, you are ready to proceed to the second part of this step: assessing the potential for bringing about needed changes. The brainstorming technique can be used to conduct a modified "force field" analysis which identifies and assesses the relative strength of forces that are "driving" and "restraining" a specific change needed to implement "the vision." These forces most likely will include: funding, organizational postures and positions, leadership (presence or absence), laws and regulations, federal or state policies, time, etc. For example, some of the stakeholders identified in Step Six may not support systems development efforts and may even activity oppose them. Or, you might discover that the envisioned system cannot be realized until certain policies or procedures are changed at higher levels of authority. If such "limits" are accepted as given, they set the boundaries for systems development. Alternatively, they become targets for change.

Traditional force field analysis usually identifies two change strategies:

a. Increase driving or enabling forces in desired direction.
b. Remove restraining forces that hold back desired movement.

Experts generally agree that the preferred course of action is to remove restraining forces rather than to increase driving forces. "Attempts to induce change by removing or diminishing opposing forces will generally result in a lower degree of tension.... Moreover, changes accomplished by overcoming counterforces are likely to be more stable than c:: !es induced by additional or stronger driving forces. Restraining forces which have been removed will not push for a return to old behaviors and ways of doing things. If changes come about only through the strengthening of driving forces, the forces which support the new level must be stable." [5t]

This is also a time to again consider how widely the vision is understood and accepted. It may be necessary to do some additional "marketing" of the vision to renew the community's consensus before you move on to the next step. It will also be important to assess the areas of compatibility and

conflict between stake-holders since they will play a key role in the steps that follow.

The "force field" or implementation analysis carried out in Step Seven directly sets the stage for the next step, developing a strategy or set of strategies to move the current system closer to the "vision."

The Dangers of Neglecting Force Field Analysis

The importance of doing a *force* field analysis is illustrated by two attempts at administative consolidation. In one case, a rural county attempted to consolidate aging and adult services into a new organizational unit within county government. The decision to consolidate, however, failed to take into account the opposition of existing stakeholders--e.g. those whose authority and "power" would be diminished by the consolidation. Not surprisingly, after less than a year of operation, the consolidation was dissolved and a new division housing only aging services was created.

Similarly, the Board of Supervisors of a geographically large county considered merging the Area Agency on Aging into the Department of Public Social Services, largely for financial and administrative reasons. In this case the AAA Advisory Council and seniors in general opposed the change.

STEP EIGHT: DEVELOP STRATEGY TO ACHIEVE VISION

Based on the assessment completed in Step Five, you are now ready to develop a strategy, or set of strategies, to bring the current system into closer alignment with the vision created in Step Three. If, for example, a community had concluded that it needed to improve communication among service providers and develop a workable management information system, it might decide to develop and implement a uniform intakelassessment tool. Or, if a community had concluded that it wanted to focus more of its resources on the frail elderly, it might develop new targeting guidelines or new performance standards for contracts with service providers.

Depending on the vision created in Step Four, you may need to consider strategies that focus on targets of influence (be person/organization specific) and modes of influence. Examples of each include:

Targets of Influence	Modes of Influence
► specific funding sources	► advocacy
► political leaders	► informing
► community leaders	► involving
► key organizational leaders	► marketing
► key elites or opinion makers	
► key service providers	
► governing boards	
► editors, writers and producers of media	
► consumer groups/advocates/families	

The information about stakeholders gleaned in Steps Six and Seven should be used in developing strategies. Your diagnosis of past collaborative efforts will also be useful for planning effective strategies. A brainstorming session with Area Agency staff or the Leadership Group is another useful approach for generating strategies.

It is important to keep in mind that it will probably be necessary to pursue both short and long range strategies simultaneously. For example, a change requiring State-level legislation might require a two year plan while a strategy for developing a common intake form might be planned and executed in six months. It is important, however, to undertake at least some activities that will bring a sense of accomplishment fairly quickly. Without a few successes, some participants are likely to become discouraged and drop out. Unfortunately, because change does not always come easily, it is often the case that "things get worse before they get better."

As a final note of caution, our experience in California suggests that most communities underestimate both the difficulty and the amount of time needed to bring about even the smallest changes in existing systems. Thus, it is not unrealistic to expect that elements of *the* strategy may need to be pursued for one, two or perhaps even more years. In addition, the "vision" and its attendant strategies may need to be revised along the way based on outcomes and changes in the environment that could not be anticipated in advance. (The enactment of major legislation at the federal or state level, for example, might significantly alter a community's "vision.")

In sum, this step requires you to synthesize what you've learned by completing the prior steps and to think strategically about how to achieve the desired CBSC.

Texas Strategy Includes Eligiblity Change

As pan of its strategy to clearly differentiate who would be served in the community versus long term care institutions, the Texas Department of Human Services modified nursing home eligibility criteria. The lowest level of institutional care, Intermediate Care Facility H, was phased out. At the same time, the Texas legislature allocated Medicaid and general revenue funds to expand community-based care to serve former ICF II clients.

STEP NINE: DEVELOP APPROPRIATE STRUCTURES/PROCESSES

This Step is focused on implementation. The specific content of Step Nine will obviously depend on the strategies developed in the prior Step. We believe that many strategies, however, will call for new organizational arrangements and/or new processes. For example, a community relatively new to systems development may have developed a number of strategies that require increased communication among key service providers. The creation and implementation of a structure for bringing about better and more frequent communication, such as a Systems Development Task *Force* or Forum, is the next logical step.

Area Agency on Aging Focuses on Empowerment Strategies

In order to implement its vision of empowennent and economic self-sufficiency, Highland Valley Elder Services, Inc., an Area Agency on Aging in western Massachusetts embarked on several strategies. *For* example, Empowerment and Quality Long Living workshops have been developed for the older persons living in each of the 24 communities served by the agency. A membership newsletter was published and distributed quarterly to every person over the age of 60. And "power postcards" provide a vehicle for elders to provide their views on a variety of subjects and issues.

Areas that may be the focus of new structures and/or processes include:

- informing older persons & their families about the CBSC
- targeting clients
- assessing clients
- communicating among service providers
- serving clients
- tracking clients
- evaluating system outcomes
- advocating for the CBSC
- making decisions for the CBSC
- financing CBSC services

It is important to recognize that the creation of a structure or process may become a goal in and of itself. While these goals are legitimate, their achievement does not usually mean the "vision" has been reached. That is, creating a case management capacity in the community may be an important sub-goal of systems development, but a case management capacity is not the "vision." Case management is the vehicle, not the destination.

STEP TEN: MONITOR, EVALUATE AND RE-VISION

Because systems development is a dynamic activity that takes place in a changing and sometimes turbulent environment, your efforts will need regular monitoring and evaluation, both formal and informal. Regular re-assessments of the current system against the "vision" will be helpful for measuring progress and, if necessary, developing new strategies. It will also be necessary to periodically reevaluate the vision itself—"re-visioning"—particularly after significant changes in the community or its external environment.

Hospital Executive Stresses Importance of Re-Visioning

Pasadena, California's Huntington Memorial Hospital established its Senior Care Network (SCN) to provide a variety oflong term care services in the community including case management. Since its inception, SCN has added a number of other services, has been the site of a major national demonstration focused on community based long term care, and has provided leadership for systems development in the community. In describing the Network's evolution, executive director June Simmons notes four distinct phases: visioning, developing of essential structures, re-visioning, and de-structuring and restructuring. She comments that it is important to "keep taking it apart or it gets stale. By the time you get "there", things have changed."

CONCLUSION

We realize that completing the ten steps outlined above will be much more difficult than we've made it sound. We believe, however, that these steps do provide a useful way of thinking about systems development at the community level. Whether or not you have followed each step exactly as it has been laid out is less important than the fact that you have moved forward in fulfilling your systems development mandate.

Some final words of advice are provided in Chapter Six.

CHAPTER FOUR

STRUCTURAL ELEMENTS OF A CBSC

Introduction

In the previous chapter we focused on describing the process communities can use to initiate and sustain CBSC development efforts. This chapter will focus on what the CBSC should include as a developed system. Based on the systems development experiences of 14 study communities in California, we will identify and describe those structural elements which were found to constitute the basic framework of an operative system. This chapter will also discuss examples of the use of these structural elements toward enhancing the effectiveness of the delivery of services to clients. While these elements are not inclusive of all the characteristics identified with systems development, they do reflect those which were found to be consistently important in developing and maintaining a viable CBS C. A viable CBSC should provide communities with the ability to achieve better coordination of agencies and integration of services at the local level with the ultimate goal of more effective and efficient delivery of services to clients.

One of the major difficulties communities experience in developing a CBSC is not knowing what constitutes the final product. The ability of communities to understand the framework of a CBSC and the structural elements which comprise it is just as important to systems development as the identification of a clear "vision." Just as the identification of a vision gives direction regarding what the system should accomplish, an understanding of the framework and structural elements of a CBSC provides the parameters within which a community can develop the appropriate system structure.

The structural elements presented below are associated with two types of activities which should be present, formally or informally, in every community's CBSC. The first type identifies those activities necessary to develop and maintain administrative coordination between agencies and the second type identifies those activities necessary to develop and maintain integration of services for clients.

The key elements associate:.! with each type of activity are described below with a discussion of their role in the CBSC framework. It should be pointed out that the scope of the elements will vary from community to community and will experience change both during the initial systems development process and during the review and revision of established systems.

Community Agency Coordination

Improving the interrelationship of programs at the local level was found to be very critical with regard to a community's ability to develop and provide an effective CBSC. While improved services are the primary goal and clients should be the ultimate beneficiaries of a developed CBSC, community organizations providing care services within the community will also benefit through activities designed to enhance coordination. A coordinated system of service has its services and program connected so they work together effectively and efficiently. In order to achieve and maintain this level of coordination, the following structural elements (reflecting specific entities, processes, efforts and activities) should be present on a continuous basis:

Lead Agency: This is a designated local organization with the responsibility of providing leadership for the developme.:t of local CBSCs, usually the Area Agency. Although the primary role of the Lead Agency is to assure the development of a CBSC, it is also responsible for assuring that the developed system is (to the extent possible) constantly supported by the necessary resources, community awareness and coordination between providers, planners, administrators and funding sources.

Systems Planning and Management Capacity: This is the development of formal interorganizational relationships and procedures to ensure that the following areas of activities are developed and maintained.

1. Planning: This activity consists primarily of two processes: *goal setting* and *targeting*. *Goal setting* is a process initiated by the lead agency, *which* brings together representative agencies from the health, social services, and aging networks for the purpose of collectively planning for the provision of the services and programs to be provided through the community-based system. *Targeting* is the process of identifying the population or service group, including community characteristics, which the community-based care system is designed to serve.

2. Needs Assessment/Resource and Services Development: This activity addresses the availability of services and programs. This includes the process of (1) identifying services needed but not available, with special emphasis on basic Title III and community-based long-term care services, and (2) the development of a plan directed toward expanding the availability of needed services based on the findings and priorities identified through a needs assessment.

3. Systems Organization: This activity provides for the structure of organizational arrangements which best facilitates the flow of clients through the system.

4. Evaluation: This activity provides for the development of performance measures for the system and the assessment of progress in meeting system goals. It should also provide for a process to modify the system as necessary.

The Systems Planning and Management Capacity element includes all entities in a community that are responsible for identifying needs, establishing policies, making funding decisions, developing new services, establishing quality standards, coordinating delivery of services, monitoring system performance and evaluating results. With regard to the total spectrum of CBSC, this element provides the continuum of planning and management capabilities spanning from broad policy considerations to detailed operations.

Management Information System: This is a system which monitors performance and status of programs and provides information about client characteristics and services provided.

Client Service Integration

The ultimate objective of a CBSC is to improve the responsiveness of, and access to, services for each client. After developing and establishing the agency coordination activities described above, the basic challenge for communities is to design a single delivery system, supported by multiple administrative and program resources, which provides appropriate levels of care and services to all eligible clients. To this end, a viable and effective community-based systems of care should, at a minimum, provide a structure to make it easier for clients to identify where to to go for assistance, reduce the burden on clients associated with multiple assessments, facilitate transfers of clients between service providers, and ensure that clients' needs are met through timely monitoring, reassessment, and delivery of services.

While the structure of a service delivery system will differ from community to community due to different capacities (staff expertise, resources, etc.), the following structural elements should be present:

Information and Referral: This is an activity designed to link clients who need assistance to appropriate services through responses to client requests for information, referrals, appointments, and arrangement of services. Also included, as appropriate, is client follow-up to ensure appropriate response and resolution.

The Information and Referral element plays a major role in the CBSC delivery system especially when it provides for a visible focal point of contact where anyone can inquire or call for help on any aging issue or service. Information and referral service providers provide a critical service in assisting the AAA in assuring that all older persons within its planning and service area have convenient access to services.

Integrated Intake: This is a defined entry point(s) into the service system designed to avoid duplication of. *efforts* and to facilitate the matching of client needs to available services. The role of this element is to provide for entry into the service delivery system in a uniform and consistent manner that avoids requiring clients to provide basic identifying information more than one time. It also helps make the system less fragmented and imposing for older persons in need of assistance.

Uniform Assessment: This is a process to obtain key information about a client's functional level. The presence of this element enhances the referral and transfer processes between agencies responsible for client assessments. It also benefits the client by requiring less time and intrusion for data gathering.

Case Management: This process (offered as a service) provides for client assessment, care planning, service arrangement, monitoring and subsequent reassessment to identify the client's problems and needs, and to coordinate available resources to address these needs. The importance of the case management element to CBSC is twofold. First, from the client's perspective, it clarifies the expectations regarding the provision of services through the development of an individualized plan of services and other problem-solving activities. * Secondly, it contributes to the control and accountability of fiscal resources through its function of arranging and ensuring that services are provided and utilized effectively.

Workable Referral Process: This is the development of appropriate channels of communication and cooperation between service providers (including other community agencies), the intake worker and the *case* manager to facilitate referral and follow through for clients. This element should provide for clients to receive a variety of needed services from one or more providers in a timely manner. It consists of a network which encompasses all agencies, individuals and services in the community which work to connect people with services needed.

Client Program Review: This is the process of identifying what services a client has received in the past, and which services they are currently receiving. Client Program Review is important for the monitoring of the client's services, planning, development, and as a uniform resource for reporting purposes.

Services: These are the ultimate outcomes or benefits to the client which the CBSC is structured to provide. The benefits consist of an extensive array of health, social, and other services available in a community and are provided at the three service levels identified in the CBSC Model in Figure 1.

System Framework

The primary objective of a CBSC is to provide for improved outcomes for eligible clients. This is achieved through enhancing the client's access and flow through the service delivery system.

The presence of the structural elements associated with client service integration is the basis for the development of a service system to achieve the CBSC objective. The application of these elements in a designated community establishes a basic system framework which enhances the development of processes to 1) make it easier for clients to identify where to go for assistance, 2) reduce the number of times that a client has to be assessed, 3) facilitate the delivery of services to clients from different service providers, and 4) ensure that clients' needs are met though timely monitoring and reassessment. In a developed system, these processes represent different stages in the service system continuum and each stage should facilitate an effective system response in meeting the needs of clients.

To illustrate the applicability of the client service elements, Figure 5 shows a conceptual framework of a service system, as adapted from Steinberg and Carter's Case Management and the Elderly." It presents a system framework which identifies the key client service integration elements associated with each stage of a service system continuum. Some elements,

such as case management, integrated intake and client tracking, span two or more stages.

It should be emphasized that the CBSC Conceptual Framework presented in Figure 5 is an abstraction and is not intended to represent a proposed model. The actual structure or model of a CBSC framework will differ from community to community, but the structural key elements should be present, formally or informally, in each designated community. Examples of the variations of approaches in utilizing the client service integration elements in a system framework are presented at the end of this chapter.

In addition to providing the basic framework of a structured and integrated service delivery system, the client service integration elements also provide the flexibility for the system to deliver the scope of services necessary to respond to the variety of eligible client needs in a CBSC. Figure 6, CBSC Response by Client Type, illustrates the application of the key elements with the outcome being the provision of appropriate services.

COMMUNITY EXAMPLES

City of Eureka

Located in rural northwest California, the City of Eureka has developed a comprehensive multidisciplinary system which has resulted in a service-enriched community with an extensive network of available services. Eureka's CBSC has developed over 15 years through concentrated efforts by dedicated leaders and individuals in the community. The Area Agency on Aging has the lead role in coordinating the resources of both the Humboldt Senior Resource Center (HSRC) and the Redwood Ombudsman Long-Term Care Committee in establishing Eureka's CBSC. The HSRC is the focal point of service delivery to seniors in the community and the Redwood Ombudsman Long-Term Care Committee is comprised of the community's health and social agencies.

In developing its CBSC, the community of Eureka emphasized the establishment of an accessible and visible focal point for service coordination and HSRC is the designated focal point for senior services in the community. The center is easily accessible via the Eureka Transit system and has ample parking. The accessibility of services is a major strength of the focal point which provides for a "one-stop shopping" approach' to providing services. There are 35 different programs and services available through the HSRC either directly at the center or through coordination and referral. A key component to this community's CBSC is the collaborative decision-making process which has been developed among the major community programs. A management team with decision makers from the three key community service agencies, HSRC, Department of Social Services, and home health agencies, and the AAA regularly meet to discuss how to overcome barriers to implement a client centered system.

Residents of Eureka who need and desire senior and/or long term care services have a very high probability of accessing them within their own community because of the structure of the service delivery system. Within the designated focal point, focused services are targeted to the functionally dependent, frail/vulnerable seniors, while preventive services are being provided to all seniors. The structure of the service delivery system in Eureka's CBSC provides for information and referral and a formal integrated intake process centrally located at HSRC. The system also included a uniform assessment instrument which is used by all three key community service agencies and several other programs. The system employs a strong case management program which is supported by a very formal case conferencing process consisting of a coordination team which meets weekly. Also, the community's emphasis on a broad-based collaborative decision process has created a workable, effective, and formal referral process. This system also uses a shared client information system to ensure timely access to and continuity of service delivery to clients.

The Eureka CBSC model is a good example of utilizing the designated community service area focal point approach to CBSC development. The CBSC in Eureka demonstrates its flexibility in providing senior services by offering a wide-range of easily accessible services in a system structure that is unique to its community and meets the needs of each eligible client. This example also reflects the use of all client service integration elements in a developed system.

Figure 5: CBSC CONCEPTUAL FRAMEWORK

STAGES	Access/Entry	Assessment	Care Planning/ Implementation	Monitoring Reassessments
CLIENT **SERVICE** INTEGRATION ELEMENTS	I & R	**Uniform Assessment**		
			Workable Referral Process	
	Integrated Intake		Client **Program** Review	
		Case **Management**		

Figure 6: CBSC RESPONSE BY CLIENT TYPE

Client Type	I & R	Integrated Intake	Uniform Assessment	Case Mgmt:	Workable Referral Process	Client Program Review	Services: Basic	Services: CBLTC	Services: IBLTC
60+ **Non-functionally Impaired**									
▸ **Service Inquiry Only**	X				X		X		
▸ **Service Assistance**	X	X			X	X			
18+ Functionally Impaired									
▸ **Reside** in **Community**	X	X	X	X	X	X	X	X	
▸ **Reside** in **Institutional Setting**	X	X	X		X	X	X	X	X

City of Riverside

The City of Riverside is a growing urban community located in the southern California basin, east of the City of Los Angeles. Riverside's CBSC service model has developed over the past six years with the Riverside County Area Agency on Aging (AAA) taking the lead role. The Riverside County Board of Supervisors designated the AAA as the lead agency responsible for proactively carrying out a wide variety of functions related to all aging issues on behalf of older persons living in the planning and service area. This designation placed the AAA is a position to take a leadership role in promoting coordinated delivery of services among the different local agencies.

Critical to its ability to structure a CBSC and actively engage other agencies in the coordination of services, the AAA identified early on a community within the PSA (the City of Riverside) as the focus for systems development. The AAA then proceeded to structure its service model by establishing an effective information and referral (I & R) program, a model case management program and a multi-disciplinary team. The identified focal point for the coordination of services in Riverside's CBSC is the case management program called ACCESS.

The essence of the CBSC in Riverside is based on a triage approach to providing services. All calls are initially received through a centralized I & R unit with inquiries requiring follow-up channeled into a multi-level case management system. These inquiries are referred to paraprofessionals who complete an intake process including conducting a mini case management service and referring clients to the appropriate agency or service. The disposition of each client referral is reviewed by a professional case manager supervisor to determine if the appropriate referral was made and to follow up on any unresolved problems. Complex or unresolved cases am referred to the case management program, which is composed of professional case managers.

The case management program, ACCESS, receives the inquiries for services, conducts a full assessment (using a uniform assessment instrument), develops a case plan, and arranges services through referral, coordination, or purchase. Cases that need special coordination with other agencies, due to their complexity, are referred to the multidisciplinary team (MDT). The MDT is comprised of representatives from ACCESS, Department of Public Social Services (in-home supportive services, adult protective services, and representative payee programs), Department of Mental Health (adult services and public guardian), and the Department of Public Health. The MDT meets regularly to identify workable solutions to these complex cases that cut across the services provided by these agencies. It should be noted that the uniform assessment instrument is used by all members of the MDT and all members have formal memoranda of understanding (MOUs) developed to enhance the referral process.

The service model that has been developed for the City of Riverside has improved services to clients and has increased coordination and cooperation among the health, mental health, and social service providers in this particular community. The development of the CBSC service model for the City of Riverside has also provided the AAA with a base of experience and knowledge to begin to incrementally achieve the development of a CBSC in other designated communities in its PSA. . Riverside's service model includes all of the service integration elements except client program review which is in the process of being developed.

Monterey County

Monterey County, located on the central coastline of California south of the City of San Francisco, is both urban and rural with numerous miles separating the City of Salinas and the Monterey Peninsula.

Monterey County is one of only a few counties in California that has established a central administrative agency for adult and aging programs. The Office for Aging and Adult Programs Division serves as the umbrella for the Area Agency on Aging, all Title XX adult service programs (information and referral, in-home supportive services), Linkages (a case management program funded through the California Department of Aging), an Alzheimer's Day Care Center, and a health insurance counseling and advocacy program.

Both the Monterey County Long Term Care Planning Council and the

County Board of Supervisors designated the Area Agency on Aging as the lead agency for CBSC development in Monterey County. Due to the advantage of having administrative control of the major adult and aging programs in the county, and the past efforts in enhancing county-wide coordination and involvement, the Area Agency elected to initiate development of a CBSC county-wide, as opposed to in a designated community service area. In developing its CBSC, the AAA placed emphasis on two areas, access services and direct services.

Access services include activities which provide assistance in obtaining needed services whereas direct services refers to the provision of services and programs to the target population such as chore services, home delivered meals, etc.

The structure of the se, 'ice delivery system established for Monterey County includes a centralized intakelscreening system developed to implement the access services portion of the CBSC model. The access services program provides for county-wide accessibility (via a 24 hour 800 number telephone coverage) into the service system and includes the functions of integrated intake, extended information and referral, assessment, and short and long term case management. Once into the system, clients are provided services through an established protocol for referrals to service providers. The AAA has developed MOUs with service providers and has enhanced the referral process through both in-service training and public service presentations to providers. Although Monterey's CBSC has established a coordinated system which allows for the opportunity to target relevant data, they have not yet developed the means to gather and analyze the data into a viable management information system.

The service model developed for Monterey County has focused on providing services on a county-wide basis through the identification of an empowered lead agency and the development of a visible focal point for access to CBSC services.

CHAPTER FIVE

ROLES FOR STATE UNITS ON AGING

IN SYSTEMS DEVELOPMENT

Introduction

The Older Americans Act makes it clear that State Units on Aging are expected to play an important role in helping Area Agencies and their local communities develop systems of care. Specifically, the OAA Regulations specify that Area Agencies shall proactively carry out functions leading to the development or enhancement of systems, "under the leadership and direction of the State Agency."

In this chapter we explore ways in which the State Unit on Aging can support Area Agencies in carrying out their systems development mandate [s']

SUM Can Assist Area Agencies and Communities in a Variety of Ways

State Units can assist Area Agencies and communities by:

1. Working with other state departments and agencies, Area Agencies and other local entities to create a CBSC vision which is feasible within that State's context and to define roles and responsibilities at both State and local levels.

In her book State Long Term Care Reform, Diane Justice describes the efforts of six states (Oregon, Wisconsin, Maryland, Maine, Illinois, Arkansas) to reform their long term care systems. Although the focus of this study was limited to the coordination of publicly financed long term care programs, many of the lessons learned from these efforts appear to be applicable to the broader task of developing community based systems of care. Justice notes that "...where collaboration was most successful, substantial blocks of time during the initial planning stages were devoted to discussing philosophy and goals."' In short, for coordination to be successful, participants must agree on the "vision" of the long term care system and subscribe to a common set of goals and expectations. Just as there must be a shared vision at the local level, so too must there be a vision at the state level to guide state and local efforts.

The six states used a variety of techniques for creating their visions, but all involved some form of regular interaction with other important state departments such as health, social services, mental health, rehabilitation, etc. For example, in Maryland the Interagency Committee on Aging Services was created to work through policy issues among the three units of state government involved in providing long term care services. Initially, most states included individuals inside and outside of state government as participants in the "visioning" process. When this process became contentious in Oregon, state officials hired .a consultant to "mediate a Negotiated Investment Strategy, a process for identifying major disagreements and attempting to reach some resolution. Four teams of five members each were formed, representing the state agency, Area Agencies, service providers and elderly advocate groups. These teams met for a full day every other week for more than six months." [SS] The Strategy resulted in the set of state policies that were agreed to by all the participants and established a common set of goals and expectations.

Officials in these six states believed that "especially during the early stages, it is important to get people at the highest level involved. While mid-level staff may actually do most of the work, the visible commitment to change and to interagency cooperation that is provided by top level participation lays a positive framework for resolving more difficult operational conflicts in the future."" Meetings of top level officials must in fact produce tangible results that can be translated into changes at the local level; symbolic discussions that give the appearance of coordination but do not produce results very quickly disillusion participants at the local level.

2. Clearly communicating the CBSC vision to service providers, older persons and their advocates.

Developing a vision of the CBSC is necessary but not sufficient for creating effective systems of care at the local level. The State Unit also has a responsibility to communicate that vision to affected participants. In addition to continued communication among state-level departments through interagency committees, State Units must develop means to communicate with Area Agencies, local service providers, older persons and their advocates.

In the six states studied by Justice, each State Unit stressed the importance of maintaining active "formal and informal lines of communication with local agencies." One common strategy was to meet regularly with directors of Area Agencies and other important local delivery organizations to discuss implementation and management issues. Training sessions were another vehicle for reinforcing the "vision" and providing skills needed for effective implementation.

State Units can also use the area plan development guidelines to help ensure that Area Agency activities are consistent with and support the CBSC vision. Similarly, applications for` other funds controlled by the State Unit can include requirements for coordination, use of assessment tools, etc. that further the CBSC vision.

The Oregon experience demonstrates the importance of including older people and their advocates in the visioning process. Continued communication with older-persons through state-wide forums, articles in senior publications, etc. is important for ensuring that older people understand the system, know how to use it, and have a stake in its maintenance.

3. Working to remove state-level barriers that impede implementation of the vision at the local level.

"Policy coordination can oftentimes create a conducive environment for coordination at the community level among provider agencies. It can free barriers to coordination; it can produce incentives for coordination. It can clarify the sense of common purpose. . it can rationalize, clarify, and streamline resource allocations, legislation and regulations in ways which positively stimulate efforts to coordinate at the community Level.""

Ideally, if local level participants have been actively involved and have communicated effectively, all of the local-level implementation barriers will have been identified during the process of creating the CBSC vision. Realistically, this is unlikely to occur. As a result, State Units will need to continue to work with their sister agencies beyond the "visioning" stage to resolve implementation issues. Several states have found it useful to delegate this responsibility to mid-level managers who bring higher level policy issues to top managers as appropriate.

4. Advocating with state decision makers and legislators to ensure adequate funding to implement the CBSC vision.

Although we might wish otherwise, the building of a viable community based system of care will usually require resources beyond those provided by the Older Americans Act and other federal funding sources. State funds are needed for the development and expansion of services, particularly to groups who do not meet Medicaid eligibility criteria, and for systems development activities themselves. Many states have recognized that "a comprehensive system cannot be built with federal funds alone" and have developed special community based programs to cover "either clients or services that fall between the cracks of federally financed programs." [m] More unusual is the commitment of funds to systems development efforts themselves. One example is Arkansas which allocated state funds for a Community Based Care Developer for each of the state's eight Area Agencies on Aging. According to Justice, "these staff determine service gaps in the community and stimulate new programs to fill those gaps.""

5. Ensuring that SUA policies and procedures are consistent with the articulated vision.

Systems development involves the coordination of a diverse set of services and programs that often differ in terms of client eligibility criteria, staffing patterns, and reporting requirements. While not all of these discrepancies can or should be resolved, the State Unit needs to carefully assess policies and procedures to ensure that they are consistent with and support the CBSC vision.

6. Providing CBSC data and policy analyses.

In order to make informed resource allocation decisions, state and local decision makers need timely, accurate information about the characteristics of the older population, their service needs and service utilization patterns. They also need to know whether existing programs are effective in meeting those needs. Drawing on the resources of other state agencies as needed, the State Unit is the logical agency to take the lead in providing this information to decision makers. The old adage "information is power" bears repeating. Armed with accurate, timely information, State Units can play an important role in informing decision makers about the needs of older people and the CBSC.

Local community service providers also need feedback on how the system is performing. Too often information residing in management information systems is never "given back" to programs and agencies in a form that is helpful for planning purposes. Experience shows that local providers are more likely to provide accurate information if they understand how it will be used and how it will benefit their organization and clients.

7. Actively supporting local level efforts that further implementation of the CBSC vision.

This role is not as obvious as it first appears. In California, we found that some communities wanted tangible evidence that the SUA supported their efforts. One community, for example, wanted representatives of the SUA to visit the local community; they believed a physical presence would help communicate the importance of systems development to local decision makers and recalcitrant system participants.

This role suggests that it may be useful to have a SUA staff member designated as the systems development "troubleshooter" or "mentor"—someone communities can call upon to lend support to local efforts. It may also be helpful for the SUA to develop "marketing" tools that local communities can adapt to meet their own particular needs.

8. Fostering the development and implementation of common intake, screening and assessment instruments..

The use of common intake, screening and assessment instruments, while not absolutely essential, is generally regarded as important for developing management information and client tracking systems and for developing a common language among service providers. A common intake/screen form is especially helpful for making referrals.

Achieving consensus on common tools does not come easy, however. In discussing assessment instruments, for example, Justice notes that "its development generally entails months of disagreement among health professionals, social workers, and various program administrators over the factors that are most likely to indicate . need for their individual programs.[n60]

While we believe the use of common assessment tools is a desirable goal of systems development, our experience in California suggests that states must take care not to become so absorbed with instruments that systems development becomes synonymous with "forms." In developing common tools, it will also be important to review the forms of all departments and agencies that provide services to older people.

9. Developing common program standards including service/unit definitions and reporting requirements.

Common defmitions for units of service and standard reporting requirements

also contribute to the development of good MIS and client tracking systems. Like the process for developing common assessment tools, this process helps service providers develop a common language for describing the types of services clients receive.

10. Facilitating client and program information sharing at the local level.

Confidentiality guidelines can make it very difficult for service providers to share even the most basic information about clients. Through legislation, memoranda of understanding (MOUs), or other agreements with sister state agencies anti tL,:.. the SUA can provide a framework for information sharing at the commutt,ty level.

11. Developing evaluation criteria and guidelines.

As outlined above, the process of developing a CBSC vision includes identifying goals and objectives for the system. A corollary task, most logically delegated to the SUA with input from the Area Agencies, is developing criteria for evaluating communities' progress in meeting CBSC goals and objectives. The SUA can help ease the burden of evaluation on local communities by reconciling inconsistencies across state-funded programs and developing' common instruments and guidelines where possible.

12. Providing training and technical assistance to individuals and organizations at the local level as needed.

Last, but certainly not least, SUM can help communities initiate and sustain systems development efforts by providing training and technical assistance. Training is particularly important when new forms or procedures are introduced. Training provides an opportunity not only to communicate information about the issue at hand, such as using a new assessment tool, but to communicate the "vision" and reinforce the importance of systems development efforts.

The provision of technical assistance is important primarily because it demonstrates to local communities the SUA's commitment to systems development. It also provides states with the opportunity to emphasize the partnership concept to CBSC development. The technical assistance to be provided will vary in type and scope, but should address the following three areas:

- Reinforcement of collaborative efforts between State and Area Agencies. Specific areas could include:

  1. Establishment of a State/local workgroup to jointly address systems development issues.

  2. Joint training efforts to community agencies by SUM and , AAAs.

  3. Joint efforts in developing communication and marketing strategies to enhance community awareness.

- Pursuit of horizontal collaboration at both the State and local levels with special emphasis on public programs. Efforts could include MOUs, interdepartmental training, inclusion of other State departments in the State Plan development process, etc.

- Enhancement of the capacity of the service system as a whole. This includes programs and services outside of the Title III service segment.

CHAPTER SIX

A FINAL FEW WORDS

Area Agencies on Aging face a challenging task in carrying out their Older Americans Act mandate to develop systems of care in communities across the country. The purpose of this guidebook has been to provide information which can help make that task more manageable.

In closing, we again want to stress that systems development is an ongoing process that is never complete. And, simply having services, structures and processes in place does not guarantee that a system will work smoothly; dedicated leadership, careful listening and observation, and active hands-on management are needed to help ensure that the system continues to be responsive to the needs of older persons and their families.

Additionally, our experience as well as research conducted by others studying how community based systems of care are established and maintained suggests that another key ingredient in ensuring continued success is the retention of key staff as the system develops. In many "successful" systems, visionary leaders have been on the job ten years or more.[b] Retention is important at the front line as well, since information and referral and intake staff are often the first point of contact for many older persons. The ability to provide accurate, timely information, something that tends to increase with tenure on the job, is crucial for ensuring that older persons have access to the system of care.

Maintenance of a successful system will also require Area Agencies to be diligent in maintaining political good-will in their own communities, as well as to become actively involved in state-level decisions that affect the system of care. The development of a strong advocacy capacity among members of the Board of Directors and/or Advisory Council is also important for sustaining systems development efforts; effective advocacy by members of the Board or Advisory Council is particularly crucial when circumstances prohibit the Area Agency Director and staff from assuming advocacy roles.

Finally, while we have stressed the importance of "visionary" leadership during systems development, we acknowledge the importance of strong managerial or administrative leadership in maintaining a system. Indeed, without good managers and administrators, a system may fail as it matures and expands, even in the presence of visionary leadership.

APPENDIX

DATA COLLECTION TECHNIQUES .

This appendix provides additional information about selected data gathering techniques recommended in Chapter Three.

BRAINSTORMING

Definition

Brainstorming is a fast-paced participatory group process that is designed to facilitate creative thinking. It can be used in a variety of contexts such as defining problems, identifying solutions to problems and speculating about the future. "The purpose of brainstorming is to free individuals from inhibition, self-criticism, and criticism by others in order that in response to a specific problem they may produce as many different ideas as possible. The assumption is that the larger the number of ideas produced, the greater the probability of achieving an effective solution."[62]

Advantages and Disadvantages

The advantages of brainstorming include encouraging unusual suggestions, breaking down mind sets and maintaining interest among group participants because of the fast pace.. On the negative side, participants may become inhibited and research suggests that the ideas produced by a brainstorming group may be no better or inferior in uniqueness and quality to those generated by individuals working alone.` Additional problems may include domination of the group by strong individuals, acceptance of majority opinions, acquiescence of low-status members of the group, and premature closure in reaching a decision.

Requirements

Individuals conducting a brainstorming session need a board or flipchart for recording ideas; chalk, pens or markers; and tape for posting flipchart pages.

Process

In conducting a brainstorming session, three rules are followed:

1. ideas are solicited without regard to their quality; "free-wheeling" is welcomed;
2. participants are encouraged to modify, improve and combine the statements/suggestions of others; and
3. ideas are not evaluated or criticized until all ideas/suggestions have been put forth.

The amount of time devoted to brainstorming is generally about 5 to 15 minutes. It is up to the group facilitator to keep ideas coming; the facilitator must take care not to make judgements about ideas to avoid inhibiting participants.

What happens next depends on the purpose of the brainstorming session. Participants may be asked to discuss, evaluate, or rank the ideas which were generated with the goal of narrowing the ideas/solutions down for further evaluation or study.

THE NOMINAL GROUP TECHNIQUE

Definition

A variation of brainstorming, the nominal group technique (NGT) is a structured process for "obtaining qualitative information from groups who are familiar with a particular problem area." [66] A unique feature of NGT is that participants "...work in the presence of others but do not interact verbally except at specific times."[w67] Like brainstorming, NGT can be used

in a variety of circumstances, but is generally associated with problem-solving, program-planning and futures research.

Advantages and Disadvantages

NGT overcomes many of the disadvantages of brainstorming because participants have an opportunity to individually generate ideas which are then shared systematically with the group. "By allowing members to think and to record their ideas first, without interacting with others, the inhibitory factors of conformity pressures, polarization on a few ideas, status incongruities, and premature closure are immediately avoided."[o] If NGT is used as part of a decision making process, however, the absence of a critical atmosphere may be dysfunctional. "In the process of finalizing and evaluating the group's solution, a critical atmosphere can prompt members to reject inferior ideas and synthesize more useful ones, thus upgrading the final product of the decision-making procedure."[a]

Requirements

Prior to conducting a nominal group meeting, the facilitator should provide participants with an overview of the problem or program objectives and indicate that the participant's role is to contribute to the definition of the problem, generate possible solutions, etc.

Depending on the total number of participants, one or more nominal groups of five to eight persons is formed. Each group meets and a recorder is appointed.

The facilitator will need a chalk board or flipchart; chalk, pens or markers; and tape for posting flipchart pages.

Process

The facilitator presents each group with the task (e.g., to define a problem). Without discussion, each member of the group spends ten to twenty minutes writing ideas/suggestions, etc. Those who are finished writing are asked not to interfere with others who are still at work.

Next, the recorder (or facilitator for single groups) asks each member of the group to present, in round-robin fashion, one of his/her ideas which is then written verbatim on the flipchart. This process continues until all ideas have been listed. Although discussion is not allowed, "...'hitchhiking' is encouraged by having members generate new ideas ..., based on items presented by others in the group.[n70] This process takes about 30 minutes.

During the next fifteen minutes, the recorder or facilitator "...leads the group in a discussion of the recorded ideas for the purpose of clarification, elaboration, and evaluation. Each item is discussed sequentially and no items are eliminated from the list.""

Participants may then be asked to spend ten to fifteen minutes ranking the ideas/definitions or selecting a prescribed number as "most important." Depending on the purpose of the NG session, the facilitator may attempt to reach consensus among group members through discussion and multiple rounds of ranking.

FORCE FIELD ANAYLSIS

Definition

Conceptualized by Kurt Lewin, force field analysis is a technique that can be used to identify the forces "working for and against a given issue or a proposed course of action."[n] In Lewin's view, behavior is not a static "thing", but a dynamic equilibrium that is thrown out of balance if there is change in the kind or strength of forces operating in a given direction. When an imbalance is created, movement or change tends to occur until the forces are re-equilibrated.

Advantages and Disadvantages

The advantage of conducting a force field analysis is that it helps identify

and assess positions, may uncover hidden allies or positive forces that were not recognized, and ***may*** help clarify a situation before change is attempted. Although not a clear disadvantage, it may be difficult to assign values (positive/negative) to some forces. That is, some individuals may see a force as driving change while another may view the same force as restraining change.

Requirements

If force field analysis is conducted in a group, it may be helpful to prepare a force-field analysis inventory which participants can use to list and diagram driving and restraining forces. Such an inventory would provide separate lined sections for participants to list driving and restraining forces as well as a diagram for recording the strength of both sets of forces. A horizontal "status quo" line with spaces to draw up and down arrows of varying lengths to represent the strength of driving and restraining forces may be helpful.

Process

Once the subject of the analysis has been presented, the facilitator distributes a force-field analysis inventory to each participant and allows 20 to 30 minutes to identify driving and constraining forces and to rate each force's importance or strength in pushing for or inhibiting change.

If desired, the results of the individual analyses can then be pooled by the facilitator and the results discussed by the group with a goal of identifying change strategies.

Implementing Change

Lewin noted that change can be brought about by increasing driving forces or removing restraining forces. While it is tempting to try to increase driving forces, this approach tends to increase tension and instability. Long-range goals are usually better met by removing restraining forces. However, "whatever change in status quo has been accomplished will be lost if the driving force is reduced. A change in the status quo, then, can best be accomplished by reducing the strength of the restraining forces while maintaining the force of the drive. If the driving forces are not maintained, the tension will be reduced without any change in the status quo. ""

1. Additional information about our research can be found in two reports prepared by staff of the Andrus Gerontology Center. California Community Based Long Term Care Stems Development Evaluation, a report submitted to the California Department of Aging and How To Develop Community Based Systems of Care: 'A Longitudinal Study, a research report submitted to the Administration on Aging.

2. Robert C. Myrtle. "The Design and Management of Plan Implementation," Working Paper. Los Angeles: U.S.C. School of Public Administration, 1978.

3. Arnold D. Kaluzny and Bruce J. Fried, "Interorganizational Coordination of Services to the Elderly," In H. T. Phillips and S. A. Gaylord (Eds.), Aging and Public Health, New York: Springer, 1985.

4. Kaluzny and Fried.

5. Myrtle

6. Myrtle

7. National Association of State Units on Aging, Considering Future Roles of Area Agencies on Aging--Capitalizing on Current Strengths and Forging New Directions. Washington, D.C.: NASUA, 1987.

8. NASUA

9. Kaluzny and Fried

10. The CBSC model discussed here was developed by the California Department of Aging.

11. Functional impairment typically includes limitations experienced in 1) performing activities of daily living (ADLs) which consist of mobility, bathing, dressing, toileting, transferring, eating, and continence, 2) performing instrumental activities of daily living (IADLs) which include housework, laundry, shopping and errands, meal preparation and clean-up, taking medications, using transportation, telephoning, and money management, and 3) mental functioning such as problems with memory, orientation, and judgement.

12. When discussing "a community based system in, or serving each community", it is important to distinguish the several senses in which community is used. The term community-based has often been used to describe an alternative setting in which long term care can be provided. In this context, community based long term care is used to describe long term care which is not provided in an institutional long term care setting such as a skilled nursing facility or nursing home. There may then be some question regarding whether or not a community based system includes long term health care facilities.

Section 306(a)(6)(12) of the OAA requires the Area Agency to "facilitate the involvement of long term care providers in the coordination of community based long term care services and work to ensure community awareness of and involvement of long term care facilities." This along with OAA provisions for serving

residents of long term care facilities (e.g., skilled nursing facilities or nursing homes) through the Long Term Care Ombudsman Program, strongly suggests that the community based system in, or serving, each community should include institutional long term health care facilities.

13. Prior to the 1978 amendments to the OAA, the planning and service area established by the SUA was more generally assumed to be the area to be served by the "comprehensive and coordinated system of services" which the OAA and its regulations enjoined and for which the Area Agency had system development responsibility. Subsequent amendments to the OAA and. implementing regulations gave increasing emphasis to the development of community focal points. This culminated in the 1988 regulations (Section 1321.53) which emphasized the narrowing of the service area focus to a community; a "comprehensive and coordinated community based system in, or serving, each community in the planning and service area."

Essentially, this established a four level structure for coordinating the delivery of services to older persons at the community level, i.e., national; state; planning and service area; community.

This focus upon a community as the service area of a CBSC represents a significant departure (in tenors of a greatly narrowed scope) from previous interpretations of service area scope. It also significantly expands the role of both state and area agencies in providing for such systems.

14. This discussion is based on Kaluzny and Fried.

15. Savant, Inc., "Community Based Systems of Services for Older Persons: A Working Definition", Reston, VA: Savant, Inc., 1988.

16. California Department of Aging, "PSA Guidance and Guidelines, 1990-91", Sacramento, CA: California Department of Aging, 1990.

17. Savant

18. John M. Bryson, Strategic Planning for Public and Nonprofit Organizations. San Francisco: Jossey-Bass Publishers, 1988.

19. Warren Bennis & Burt Nanus, Leaders. New York: Harper and Row, Publishers, 1985.

20. Bryson, page 186.

21. Bryson, pp. 187-189.

22. Bennis & Nanus, page 92.

23. Bryson, page 226.

24. Bryson, page 226.

25. Bennis & Nanus, pp. 17-18.

26. Bennis and Nanus, page 20.

27. Bennis & Nanus, page 21.

28. To maintain consistency throughout this chapter, we refer to the activities described below as if they were being carried out in a single community. As pointed out in Chapter Two, community will mean different things in different PSAs; in some cases the community and PSA will be the same; in others the PSA may include a number of communities, each the target of systems development efforts. Even when a PSA is comprised of several communities, some systems development efforts will necessarily have to be concentrated at "higher" levels, such as a county, since some decisions, such as funding, am made at these levels. It may be helpful early on to identify and distinguish the geographic and political levels at which services are funded, produced, consumed and evaluated.

29. Helen Kerschner and Robert C. Myrtle, Strategies for the Implementation of Areawide Health Plans, Los Angeles: University of Southern California, 1975.

30. C. A. O'Reilly, J. A. Chatman, & J. C. Anderson, "Message flow and decision making" in F. M. Jablin, L. L. Putman, K. H. Roberts, & L. W. Porter, (Eds.), Handbook of Organizational Communication, Newbury Park, CA: Sage Publications, 1987.

31. The lead agency designation will fall naturally to the Area Agency on Aging in some communities because it is recognized as having responsibility for developing the CBSC and because it has already established itself as a leader in this area. This will not be the case in every community, however, and the Area Agency will need to honestly assess its capacity to play the "lead agency" role for CBSC. (See Introduction for a discussion of Area Agency CBSC leadership stages.)

32. This checklist was developed to describe the process by which managers effectively delegate to their subordinates. As such, it has a top/down quality that is unlikely to be present in most systems development efforts which rely on collaboration and cooperation. Thus you will probably need to modify the checklist to more accurately reflect your own set of circumstances. Adapted from Michael N. O'Malley and Catherine M.T. Lombardozzi. "Delegation: Using time and resources effectively." In J. William Pfeiffer, (Ed.) The 1988 Annual: Developing Human Resources, San Diego: University Associates, 1988.

33. Diane Justice, State Long Term Care Reform: Development of Community Care Systems in Six States. Washington, D.C.: National Governor's Association, 1988.

34. This discussion draws extensively from Bennis and Nanus.

35. Bryson, page 193.

36. Bryson, page 193.

37. Bennis & Nanus, page 98.

38. Bennis & Nanus, page 101.

39. Bennis & Nanus, page 103.

40. D. Nelson, Pulling it all together. Implementing state long teen care systems reform—State of Wisconsin. In National Governor's Association (Ed.), Building Affordable Long Term Care Alternatives. Washington, D.C.: NGA, 1987.

41. Bennis and Nanus, page 107.

42. Bennis and Nanus, page 108.

43. Ernest McKenney, "Management and financing strategies -- State of Texas." In National Governor's Association, Building Affordable Long Term Care Alternatives, Washington, D.C.: NGA, 1987.

44. Nelson

45. Based on personal interview by Robert C. Myrtle with Robert V. Gallant, Executive Director, Highland Valley Elder Services, Inc., 1990.

46. Charles H. Smith. "The robotics decision: Solving strategic problems." In J. William Pfeiffer (Ed.), The 1988 Annual: Developing Human Resources, San Diego: University Associates, 1988.

47. Figure 2 is adapted from "Analyzing planning-team effectiveness (xerox) by Eli Glogow, School of Public Administration, University of Southern California, Los Angeles, CA, no date.

48. Richard H. Fortinsky and David Karraker. Successful Systems of Community Based Care for Older Adults. Presentation at the annual conference of the National Association of Area Agencies on Aging, Nashville, TN, August 1990.

49. Smith

50. Smith, page 94.

51. Spier, M.S. "Kurt Lewin's force field analysis", In J. E. Jones & J. William Pfeiffer (Eds.), The 1973 Annual Handbook For Group Facilitators, La Jolla: University Associates, 1975.

52. Raymond M. Steinberg and Genevieve W. Carter, Case Management and the Elderly, Lexington, Massachusetts: D.C. Heath and Company, 1983.

53. This section draws extensively from ideas presented in The Role of New York State's Aging Network in Long Term Care, a report repared by the New York State Office for the Aging and the New York State Association of Area Agencies on Aging, Albany, 1984.

54. Justice

55. Justice

56. Justice

57. Savant, page 20.

58. Justice

59. Justice

60. Justice

61. Fortinsky and Karrakas

62. Taylor, D.W., Berry, P.C. & Block, C. H. Does group participation when using brainstorming facilitate or inhibit creative thinking? Administrative Science Quarterly, 3, 23-47, 1958.

63. Malasky, E. W. Instructional strategies: Nonmedia. In Nadler, L. (Ed.) The Handbook of Human Resource Development. New York: John Wiley & Sons, 1984.

64. MacCriinmon, K. R. & Taylor, R. N. Decision making and problem solving. In Dunnette, M. D., Handbook of Industrial and Organizational Psychology. Chicago: Rand McNally College Publishing Company, 1976.

65. Ford, Jr., D. L. & Nemiroff, P. M. Applied group problem-solving: The nominal group technique. In Jones, J. E. & Pfeiffer, J. W. (Fds.) The 1975 Annual Handbook for Group Facilitators. La Jolla: University Associates, 1975.

66. This discussion draws from Ford, Jr., D.L. & Nemiroff, P. L. "Applied group problems-solving: The nominal group technique". In Jones, J.E. & Pfeiffer, J.W. (Eds.) The 1975 Annual:Handbookfor Group Facilitators. La Jolla University Associates, 1975.

67. Ford & Nemiroff.

68. Ford & Nemiroff, page 181.

69. Ford & Nemiroff, page 181.

70. Ford, Jr., D. L. Nominal group technique: An applied group problem-solving activity. In Jones, J. E. & Pfeiffer, J. W. (Eds.), The 1975 AnnualHandbook for Group Facilitators. La Jolla: University Associates, 1975.

71. Ford & Nemiroff, **page** 180.

72. Bittel, L. R. (Ed). Encyclopedia of Professional·**Management; New York: McGraw-Hill Book Company, 1978.**

73. Pfeiffer, J. W. & **Jones,** J. **E. Force-field analysis: Individual problem-solving, Handbook of Structured Experiences for Human Relations Training, Vol H. La Jolla: University Associates, 1974.**