State Implementation of Collaborative Aging and Disability Policy

by

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Abstract

This research examines aging and disability collaborative arrangements at the state level. The focus is on how states design their collaborative long-term care service delivery programs through the Aging and Disability Resource Center grants. This study uses state determinant theory to isolate factors that influence the variation in program design. The primary concepts of interest are; fragmentation of policy decision making, state commitment to public welfare spending, and state spending on long-term care infrastructure. Based on the unique development of the aging and disability networks, the following research questions were derived:

Question 1: Does the bureaucratic arrangement of state aging and disability agencies influence the adoption of coordinated referral systems?

Question 2: Does a state's financing for public welfare programs influence the adoption of coordinated referral systems?

Question 3: Does the pattern of state's long-term care spending influence the adoption of coordinated referral systems?

This paper investigates the Aging and Disability Resource Center program to assess how specific structural and budgetary policies within each state may influence how states chose to implement their collaborative programs. This was accomplished through a mixed methods approach that first implements a quantitative analysis of secondary data on state program design, state government structure, public welfare spending, long-term care infrastructure, and several

social, economic and political control variables. This was followed by a semi-structured interview of state program directors that analyzes grant processes and outcomes.

This study found no relationship between state government structure and long-term care infrastructure and the ADRC program design models. It found limited support for the positive relationship between increase in public welfare spending and the adoption of a decentralized ADRC model. It found that the key factors influencing aging and disability collaboration were state ADRC advisory councils, where states 'housed' their programs and federal incentives.

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List of Abbreviations

AAA	Area Agency on Aging
ACL	Administration on Community Living
ADA	Americans with Disability Act
ADRC	Aging and Disability Resource Center
ADRD	Alzheimer's Disease and Related Dementia
ADSSP	Alzheimer's Disease Supportive Services Program
AGID	Aging Integrated Database
AoA	Administration on Aging
BIP	Balancing Incentives Program
CIL	Centers for Independent Living
CLP	Community Living Program Grants
CMS	Centers for Medicare and Medicaid Services
DHHS	U.S. Department of Health and Human Resources
EAHCA	Education for All Handicapped Children Act
FMAP	Federal Matching Assistance Percentage
HCBCO	Home and Community Based Care Options
HCBS	Home and community based services
LTC	Long-term care
LTSS	Long-term Services and Supports

NAO	Network Administration Organization
NASUAD	National Association of State Units on Aging and Disability
NPM	New Public Management
NWD	No Wrong Door
OAA	Older Americans Act
OBRA	Omnibus Budget Reconciliation Act
PSA	Planning and Service Area
SNF	Skilled Nursing Facility
SPE	Single-point of Entry
SRT	State Reporting Tool
SUA	State Unit on Aging
TAE	Technical Assistance Exchange
VHA	Veterans Health Administration

Chapter 1: Policy Networks and the Study of Collaboration

This research project is a targeted effort to identify, describe, and analyze state collaboration within a specific policy network and the factors that influence the differences in programmatic design. This project did this by specifically looking at the aging and disability policy environment within the United States and the organizational arrangements of that environment. This study utilized existing evidence that supported the argument that state specific political, economic, and social factors would influence state policy adoption and applied this to the variance in state program design of coordinated referral systems. The study broadens the understanding of what specific factors influence the adoption of different collaborative models and mechanisms for control. This study also advances the knowledge and understanding of these economic, social, and political factors by adding new budgetary and bureaucratic structure factors that are unique to each state.

The aging and disability policy environment is ripe for exploration due to the recent initiatives undertaken by the federal government to encourage aging and disability policy networks to collaborate in an effort to produce an integrated service delivery model for all long-term care options. This policy area is increasingly important due to the demographic shifts that occur as members of the U.S. population age. The graying of the population will strain the long-term care infrastructure as well as the state and federal budgets. In an effort to address the increase in demand for long-term care services, the federal agency tasked with administration of aging and disability related public spending, the U.S. Department of Health and Human Services,

began the Aging and Disability Resource Center program initiative through the awarding of federal grant funding.

This project examined aging and disability organizational arrangements primarily focusing on four major concepts: 1) Aging and Disability Resource Center (ADRC) collaborative network design, 2) fragmentation of policy decision making, 3) state commitment to public welfare spending, and 4) state long-term care infrastructure. Specifically, it examined state approaches to federal grant incentives that established coordinated referral systems. These concepts were hypothesized to influence how states designed their coordinated referral systems through the ADRC grant. This initiative asked three broad questions about coordinated referral systems:

Question 1: Does the bureaucratic arrangement of state aging and disability agencies influence the adoption of coordinated referral systems?

Question 2: Does a state's financing for public welfare programs influence the adoption of coordinated referral systems?

Question 3: Does the pattern of state's long-term care spending influence the adoption of coordinated referral systems?

This chapter draws upon the policy network literature to provide a theoretical foundation for the study of collaboration within the U.S. It places the ADRC program objectives within the existing literature and defines it as a collaborative service delivery network. This type of network has been identified within the field of public administration scholars (Agranoff 2007; Hale 2011).

Collaboration as a Form of Governance

Collaboration, and the extent to which it has become part of the process of implementing policy, has increased as the national and state governments tackle complex public problems (Kettl 1996). Collaboration is often defined as a tool used by multiple organizations solving complex or 'wicked' problems that are not easily addressed by a single core agency (Agranoff and McGuire 2001; O'Toole 1997). The emergence of this mode of governance can be informal agreements between network providers or more formally established as a result of a common purpose or legislation, such as a federal grant.

Federal grant funding often supports these intergovernmental relations by requiring them to collaborate with local, nonprofit entities and other governmental organizations (Hale 2011). In Mossberger and Hale's (2002) study of school-to-work networks, the school-to-work initiative was supported by federal grant funds that encouraged collaboration between schools, parents, communities and businesses. Similar to the ADRC program, the school-to-work program sought to bring together two separate policy communities: education and workforce (405). On the contrary, unlike the ADRC program, the school-to-work program was jointly managed by the Department of Education and the Department of Labor-- the lead federal agencies over the two policy communities. The authors found that federal sponsorship promoted interest in the collaborative effort from subnational governments and other entities in the policy community (417).

This increase in the use of collaboration to tackle these complex social issues has spurred research into the dynamic nature of these partnerships. The literature on collaboration is extensive and scholars have sought to define collaboration from multiple perspectives. Kagen (1991) defined collaboration as "organizational and interorganizational structures where resources, power and authority are shared and where people are brought together to achieve

common goals that could not be accomplished by a single individual or organization independently" (3). O'Toole and Marshall (1988) stated that networks consist of "all or part of multiple organizations where one unit is not merely the formal subordinate of the other in some larger hierarchical arrangement" (414). Other scholars look at collaboration in terms of the relationships between institutions, both governmental and nonprofit. These are termed intersectoral networks. Hale (2011) defines the current intergovernmental system of institutions as a "network of interdependent relationships" (9). Public administration research has sought to identify these networks and learn from them.

Networks in Public Administration Literature

The existence of networks is important in the study of public administration due to the increase in reliance on multi-jurisdictional, cross-sector, and interdisciplinary collaboration by many federal and state programs. Because networks can span these traditional boundaries, the term 'network' has different meanings to different public administration scholars. Isett et al. (2011) outlined the three main streams of research within the field pertaining to the term networks. They defined these streams as policy networks, collaborative networks, and governance networks (i158). Policy networks are defined as a group of partner organizations that share a common policy area and come together for the purpose of influencing public policy through the decision making process of resource allocation (Isett et al 2011). Collaborative networks are defined as a group of partner organizations that come together to provide for a public need. These are collaborations that form when there is a public problem that cannot be addressed by a single agency (Isett et al 2011). The final stream of network research focuses on governance networks, which develop to achieve a common goal instead of a specific policy or service objective.

Isett et al. (2011) categorization is based on the goal of the network, i.e. does it seek to change policy, does it seek to change the delivery of direct services, or does it seek to do both? Other scholars have looked at the classifying networks by evaluating different network arrangements. The next section reviews current literature on network arrangements that have categorized networks based on similarities and differences.

Collaborative Network Arrangements

The literature surrounding the type of collaborative networks defined above developed over the last two decades, so much more is now known regarding the structure and governance of these types of service or product oriented partnerships. Following O'Toole's challenge in 1997 to direct research efforts at identifying what kinds of networks are found in current administrative settings, how they formed and how they differ from each other, research emerged to address each of these questions (Agranoff 2007; Gray 1989; Hale 2011; Huxham 1996; Thomson, Perry and Miller 2007).

Public administration scholars have identified key similarities in collaborative arrangements (Huxham 1996; Thomson et al. 2007). Thomson et al. (2007) summarize this likeness as joint governance and administration while maintaining organizational autonomy. In addition, these collaborations produce mutual benefits and require a level of trust among the partner organizations (25-28). Likewise, an organization must have a certain level of 'collaborative capacity' that allows it to successfully enter into and become a productive member of a collaboration (Huxham 1996). This capacity is gauged by the level of organizational and individual autonomy, the cohesiveness of the organizational structure, the existence of strategic processes, and the level of flexibility within those processes (Huxham 1996).

Agranoff (2007) posed the questions: how do public administrators and nongovernmental organizations see their expanded roles, and do they manage differently in networks than they do in their home organizations? He found that networks could be categorized into a fourfold typology of collaborative networks that included informational, developmental, outreach, and action. Informational and developmental networks are created to exchange information and technology that could benefit either the partner agencies or their clientele. They do not address policy or service delivery in a direct way, meaning they do not take action to influence policy or how services are delivered (51). The difference among these two types of networks is in how much exchange takes place. Informational networks will exchange information in a best practices method. Developmental networks will cross-train to build capacity for better service delivery (51).

Outreach and action networks are those partnerships that become actively involved in influencing policy and programs. Outreach networks exchange information, which includes resource information, client contacts, and any future program opportunities. In addition, they produce informal agreements to develop programmatic changes (Agranoff 2007, 67). The final type of collaborative network is the action network. This type of network makes formal collaborations and produces interagency changes for how services are delivered.

Although Agranoff acknowledges the overlap in these categorizations, this typology provides a foundation for examining the differences in collaborative network arrangements. The issue evident in this typology is the degree to which partner organizations commit to the common purpose. The level of commitment, whether it is the agreement to provide information, cross train partner agency employees, assist in the development of new program initiatives, or formally change agency policies to achieve collaborative goals, is a key aspect in how

collaborations evolve and how they are managed. Therefore, how public collaborations are managed greatly influences how policy goals are achieved.

Hale's (2011) study focuses on the participants within information networks. She categorizes participant nonprofits as champions, supporters, bystanders or challengers. Champion organizations develop and advocate a policy solution. Supporters will support the policy solutions of the champions and collaborate with them when the policy solution is in sync with their organizational mission. Bystanders are participants in an information network that are informed but not engaged. They are typically the direct service organizations. The final category of nonprofit participants is the challenger. These organizations are critical of policy alternatives of the champion and seek to reframe the issue.

Public Service Delivery Networks

Fitted within the definition of a collaborative network (Agranoff 2007; Isett et al. 2011), are public service delivery networks. These networks address a specific service within a policy area. There is scholarship on service delivery networks from multiple disciplines, including public management (Bode 2006), nursing (Ervin 2004), sociology (Powell, White and Koput 2005), and other social science fields (Rodger, Jorgensen, D'Elia 2005; Shelley et al. 2008; Vai et al. 1995). The commonality among the definition of service delivery networks is the focus of the network around a specific public good or service. Bode (2006) asserted that these networks developed their infrastructure prior to the market or New Public Management era, and they have evolved on the basis of 'domain consensus' between welfare bureaucracies, professionals, and civic actors.

This trend to bring together a partnership is fraught with barriers. One of the major issues facing public managers within these networks is the roles of the partner organizations

(Agranoff and McGuire 2001). In many cases, these partnerships require organizations to cross jurisdictional, sectoral and disciplinary boundaries (Hale 2011). How do public managers balance government accountability and the network's need to disperse power among the respective partners? This pull from the bureaucracy that has its foundation in the hierarchical system is contrary to the flexibility needed for network cohesion (Agranoff and McGuire 2001).

Managing Networks

The participants of each network and the resources or influence they bring to the partnership are the foundations of the network. According to Kenis and Provan (2006), there has been limited research into the control over networks because the very nature of networks is self-governed entities that bring multiple organizations together for a common purpose. Agranoff and McGuire (2001) discuss the difficulty in accountability over networks due to the non-hierarchical nature of networks.

Provan and Kenis (2008) address the lack of theoretical understanding of network control and develop a framework for studying three models of control that include: participant governed, lead organization governed, and network administration organization (NAO) governed. The authors assert that there are two dimensions of network governance: one where the network is governed by the participant organizations and one where there is one organization that is the lead entity, directing the activities of the network (2008, 233-34). In addition, within these two types, there is variance in the control that can be allocated to different organization or groups of organization within the network.

Participant governed is defined as a network that is truly self-governed and has no outside entity that is responsible for oversight of the goal or purpose of the organization. The participant governed networks can be highly decentralized where all organizations participate equally, or

they can have a "lead organization" that is a member of the network but has more of a steering role (Provan and Kenis 2008, 234). Through the lead organization, the network can become more centralized. Lead organizations also provide greater control and accountability. The final form of governance that is stipulated by the authors is the network administrative organization (NAO). This model of network control designates a separate administrative entity to oversee the network and all activities. This NAO is a "network broker" and not a network participant. The issue of control is complex and varies depending on the type of network and how it formed.

Over time, networks can become more centralized as members seek to coordinate activities or as one organization takes the lead role in managing these activities. Sometimes the centralization of network management can come from external mandates as well. These formal and informal governing mechanisms can influence the overall effectiveness of networks (Bryson et al. 2006). It is not yet understood the exact extent the change in governing mechanism on an existing network will have on network participation. Gazley states, "we must continue the exploration of how federal and state-level mandates and incentives influence the nature and outcomes of local collaborations and government-nonprofit partnerships" (2008, 43).

Network Control Mechanism

The manner in which networks are tied together through the use of certain collaborative tools can have an impact on the overall coordination of the networks (Huang and Provan 2006). In a study of mental health networks in Maricopa County, Arizona, Huang and Provan studied the influence of certain types of resource dependency on both the interaction and patterns of interaction of network participants (2006). They found that there was a high degree of information sharing among participants and claimed that this was not unexpected because information sharing is relatively easy to initiate. Furthermore, they found that when resources

were intangible, that is knowledge-based resources; the networks were more decentralized in their control. Inversely, when the networks had more tangible resources (i.e. funding) their control was more centralized (443-46).

Centralization and Decentralization

Through the study of collaborations, the importance of the degree of centralization has emerged as a significant factor in program design (Imershein et al. 1986; Provan and Milward 1995). In Provan and Milward's (1995) study of four mental health delivery systems, they found that network effectiveness could be influenced by network structure and context, that is, centralized integration, external control, stability, and resource munificence. Furthermore, they found that states have the ability to influence the collaborations to be more centralized. Provan and Milward state that "by creating incentive structures and monitoring mechanisms so that services are provided locally through a system that is centrally integrated and coordinated through a single, powerful core agency, system effectiveness for clients can be increased" (30). Their study found, at least in this limited case study, that systems that did not have this centrality were more likely to experience discontinuities in service delivery.

In a study of Florida's Department of Health and Rehabilitative Services, Imershein et al. (1986) examined the implementation of an integrated service delivery model for the human service delivery network of agencies and providers. Key elements of this integrated service system that were investigated included: 1) a unified administrative structure; 2) collocated service delivery unities; 3) local administrative control; 4) a case management system; and 5) single intake (165). They examined the formal structure of unified administrative controls and found that they could foster positive client results. In addition, they found that although Florida had adopted an integrated model with a unified administrative structure, it remained

decentralized by allowing local control. This "local control allows those units to develop their own patterns of coordination in the process of actual service delivery" (168).

In case of fragmented administrative control over a human service delivery with no state leadership or mandate for integration, organizations can coordinate services without implementing the five key elements maintained by Imershein and colleagues. However, this pull for more centralized control over service delivery networks has led to the 'one-stop shop' model of service delivery.

Centralization and One-stop Shops

One-stop shops have been described as a mechanism for seamless public service delivery. The purpose of this model is to provide individuals with easier access to public services, specifically for those target populations that have difficulty navigating bureaucratic channels. In addition, this model seeks to coordinate services between policy officials (Wettenhall and Kimber 1996). Although much of the literature that focuses on the conceptual definition of one-stop shops has come from studies involving mostly European countries and Australia (Askim et al. 2011; Finn 2000; Kubiceck and Hagen 2000; Wiggan 2007), this model for service delivery is not new to the United States. The one-stop shop for public service delivery was introduced in Australia in the 1970s and was based on access theory developed by Bernard Shaffer (Wettenhall and Kimber 1996).

Conceptually, one-stop shops fit within the New Public Management (NPM) paradigm (Poddighe et al. 2011; Provan et al. 2004). The core mission is to make government services more accessible and comprehensive. The NPM movement, which pushed for more privatization and specialization, also created issues of uncoordinated service delivery (Hale 2011; Kim and Lee 2006; Williams et al. 2009). One-stop shops attempt to make the system more user-friendly

so that consumers are not searching for available services and where to go to access them. Services, like those in aging and disability, are often the same for multiple target populations. In the case of older persons in the United States, many may qualify for services that are available to persons with disabilities because they may also have a disability. With one-stop shops, all services that are available to an individual are coordinated so that service delivery is more comprehensive and person-centered. This model is in alignment with the business model of customer service (Poddighe et al. 2011).

Kubicek and Hagen (2000) developed a threefold typology of one-stop shops in their study of 11 national surveys of European one-stop shop collaborations. They categorize them as first-stop shops, 'convenience store' or 'true one-stop shop'. First-stops are the reception desk or information counter approach where a citizen is assisted with services that are related to his/her needs. This front desk could be an actual desk manned by a service specialist or it could be a virtual one. The convenience store is more comprehensive in the way that it offers many "transactional services," not just information through one office or website. These types of one-stop shops are characterized by their decentralized or local nature. The true one-stop is where services related to a specific public concern or problem(s) have been integrated to allow that one location to handle it or them. This categorization highlights the complexities that exist in the program design of this concept. Designs may be as simple as one organization that provides information to another or a complex partnership of multiple government organizations and private service providers working together to provide comprehensive case management.

Askim et al. (2011) attempts to build on this idea of the complexity in program design by identifying five key characteristics of one-stop shops: task portfolio, participant structure, autonomy, proximity to citizen, and instruments. Task portfolio includes all of the goods and

services accessible through the 'shop.' Participant structure can be considered the network of organizations partnering to provide the goods and services. Autonomy is the mandatory or voluntary nature of the partnership. The proximity to citizen gauges the physical accessibility or the convenience-level of the service in regard to the consumer. Finally, the instrument can be the physical location of an office where organizations are co-located or it can be the full integration of all services under one organizational umbrella.

The trend to adopt a one-stop shop model of service delivery is tempered by the need to include partners. The one-stop demands a high-level of trust and commitment by partner organizations because they allow the 'shop' to carry out at least part of their organizational goals or mission. Partner organizations that are not 'all in' to the collaborative mission will pull more towards the autonomous nature of the partnership creating what is commonly referred to as 'turf wars' (Isett et al. 2011). Even Kubecik and Hagen (2001) argue that the "one building for all services" method is not perfect and should not be considered a 'cure all' for integrated service delivery (3). The pull of the networks to remain autonomous sets the stage for another type of service delivery model that is being employed by some service delivery networks, called the 'no wrong door' (NWD) model.

Decentralization and the No Wrong Door

The NWD model is an integration model that uses multiple points of entry for service delivery and requires a high degree of coordination for standardized services. Although the idea of a NWD approach is often discussed in practice by medical journals (Roberts 2012; Steves and Blevins 2005; Van Voorhees et al. 2014), this is an emerging model of collaborative governance in public administration literature. In Steves and Blevins' (2005) exploratory study of the 1999 mass shooting that took place in Wedgewood Baptist Church in Fort Worth, Texas and the

subsequent restructuring of the mental health systems for that county, they describe a 'no wrong door' system as having open lines of communication between service providers and "community wide protocols for more standardized care" (314). In Van Voorhees et al. (2014), the NWD approach sought to utilize military chaplains as a resource for delivering information on smoking cessation efforts.

Although much more integrated, this approach is a less centralized control model. This NWD approach enlists all potential stakeholders to participate in the dissemination of information. To accomplish this, there must be a high-level of information sharing between partner organizations, so that no matter where the consumer enters the system, they receive the same comprehensive information on services and eligibility. In addition, it can require a high-level of respect and trust in partnering agencies (Roberts 2012).

This study defines the NWD approach as the coordination of comprehensive and consistent service delivery and information among multiple stakeholders with multiple points of entry into the service network. Figure 1.1 shows the NWD and one-stop shop models of service delivery when public, private and nonprofit organizations partner to coordinate a shared mission or goal.

[Insert Figure 1.1 about here]

Under the NWD, the clientele would enter the system or seek assistance from any of the partner entities, which are illustrated as three overlapping circles that represent the public, private and nonprofit sectors. These sectors overlap within a policy area. An example of this was seen in the school to work program discussed earlier (Mossberger and Hale 2002). The sectors in that study included the schools, which were the public sector, the businesses, which were the private sector, and the parents and the community, which represented the nonprofit

sector. These entities are connected by 'links' to the other entities in the network. These are sometimes formal written contracts or memorandum of understanding that organizations enter into to provide services to the target population. Organizations can also have informal agreements to share information or provide services within this network model. The 'links' are represented in the figure as arrows between the sectors because information and services are provided mutually.

The figure illustrating the one-stop shows where each of the sectors converges in the center. In this model, each sector provides a resource, either tangible or knowledge-based, to the 'shop' that then becomes the designated gateway into the system. Clientele seeking assistance from any sector would be directed to the single entry point or the 'shop' to receive assistance and services.

Foundation of this Study

The literature discussed in this chapter outlines the way in which networks are governed using a centralized to decentralized spectrum of control. This is supported by Provan and Kenis' (2008) assertion that control of networks can be viewed from two perspectives: the control exercised over the network to maintain accountability and the control exercised within the network by network partners to maintain consistency and achieve goals. Internal mechanisms of control for both centralized (one-stop shop) and decentralized (no wrong door) approaches include systems for sharing resources-- both tangible and knowledge-based.

As will be discussed further in the following chapter, aging and disability policy within the U.S. have traditionally had separate and distinct network arrangements. These arrangements fall within the public service delivery networks examined in this chapter. This study will examine the relationships between network participants in terms of the spectrum of control and

integration. Figure 1.2 illustrates the variance of control within the two ADRC models and places it within the existing theoretical framework laid out by Provan and Kenis (2008) and Kubiceck and Hagen (2000).

[Insert Figure 1.2 about here]

The figure illustrates a spectrum of control which ranges from highly centralized on the left to highly decentralized on the right. The NAO and the true one-stop shop as defined by Kubiceck and Hagen are both highly centralized control models. They both place the control of service delivery within the control of a single entity. These entities make decisions for the network as a whole. Less centralized is the Lead Organization model, which designates an organization within the network that coordinates the service delivery but does not exercise direct control over services delivered by the respective partners. The ADRC Single Point of Entry model of coordinated service delivery seeks to create a single entity that will be the 'place' where clients enter the LTC system; however, as will be discussed in the following section, most state programs are not administered by a designated entity but rather, are guided by the state unit on aging.

On the decentralized side of the spectrum is the participant governed model, which requires that all partners have equal control over the network. Likewise, the convenience store model requires partners to share information effectively to provide comprehensive information and some services. The ADRC no wrong door model most closely resembles the characteristics in the more decentralized network participant or convenience store model.

On the far end of this spectrum is complete decentralization, which is defined as fragmented service delivery. In this model, there is a lose network of organizations that provide information and services; however, there is little collaboration to coordinate these services.

Kubicek and Hagen's first stop model resembles more of a fragmented, uncoordinated service delivery model whereby organizations provide information, but do not coordinate with other organizations that provide similar information. This is more closely aligned with a siloed system of service delivery.

Outline of Chapters

This section provides a layout of the chapters within this dissertation. Chapter 1 establishes the theoretical foundation for the study of collaborative arrangements within the U.S. administrative structure. It summarizes the major streams of literature pertaining to networks within the field of public administration. It defines the ADRC as a public service delivery network within the framework of collaborative networks. It poses questions about the control of network structures and establishes the key elements of network evolution as: joint governance and administration, organizational autonomy, mutually beneficial, and levels of trust.

Chapter 2 addresses the unique policy environment of aging and disability in the U.S. It summarizes the history of aging and disability policy and advocacy as well as the social, legal and economic changes that have influenced the creation of the ADRC program. It defines the functions of the ADRC as, public service delivery collaboration established to provide long-term care (LTC) options to all clients in need, regardless of their age or disability. It also focuses on the variations in ADRC program designs and the influences of these variations. Finally, this chapter outlines state policy determinant theory as an explanatory theory for the differences in state policy design adoption. It will focus on the empirical studies of political, social and economic factors that influence policy adoption. This chapter will also address studies conducted using public service delivery network and specific factors pertinent to the study of aging and disability policy in the U.S.

Chapter 3 profiles the study's methodology and offers initial descriptive statistics on how the network arrangements differ among the 50 states. It shows the program design models that are categorized based on program descriptions provided by each state. From these variations, the following hypotheses will be tested, using state policy determinant theory.

H1: A state will be more likely to adopt a decentralized model or no wrong door model, when the state unit on aging (SUA) is housed with other state long-term care entities.

H2: A state will be more likely to adopt a decentralized model or no wrong door approach, when there is a lower level of spending for public welfare, all else being equal.

H3: A state will be more likely to adopt a decentralized model or no wrong door approach, when there is a higher level of home and community based service (HCBS) infrastructure, all else being equal.

H4: A state will be more likely to adopt a higher level of integrated program design, when the SUA is housed with other state long-term care entities, all else being equal.

H5: A state will be more likely to adopt a higher level of integrated program design, when there is a higher level of spending for public welfare, all else being equal.

H6: A state will be more likely to adopt a higher level of integrated program design, when there is a higher level of HCBS infrastructure, all else being equal.

These methods are followed by a follow-up qualitative study of a semi-structured interview of state program directors.

Chapter 4 contains the descriptive statistics on all variables within this study. It reports those variables that were found to be significantly related to each other and then provides the results of the quantitative analysis of the bivariate and ordered logistical regression models. The findings of these analyses demonstrate no significant relationship between the variables of

interest, state bureaucratic structure, spending on public welfare and long-term care infrastructure, and the adoption of varying ADRC program design models.

Chapter 4 also includes the findings from the qualitative analysis of an interview conducted with 16 state ADRC program directors. It was found that this study did not include the ADRC advisory council in the quantitative analysis, a major factor that the respondent felt contributed to the overall ADRC program design. It was also found that the ADRC program was an evolving partnership that was highly influenced by state and federal actions.

Chapter 5 discusses the findings reported in chapter 4 in relation to the overall policy environment and the contribution to the existent literature on collaborative networks. This study found that there were three key issues influencing the development of the ADRC collaborative model: state ADRC advisory councils, where states 'housed' their programs and new federal incentives.

ADRC advisory councils were not considered in the quantitative analysis conducted in this research. This factor emerged from the responses to the interview portion of this project. The majority of the respondents indicated a relationship between the inclusion of disability organizations in the advisory council and the overall level of program success. Respondent indicated that when disability organizations were invited to participate early in the process of implement the ADRC grant, that there was a higher level of buy-in from these organization and greater success in integrating the two networks.

Where states placed their ADRC programs was considered by all respondents to be an important aspect of integrating the two service delivery networks. States that housed their ADRC programs within the area agencies on aging (AAAs), that are typically in the aging policy domain, indicated difficulty in including disability organizations into the ADRC fold. States that

began their programs as a no wrong door model and did not house their program anywhere but rather designed it as a network of core partners, indicated a greater level of inclusion of disability organization into the ADRC mission.

The final key factor found to influence the ADRC program design was further federal incentive grants provided to states. After the initial ADRC grants in 2003 to 2008, states began offering expansion grants and new No Wrong Door planning grants. These grants were accompanied by more technical assistance and guidance from the Administration on Community Living (ACL). These new grant initiatives had a strong impact on the evolving nature of these collaborative programs at the state level. They provided clarity on how states can develop their models to include more existing public resources and eliminate duplication within their LTC systems.

Chapter 2: U.S. Aging and Disability Policy

This chapter will examine the current United States long-term care system and the evolution of aging and disability policy. This evolution is a key factor in how these two policy fields developed separate service delivery networks. It also covers the social, legal, and economic changes that have led to the creation of collaborative networks known as the Aging and Disability Resource Centers (ADRC). This background analysis reveals the importance of three conceptual factors that are theorized to influence state adoption of specific ADRC models. The three factors include: fragmentation of policy decision making, state commitment to public welfare spending, and state spending on long-term care infrastructure. These are the major focus of inquiry for this research.

Long-term Care Service Delivery in the United States

In the U.S., LTC is delivered directly by private or nonprofit organizations. Public financing for these services is fragmented in most states and funneled through multiple state agencies. These agencies designate target populations based on characteristics, such as age, type of disability, level of care, and income level. For example, an individual over the age of 60 is eligible to receive home and community based services (HCBS) through Older American Act (OAA) funding, regardless of the existence or type of disability. This individual would typically seek assistance through a local area agency on aging (AAA) that receives funding through the state unit on aging (SUA). The AAA would provide direct services through contracts with local agencies, such as a personal care agency that provides homemaker services or a local church that

provides facilities to house a senior center. The AAA would assess the individual's level of need and seek to arrange services through a case management process.

Individuals under the age of 60, who have a disability, would seek assistance in many possible locations; the location depends on the type of disability. If a person is diagnosed with a mental illness, many states have separate departments of mental health that oversee local or regional mental health authorities. If an individual has a physical disability, most states have another division or department of rehabilitation or vocational rehabilitation. In addition, the state public health agency provides additional services through local public health offices, including HCBS waiver services for persons with disabilities. There are departments or divisions of state agencies designated for representing and providing services for persons with intellectual and developmental disabilities.

For decades, the public financing of LTC services and supports in most of the United States has been highly imbalanced, that is, it has depended more heavily on institutional care provided within skilled nursing facilities than it has on offering home and community-based care (Reed 2012). The reasons for this type of service imbalance stems from the separate and different developments of aging and disability policy within the United States.

The development of these two service sectors, as distinct policy areas, can be traced back to this country's individualistic roots and to the emergence of the medical model in the 20th century. Figure 2.1 presents a timeline of important policy developments for both policy fields.

[Insert Figure 2.1 about here]

The figure illustrates the simultaneous policy advances that took place in the aging and disability policy fields. Aging policy was advanced by three major pieces of legislation: the Social Security Act of 1935, the Older Americans Act of 1965, and the renewal and amendment of that

act in 2000. The disability policy area was advanced with the amendments to the Social Security Act in 1965 that established Medicaid health insurance that was later expanded to include persons with disabilities. Smaller pieces of legislation that were the result of advocacy efforts that focused on a person's ability to access public places and public services, included the Architectural Barriers Act of 1968, the Rehabilitation Act of 1975, and the Education for All Handicapped Children Act of 1975. These efforts culminated into the passage of a comprehensive piece of legislation called the Americans with Disabilities Act of 1990 (ADA).

While these policy advances were being made in the respective policy areas, there were developments that impacted both policy fields. For example, the Social Security Act of 1965 created Medicare for those over the age of 65 and Medicaid for individuals with low income, children, caretaker relatives, the blind, and persons with disabilities. In 1973, Medicaid was expanded to include coverage for intermediate care facilities that treated persons with mental illness. This covered elderly individuals and persons with disabilities.

In 1981, the Omnibus Reconciliation Act (OBRA) was passed, and this created a host of HCBS waivers available to both elder persons and persons with disabilities. These are commonly referred to as the Elderly and Disabled Waiver programs that are funded through state Medicaid agencies. The OBRA bill was renewed in 1987 and included quality of care standards to institutional care. This greatly aided in the proper care and treatment for the elder and persons with disabilities residing in long-term care facilities. States adopted these standards of care and in some cases went further than the minimum federal standard.

The final policy development did not come from legislation but rather from judicial ruling. The Olmstead v. L.C. was a pivotal case that found confinement of persons within long-term care facilities was a form of discrimination and violated the ADA.

These developments and the impact to aging and disability services are explained in the following two sections.

Aging Policy in the U.S.

The care for the elderly population within the United States has traditionally been provided by family, within a private home setting (Baggett 1989). In certain situations where family could not provide for an elder's LTC needs, seniors who needed assistance with activities of daily living were assisted by charitable organizations (Baggett 1989). Religious groups played a large role in providing for in-home care, as well as for funding charitable institutions. Modern medicine evolved hospitals into what they are today, and total care individuals or those that needed around the clock care, were kept in these hospital settings (Erkulwater 2006). Many hospitals had LTC units to house those individuals that were too frail or ill to return home.

The emergence of the medical model of care and its view on aging as a medical condition has contributed to disparate public resources directed to hospital and physician care instead of home and community based services (HCBS) (Baggett 1989). The pressures to provide for HCBS came later through the efforts of advocacy groups that included many disability groups.

Aging policy in the United States evolved slowly with the passage of the Social Security Act of 1935 and the amendments that followed in 1965, which created Medicare and Medicaid. Medicare was designed to assist persons over the age of 65 to receive medical services. Medicare included both physical and hospital services and some short-term rehabilitation. The gaps in Medicare were partly filled in with the passage of the Medicare Modernization Act of 2003 that created the Part D drug coverage. Persons with Medicare could receive services in LTC facilities for limited rehabilitation.

In addition to Medicare, which was administered by the U.S. Department of Health and Human Services (DHHS), the federal government created Medicaid to assist with medical insurance for individuals under the age of 65 who were getting cash assistance from the state (Center for Medicare and Medicaid Services 2015). This was later expanded to include low-income families, pregnant women, people of all ages with disabilities, and people in need of long-term care.

Unlike Medicare, Medicaid was administered and co-funded by the states. The law stipulated core services that each state were to provide and allowed discretion on any optional services that they wanted to make available to their citizens. Because of this, states implemented Medicaid in many different ways. States with strong social service cultures had extensive Medicaid programs that covered more individuals and provided more benefits. Other states chose to maintain basic Medicaid insurance with fewer optional services (Medicaid 2015).

Because Medicaid was expanded to include persons in need of LTC, individuals who were not currently eligible for Medicaid, could receive LTC Medicaid if they met certain qualification requirements. This meant that a person over 65, who had Medicare and was admitted for LTC in a nursing facility, would potentially be eligible for Medicaid after they no longer had assets to pay privately. The federal and state funding of institutional LTC produced an infrastructure of private skilled nursing facilities, assisted living facilities and group homes. The institutions that were created in the 1950s and 1960s resembled the hospitals of the time. They were designed under the medical model and not a person-centered model of care.

There was little support for HCBS through Medicare and Medicaid. Medicare provided limited home health services as well as hospice services. Medicaid provided limited HCBS waivers that provided in-home assistance. Some states focused discretionary Medicaid dollars

on HCBS, but this was also limited due to the explicit nature of the law. Some states created state supported HCBS, but in most cases, assistance with in-home care came from non-profit entities and through OAA services.

In 1965, Congress passed the OAA, which created a host of programs aimed at assisting seniors over the age of 60 to continue to reside within their homes. The OAA required each state to create a state unit on aging (SUA) that would be designated through state legislation to administer OAA funding. The SUA then designated planning and service areas (PSAs) that would administer the OAA funds at a local or regional level. These PSAs became known as area agencies on aging (AAAs).

The organization of the aging networks varied considerably from state to state. Figure 2.2 illustrates the most common bureaucratic organization of state aging networks.

[Insert Figure 2.2 about here]

Some smaller states and some very rural states such as Delaware, New Hampshire, Alaska and Nevada are comprised of only one PSA. They do not have AAAs but rather administer OAA funding through the SUA directly. In some cases, the functions of the AAA are carried out in senior centers. Within the majority of the states though, PSAs divide the state into regions and within these regions, the AAA coordinates services in their counties through senior centers.

The AAAs supported a host of LTC support services; the most notable one being the senior nutrition program, which became known as Meals on Wheels. Other OAA supported programs included health and wellness programs designed to assist seniors to age in place or remain in their homes. The OAA also funded legal assistance programs and elder justice and protection programs, such as the LTC Ombudsman program, which advocates for seniors who reside in LTC facilities (Administration on Community Living 2015). Each state was faced with

limited OAA funding and therefore required support from local governments as well as community partners.

Through the nutrition program, the OAA has been creating a network of LTC, providing and establishing partnerships with nonprofit organizations to create senior centers throughout the communities that deliver direct services to seniors. This network increased to include new service providers, both for-profit and nonprofit, as the OAA expanded its programs through subsequent renewal. In 2000, the OAA was amended and created the National Family Caregiver Support Program that provided grant funding to states to create state programs. These state programs provided support to caregivers in an effort to keep an elder at home for as long as possible (Administration on Community Living 2015).

In today's environment, the care for seniors has become a major issue within the health care debate. The cost of providing long-term care has skyrocketed, and the institutional bias of some state funding systems has come under attack from disability groups. This affected the passage of legislation such as the American Disability Act of 1990 (ADA) and the Nursing Home Reform Act within the Omnibus Budget Reconciliation Act of 1981 (OBRA). These forms of legislation have transformed the community view of persons with disabilities and the care of those residing within institutional settings.

Disability, ADA and the Olmstead Decision

The history of disability policy within the U.S. is very similar to aging in its fragmented evolution. In addition to the lack of support and fragmentation, the disability community faced a form of discrimination that did not exist for seniors. Switzer (2003) reviewed the efforts of scholars that sought to map out the change in how society has come to view persons with disabilities. She states that "the word that best describes the historical treatment of persons with

disabilities is separation" (31). Unlike seniors, care for persons with disabilities has not been provided by family; care has primarily been provided in institutional settings (Switzer 2003). Children and adults alike who were unable to care for themselves were placed into state run or charity based asylums. In many instances, as was the case for facilities designed to house the indigent elderly, the conditions within these facilities were deplorable and residents suffered many abuses. Persons with mental health disabilities were considered criminals for the most part and were sent to jail or prison (Switzer 2003).

The model for care for individuals with physical or developmental disabilities was a medical model. This model viewed persons with disabilities as sick and therefore sought to cure them and return them to fully functional citizens (Erkulwater 2006; Hahn 2003). This was especially problematic for persons with a permanent disability.

The publicly supported programs designed to assist persons with disabilities only began to emerge in the 1950s with the extension of Social Security to those persons who were over 50 and had a complete and permanent disability that prevented them from working (Erkulwater 2006). Since that time, Congress has expanded these benefits tremendously. In fact, federal spending for Disability Insurance, controlling for inflation, has jumped from $3.2 billion in 1974 to exceeding $66 billion in 2003 (Erkulwater 2006). The definition of disability has expanded as well to include persons with mental illnesses and developmental disabilities such as, depression, anxiety disorders, Autism Spectrum Disorders, etc.

During the 1960s and 1970s, the medical model was contested by the social model. This model presented a disability as a conflict between a person's natural state and society's perception of what is normal. The social model posits that "disability is not an objective characteristic or defect of a person but rather is a socially constructed category used to justify

discrimination against individuals whose bodies made them different from the social norm" (Erkulwater 2006, 29).

This shift led to new disability advocacy and a fight for disability rights. Advocates sought to change society to meet the needs of persons with disabilities rather than cure the disability. This led to legislation such as the Architectural Barriers Act of 1968, the Rehabilitation Act of 1973, and the Education for All Handicapped Children Act of 1975 (EAHCA) (Erkulwater 2006). These efforts culminated into the passage of the Americans with Disabilities Act of 1990. The ADA was civil rights legislation that promoted equality through accommodations and nondiscrimination (Krieger 2003).

Because of the shift from the medical model to one of inclusion and accommodation, state programs for persons with disabilities had to evolve. Many state-run programs, such as Medicaid and state hospitals that served the mentally ill, were now being challenged by new legislation.

OBRA 1981 gave DHHS authority to change Medicaid requirements that were previously imposed on states. OBRA allowed states to create Freedom of Choice Waivers. These waivers would allow states to begin funding more HCBS, such as case management, homemaker, home-health aide, personal care, adult day care, rehabilitation, and respite care (Harrington et al. 1985 as cited in Baggett 1989).

In the pivotal Supreme Court decision *Olmstead v. L.C., 527 U.S. 581*, the court used the ADA to attack the separation of persons with disabilities from society. The case was the result of a suit filed by two women who were diagnosed with mental illnesses and developmental disabilities. They were admitted to a psychiatric unit in a State-run hospital in Georgia. These women were treated and assessed for community placement, which was approved by their

physicians. The women were not transitioned to the community but instead confined to the institution for years. They filed suit under the ADA asserting that due to their disability, they were discriminated against and not allowed to return to the community. (Americans with Disabilities 2015)

The Olmstead decision provided a legal mandate that states must allow for the least restrictive environment for persons needing LTC. This included both persons with disabilities and the frail elderly. The Court's decision is based on the ADA, which classifies isolation or segregation of persons with disabilities as a form of discrimination (National Council on Disability 2003).

Unlike the aging network, the disability network developed more from advocacy groups than from a single piece of legislation. Whereas the aging network and the providers evolved from the passage of the OAA, the disability network evolved through separate advocacy groups that banded together to promote the passage of legislation, much of which was done at the state level. These advocacy groups were usually formed to promote the recognition of one type of disability, i.e. developmental disability, mental illness or mental retardation. Seldom did groups advocate for all forms of disabilities. Thus, disability services within states are typically not housed within one specified agency. Services for physical disabilities can be provided by a number of state agencies that can include vocational rehabilitation, labor, health, veterans, and Medicaid. Other forms of disability may be grouped together or housed in different agencies, such as developmental disabilities and behavioral or mental health entities. These are sometimes grouped under a department of health but typically separated from a department of rehabilitation. Figure 2.3 illustrates this and uses Alabama's disability agencies and services as an example.

Although every state is different in the exact arrangement of services, this is a guide to how fragmented services for persons with disabilities can be.

[Insert Figure 2.3 about here]

Statement of the Problem

In addition to the legal obligation of states to provide for less restrictive environments to persons with LTC needs, the average cost to provide skilled nursing care per year in 2011 was $89,812 (Northwestern Mutual 2011). Once an individual, who resides in a nursing facility, has depleted his or her assets and can no longer afford to pay for care, he or she is then eligible to apply for LTC Medicaid. Once approved, the state pays a set amount to the LTC facility minus the patient allocation. The patient allocation is the patient's income minus a set amount that the individual is allowed to keep for personal expenses. In Alabama, the personal care allowance is thirty dollars a month. Not only has the cost of skilled nursing care risen with the cost of health care in general, but more and more people need skilled nursing care. This cost, although not fully reimbursed by the Medicaid program, has pushed for alternatives to institutional care in the form of assisted living, adult day, and community-based waiver programs.

Even without the rising cost of healthcare, the entitlement programs would eventually face increased scrutiny due to the 'graying' of the population. Figure 2.4 shows the population growth for the 20th century. The blue 1900 pyramid in the center is representative of a traditional population chart.

[Insert Figure 2.4 about here]

It is 'traditional' because as people age they are more likely to die from disease or age related infirmities. According to the Center for Disease Control and Prevention (2011), the average life expectancy, in 1900, for males and females were only 46.3 and 48.3, respectively. In the 1950's

the U.S. and other countries around the world had an increase in birth rates. This expanded the number of children in the U.S. under the age of 5. By 2000, this portion of the population had aged into their late 40's and 50's.

Starting in January of 2011, the oldest baby boomer reached the age of 65. From that time, 10,000 people turned 65 every day and this trend will continue at this rate for the next 19 years (Pew Research Center 2012). From 2000 to 2010, the increase in the population age 65 and older increased by the rate of 15.1 percent. This was greater than the increase for the entire U.S. population, which increased by only 9.7 percent during that same period (Werner 2011). These numbers, though staggering, neither show the true picture of healthcare costs in general nor for institutional care, specifically.

This increase in the aging population has a direct impact on all healthcare expenditures, not just those for LTC. Table 2.1 shows the direct impact of aging on the per capita personal health care spending. As reported by Keehan et al. (2004), the average person spent $3,834 on personal health care in 1999; however, if that number is broken down by age group, as seen in the table below, the spending for personal health care increases exponentially after age 54. The greatest expenditures are incurred by those ages 85 and older who spent an average of $20,001 per year on personal health care. Of those ages 85 and older, 22 percent were residents in nursing homes in 1999. And although that age group only made up 1.6 percent of the total U.S. population, they are credited with 8 percent of the total health care spending (U.S. Department of Health and Human Services 2005).

[Insert Table 2.1 about here]

Coupled with the increase in older Americans in 2008, the U.S. entered into what many people are calling The Great Recession, the largest fiscal downturn since The Great Depression

of the 1930s (Klase 2011). This economic crisis was particularly difficult for states because of the revenue sources and fiscal rules governing specific state budgets (Hong 2015; Klase 2011). Responses to the unexpected decrease in revenue were much more pronounced in states with balanced budget requirements than states without these types of restrictions (Hong 2015). This is partly due to the fixed nature of the state budgets and the lack of diversified revenue sources (Klase 2011).

There was a rapid growth of state budgetary expenditures in entitlement spending, such as health and Medicaid, leading up to the economic downturn (Klase 2011). To add to the deficit challenges, state tax bases have been eroded, creating long-term revenue shortages (Klase 2011; Ward and Dadayan 2009).

With public welfare policy so connected to budgeting, policy makers have made several attempts to attack this issue of providing for LTC with bureaucratic measures rather than congressional action. In October 2010, the Center for Medicare and Medicaid Services (CMS) revised their Minimum Data Set, an assessment tool conducted on anyone entering and residing in a skilled nursing facility (Center for Medicare and Medicaid Services 2012). The revisions included a section that required nursing home personnel to inquire as to whether the individual wanted to return to community living. If so, nursing home personnel were responsible for providing information and assistance along with another state designated entity, also known as the local contact agency, to help the individual return to community living.

The Administration on Aging (AoA), now under the auspices of the Administration on Community Living (ACL), has also attempted to create measures that would encourage community living by first offering nursing home transition grants, Alzheimer Disease Supportive

Services Program (ADSSP) grants, and most recently, the Aging and Disability Resource Center Grants (ADRC) and Community Living Grants (CLP).

In 2008, AoA began funding what would become 80 ADSSP projects. The goal of these programs focused on the dissemination of evidence-based programs, creation of integrated, dementia capable service systems, and exploration of new models of care (Administration on Aging 2015). The evidence-based programs were to demonstrate how certain interventions for persons with Alzheimer's Disease and Related Disorders (ADRD) could result in effective community-level services (Administration on Aging 2015).

The CLP grant initiative was started in 2007 when AoA offered states the opportunity to competitively bid for grants that would transform how they managed their OAA and non-Medicaid funding in an effort to create supportive services to high-risk individuals (Administration on Aging 2015). The goal of the CLP grants was to create a LTC system that would be person-centered or consumer-directed and would target persons that were at the greatest risk for nursing home placement (Administration on Aging 2015). The method for this transformation would be to create a single-point of entry (SPE) for all LTC services. These new grants recognize the complex environment that surrounds long-term care. They aim to broaden the definition of long-term care and provide access to more options.

Aging and Disability Resource Centers (ADRCs)

In 2003, the ACL began offering states the opportunity to apply for ADRC grants. This new initiative was designed to offer states an incentive to create collaborative partnerships between all long-term care stakeholders in an effort to provide all available long-term care choices to consumers. This collaborative partnership would include the disability networks, other public and private organizations, such as Medicaid, Mental Health, Rehabilitative Services,

and the Centers for Independent Living (CIL), as well as the existing aging network. The ADRC vision was to redefine LTC and how the states would provide services to those in need.

Although only 12 grants were awarded in 2003, more funding and state willingness to participate would follow. In 2009, all states were awarded ADRC grants and were implementing these grants in different ways. This restructuring of existing networks of service providers in various environments offers a potential wealth of information for researchers of collaborative networks. Use of the ADRC as a systems change grant is a way the national government has encouraged states to implement a collaborative approach to service delivery.

Programmatic Differences among State ADRCs

The initial ADRC grant required just three core functions: awareness, assistance, and access (The Lewin Group 2011). Initial state programs had tremendous discretion on program design and implementation. This study will analyze two state modalities for the ADRC program as well as various program tools that states chose to adopt.

One of the key components of the ADRC mission is to coordinate service and information delivery so that consumers can access all LTC options. States have achieved different levels of coordination that have been in direct response to the SUA's respective goals for the ADRC program. In some cases, states have developed formal collaborations with other organizations, such as Medicaid, Mental Health, Rehabilitation Services, and Centers for Independent Living. These collaborations attempt to bring multiple players into the policy-making fold and produce a "seamless" system of service delivery. In this way, the collaborations work together to provide the same information and access to services to clients regardless of where the client first makes contact. This system is sometimes referred to as the "no wrong door"(NWD) model.

This NWD approach produces a high amount of information sharing because member organizations can help clients enroll in programs from other agencies. In addition, organizations can offer detailed case management to assist a client's specific needs and in this way provide person-centered care.

Other states have attempted to coordinate with other departments to create a single-point of entry (SPE) model. Through this coordination, clients are referred to a single-point of contact that collects information of all LTC services and provides soft referral to other agencies. Soft referrals are where the SPE organization collects information through an assessment, then contacts the service agencies for the client, and ultimately transfers client information to them for follow-up. In this way, a client is not given multiple providers to contact for follow-up. Some states have designated that the SUA is the SPE organization and in other cases, states have designated an external agency, such as the area agency on aging (AAA) or a nonprofit.

States have also adopted multiple policy tools, such as virtual web portals, decentralized eligibility determination procedures and standardized assessment tools. A virtual ADRC uses technology to share information by providing an online database to consumers as well as network participants. Decentralized eligibility is the ability of multiple network participants to determine consumer eligibility and enrollment for program services with other network participants. Single assessment tools are consumer assessments that determine what services the consumer may need and be eligible for. The assessment is agreed upon by all network participants.

Factors Influencing Policy Adoption by States

From the beginning of aging and disability policy in the United States, federal, state and local governments have had to work together and partner with nonprofits to implement senior

programs. New programs, such as the ADRC, directly incorporate collaborative networking into their underlying principles. Within this new program is a policy environment that is ripe for exploration on many levels of collaborative governance.

This study uses state policy determinant theory as an explanatory foundation for why state ADRC programs are designed differently. The following section reviews pertinent literature of this theory, laying the foundation for the hypotheses tested in this project.

This section examines significant literature on state policy adoption. This will review two major political science theories: state determinants and policy diffusion. Multidisciplinary literature, on public service networks, is reviewed to specify factors pertinent to the study on aging and disability policy within the U.S.

State Policy Adoption

The two major theories in public administration that explain state policy adoption decisions, center on state specific determinants and the diffusion of policy ideas from state to state, also termed regionalism (Canon and Baum 1981; Berry and Berry 1990; Rogers 1995; Walker 1969). These theories point to internal and external explanations for state choices (Berry and Berry 1990). Walker (1969) and Rogers (1962) called for research on the diffusion of innovation policy. Walker (1969) first proposed that there was a pattern in states that followed the lead of regional state leaders. He asserted that states compared themselves to other states in their region. Walker tested his theory on state adoption of innovative policy by constructing an 'innovative index' (Walker 1969).

Rogers (2003) asserts that the four main elements of diffusion are: 1) innovation, 2) communication through channels, 3) time lapse, and 4) a social system (36). He contends that there are four types of innovation decisions. The first is the optional innovation-decision;

whereby, the decision to adopt an innovation is independent of others. The second is the collective innovation-decision, which is made by agreement between the members of a group. The third type is the authority innovation-decision, which is where a few individuals are given decision making authority based on their power or position. The final category of decision making is that of the contingent innovation-decision, which is dependent on a prior innovation decision having been made.

Internal determinants include, state political, social, and economic characteristics that influence states' adoptions of innovative policies (Canon and Baum 1981; Gray 1973). Most of these studies have focused on legislative or administrative innovations (Baum 1981). Empirical testing began with Walker's study of state innovation, which showed a strong relationships between innovation, population, urbanism, wealth, and industrialization (1969, 883-84).

The term for the diffusion of policy ideas based on location varies by author. Canon and Baum (1981) called this regionalism in their study of tort law innovations. They define this as the "existence of regional communication patterns and by the tendency for officials and citizens to measure their state's performance and programs against those of neighboring states" (983). Gray defines this communication of new ideas in a social system as diffusion.

The 1990 study produced by Berry and Berry justifies a combined model and asserts that "neither a pure regional diffusion model nor a pure internal determinants model is a plausible explanation of state innovation in isolation" (396). The authors tested this combined model on state lottery adoptions using an event history analysis to test how both internal determinants as well as geographical proximity encouraged states to pass legislation creating a state lottery. They argue that a comprehensive research model will include political, economic and social factors. Although the main categories of factors have been classified in different ways (see Creek and

Yoder 2012; Sapat 2004), many of the factors are consistent with their original state specific indicators. Factors tested are often specific to the policy area under investigation. Mooney and Lee's (1995) study of pre-Roe abortion reform adoption argues that certain factors may be more relevant in moral policy studies than in other policy areas. One such factor could be religious affiliation.

Scholars have used political factors, such as party affiliation of state legislature, as well as that of the state executive, proximity to elections, liberalism indexes, district-level party competition, and unified legislative control (Berry and Berry 1990; Creek and Yoder 2012; Holbrook and VanDurk 1993; Miller 2005; Miller and Wang 2009; Mooney and Lee 1995). These political factors have had mixed results on their relationship to policy adoption by states.

Economic factors shown to influence state policy adoptions include, population wealth and state's fiscal health (Berry and Berry 1990; Mooney and Lee 1995). In a synthesis of health care research focused on state health policy making determinants, Miller (2005) indicated a positive relationship between supply and demand factors. Specifically, he found that poverty, unemployment, and medical prices may explain an increase in Medicaid expenditures and recipients. This is supported by Sapat's (2004) classification of factors related to problem severity that will influence state policy adoption. Therefore, this supports a causal theory that when there is greater demand or need, there is increased government spending for social support programs. Some policy specific factors in LTC could be level of income and cost of institutional LTC.

Another economic factor that has emerged in the literature is the supply factor (Huxham 1996). Miller (2005) examines the negative relationship between number of nursing home facility beds and the level of spending for HCBS. Likewise, he shows that there is a positive

relationship between Medicare home health utilization and agency availability and Medicaid funding for HCBS. This would support a theory that a private or non-profit infrastructure could influence the state's policy decisions and vice versa.

Finally, social or sociodemographic factors that have been used in determining state policy adoptions include female workforce participation, urbanization, and percentage of non-white population (Berry and Berry 1990; Creek and Yoder 2004; Miller 2005; Mooney and Lee 1995). The results have been mixed and again, these factors are often based on a logical relationship between the factor and the specific policy area under investigation. Mooney and Lee (1995) state that these variables can be considered "resource and constraint variables for these policies" (611). They found that female workforce participation was significantly related to abortion reform policy adoption. They also cite Hwang and Gray's (1991) study of state spending for highways, drawing on the relationship between less urbanized states and the demand for highway systems that will connect small towns. If drawn from a logical influence with the specific policy under investigation, these sociodemographic factors will influence policy adoption (Creek and Yoder 2012).

More recent emerging literature suggests a link between the fragmentation of policy decision making and the adoption of policy and program design. Lienert, Schnetzer and Ingold (2013) investigated fragmentation in water infrastructure planning and determined that a high-level of fragmentation exists in decision making and planning, leading to low-levels of collaboration among participants in the network. This line of investigation examines fragmentation as another factor of state determination. The next section discusses the organizational structure of decision making in LTC in the U.S.

Organizational structure of decision making in LTC

LTC decision making has historically been a disjointed process involving multiple agencies that did not coordinate their decisions (Reed 2012). The former deputy secretary of the Washington State Department of Social and Health Services, Charley Reed, wrote about his experiences in transforming the nature of LTC funding in his state (2012). He outlined several key elements to a more integrated system on LTC service delivery, which included a single-point of entry for consumers, a fast and timely standardized way to determine eligibility, statewide case management system, a process for assuring quality oversight, training and support for providers, an ongoing process for developing resources to meet demand, and a well-organized, articulate, sophisticated group of consumers and providers who advocate for a balanced system (Reed 2012). Most importantly, Reed states:

> The first and most important factor needed to achieve a balanced state long-term-care system is having a single organization in state government to plan, develop, and operate that system. This single organizational unit in state government is responsible for all parts of the state long-term-care system, including all state funding, as well as the Older Americans Act, and Medicaid funds for LTC. (2012, 61)

This is supported in the network literature. In their study of four Mental Health systems, Provan and Milward (1995) state that:

> Networks integrated and coordinated centrally, through a single core agency, are likely to be more effective than dense, cohesive networks integrated in a decentralized way among the organizational providers that make up the system…centralization appears to facilitate both integration and coordination (24).

There is not yet a consensus on how power imbalances affect network outcomes. Much of the imbalance occurs when there are member organizations with a disproportionate amount of resources or influence. Sometimes the imbalance can occur when one organization controls the direct flow of funds to the other organizations within the network. This direct flow of funding can reduce competition for funds but also impacts how information flows throughout the network and how network members participate (Provan and Milward 2001).

Budgeting Decisions as Policy Decisions

Budgets are a fiscal reflection of public policy choices. The legislature appropriates based on public priorities (Fisher 2002). Wildavsky (1961) states that:

> The budget is the life-blood of the government, the financial reflection of what the government does or intends to do. A theory which contains criteria for determining what ought to be in the budget is nothing less than a theory stating what the government ought to do. (44)

Government spending patterns show a state's commitment to public policy and therefore can be used as an indicator of future policy adoption. Creek and Yoder (2012) found that the adoption of immigration reform policy is positively influenced by the level of government spending on education, healthcare, and public welfare spending. In addition, government's commitment or spending can influence the institutional capacity to adopt certain policies (Sapat 2004). This supports a theory that budget decisions could positively or negatively influence the adoption of policies by government agencies.

Budget theory has not yet addressed the discrepancy between the budgeting process and policy outcomes when fiscal policy is highly fragmented as it is in the LTC service sector. Hackbart and Ramsey state that the theories of public sector budgeting, for the most part, examine budgets from a one government perspective (2002). Through fiscal federalism, state and local governments can receive federal funding to provide the services that are best provided at their respective levels. They argue that "the optimal government organization for achieving the allocative function would be one whereby goods are allocated by the level of government that best represents the beneficiaries of the consumption of the good" (185). This is relevant when considering the highly varied environments in which policies are implemented. However, this argument only looks at the vertical, not the horizontal nature of our federalist system and the

interconnectedness of the independent government institutions. Examining the LTC funding sources at the state-level and how they combine to provide for all LTC services may be a way of investigating if they impact state policy design decisions. This literature on state policy determinants and the specific theoretical and empirical studies that have been conducted in human service delivery networks leads to important questions regarding the integration of aging and disability services in the U.S.

Research Question

Knowing how states may choose to implement network arrangements, it is important to understand when there is variance in the implementation and why that variance occurs. When federally funded grant programs requiring collaboration are designed and implemented, why do states choose different network arrangements? Combining the state determinant research as a theory of explanation, this paper answers these questions in the context of the aging and disability service networks in the United States. This study investigated the following question: What factors influence state adoption of varying network arrangements where there are federal grants that are present?

The following chapter explains the methodology used to investigate the research questions. It contains a description of the variables used to operationalize the key concepts of ADRC: collaborative network design, fragmentation of policy decision making, state commitment to public welfare spending, and state long-term care infrastructure.

Chapter 3: Methodology

This chapter reports the methodological choices used to investigate the main research question of interest: What factors influence state adoption of varying network arrangements, when presented with federal grant incentives? The chapter then explains the variables used to operationalize the four major concepts of ADRC: collaborative network design, fragmentation of policy decision making, state commitment to public welfare spending and state long-term care infrastructure. It concludes with descriptive statistics on the variables used in the analysis.

To investigate which factors influence state adoption of varying network arrangements, this study analyzed the policy adoption of the Aging and Disability Resource Center grant by all fifty states. The ADRC grant called for a coordinated referral system that would provide citizens of each state with comprehensive long-term care (LTC) options. This study drew on the existing literature of state determinants to control for political, economic and social factors that could influence the design adoption. From an organizational perspective, this study sought to answer whether the state government structure of aging and disability agencies influences ADRC program design adoption. From a budgetary perspective, this study sought to answer whether long-term care budgetary decisions made by state policy makers influenced the ADRC program design adoption.

The following questions and hypotheses are drawn from the above research question: Question 1: Does the bureaucratic arrangement of state aging and disability agencies influence the adoption of coordinated referral systems?

The ADRC program most closely resembles Provan and Kenis' (2008) lead organization governed model because the grant is issued solely to the state unit on aging in each state. How fragmented the aging and disability services are within that state would influence the network integration and coordination (Provan and Milward 1995). Since they assert that centralization facilitates coordination, then this study assumes that there is be a negative relationship between fragmentation of policy decisions and a centralized model of governance. This study tested if the bureaucratic separation or siloed nature of aging and disability agencies within state government influenced the choice of centralized model of governance as well as adoption of additional network control mechanisms.

Question 2: Does a state's financing for public welfare programs influence the adoption of coordinated referral systems?

Question 3: Does the pattern of state's long-term care infrastructure influence the adoption of coordinated referral systems?

Miller's (2005) research supports the supply and demand factors of infrastructure building. Just as Medicare home health spending had a positive relationship to the availability of home health agencies, likewise state spending on public welfare, and specifically long-term care, could have a relationship to LTC infrastructure or capacity. Without an infrastructure of balanced LTC options, the state ADRC programs have little incentive to consolidate information and referral services. The specific state commitment to public welfare programs and balancing long-term care spending is therefore considered a determinant of the adoption of differing approaches to the ADRC program. Other factors that could indicate the level of LTC infrastructure available in each state were; number of facility beds and number of home health organizations within each state (Miller 2005).

The following hypotheses are therefore drawn from these underlying theories:

H1: A state will be more likely to adopt a decentralized model or no wrong door model, when the SUA is housed with other state long-term care entities.

H2: A state will be more likely to adopt a decentralized model or no wrong door approach, when there is a lower level of spending for public welfare, all else being equal.

H3: A state will be more likely to adopt a decentralized model or no wrong door approach, when there is a higher level of HCBS infrastructure, all else being equal.

H4: A state will be more likely to adopt higher level of integrated program design, when the SUA is housed with other state long-term care entities, all else being equal.

H5: A state will be more likely to adopt higher level of integrated program design, when there is a higher level of spending for public welfare, all else being equal.

H6: A state will be more likely to adopt higher level of integrated program design, when there is a higher level of HCBS infrastructure, all else being equal.

Research Design

This research employed a mixed methods approach using a state-level unit of analysis. This approach is commonly used in applied research of this type (Brown and Hale 2014). A retrospective cross-sectional analysis is conducted of secondary data. This is complimented by a qualitative analysis from primary interview data collected from ADRC program directors in a sample of states.

Quantitative Analysis

The quantitative stage of this study measured the effect of several independent variables on ADRC program adoption. The independent variables measured include public welfare spending, long-term care infrastructure, and organizational structure. Data for the dependent

variable was collected using quantitative content analysis of the ADRC Technical Assistance Exchange website that was created by the U.S. Administration on Community Living. This stage controlled for the specific state determinants of gubernatorial party, voter turnout in 2004, legislative professionalism, state fiscal health, median household income, percentage of population over 65, percentage of nonwhite population, and the percentage of population living in rural areas.

Operationalization and Measurement

The principle concepts used in this study were: 1) program design, 2) public welfare, 3) long-term care infrastructure, and 4) bureaucratic structure.

Dependent Variables

The dependent variable was ADRC Program Design. The data for this variable was collected through content analysis of state ADRC programs as reported on the ADRC Technical Assistance Exchange (TAE). The TAE is a semi-public website where all SUAs report their program design and post yearly program reports and best practices. State program design data is available to the public. The TAE is a self-reporting program and therefore there are some limits to the validity of the data collected. Program managers may exaggerate the aggressiveness of their program efforts to make their state program look better, or they may under-report the program design to minimize the expectations of the CMS. Also, program managers may simply be mistaken in their understanding of program element definitions (i.e. labeling their program as a Single-Point of Entry when in actuality it is a "no wrong door" approach). However, since all reporting data collected on the ADRC program is self-reported and these data are available for all 50 states, this is the most reliable data source available on ADRC program design for the entire United States.

Conceptual Elements from Content Analysis

State ADRC programs indicated similar type models of coordinated referral systems. These models are identified by state programs within the parameters of two main approaches: the single-point of entry and the no wrong door models. In addition, there were similar types of program tools that were adopted as mechanisms for information sharing among network participants. These program tools focused on integrating aging and disability networks and were labeled into three categories: virtual or online resource database (AKA Virtual ADRC), single or standardized assessment tool, and decentralized eligibility determination for programs. These models and tools are not uncommon to collaborative programs. Each is defined and discussed in terms of the available literature in the following sections.

Single-Point of Entry (SPE)

The single-point of entry is often referred to as the "front door" of social services (Reed 2012). It is a program design element that allows consumers to enter the system through one organization. This point agency coordinates with all other organizations within the system to provide consumers with information on services and eligibility. It is a key aspect of the one-stop shop approach.

No Wrong Door Approach (NWD)

The "no wrong door" approach depends highly on the coordination of network participants. This program design element calls for a high-level of information sharing so that no matter where the consumer enters the system, they receive the same comprehensive information on services and eligibility.

Virtual or Online Resource Database

The virtual ADRC is a program design element that assists both consumers and network participants in the sharing of information. Virtual ADRCs utilize online technology to provide consumers and network participants with a database of all other providers within the network. Many virtual ADRCs have screening tools and allow for online eligibility determination. Most virtual ADRCs are state-run and provide soft referrals for clients who utilize the prescreening tools.

The ADRC program seeks to coordinate agencies to provide consumers with all LTC options in their respective areas. This establishes a need for the use of technology by professionals as well as the public. Aside from Shelley Ii and Auh (2008), there has not been any research of the effective use of the ADRC's online component. The authors research the "user e-readiness and the usefulness and impact of e-government approaches to providing information and referral services on aging and disability to support community-based care options and LTC planning" (1).

The SUA have incorporated various modes of technology into their ADRC program design. Some ADRCs have no independent website for consumers but information on the program is provided on the SUA's website. Others have created their own independent sites with information on services, assessment forms, contact forms, and enrollment capabilities. Some state ADRCs have either partnered with other departments or been incorporated into one state "gateway" portal. This study examined the use of technology for sharing information among professionals.

Single Assessment Tool

A single assessment tool is a program design element that is used by all providers in the service network. This assessment tool is used to assist providers in determining consumer needs

and eligibility. A single assessment tool used by all network participants indicates that participants have shared eligibility criteria as well as program specific information with multiple network partners. This sharing of assessment information provides for a more coordinated referral because partner organizations have a built-in level of trust that organizations within the network are competent in referring clients that will in fact be eligible for services.

Decentralized Eligibility Determination

Decentralized eligibility determination requires a high-level of trust and information sharing among agencies. It is defined as the ability of multiple agencies to screen for and determine the eligibility of consumers for services provided by another agency. This is mostly utilized by state agencies that screen clients for Medicaid funded services but can also be applied to consumers applying for Medicaid as well as being screened and approved for disability or aging services.

Each program design element is considered by CMS as an innovative element and draws from previous innovation grants (Administration on Community Living 2015). All states chose to adopt either a SPE or a NWD model. In addition, some states chose to implement additional information sharing tools. These tools indicate a level of coordination with other long-term care entities within their state. Table 3.1 illustrates each model and the tools adopted by each state.

[Insert Table 3.1 about here]

The table categorizes states as either a single point of entry (centralized) or a no wrong door (decentralized) model. Within these models, states chose to adopt programmatic tools that increased the integration of the network. These tools included decentralized eligibility determination, a single assessment or intake tool, and a virtual or e-government web portal.

States also adopted an overall model but did not choose to adopt any of the integration tools. This category is designated as ‘none’.

This typology creates two dependent variables that were tested in this study. The first dependent variable is a binary variable of program model and is indicative of the adoption of either the no wrong door or the single point of entry model. This variable was coded 1 for no wrong door and 0 for single point of entry. The second dependent variable that was tested is an ordinal variable of level of integration. This variable range is 1-8 with 1 being the least integrated and 8 being the most integrated. Figure 3.1 shows the levels of integration and where each category from Table 3.1 falls within this scale.

[Insert Figure 3.1 about here]

Categories 1 through 4 represent states that chose the overall single point of entry (SPE) model. Category 1 states chose a SPE model but did not select any additional integration tools. Category 2 states chose a SPE and a virtual portal (VP). Category 3 states chose a SPE and a single assessment tool (SAT). Category 4 states chose a SPE and a decentralized eligibility determination (DED). Categories 5-8 represent states that chose the overall no wrong door model (NWD). Category 5 states chose the NWD model but did no select any additional integration tools. Category 6 states chose a NWD and a VP. Category 7 states chose a NWD and a SAT. Category 8 states chose a NWD and a DED. The analysis coded these categories 1-8. The following sections lay out the explanatory variables of interest in this study. All observed explanatory variables that were tested in this study, along with data sources, are summarized in Table 3.2 below.

[Insert Table 3.2 about here]

Bureaucratic Structure

Data on the bureaucratic structure of state long-term care systems was coded using the state plan on aging for the time frame of 2003-2008. The ADRC program is administered by the state units on aging (SUAs); therefore, the placement of the SUAs within the state bureaucratic structure was the focal point of this variable. States are categorized based on three factors: was the SUA a standalone department within the state government; was the SUA a division of a larger state department; and was the state disability agency housed in the same state department as the SUA? Using these factors, there are five possible bureaucratic arrangements that were found to be mutually exclusive and exhaustive categories. These categories are listed below in Table 3.3.

[Insert Table 3.3 about here]

The categories express the SUA's proximity to other state level long-term care entities. Category 1 indicates that the SUA was a standalone state department. This is typically cabinet-level position and the director is appointed by the governor of the state. This category also indicates that the SUA was responsible for administering some disability funding. This is usually done through the Elderly and Disabled Waiver program. Category 2 indicates that the SUA was a division of a larger state agency and has a close bureaucratic connection to other key state long-term care entities, including the state Medicaid agency and other state disability agencies, such as Developmental Disabilities, Mental Health, and Rehabilitation Services. This category also indicates if the SUA was responsible for administering disability funding. Category 3 indicates that the SUA was a division of a larger state agency and has a bureaucratic connection to the state disability agency with the added responsibility of administering some disability funding. Category 4 indicates that the SUA was a division of a larger state agency and has a bureaucratic connection with the state Medicaid agency. Category 5 indicates that the SUA was a division of

a larger state agency; however, it more closely resembles a standalone SUA because it is not housed with Medicaid or other state long-term care entities. These categories were coded 1-5.

This variable was also recoded into two binary variables that group states more generally in terms of the three main factors of interest: if the SUA was a standalone, a division of a larger state agency, or housed with Medicaid. These two binary variables are: Government Structure One (GOVSTR1), which will indicate if a SUA was a standalone state agency or if it was a division of a larger agency and Government Structure Two (GOVSTR2), which will indicate if a SUA was housed with Medicaid or not. GOVSTR1 was coded 1 if the SUA was a division of larger state agency and 0 if it was a standalone state agency. GOVSTR2 was coded 1 if the SUA was housed with Medicaid and 0 if it was not.

Public Welfare Spending

This study used public welfare spending data for all 50 states from the Census of State and Local Governments for 2005 through 2008. This study calculated the state spending on public welfare per every $1000 of person's income. This was based on the model used by Creek and Yoder (2012). Creek and Yoder's (2012) study found that state commitment to public welfare spending was a predictor of earlier adoption of cooperative agreements.

Long-term care infrastructure

The long-term care infrastructure variable was comprised of three separate measures. It is operationalized first using LTC spending data. Data on long-term care spending was obtained from the Federal Medicaid Agency and the Administration on Community Living (ACL). This data represents budgeting decisions made by the Center for Medicare and Medicaid Services (CMS) as well as the ACL. Although these two agencies are under the umbrella of the U.S. Department of Health and Human Services, the administration of program funding is

considerably different. Medicaid provides for state discretion on issues of services provided as well as eligibility determination. The Older American Act funds are categorical grants with specific requirements and little state variance on services.

Medicaid expenditures are compiled from the MBES/CBES reporting system, which is an automated system that states use to report itemized spending for Medicaid services. The CMS has multiple auditing programs to help prevent fraud due to overpayments to providers and state reporting. Some of these programs include regular yearly state audits by CMS, the Recovery Audit Program, and the Medicaid Integrity Program (Center for Medicare and Medicaid Services 2014). The data used to calculate long-term care spending is collected by the same reporting procedures for each state, with guidance from CMS as to how to categorize all types of payments to providers. It is therefore, a reasonably reliable measure of state expenditures for LTC programs when combined with Older American Act spending.

Form CMS-64 requires states to group expenditures into service categories. Table 3.4 contains the service category definitions and these are grouped by their care settings.

[Insert Table 3.4 about here]

A complete list of all categories and their service definitions is found on CMS.Gov. From these service types, this study utilized all categories that provide any form of LTC. This study adopted the more comprehensive definition of LTC provided by the National Association of State Units on Aging and Disability (NASUAD). This definition of LTC is used by CMS, AoA, and the ADRC program. It states that LTC is:

> Range of medical and/or social services designed to help people who have disabilities or chronic care needs. Services may be short-term or long-term and may be provided in a person's home, in the community, or in residential facilities (National Association of State Units on Aging and Disability 2014).

Using the above definition, the following service categories were identified as providing a form of LTC based on the CMS service definitions: mental health facility services, nursing facility services, intermediate care facility services, home health services, home and community-based waiver services, all-inclusive elderly, personal care services, case management, primary care case management, and hospice services.

Mental health facility services are those services provided to persons 65 and older or under 21 in an accredited institution for mental illness. Nursing facility services are those services provided to residents of skilled nursing facilities on a regular basis and can include rehabilitation services. Intermediate care facility services are health and rehabilitation services provided in an institution for persons with mental retardation or related conditions. Home health services are medical services provided to patients in their homes, in compliance with a doctor's plan of care instructions and is provided by a home health agency or registered nurse. Personal care services are provided to individuals in their homes according to a doctor's prescribed plan of care. Case management is services that assist individuals with access to medical, social, educational, and/or other services. Form CMS-64 separates case management into three types: targeted, statewide, and primary care. Targeted case management is for individuals who are members of specific classes or live in specified areas. Statewide case management is for all others who are not classified under targeted; however, each state may set its own specific eligibility requirements for these services, which may include geographic location or other group designation. Primary care case management is performed under a contract within some states by a private provider. For the purpose of this study, all case management expenditures were grouped into one category, designated as case management. Hospice benefits are services

provided to persons that are terminally ill. These services can be provided in an institutional or community environment.

Other services that could be considered within the NASUAD definition of LTC are physician services, in-patient hospital services, outpatient hospital services, and prescription drugs. However, these categories cannot be differentiated between LTC spending and general health care spending and therefore were not included in this analysis.

The Older American Act spending is reported to the ACL and this data is available through the AGing Integrated Database (AGID). This database consists of several reports, as well as census data for comparison purposes. The State Program Reports are the main system of reporting of state Older Americans Act (OAA) programs. This includes supportive services, nutrition, caregiver support, and other services specific for each state. This report is ideal for this study because it includes what funding is expended by the state on each type of program service. This provides a more comprehensive variable of long-term care spending since all Older American Act funding is considered HCBS.

Data for the state reports are collected annually through the State Reporting Tool (SRT) web portal. These reports undergo "multiple data checks for consistency, including multi-year comparison reports that are reviewed by AoA and state staff. The states certify the accuracy of their data once review procedures are complete." (Administration on Community Living 2014)

The Medicaid service categories and OAA spending are grouped into two categories: institutional care and Home and Community Based Care Options (HCBCO). Institutional care included expenditures in three Medicaid service categories: mental health facility, nursing facility, and intermediate care facilities. HCBCO included expenditures from the remaining seven service categories: home health services, home and community-based waiver services, all-

inclusive elderly, personal care services, case management, primary care case management, hospice services, and all OAA expenditures.

These data were compiled into one dataset to provide a continuous independent variable to test against the dependent variable of Program Design. These data provided a ratio of institutional versus community-based expenditures. States that spent a higher percentage of their LTC expenditures on institutional care were viewed as having a higher-level of institutional spending and vice versa.

To examine the true nature of state LTC infrastructure, this study incorporated two additional measures of LTC capacity by including the number of skilled nursing facility (SNF) beds and the number of home health organizations that were licensed or certified in 2000 and 2002 per capita. The number of SNF was compiled from data available through the Centers for Disease Control and Prevention Trend Tables. The number of home health organizations established in 2002 was compiled from data obtained from the 2002 Economic Census through the U.S. Census Bureau. Per capita figures were calculated using U.S. Census data.

Control Variables

Previous studies have shown that state-specific political, economic and social factors can influence the adoption of innovative programs (Berry and Berry 1990, Mooney and Lee 1995). To isolate the independent variables and measure the effect size on the dependent variable, this study controlled for political, economic, and social factors (Table 3.5) that may have influenced the adoption of the policy tools within the ADRC coordinated referral systems.

[Insert Table 3.5 about here]

Political factors included the gubernatorial party for 2004, voter turnout in 2004, and level of legislative professionalism. Gubernatorial party was coded 1 for Democrat and 0 for

Republican, according to data from the National Governors Association. Data on voter turnout for the presidential election in 2004 was obtained from the U.S. Census Bureau's Statistical Abstract of 2006. And finally, Squire's 2003 Index of Legislative Professionalism was used to measure legislative professionalism.

Economic factors, included as control variables, were median income and state government fiscal health. Both measures were obtained from U.S. Census data. The social factors included in this study were: percentage of population over the age of 65, percentage of population in rural areas, and percentage of population that are non-white. This study used 2000 Census and the 2001 Census of State and Local Government data for all of social and economic measures. Appendix A contains a full table of dependent, explanatory and control variables used in this study, along with specific sources for each as well as the timeframes used.

Analysis

When analyzing categorical dependent variables, a logistical regression model is typically used that is consistent with the properties of the variable. This study consists of two categorical dependent variables. One was the binary variable of the overall ADRC program model and the second was the ordinal variable of the level of ADRC integration. Therefore, a binary logistical regression and an ordinal logit model were conducted to test the significance of the independent and control variables. Prior to this analysis, to assess the existence of multicollinearity, a pairwise correlation was conducted. Variables were then tested using a bivariate and then a multivariate analysis.

After the quantitative analysis was completed, the qualitative research was conducted. The following sections discuss the methodology utilized in conducting the remainder of this research project.

Qualitative Analysis

The second stage of this research was a qualitative analysis of interviews conducted with state ADRC program leaders. Rubin and Rubin (1995) state that qualitative interviewing can lead to a deeper understanding of experiences and help the researcher to "reconstruct events" after they have happened (1). These interviews provided an opportunity to understand not only details of the program design that may not have been captured by content analysis of the TAE, but also the evolution of the program from the beginning of the grant period. Some data may not have been included in the TAE reports that may lead to a different typology than the one developed for this study. The interviews sought for a better understand the relationships between the different LTC decision makers in the state, how they interact now and how it may have changed over time.

This stage collected primary data using semi-structured interviews conducted with state program directors in these sample states. The sample was chosen based on systematic sampling from each of the dependent variable categories. If available, two states from each category were selected. Selection of these states invited to participate was influenced by their regional location. Table 3.6 below lists the categories of program design and the sample states selected to participate. It also indicates which states declined or did not respond to the invitation to participate.

[Insert Table 3.6 about here]

From the eight categories of program design, two states were chosen from each of the dependent variable categories and then prioritized based on the geographic location. The regional classification that was used was that of the Administration on Community Living and the Centers

for Medicare and Medicaid Services. Within this scheme, states are grouped into 10 regions. Figure 3.2 below shows the states within each region as well as the sample states selected.

[Insert Figure 3.2 about here]

Invitations were sent to the selected sample states through email. Initially, ten states replied that they would participate. Follow-up emails were sent to the remaining six states that had not responded and four additional states replied affirmatively. The remaining two states were called and personally invited to participate, however, one state, Oklahoma, declined. Based on the research design, an additional state was chosen from the same category and contacted via email with the same original invitation. Oklahoma was in a category with only two other states so there was only one state, New Jersey that had not previously been invited to participate. New Jersey did not respond to the email invitation and did not respond to a phone message left on the ADRC coordinator's voice mail.

Recruitment and interviews were conducted simultaneously, depending on receipt of agreement to participate and the respondent's schedule. Interviews commenced in January 2015. It was stated by several respondents that Georgia's ADRC program had provided technical assistance to many states; therefore, Georgia was invited to participate on the basis that their program was influential and important to the overall understanding of program design implementation. This provided for the original sample size of 16 states.

When states responded affirmatively to the email invitation, an informed consent form was mailed or emailed to the respondent. After receipt of the signed consent form, an interview time was scheduled with the ADRC program director or grant manager. Interviews were scheduled to accommodate the program director's schedule. Interviews were conducted over the phone and recorded for transcription and later analysis. All interviews were conducted in

confidentiality and therefore, any state identifiers connected to data that were collected during the interview will be omitted from this document. States responses are reported based on a randomly assigned code.

Duration of the interview was from 30 minutes to an hour and 15 minutes. The respondent and their title varied depending on where the ADRC program was administered within the state bureaucratic structure and whether the position was currently occupied or vacant. In cases where the position was vacant or more recently filled, the interview was conducted with the supervisor and in some cases the new employee and the supervisor. The background and experience of the respondent varied from only a few months on the job to more than 20 years. In addition, some respondents had a wide array of experience in multiple disciplines including mental health, developmental disability, substance abuse, aging, and clinical social work.

The respondents worked on the ADRC for varying lengths and this influenced the quality of data that was available. In some cases, data was lost due to staff turnover or from the movement of the ADRC grant from one grantee agency to another. In general, the ADRC grant was awarded to the state unit on aging within each state. However in some cases, the initial grant was awarded to an outside organization, such as a state university or nonprofit. In these cases, very little information regarding the implementation of the original grant was retained.

Interview Instrument

The development of the interview instrument began with a series of key areas of interest: aging and disability resource grant processes, organizational information, home and community-based services, national perspectives, and strengths and weaknesses. Each became a section of the interview and questions were developed around each. The interview was piloted with Ms. Julie Miller, Programs Division Chief for the Alabama Department of Senior Services. Ms.

Miller has had over thirty years of professional experience working in the field of aging and disability and is currently responsible for the administration of all federal and state aging programs in Alabama.

From the pilot interview, several key issues were identified as important in the development of the ADRC. Questions were added to address the involvement of state agencies in the ADRC decision making process. The final interview instrument is attached as Appendix B. Institutional Review Board approval was then applied for and granted in December 2014.

The interview questions began with the grant processes section, which examined the overall program design and how it developed or evolved over the course of implementation. The organizational information section examined the type of relationship that SUA's have with other long-term care entities at the state and local-level. The home and community-based services section looks at the availability of non-institutional LTC services within the state and the availability of state funding for these services. The national perspective section examined the impact of other state ADRC program designs on the sample states as well as if there were any national conferences or national organizations that provided information and training on ADRC program designs. The final section examined, from the state coordinator's perspective, the ADRC program design's strengths and weaknesses as well as any lessons that were learned.

At the beginning of each interview, the interviewer asked if the respondent had any questions regarding the study, particularly those related to its use and the overall confidentiality of information collected. If questions were presented, they were answered. The respondent was then asked about their professional background, including their experience in the ADRC program and other aging and disability programs. They were then asked to describe the ADRC program in their state in their own words.

From these initial questions, specific questions regarding tools used and developed, such as an online database, standardized assessment, eligibility determination procedures, and marketing, were discussed. In some cases, this information was consistent with that which was reported on the ADRC Technical Assistance Exchange website. In most cases, however, this information differed significantly from what had been reported. In one case in particular, the respondent stated that the information on the TAE website was outdated and that their state had intended to update that information for some time.

In addition to the preplanned questions on Appendix B, most states indicated that they had some form of advisory council for the ADRC program. If this was not mentioned during the initial description of the state ADRC program, the second set of interview questions regarding the state structure and relationship of state aging and disability programs fostered the discussion of these councils or partnerships. The inclusion of different partners within these councils and whether they originated at the state or the local/regional level became the primary focus of most interviews. The issue of leadership from a state perspective and in some cases from a national perspective was brought up repeatedly by the respondents. This concept will be discussed at length in the following analysis section.

The national perspective section of the interview questions did not reveal much state to state collaboration that was independent of federal efforts. All states indicated that they had participated in the Home and Community Based Service conference in Washington, DC annually. This conference is sponsored by the National Association of States United for Aging and Disability (NASUAD). This conference "includes federal, state, and local policymakers and those who administer, manage and deliver waiver and other HCBS programs" (National Association of State Units on Aging and Disabilities 2015). Initial grantee conferences were also

arranged by ACL during the first years of the ADRC grant. Several states indicated issues with budget constraints, which consequently restricted opportunities for travel. States that have received additional grants since the initial ADRC and ADRC Expansion grants have had the opportunity to participate in monthly conference calls and webinars with other states. Most states indicated that although they valued the opportunity to see and hear about what other states were doing, what works in one state may indeed work well for it but would not work in their own unique situation.

The additional grants that states received, since the ADRC and ADRC Expansion grants were awarded, have had in impact on many state ADRC designs. This was not part of the focus of this research; however, it became apparent through the responses that this was a key factor in evaluating the ADRC program today, versus the initial design. More about these grants will be discussed in Chapter 5 because of their tie into the responses to the ADRC strengths, weaknesses, and lessons learned portion of the interviews.

When each interview was concluded, the respondent was thanked for his or her participation and told that if he or she had any questions in the future regarding the interview or the research project in general, he or she could contact the principal investigator or the faculty advisory. The interview was then concluded. Each interview was then transcribed from an audio file to an electronic word document.

Per the research design, the researcher conducted a systematic qualitative content analysis was conducted in line with Patton's (1990) guide to qualitative analysis of interview data. The process for analysis was to label relevant pieces, code for the most important concepts discussed, create categories, and then examine trends and relationships between these categories (Cho and

Lee 2014). This method is most appropriate since the researcher has already formed a theory according to both the literature and her descriptive analysis of the program.

This chapter detailed the methodology used to conduct a mixed methods investigation of ADRC program in all 50 states. The following chapter reviews the initial findings of this two staged research.

Chapter 4: Findings

This chapter explains the findings of the descriptive statistics on the variable of interest as well as the two statistical models that were used to test the hypotheses. This is followed by the qualitative findings from the 16 interviews conducted with ADRC state program managers.

Summary of Descriptive Statistics

This statistical analysis will begin with basic techniques to summarize the variables of interest and show the frequency of occurrence in all 50 states. Initial analysis of proportional distribution of the ADRC program model and level of integration is shown in Table 4.1.

[Insert Table 4.1 about here]

The results show that the ADRC program model variable was only slightly skewed. Whereas 42% of states chose to adopt the more decentralized model of the NWD, a majority of 58% chose the SPE model.

The government structure variables were assessed to examine the proportional distribution as well. Table 4.2 below shows the five categories of state structural arrangements for their state units on aging (SUAs).

[Insert Table 4.2 about here]

38% of all states house their SUAs in a separate standalone state agency, typically as a cabinet-level position that has a director appointed by the governor. That means that the remaining 62% or 31 states house their SUAs within a larger state department. These divisions have been categorized to distinguish whether or not they are housed with other LTC funding sources, such

as disability agencies or Medicaid. Category 4 is the largest of these with 30% of all SUAs being housed with Medicaid as a sister division without other disability services.

Additional summary statistics were performed on the recoded binary variables measuring the broader category of government structure. Table 4.3 below shows the results of the initial summary statistics on these variables.

[Insert Table 4.3 about here]

The distribution is based on the binary categories derived from the original government structure variable. The government structure (1) distribution indicates that the majority (62%) of state units on aging were housed within a larger state agency. The government structure (2) distribution indicates that slightly more than half of the state units on aging are housed with Medicaid.

State spending for general welfare and LTC was measured using a percentage. Public welfare was assessed as the amount of spending for public welfare to that of the total state budget. The percentage of public welfare spending on average decreased from 2005 to 2008 by approximately 1%.

The institutional spending variable was likewise coded as the percentage of institutional spending to that of all long-term care spending. The descriptive analysis of this variable is presented in Table 4.4.

[Insert Table 4.4 about here]

The amount of institutional spending decreased on average by 3.6% from 2005 to 2008. The shift could be the result of state efforts to rebalance the long-term care spending to provide for greater home and community-based care as well as greater fiscal pressure on state budgets at the

time. During the same time frame, the amount of public welfare spending on average declined by 1.04%.

Following this initial analysis of the independent and dependent variables, a correlation model of all variables was run to identify strong relationships between variables that could lead to multicollinearity in the models. Table 4.5 below shows the results of the analysis.

[Insert Table 4.5 about here]

This test indicated several statistically significant relationships between variables. The changes in public welfare spending and level of legislative professionalism were shown to be positively related to a state's adoption of the NWD or decentralized model. The number of SNF and home health organizations as well as the state unit on aging being housed with the state Medicaid agency, was shown to be positively related to the change in public welfare spending. The number of skilled nursing facilities was also positively related to the control variable of voter turnout. Several of the control variables indicated a statistically significant relationship. Most of these relationships were previously established in the literature.

Based on this initial testing several variables were not included in the bi-variate logistical analysis. Both the institutional and the public welfare spending change variables were kept; however, the percentage of spending for 2005 was dropped to reduce multicollinearity. Likewise, the number of home health organizations were dropped due to the relationship with the number of skilled nursing facilities and the institutional spending variable. The following section will report the findings of the bi-variate analysis of all independent and control variables on the binary and ordinal dependent variables.

Bivariate Analysis of ADRC Model

The first step was to run a series of bivariate logistical regressions that used the overall ADRC model of NWD as the dependent variable. The following hypotheses were tested:

H1: A state will be more likely to adopt a decentralized model or no wrong door model, when the SUA is housed with other state long-term care entities.

H2: A state will be more likely to adopt a decentralized model or no wrong door approach, when there is a lower level of spending for public welfare, all else being equal.

H3: A state will be more likely to adopt a decentralized model or no wrong door approach, when there is a higher level of HCBS infrastructure, all else being equal.

The regression model predicts the logit, or the natural log of the odds of having made the decision to adopt the NWD model; therefore, the predicted probability of the event is coded 1 for NWD. This model was constructed by an iterative maximum likelihood procedure using STATA. A bi-variate analysis was conducted first with each of the variables of interest against the dependent variables. The results for the testing of all explanatory variables against the ADRC program choice is presented in Table 4.6.

[Insert Table 4.6 about here]

Of the variables of interest, only the change in welfare spending from 2005-2008 was found to be significant at a .10 level of statistical significance. These results indicate for every percentage increase in public welfare spending, a state was 3.49 times more likely to adopt a decentralized NWD model for their ADRC program.

Table 4.7 shows the similar result for all control variables. As was indicated by the correlation test, the legislative index developed by Squire (2003) shows a positive relationship to the state adoption of the decentralized ADRC model.

[Insert Table 4.7 about here]

Multivariate Analysis of ADRC Model

A multivariate model was then performed using change in institutional spending, skilled nursing facilities per capita, change in welfare spending, the division of a larger state agency (GOVSTR1), and all control variables. Table 4.8 displays the result of this analysis.

[Insert Table 4.8 about here]

This analysis indicates that contrary to the hypotheses, there is no statistical relationship between the change in institutional spending and the number of skilled nursing facilities per capita and the state choice to adopt a NWD model. These two variables were utilized to measure the long-term care infrastructure of the state. Both were indicators of state reliance on long-term care institutions. This was shown to be unrelated to the decentralized or centralized choice presented to the states through the ADRC grant.

Likewise, the other two explanatory variables; change in welfare spending and the state unit on aging's placement within the state bureaucratic structure, were both found to be unrelated to the choice of a NWD model. Because of these findings, the null hypotheses are accepted for H1 through H3.

The only significantly related factor found within this model was the level of legislative professional. This variable was shown to be statistically significant at the .05 level. This indicates a positive relationship between these variables. For one unit increase in the legislative professionalism index, the state was a 3.26 time more likely to choose a NWD model for their ADRC program.

The logistical regression model above has a Chi-square value of 0.0809, which indicates that this model is a poor fit. This model included many variables that were found through the bi-variate analysis to have no statistical significance and could be excluded to produce a better

fitness level. The Pseudo R2 demonstrates that this model explains 28% of the variance in the dependent variable. This means that there are additional factors, not yet explained.

Bivariate Analysis of Level of Integration

The final statistical test used is an ordinal logistical regression model that tests the significance of all explanatory variables on the categorical ADRCINT. This model will test the following hypotheses:

H4: A state will be more likely to adopt higher level of integrated program design, when the SUA is housed with other state long-term care entities, all else being equal.

H5: A state will be more likely to adopt higher level of integrated program design, when there is a higher level of spending for public welfare, all else being equal.

H6: A state will be more likely to adopt higher level of integrated program design, when there is a higher level of HCBS infrastructure, all else being equal.

For the probability of overall ADRC program design selection based on the independent and control variables, a bi-variate model was conducted on each variable. The results for the testing of all explanatory variables against the ADRC program choice is presented in Table 4.9.

[Insert Table 4.9 about here]

This model determined that the change in institutional spending was statistically significant at the .10 level. The odds ratio for this indicates that a positive change in institutional spending slightly decreases the odds of selecting a higher-level of integration model by .0001 times.

The bivariate analysis was then conducted on each of the control variables. The results are displayed in Table 4.10.

[Insert Table 4.10 about here]

The model demonstrated that the change in state fiscal health from 2005 to 2008 was significantly related to the level, at the .05 level. A multivariate model was then performed with all explanatory variables and control variables. The results are displayed in Table 4.11.

[Insert Table 4.11 about here]

The multivariate model has a chi-square of .0206, indicating a good fit for this model. The Pseudo R2 was .1789, indicating that this model explains only 17% of the change in the dependent variable. Two variables in this model were found to be significantly related to the state adoption of a more integrated model, legislative professionalism and the change in fiscal health. Both had a negative relationship with the level of integration.

The state government structure variable showed no statistical significance; therefore, the null hypothesis for H4 is accepted. The state welfare spending variable showed no statistical significance; therefore, the null hypothesis for H5 is accepted. Using the state's change in institutional spending and the number of SNF beds per capita, the state's LTC infrastructure was shown to be unrelated to the level of integration; therefore, the null hypothesis for H6 was accepted.

These results were unexpected, given the literature surrounding the influence of these factors on policy adoption. Many of the control variables, which had been previously tested in public service delivery networks, were also found to be unrelated in this case. The qualitative portion of this research sheds some light on why these findings were in contrast to the hypothesized statements.

Interviews with State Program Personnel

After the quantitative analysis, the sample states were chosen from the categories of program design used in the qualitative analysis testing. This section reports the initial findings from the systematic content analysis of the transcribed interview data.

Findings

Throughout the interview process, certain concepts were consistently repeated by states that participated. Although the sample states varied in great degree, there were similarities that present interesting new variables in assessing state program design. These concepts focused on where states housed their ADRCs, how they first envisioned the ADRC to function, the changes and adaptations to the program, and the formal and informational relationships with the other LTC entities within their respective states.

Each of these concepts had some connection to what respondents believed to be the most effective element of their ADRC program design, what challenges they faced, or the important lessons learned in implementing the grant. The states' respondents expressed generalized impressions of how effective their ADRC program was at providing the ACL core functions, or how well the state was doing at implementing the grant. The challenges focused on either new developments to the program or long-standing problems that have been present since the initial grant. The lessons learned varied in their importance to the respondents and generally corresponded to their overall feelings toward the program. Each of these concepts will be described and a table of responses will be given to illustrate them. In addition, the connections between these concepts will be explored for significant trends.

First Steps/First Vision to ADRCs

In 2003, the Administration on Community Living awarded 12 grants to states to implement the ADRC program. These states had core objectives or standards set by ACL;

however, ACL allowed for discretion in design of the ADRC program by the SUA. States generally saw their ADRCs as either a single-point of entry model or a no wrong door model. Although the first vision, in many states, evolved through the implementation process or through the awarding of expansion grants, this first look shows how differently states saw the function of the ADRC.

Appendix D shows the responses of the sample states to the overall program design question, focusing on the first vision of program design and/or the first steps to implementation of that ADRC vision. The majority of states within the sample chose to designate pilot sites or test sites that would be the start of the ADRC program. Many of these state's first steps were driven logically by their vision of what the ADRCs were meant to be. However, as indicated by the quantitative analysis of this paper, not all states that had the same overall vision chose to adopt the same program tools.

The initial steps varied from defining what an ADRC would do or how it would look different from an AAA, to creating online, e-government tools for consumers as well as professionals. Other tools included standardized intake and/or assessment forms, client tracking systems, toll-free numbers with geolocation capabilities, training materials for ADRC staff or staff of other LTC agencies, marketing tools that would establish a recognizable brand for the consumer, and advisory councils. Of the sample states, only two indicated that an initial step was to form a group of stakeholders to advise the ADRC program. Neither of these two states indicated a process of defining the functions of an ADRC. Many of these initial steps and tools that were adopted were omitted from the overall program description provided by states on the TAE website and therefore were not included as elements of the quantitative portion of this study.

An issue with SUA discretion, over program design and a few specified program objectives within the grant, was the propensity for states viewing the ADRC as an enhancement to aging services. Some states envisioned the ADRCs as an extension of services already being provided by the AAAs. One respondent encapsulated the comments made by several participants by stating:

> I think a lot of our AAAs looked at ADRC and maybe still do, as kind of a beefed up version of I & A, information and assistance. They've all done that for years and it is key function that they perform at the AAA. So for a lot of them, ADRC meant just adding staff to their I & A department or doing more of the initial workup and intake on waiver clients in your I & A department. It wasn't. So it ended up being just add some staff on or you now have a little department that you call ADRC and I think they missed the point. The money and the investment was supposed to be more about transforming your whole agency into an ADRC and connecting it to a network and so we missed the boat with a lot of that and so as a result the grant ended and the money dried up, we had a lot of AAA that were really lost with that, saying how are we supposed to fund the people that I hired, because they missed the sustainability part of it, in that you transformed your agency and your focus and you met all the requirements of being an ADRC and then you made that into a network, and we didn't do that.

This organizational connection to the AAA links directly to where the SUA chose to place or contract their ADRC program, which will be discussed in the following section. Since the ADRC grant was awarded the SUAs, the SUA were responsible for administering the OAA funds which produced an established infrastructure for service delivery. This placed the ADRCs within an existing structure. However, as one state respondent reported, there were conflicts with the mixing of clientele (See Challenges p. 81). In envisioning the ADRC as a "beefed up version of I&A" the SUA would expect AAAs to expand services to clients under the age of 60. AAAs were specialized in addressing the needs of persons over 60 but had very little experience working with clients under that age limit. This was not indicated by the states that chose to "house" their ADRCs in local or regional nonprofit organizations.

Finally, two of the sample states indicated that they envisioned the ADRC as a systems change or a different way of organizing existing service networks. The first state indicated that their ADRC was "built on the existing infrastructure" and that these service entities all have their core services that they provide. The ADRC is then viewed as a mechanism for crossing over from one network to the other. The second state utilized technology to take advantage of the services and knowledge that already existed within their state and provided a way for all separate entities to communicate in a seamless fashion.

By envisioning the ADRC as a mechanism for systems' change, these states adopted different tools from the beginning. They focused on establishing technology infrastructure that would enable the network to better communicate and share information and on creating a group of stakeholders that would consist of key partner agencies or organizations. Both of these tools were adopted to improve communication and build a certain level of buy-in between the aging network and the disability network.

Although the sample states were selected based on how they classified their programs via the TAE website, through the interview process, it was determined that only three states indicated a true NWD model. One of the main reasons indicated for this inconsistency was the lack of a clear definition or guidance on what a true NWD model of service delivery looked like. Many states that were interviewed stated that there was little guidance in the beginning on how to partner with other LTC entities and who those partners should be.

Where are the ADRCs?

The states selected for the sample were not selected based on where they chose to place their ADRCs within the state's aging and disability networks; however, states within the sample did have a variety of different organizational structures that were part of their overall ADRC

design. Appendix D shows some of the responses to the overall program design questions that focused on "where" the ADRC is located in the state. This concept was so drastically different in different states because some states did not see the ADRC as a program that was "housed" anywhere but rather a partnership or agreement between key stakeholders. These states describe their ADRC in terms of select partners that share information and/or technological infrastructure that helps in the coordination of services across the long-term care spectrum.

As an example of this, one state developed software that all partners in their network could install on their desktop computers. This software provided not only a resource directory and client database but also communication capabilities to video chat with other partners. A client of any age or disability that tried to access services or supports through any of the partner organizations would be linked to all other partners. So that in the eventuality that the agency where the client sought help did not have the supports needed, they could contact another partner agency that did have those supports. Of the three states in the sample that chose a true NWD model, two chose this model from the initial grant cycle. The third chose to adopt a SPE model with the initial grant award. However, through subsequent expansion grants, the third state chose to modify its original vision and implement the NWD model.

States that chose to envision their ADRC as a single-point of entry (SPE), initiated the ADRC through pilot programs within certain local agencies. These local entities varied; however, the majority of the states that chose the SPE model, chose to "house" the ADRCs within the preexisting Area Agencies on Aging (AAAs). The AAAs are designated agencies that correspond to the states' planning service areas (PSAs). Some AAAs are housed in planning and development commissions and some are standalone nonprofits. AAAs contract with the SUA to provide or administer Older American Act funding for HCBS within their region.

The AAAs have an established history of providing services to seniors in their respective communities. They have contracted with churches and nonprofits to create local senior centers and use these centers as a way of locally administering OAA services, such as the nutrition program, legal services, insurance counseling, etc. On the other hand, disability services have been contracted through centers for independent living (CILs). A few of the states interviewed indicated that the ADRC assisted in the communication between the AAAs and the CILs who had very little history of working together. States that chose not to place the administration of the ADRC program within the AAAs indicated that this put all the partners on an even footing if they were all brought into the ADRC fold at the onset. Some states that chose to place the administration of the ADRC within the AAAs stated that this presented networking challenges.

Still other states chose to contract with nonprofit organizations to administer the ADRC program, and one state chose to designate the SUA office, through a toll-free number, as the ADRC. In this case, the ADRC is a call center whereby clients will call in and request information, and the SUA will direct them to the appropriate community agency.

The Role of the Advisory Council

As previously stated, only two states indicated that the creation of an advisory council was part of the initial ADRC grant process. Nevertheless, six additional states created advisory councils at the state and local levels after the initial grants were implemented. One state indicated the advisory council to be one of their ADRC program's "strongest attributes" according to a program assessment conducted by their SUA. The council makeup varied slightly; however most included the SUA, Medicaid, and state-level disability entities, which included mental health, developmental disabilities, and vocational rehab. Some councils included representatives from the CILs; however, most of the states indicated that the formalized

relationship between the ADRC and the CILs happened at the local or regional-level, not at the state-level. Table 4.12 shows a full list of agencies that were reported to be included in the various state councils.

[Insert Table 4.12 about here]

Two states had very clear visions from the initial grant award, and both states chose decentralized NWD models. As stated previously, neither state designated a single organization to "house" the ADRC. Both of these states described their relationships with the disability entities in their state to be exceptional; however, both took different approaches to formalizing those relationships. The first indicated that the SUA had an advisory council and that when the grant first started, they had initially created a separate advisory council for the ADRC program. The respondent believed that due to the size of their state, these councils were a duplication and consisted of the same representative stakeholders. They then created a leadership team, which they described as the "work horse" for ADRC planning. These plans were later approved or disapproved by the SUA advisory council.

The second state also described their ADRC vision as a core partnership; however, they chose not to have any type of advisory council. The respondent pointed to the interconnectedness of their infrastructure as being a direct line of communication. An advisory council was therefore deemed unnecessary. They stated that it provided no "added value" to their program and still had chosen not to adopt one after 10 years of having ADRCs within their state.

Three states that had responded that they did not have advisory councils at the time of the interview indicated that they were moving in that direction; were in the process of developing or planning what that group would look like in their state and what would be the core functions.

These three also mentioned additional grants by ACL that were specifically asking for states to develop this type of council.

Respondents indicated three new or recent initiatives that were presented by ACL to the states in the form of additional grants. These included the Balancing Incentives Program (BIP), the ADRC Part A grants, and the No Wrong Door grants. Not all of the sample states applied for and/or received all of these grants. In some cases, grants were received by states; however, they were unable to meet the goals of the grant and were canceled at the state's request. Respondents indicated that these grants had many more stipulations on partnering than the ADRC grants had. There were requirements for 5-year plans on how to better coordinate services. There were also requirements for key stakeholder groups to be established and guidelines on which stakeholders should be invited to participate.

Programmatic Strengths

States within this sample responded overwhelmingly in support of the increased communication between aging and disability networks. Seven states indicated that the greatest strength of their program was to open up lines of communication that had previously been limited or nonexistent. One respondent stated that although these relationships were the most beneficial to their overall program design, it was difficult to measure their influence or effectiveness. Another state described the relationships of aging and disability prior to the ADRC as unhealthy, and another respondent described the transformation from one where stakeholders would leave the meetings angry to one of productive interaction.

Four of the sample states believed that their program's greatest strength was in the knowledgeable staff and their ability to provide options counseling to clients. In two of these states, this dependence on staff as a resource due to their expert knowledge of LTC resources was

both an asset and a challenge. These two states indicated a difficulty in capturing resource information in a centralized location where that knowledge could be both shared and transferred in the event of staff turnover.

Technological infrastructure was highly important to three of the sample states. These states indicated an original ADRC vision that was strongly dependent on this technology. One of the three felt that their LTC resource database was a program strength but acknowledged its limitations and the desire to improve its capabilities. The technology most discussed by the respondents included a database of resources and of clients. Those states seeking to improve their online tools sought to have a public facing site that would assess clients' needs and provide them with resources and information regarding those needs. States also indicated that a shared client tracking system was very beneficial as this allowed multiple agencies to view client assessments, needs, and existing services.

Challenges

The challenges that were discussed by the respondents were varied. Three states indicated that funding in the ADRC program was a continuous challenge. One state responded that funding for young people with disabilities was a challenge and this corresponded to another state's response that there was a lack of resources in the community to keep up with the growth in demand. Interestingly, this contradicted statements by other states that believed that the ADRC was not an expensive program. These states felt that the services were already established within the community and the knowledge about these services were already being collected, albeit by different groups of service providers. Those states indicated that funding was not an issue, but the coordination of the existing services was the key issue.

Technology, although considered a strength, also presented a challenge. Two respondents stated that it was difficult not having all ADRCs using the same IT system, and another discussed the lack of consistency across all ADRCs as a being very problematic. Another state discussed the challenges associated with keeping resource databases current. S9 (See Appendix D), who depends heavily on the technological infrastructure of their program, stated that the challenge of relying on this form of tool was the lack of broadband and the lack of technology used by some local partners.

The partnerships developed during the implementation of the grant also presented challenges from within. One state respondent indicated that there were territory issues or turf battles between stakeholders and a difficulty for staff in learning how to assist different clientele than they were used to serving in the past.

In addition, states struggled with the lack of flexibility on the part of the partner organizations. One respondent believed that partner organizations had difficulty in accepting the idea of shared funding or shared resources. Each partner organization having its own mission and its own goals, had difficulty in adapting those agency goals to include the seamless coordination of all LTC services.

Another state discussed the heavy reliance on the AAA as a source of difficulty in partnering with the disability network. As stated earlier, some respondents believed that there was a lack of equal partnership and less buy-in from the disability community when the administration of the ADRC program was controlled by the AAAs.

A final issue facing these partnerships was a lack of shared language. Since the ADRC grant was issued to the SUA, the terminology used is recognized by the aging network and not the disability network. One respondent indicated that this was a particular challenge in

developing shared tools. An example given was that of developing a standard assessment form as well as a shared resource database. The assessment tool would require information that would be specific to both aging and disability populations. Questions that might be appropriate for persons with disabilities, such as employment opportunities or job skills, may not have been previously included in aging assessments. Likewise, resource databases that had LTC resource information initially collected for the aging population needed to adopt new terminology or language that would encompass the types of disability resources that were being added.

Other challenges included political barriers to implementation through independent government entities at the county-level, defining options counseling and lack of name recognition by clients. The political barriers discussed were mainly at the county-level where ADRCs attempted to work with county governments to coordinate services. Options counseling is an element of the ADRC program that was thought to be similar to I & A; however, it was much more in-depth in nature. ADRCs were challenged to define what options counseling would entail and how to provide it consistently within all of the state ADRCs.

Finally, name recognition presented a challenge since the two main target populations were sometimes uninformed as to what services were traditionally available to them. These populations may not have been aware of what a CIL was, let alone how it was connected, formally or informally, with the ADRC. Many states indicated that they had developed a marketing strategy; however, this too presented challenges. Since most states began their ADRC as pilot sites, states delayed their marketing of the ADRC until they determined whether it was working, if it would be a permanent initiative of ACL and was expanded statewide. Marketing of the ADRC also presented increased demand for services. In some instances, this was overwhelming to the ADRC.

Lessons Learned

The lessons learned question addressed how states would implement future grants with similar collaborative components. The responses focused on leadership and equality of partnership.

As seen in Table 4.13, the state respondents had clear opinions about how leadership played an important role in the design of the ADRC program.

[Insert Table 4.13 about here]

All of these states responded that there needs to be strong leadership at the state-level that would direct the actions at the local level. Not only would this present more consistency but also would be an example to the local networks that if they are working together at the state-level, then that is what is supposed to happen at the local-level as well. One state respondent expressed the need for leadership as essential in breaking down barriers to traditionally siloed agencies. These agencies that had never worked together in the past and had no resource dependency on each other were in most cases housed in separate administrative agencies at the state-level that had distinct organizational missions. They traditionally served different clienteles and did not cross train into other service sectors. The grant, being given to one of those partners but not having any incentive for the others, was difficult to implement without leadership from above.

One state also mentioned having better leadership from ACL in what were the programmatic expectations. Since the initial ADRC grant was awarded with very limited goals, states had tremendous discretion on how to design their programs. Additional expansion grants came with criteria for a fully functional ADRC and what that should look like at the local or regional-level (See Appendix E). This did not address the collaboration aspects of the program at a state-level and did not mandate any type of advisory council or their participation at the

higher levels of government. ACL, since the initial grant, has provided further guidance of the ADRC vision. This was in the form of additional grants. One respondent from Table 4-13 above indicated this when discussing the new Part A grant and another respondent mentioned the new NWD grant. These grants will be discussed more in depth in Chapter 5; they resulted in new leadership from the federal-level that impacted state collaboration.

The other major focus of the responses was the existence or the need for equal partnership from the beginning of the grant. This was a key lesson learned by five of the sixteen respondents. It may also be inferred to be a key lesson by a sixth state. This response addresses the issue of designating the AAAs as the ADRC.

> It's like with the 1-800 number, you would go to the AAAs. Again, it's all set up to have them (as the ADRC). Like I said, hind sight is 20/20 because that has really been problematic for our system. Because they do think they are in charge, they do think that they make the call because they have the money, because that's how we set it up.

In this response, the perception of the network is that the AAA is in charge of the ADRC because it receives the grant funding from the SUA. Partners in the network may or may not receive any of this grant funding. In most cases, there is no distribution of ADRC grant funds outside of the aging network. Several respondents saw the original vision of a SPE model as being flawed. One respondent stated the following on the issue of how the state first envisioned the ADRC program and how grant managers learned through implementation that this would not meet the goals of serving all persons in need of LTSS.

> I would just say that when we first got started, we really had this envisionment of these physical location where people could walk in all the time and we took the money we had and we built, we didn't actually build them, we rented building space. So I guess I had this envisionment that we had to be this separate entity… We really quickly found that we couldn't specify a very specific population that you are going to serve because within that population are other needs and populations that need the service. And it's really not possible for one person to know everything.

This respondent expressed the main reason for a NWD model or what some states described as a core partnership model. This respondent states that it is impossible to "house" the ADRC as a separate government program designed to accumulate knowledge in one centralized location.

Table 4.14 below has condensed the six key concepts that were identified through the systematic content analysis of the raw data collected during the interviews.

[Insert Table 4.14 about here]

Overall Connections

The overall connections that can be drawn from these six conceptual findings address issues that were present at the start of the ADRC grant award. The initial grant was awarded to 12 states and had limited guidance on how the ACL wanted it to be implemented. The goals of the program were ambiguous, and the vision of the ADRC was to provide all LTC options available. States that applied for the ADRC grant had their own visions of what the ADRC would look like in their states. Some had already been designing an integrated service delivery model even prior to the ADRC grant award. ACL did provide functional criteria to states after the initial grant award.

Some SUAs took an active role in designing the ADRC concept and guidelines for the state to ensure consistency. This provided a model for local programs and also a sense of control by the SUA. In other states, the SUA acted more as a mechanism for distributing funding to the local entity who would be the direct service provider for the ADRC. This may have been an organizational culture within these SUAs or a standard way that OAA funding and similar grants were handled. However, this led to separate and distinct programs at the local-level and the

control over the program was handed over to the local entities. In many cases, this was the AAAs.

Technology was largely important to this grant, either through the initial vision of how the ADRC would function in the state or through necessity of collecting LTC resources into one database. Some states' initial vision was to have a "virtual ADRC" or an online resource where clients could go and research the available resources in their local communities. These are what respondents described as "public facing" databases. Many professional ADRC staff members also used these databases in their effort to provide options counseling to clients, either over the phone or in person. Discussion of the use and limitations of technology were consistently addressed by all 16 sample states, either as a challenge due to the lack of technology, designing the best technology to fit the state's need, keeping the technology and/or data up to date, or using one type of technology consistently across all ADRCs or all partner organizations.

As will be discussed further in the following chapter, the vision of the overall ADRC model has evolved since it was first implemented. Many of the states that had a strong vision of a SPE model were forced either through additional grant requirements or through necessity to incorporate more of a NWD approach. Several of the sample states discussed the error of viewing the ADRC as a place rather than an opportunity to partner or coordinate what LTC entities throughout the state were already doing. Several states lamented lack of funding; yet others discussed the fact that this program doesn't or shouldn't cost much to run. Since most LTC service agencies have a form of information and assistance provided to clients that call or walk in, these I & A services can be enhanced through the use of cross training and information sharing.

This chapter presented the raw findings of this mixed methods approach to the study of ADRC program design adoption. The following chapter will discuss the implications of these findings for both theory and practice.

Chapter 5: Discussion

The previous chapters presented six hypotheses to the main research question: why do states, when presented with federal grant incentives, establish varying models of collaborative networks. The research addressed this question by focusing on four major concepts: 1) Aging and Disability Resource Center (ADRC) collaborative network design, 2) fragmentation of policy decision making, 3) state commitment to public welfare spending, and 4) state long-term care infrastructure. This chapter will discuss the implications of the findings presented in Chapter 4 on the theory and practice.

Limitations of this Study

This study was initiated using self-reported data on a public website designed to support ADRC grant managers and inform the public as to the nature of the ADRC initiative in each state. Since the initial inception of the ADRC grant in 2003, additional expansion grants and specialty grants for Options Counseling and Care Transitions were awarded to states that applied. These grants provided additional funding and additional requirements and guidance for state programs.

The data obtained from the TAE website was shown to be problematic in that much of the information was found to be either outdated or inaccurate. The finding that only three states sampled and interviewed described themselves as a true NWD model, indicated that the initial regression analysis conducted in this study was based on inaccurate data. Although states that were sampled indicated that they were moving towards the NWD, their description of how their

ADRC was initially set up and was being administered at the time of the interview, did not match the definition of a NWD model.

In addition to the inaccuracy of some of the program design descriptions, there were certain program elements that were found through analysis of interview data to be essential to the ADRC program design. The first was the existence or creation of the advisory council as a collaborative tool. When these councils were created, who was asked to participate and what the expected role of each partner would be was found to be very important. Also the location of the ADRC at the regional or local level was said to have tremendous impact on the collaboration itself. Neither of these elements were found to be consistently a part of the program design description which lead to the ADRC Program Design variable used in the quantitative analysis of this project.

Significance of the Research Study

Theoretical Significance

This study attempts to develop a new understanding of what sort of state specific factors influence the adoption of collaborative policy within state bureaucratic agencies. How states implement the collaborative directives of the federal bureaucracy is important for all service sectors. The previous research into policy adoption leads to the assumption that specific social, economic and political factors will influence policy adoption. This study addresses the question of whether state bureaucratic structure and state spending can be included as state determinant variables. It also draws from the network literature and applies the participant governed spectrum in the context of a coordinated service delivery model. This study defines a NWD system of coordinated service delivery.

Applied Significance

This study observed the characteristics of evolving aging and disability policy in the United States. It attempts to categorize state program design into existing typologies used by network scholars. It also sought to develop an understanding of the state specific factors that would influence state bureaucratic entities to adopt certain policies. Since the movement by the DHHS to combine the aging and disability programs at the federal-level under the auspices of ACL, it is clear that some states have followed their lead. Some states have reorganized their state departments to mirror the ACL and bring aging and disability entities at the state level, closer together. This study demonstrates, through the respondent interviews, how this positively influenced more collaboration at the state and local levels.

The assumption that standalone SUA would be less likely to adopt collaborative tools was found to be false. In addition, there was no indication by the respondents that were interviewed that this was a significant factor in how they designed their policy. Both respondents from standalone state aging offices and those that were housed under a larger department expressed concern over silos that were cut off from each other and unable to coordinate services. However, both standalone agencies and divisions of larger state agency respondents expressed similar variance in program design and similar challenges to implementation.

Finally, the placement of the ADRC can lead to collaboration challenges. This was seen through multiple responses and 'lessons learned' through implementing the program over a 12-year period. State respondents considered the placement of the ADRC program within the AAAs to be problematic. This created a barrier in collaboration because it presented the ADRC as being mainly an 'aging' program. Funding and control was maintained by the AAAs and therefore, inclusion of disability organizations was difficult. States that began their programs with equal participation of all members reported more success in integrating the collaborative

service delivery model. This information can assist bureaucratic agencies at the state and federal level better assist in future grants of this type.

Theoretical Analysis

This research shows many aspects of the ADRC program model that could not be quantified in the initial content analysis of the ADRC program. This may be due to the limited nature of the information provided within the ADRC TAE site or the self-reporting nature of the data source. States reported their programs in a variety of ways. Some states reported a detailed list of ADRC goals, functions and structure, whereas some states reported very little. States that reported very little may have been doing more than was reported but did not want to be held accountable or these goals and objectives. Also, as was indicated in one interview, the data reported on this site was out of date and did not accurately depict the program as of 2014.

The interviews revealed also that the ADRC program began as a limited grant program that used the first 12 states as a laboratory to test the ADRC vision. Much like the states, with the pilot sites, the ACL awarded the initial grants with limited guidance on design. In the years that followed, additional expansion grants were awarded, the TAE site was created and new training became available at grantee meetings and the HCBS conference conducted in Washington annually. This created a policy environment within SUA that was for the most part constantly evolving. There were a few states in the sample that had envisioned their ADRC program as a NWD model of service delivery from the beginning and these states have stayed consistent to that vision. The main reason for this lack of change is that they had what ACL desired in a model from the beginning. States that began their programs with a SPE model have experienced the limitations that this places on their programs from a knowledge-based resource stand-point as well as a collaborative network approach.

Concluding Observations

The most important aspects of the analysis were the use of technology as a collaborative tool and the creation of advisory councils within the ADRC program. The technology piece was significant in both the quantitative and qualitative analysis. The creation, composition and functions of the advisory councils were significant in the qualitative analysis.

The creation of a resource database was found to be a first step in the ADRC program implementation. The reason for this was indicated by the majority of the respondents as being a necessity for information sharing as well as the ease of adoption. Some respondents indicated that the virtual ADRC was seen as the entire ADRC program design. Thus, states could utilize online technology to create a gateway for consumers to access all available LTC resources. This sharing of information options was the only criteria stipulated by ACL.

The grant funding was used to pay for a database product that varied in its complexity. Some virtual portals were simply a database of resources that had a limited taxonomy and provided only contact information. Some provided more information on the resource, such as the types of services available, eligibility for those services and how to apply. Other products included links to outside information as well as an assessment component. These online tools could be used by clients (public facing) as well as by professional options counselors (backward facing).

State respondents indicated a major drawback to the use of a virtual ADRC in that the information required constant updating. This presented a challenge for states in designating what agency would be responsible for updating information and how to hold them accountable. Many respondents indicated that the responsibility for updating resources was assigned to the local or

regional ADRC but was later taken over by the state. Some states indicated a contract with an outside provider, such as 211, to keep their database current.

Probably the most effective use of a virtual ADRC combined the technology to a network approach and provided the core partners with not only a database of resources but a means to easily communicate. This required that each partner designate a staff person that would have the software loaded onto their PC and would be responsible to communicating to other partner agencies when needed. Although this state indicated a high-level of satisfaction with the model and technology package that they use, they too indicated that the use of technology as the foundation of the ADRC program design does have its draw backs. One challenge was incorporating partners into the program that did not have the technology resources within their organizations. These were usually smaller nonprofits that work out of local churches or food pantries. These organizations provide a resource, however, due to limited budgets; they may not have computers, internet or even paid employees that could be a designee. In this case, the respondent stated that their ADRC adopted a four-pronged approach to service delivery that included the website, phone, in person and print communication.

Advisory councils

Although the existence of advisory groups were mentioned sporadically by states on the TAE website, the use of them as a collaborative tool did not appear as a primary element of the program design. This element was not incorporated into the statistical dependent variable for use in the statistical analysis of this study. After the qualitative analysis, it became evident that the use of the advisory council was an important aspect of the program design.

State respondents that had active councils indicated a high-level of satisfaction with the amount of information sharing. Some respondents that did not have an active council indicated

that this was a major challenge in full participation by the partners. Those states interviewed that described their ADRC as a core partnership were most concerned with bringing partners in from the beginning, stating that partners that are brought in later may not feel as committed to the program as those who were brought in during the planning stages. One respondent also had concerns that to be a partner the new organization would have to provide the same level of commitment and not be a partner in name only.

States that had advisory councils at either the state or local-level but not at both, had concerns about leadership or control over the ADRC program. Those states that had active councils at both the state and local-level did not indicate these concerns. This has a significant impact when public administrators consider the control mechanisms within networks. Several respondents indicated that a major lesson learned from implementing the ADRC program was to have strong leadership from the state and federal government entities. This leadership doesn't mean lack of local flexibility however. One respondent said there was a balance between leadership or guidance and providing regional or local ADRCs to have some flexibility of program implementation.

In this way the advisory councils demonstrated a way to show local programs that state leadership was working together and it gave local programs and organizations a paradigm to follow. When local programs found a lack of collaboration at the state level, these programs had more difficulty in partnering at the local-level.

Policy Implications

The policy implications of this study show that with the continued support and technical assistance provided by federal leadership, states are responsive to changes in how they implement the collaboration. Without guidance, however, states will base their policy adoption

based on state specific factors. Understanding of LTC systems and funding in each state will be important to policy makers when issuing similar type collaborative grants. Specific language on how to form collaborations should be included, as was done recently with the NWD grants.

SUAs have excellent knowledge and understanding of aging related needs and services within their state, however, there is much work that still needs to be done to fully envelop the disability network. States that have developed a core partnership or have "housed" their ADRCs outside of the aging infrastructure have had more opportunity to engage the disability community into the ADRC mission. Policy makers should recognize the limitations of placing a collaborative program within the "walls" of one of the network participants. This NAO may present more control and provide potential accountability, however, it does not, in the case of the ADRC, provide tangible resources. One respondent explained the situation as having little control over network participants who have no vested interest by way or funding in participating. Use of a NAO may therefore be better suited for those networks that have a distribution of funding that flows through the NAO. In the case of the ADRC network, the main resource is information. To distribute information throughout the network, the participants need equality. Based on the interviews, the perception of who is in control can lead to challenges in engaging new partners.

Future Research

States that indicated that they had begun their programs with a SPE model, have since received guidance from ACL through new NWD grants that ask states to develop a NWD council among other directives. These councils are similar to the advisory councils that many states have. The functions of those councils are much more influential under the new guidelines.

The Balancing Incentives Program (BIP) began in 2010 as part of the Affordable Care Act Section 10202. The grants associated with this program offer states additional funding if they transform their existing LTC service delivery and supports into a NWD model. Specifically, states must increase the access to non-institutional long-term supports and services (LTSS). This program is funded using an enhanced Federal Matching Assistance Percentage (FMAP) for states based on the percentage of institutional spending. As an example, a state that spent less on their non-institutional or HCBS care would be eligible for greater (up to 5%) federal funds, as an incentive to these states to increase the HCBS by the end of the grant cycle (Medicaid 2015).

This program was quickly followed up by the new NWD program grants in 2014. These grants were jointly sponsored by the ACL, CMS, the Veterans Health Administration (VHA) in an effort to transition a state into a NWD model. The grants are offered in exchange for state led planning to be conducted over a 12-month period of time and would culminate with the recommended actions that would lead to implementation of a NWD model (Administration on Community Living 2015). The specific requirements of this grant are to involve partners, which are specified within the grant, in the implementation of the NWD model. These specific partners include the SUA, the state Medicaid agency and the state disability agencies that represent persons with physical disabilities, intellectual and developmental disabilities, and with behavioral health needs (Administration on Community Living 2015). At the conclusion of the grant, the state would produce a 3-year plan on how they will proceed with the transition of their LTSS.

Meanwhile, states were also given the opportunity to apply for ADRC expansion grants that were broken down into two parts, Part A and Part B. Grants provided under Part B had smaller awards and were designed to support states in sustaining their existing ADRC programs.

The Part A grants were awarded to only eight states and the goals and the awards for these grants are much greater. These grants require that the eight states become models for integrated ADRC options counseling (Administration on Community Living 2015).

From the evidence of the new initiatives, it is clear that ACL and CMS, along with more recent partnerships developed at the federal-level with VHA, are continuing to advocate for a NWD systems model of LTSS. This persistent push by federal agencies is having an impact on state programs, as was evident in the interviews conducted in this study. Not only are these federal agencies offering more funding to states as a dangling carrot, they are placing more requirements on the grantees and providing detailed guidelines for how the state is to implement this approach. This was not the case with the original grant; therefore, this study leads to additional unanswered questions of how these new initiatives will reshape existing programs in each state.

As the importance of the advisory stakeholder groups in the collaborative design model becomes more and more the focus of the federal grant agencies, the impact of these groups will need to be measured. This study did not evaluate the advisory groups, however, as indicated by many of the interviews within this study, the advisory groups can be seen as a measure of effective collaboration and as a measure of overall program success. Further research should be done using a network analysis of the advisory groups.

Another avenue for future research is the investigation into the changing bureaucratic structure of state aging and disability agencies. There was some evidence in this study to support that changes at the federal-level in how aging and disability programs were administered, namely the creation of the Administration on Community Living, did impact the state bureaucratic arrangement. In some cases, states had begun to combine aging and disability under one agency

umbrella, only to separate them later when the federal government combined them. Some respondents indicated that this was part of the backlash against the Affordable Care Act. In other cases, states mirrored the actions of their federal counterpart. Future research should be done to investigate the factors influencing the restructuring of how these programs are administered.

Conclusion

This study was a two-fold process whereby the researcher used existing data to investigate the state factors that could have influenced policy adoption by the administrative agency. The second stage of this research was a fact finding procedure meant to investigate the details of the ADRC program for minute factors that may not have been evident in the secondary data. This study was successful in uncovering other important factors that were not present in the secondary data that was currently available for this study. The analysis of the interview data led to a better understanding of the full makeup of the ADRC program at the state-level as well as how it has evolved over time. It shed light on concurrent initiatives that have had an impact on the evolution of the program and may be used as an explanatory factor for how states developed the final NWD network.

Another interesting aspect of these new initiatives and the collaboration at the federal level is the changes to the bureaucratic structure at the state-level. These changes are mirroring the actions of the federal agencies that fund the lower state agencies. This could lead to further exploration of state specific determinants that influence the adoption of the organizational structure of their federal counterparts.

Figure 1.1 No Wrong Door and One-Stop Shop Service Delivery Model

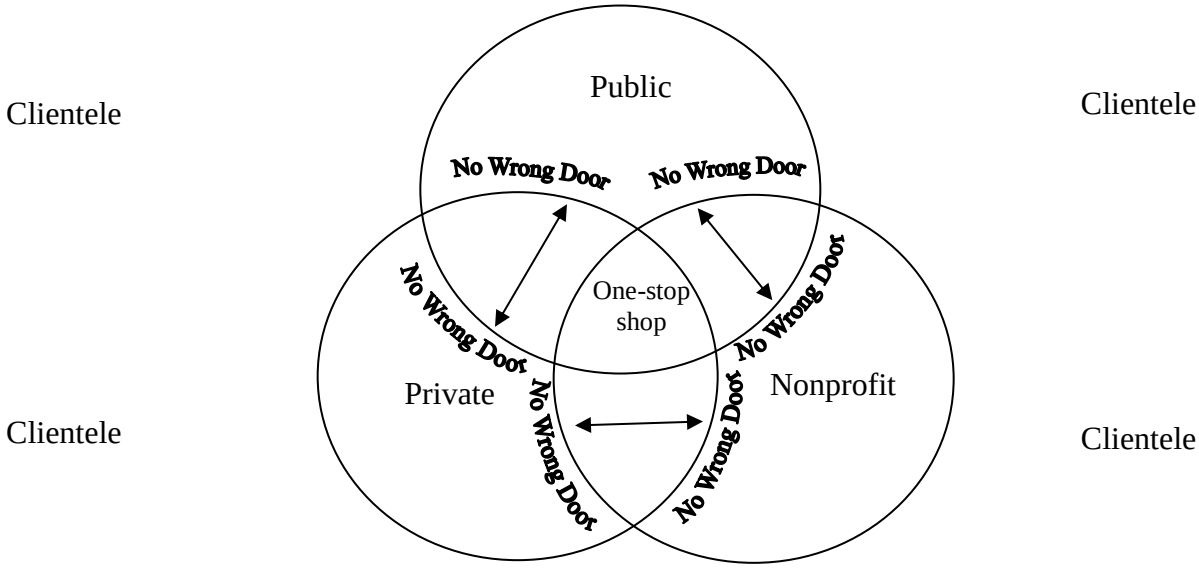


Figure 1.2 ADRC Service Delivery Models within the Spectrum of Network Control

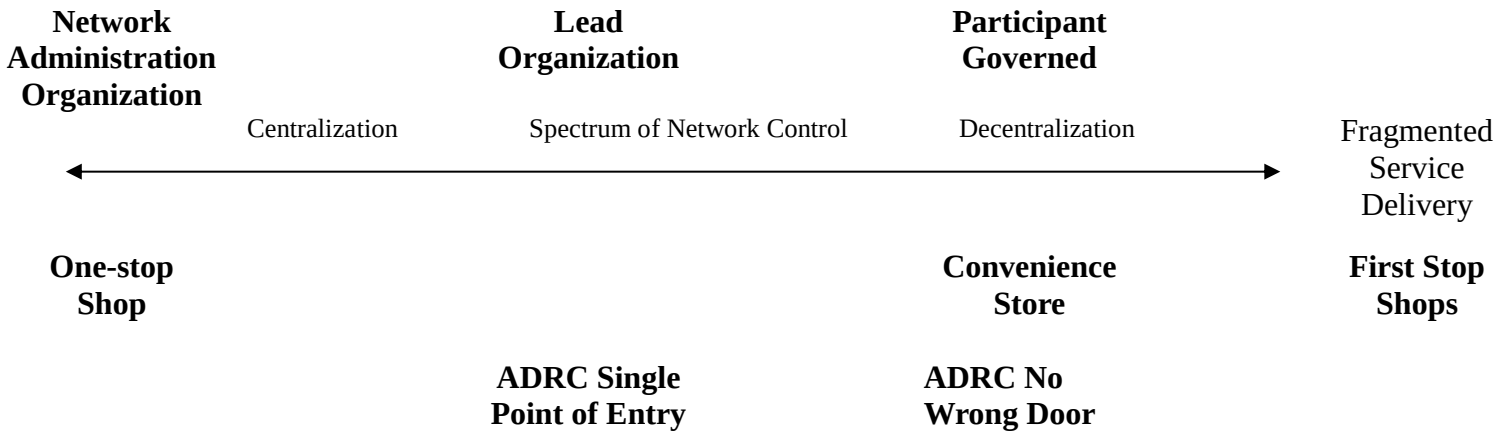


Figure 2.1 Timeline of Aging and Disability Policy in the U.S.

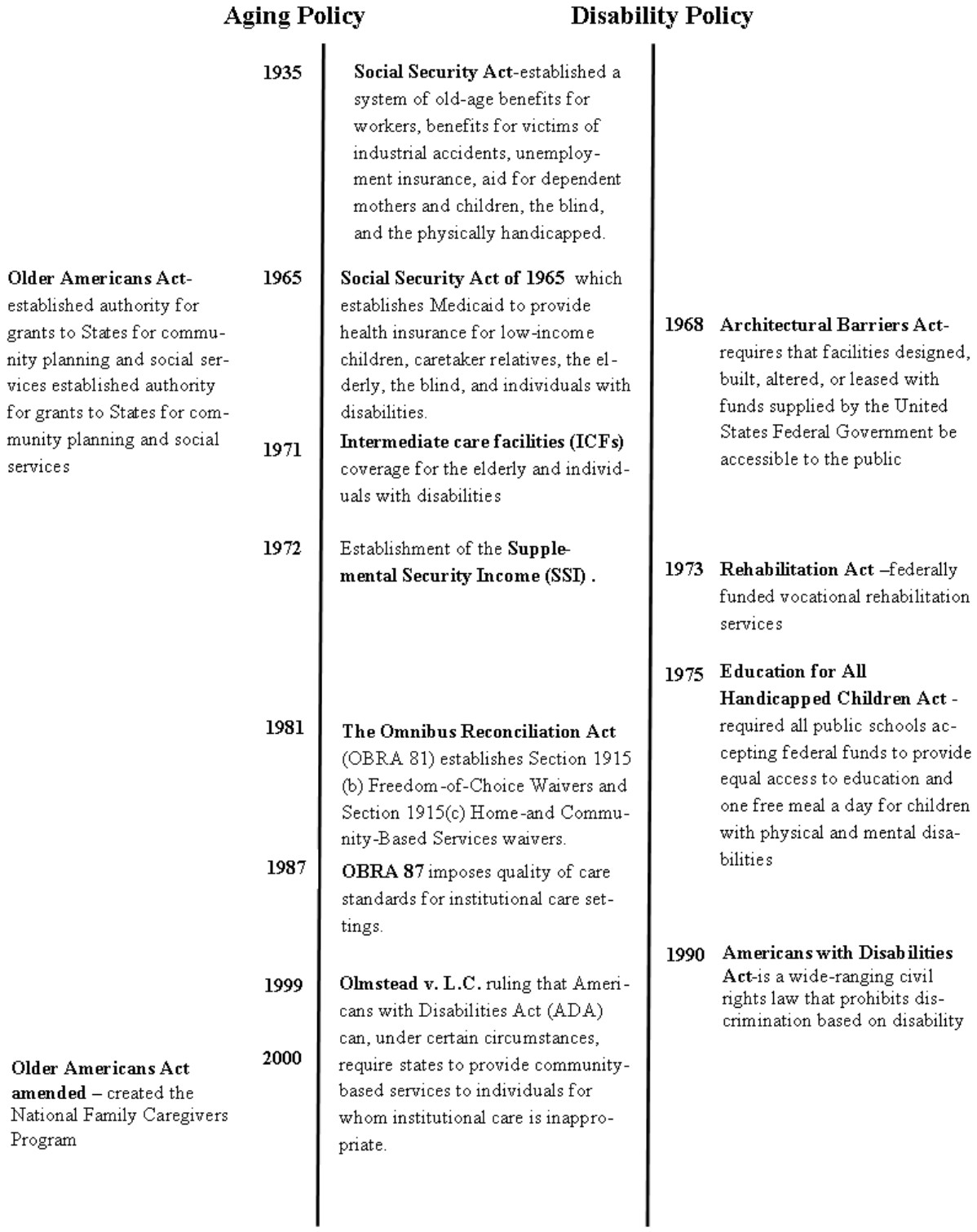


Figure 2.2 Aging Network

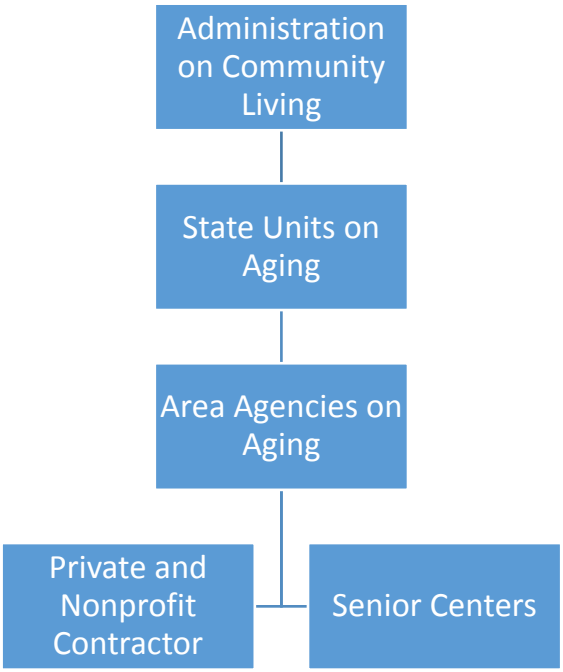
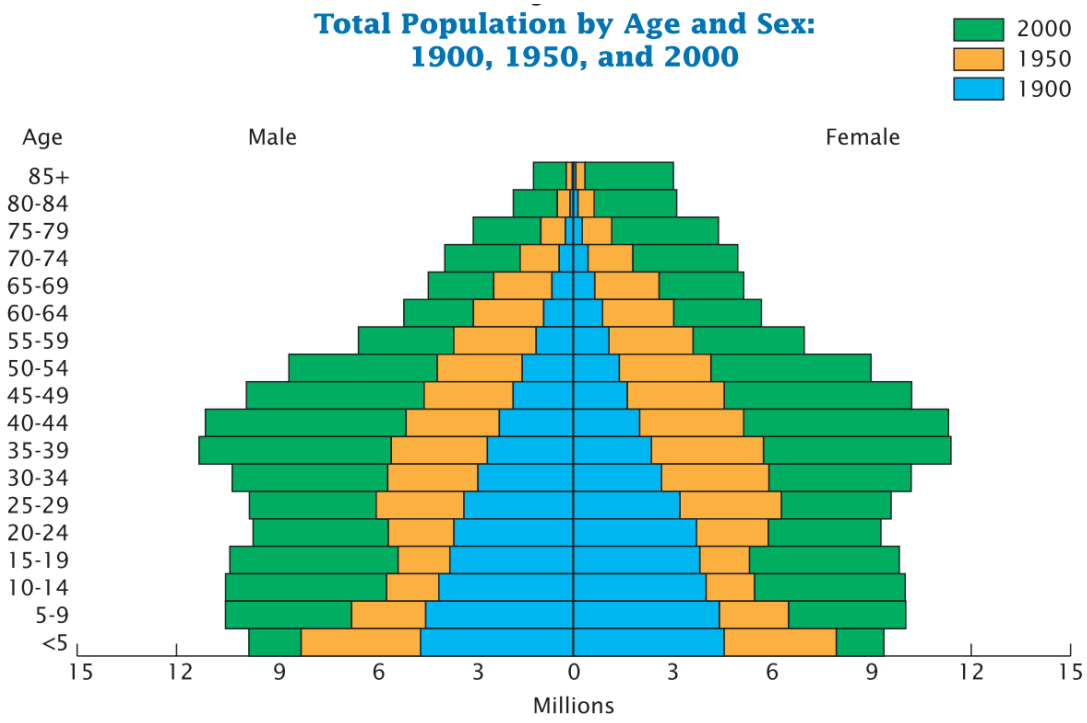


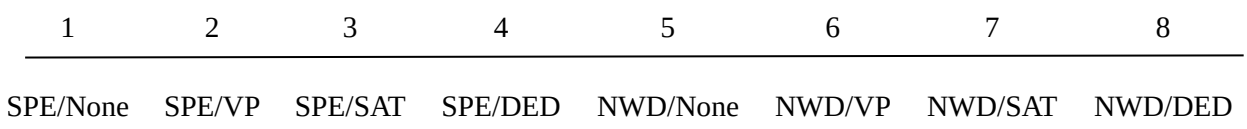
Figure 2.3 Alabama Disability Agencies and Services

Figure 2.4 Total Population by Age and Sex 1900, 1950, and 2000



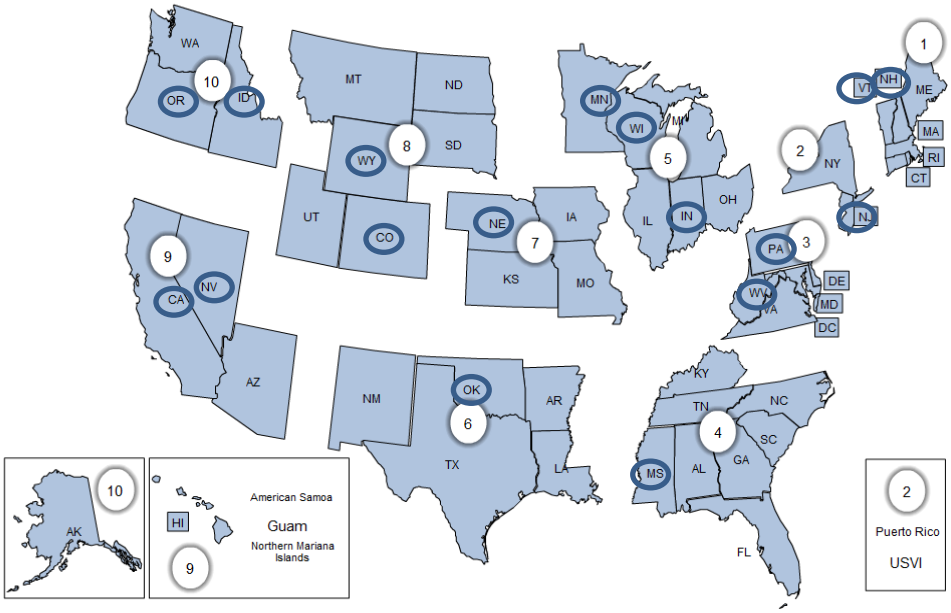
Source: Demographic Trends in the 20th Century: Census 2000 Special Reports

Figure 3.1 Level of Integration Variable



Legend
SPE-Single Point of Entry
NWD-No Wrong Door
VP-Virtual Portal
SAT-Single Assessment Tool
DED-Decentralized Eligibility
None-No program tools selected

Figure 3.2 United States Regional Classifications used by ACL and CMS 2015



Administration on Community Living Regions
Region 1-Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island and Vermont
Region 2-New York, New Jersey, Puerto Rico and the Virgin Islands
Region 3-Washington DC, Delaware, Maryland, Pennsylvania, Virginia, West Virginia
Region 4-Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee
Region 5-Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin
Region 6-Arkansas, Louisiana, Oklahoma, New Mexico and Texas
Region 7-Iowa, Kansas, Missouri and Nebraska
Region 8-Colorado, Montana, Utah, Wyoming, North Dakota and South Dakota
Region 9-California, Nevada, Arizona, Hawaii, Guam, Mariana Islands and American Samoa
Region 10-Alaska, Idaho, Oregon and Washington

Table 2.1 Per-Capita Health Care Spending by the Age, 1999

Age Grouping	Per-Capita Personal Health Care Spending
All Ages	$3,834
Under Age 65	$2,793
65 and older	$11,089
19-44	$2,706
45-54	$3,713
55-64	$5,590
65-74	$8,167
75-84	$12,244
85 and older	$20,001

Source: Age Estimates in the National Health Accounts, Keehan et al. 2004

Table 3.1 Typology of Integration of Referral Systems

Single-point of Entry (Centralized)			
Decentralized Eligibility Determination	Single Assessment Tool	Virtual Portal	None
Delaware	Kentucky	Alabama	South Dakota
Georgia	Mississippi	Louisiana	Wisconsin
Hawaii	New Hampshire	Nevada	Wyoming
Indiana	Tennessee	Utah	
Minnesota		Washington	
New Mexico		West Virginia	
Rhode Island			
South Carolina			
No Wrong Door (Decentralized)			
Decentralized Eligibility Determination	Single Assessment Tool	Virtual Portal	None
Alaska	Arizona	Idaho	California
Arkansas	Colorado	New Jersey	Maine
Connecticut	Illinois	Oklahoma	Michigan
Florida	Maryland		Missouri
Iowa	Massachusetts		New York
Kansas	North Carolina		North Dakota
Montana	Oregon		Vermont
Nebraska	Texas		
Ohio	Virginia		
Pennsylvania			

Table 3.2 Explanatory Variables and Sources

Variable	Source	Measure	Time Frame
Public Welfare Spending	Census State and Local Government Data2005-2008 Annual Surveys of State and Local Government Finances; US Census Bureau	Of total State budget, % of spending towards public welfare programs	2005-2008
Long-term Care Infrastructure	CMS Form 64 Financial Management Report And Older American Act Expenditure Report	Percentage of all long-term care spending directed to institutional care	2005-2008
Long-term Care Infrastructure	Centers for Disease Control and Prevention Trend Table 101	Number of Skilled Nursing Facility beds per state	2000
Long-term Care Infrastructure	2002 Economic Census	Number of registered Home Health organizations per state	2002
Bureaucratic Structure	State Unit on Aging –State Plan on Aging 2004-2008		2008

Table 3.3 Observed Categories of State Aging Structure

Category Coding	Category Description
1	Standalone state agency or department
2	Division of larger state department or agency with sister agencies including disability and Medicaid
3	Division of larger state department or agency with sister agencies disability
4	Division of larger state department or agency with sister agencies Medicaid
5	Division of larger state department or agency

Table 3.4 CMS Service Category Definitions as Categorized by Care Setting

Institutional Care Setting	Community Care Setting
Inpatient Hospital Services- Are ordinarily furnished in a hospital for the care and treatment of inpatients	Home Health Services-These are services provided at the patient's place of residence in compliance with a physician's written plan of care
Mental Health Facility Services- Refers to those inpatient hospital services provided under the direction of a physician for the care and treatment of recipients in an institution for mental disease.	Home and Community-Based Services- These are services furnished under a 1915(c) waiver
Nursing Facility Services- Skilled nursing care and related services for residents who require medical or nursing care	Programs of All-Inclusive Care for the Elderly (PACE)- PACE provides pre-paid, capitated, comprehensive health care services designed to enhance the quality of life and autonomy for frail, older adults.
Intermediate Care Facility Services- These include services provided in an institution for the mentally retarded or persons with related conditions	Personal Care Services-Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
Private Duty Nursing-Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.	Case Management Services- Case management services means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services
	Hospice Benefits- The care furnished by a hospice program to a terminally ill individual who has voluntarily elected to have payment made for hospice care

Table 3.5 State Determinant Control Variables

Variables	Source	Definition	Time
Political Factors			
Voter turnout 2004	U.S. Census Bureau, Statistical Abstract of the United States: 2006. U.S. Census Bureau	Percentage of voting age population that cast a vote in the Presidential Election of 2004	2004
Gubernatorial Party	National Governors Association	Party of Governor 2004 1-Democrat or independent 0-Republican	2004
Legislative Professionalism	Squire's Index of Legislative Professionalism		2003
<u>Social/Demographic Factors</u>			
Population 65+	2000 Census Data	Percent of population aged 65 and older	2000
Population in Rural Area	2000 Census Data	Percent of population living in Rural area	2000
Race	2000 Census	Percentage of non-white	2000
<u>Economic Factors</u>			
Median Income	2000 Census	Median household income	2000
State Fiscal Health	2005-2008 Annual Surveys of State and Local Government Finances; US Census Bureau	Ratio of total state revenue minus total state spending: to total state spending	2005-2008

Table 3.6 Qualitative Sample by ADRC Program Model Category

Single-point of Entry (Centralized)			
Decentralized Eligibility Determination	Single Assessment Tool	Virtual Portal	None
Georgia***	Mississippi	Nevada	Wisconsin
Indiana	New Hampshire	West Virginia	Wyoming
Minnesota			

No Wrong Door (Decentralized)			
Decentralized Eligibility Determination	Single Assessment Tool	Virtual Portal	None
Nebraska	Colorado	Idaho	California
Pennsylvania	Oregon	New Jersey**	Vermont
		Oklahoma*	

* Oklahoma was invited to participate but declined.

** New Jersey was invited to participate after Oklahoma declined. No reply was received from New Jersey. Since there were no other states within this category, Georgia was invited based on their program design.

*** Based on interview responses regarding the innovative nature of Georgia's ADRC program, they were invited to participate after.

Table 4.1 Distribution of Dependent Variable ADRC Program Design

Dependent Variables	Proportion
ADRC Model	
No Wrong Door	.42
Single-point of Entry	.58
ADRC Level of Integration	
Single Point of Entry/No Policy Tools	.20
Single Point of Entry /Virtual Portal	.15
Single Point of Entry /Single Assessment Tool	.06
Single Point of Entry /Decentralized Eligibility	.14
No Wrong Door/No Policy Tools	.16
No Wrong Door /Virtual Portal	.08
No Wrong Door /Single Assessment Tool	.12
No Wrong Door /Decentralized Eligibility	.06

Source: Administration on Community Living, Technical Assistance Exchange Website 2011

Table 4.2 Distribution of Government Structure Variable

Government Structure Variables	Frequency	Percentage	Cumulative
Category 1: Standalone state agency or department	19	38%	38%
Category 2: Division of larger state department or agency with sister division including disability and Medicaid	6	12%	50%
Category 3: Division of larger state department or agency with sister division disability	5	10%	60%
Category 4: Division of larger state department or agency with sister division Medicaid	15	30%	90%
Category 5: Division of larger state department or agency	5	10%	100%

Source: State Plans on Aging 2004-2008

Table 4.3 Distribution of Government Structure Variable

Recoded Government Structure Variables	Proportion
Government Structure (1)	
Standalone State Agency	.38
Division of Larger Agency	.62
Government Structure (2)	
Not Housed with Medicaid	.58
Housed with Medicaid	.42

Source: State Plans on Aging 2004-2008

Table 4.4 Measure of Centrality and Change of State Spending on LTC

State Spending Variables	Mean	Std. Dev.	Min	Max
Welfare Spending				
Welfare Spending 2005	.2204	.0453	.13	.35
Welfare Spending 2006	.2136	.0406	.13	.31
Welfare Spending 2007	.2112	.0407	.13	.31
Welfare Spending 2008	.2100	.0418	.13	.31
Mean Percentage Change	-.0104			
Institutional Spending				
Institutional Spending 2005	.6030	.1200	.2379	.7848
Institutional Spending 2006	.5932	.1170	.2721	.8193
Institutional Spending 2007	.5769	.1112	.2732	.8173
Institutional Spending 2008	.5665	.1127	.2623	.8092
Mean Percentage Change	-.0365			

Source: Census State and Local Government Data 2005-2008 and CMS Form 64 Financial Management Report and Older American Act Expenditure Report

Table 4.5 Results of Pearson Correlation

	ADRC MODEL	ADRCIN T	Gov. Structure	Govstr1	Govstr2	Inst. Spend 05	Inst. Change	Welfare 05	Wel-Chan ge	SNF	Home health	VOTER0 4
ADRCMODEL	1.000											
ADRCINT	-.8639 .0000***	1.000										
Gov. structure	.1099 .4472	.0126 .9310	1.000									
Govstr1	.0852 .5566	.0384 .7914	.8559 .0000***	1.000								
Govstr2	.0673 .6423	.0018 .9901	.4644 .0007***	.6662 .0000***	1.000							
Inst. Spend 05	-.0530 .7149	-.0096 .9474	.0465 .7486	-.1114 .4412	-.0421 .7717	1.000						
Change in Inst. Spend	.1513 .2942	.0011 .9941	.1067 .4610	.2810 .0480*	.2155 .1328	-.3685 .0085***	1.000					
Welfare05	-.0827 .5682	-.0055 .9696	-.1841 .2006	-.2500 .0800	-.1520 .2920	.2317 .1054	-.0380 .7932	1.000				
Change in Welfare	.2827 .0467*	-.2756 .0527	.1258 .3842	.2184 .1275	.3217 .0227**	-.0601 .6784	.1282 .3751	-.3857 .0057***	1.000			
SNF	.1461 .3114	-.1603 .2662	-.0563 .6975	-.0899 .5345	.0742 .6087	.3155 .0256*	-.0778 .5912	.3783 .0068***	.1357 .3475	1.000		
Home Health	.1808 .2088	-.0865 .5504	.0600 .6788	-.1165 .4204	-.0687 .6355	-.1055 .4658	-.0657 .6502	.2945 .0379*	-.0527 .7162	.1506 .2967	1.000	
VOTER04	.1016 .4825	.0008 .9957	-.0117 .9357	.0928 .5216	.1147 .4277	-.2730 .0551	.1413 .3276	.0337 .8164	.0120 .9343	.3366 .0169**	.1860 .1959	1.000
GOVPARTY	-.0148 .9189	.0736 .6113	.0268 .8534	-.0852 .5566	-.1494 .3003	.0232 .8728	-.1326 .3587	.0014 .9921	.2055 .1522	.0452 .7550	.1806 .2094	.1599 .2673
LEGPROF	.3641 .0093***	-.2325 .1042	-.0419 .7728	-.1025 .4786	-.0088 .9518	-.0144 .9210	-.1134 .4331	-.1511 .2948	.1131 .4341	-.0884 .5417	.0288 .8426	-.1330 .3571
FISCH	-.1791 .2133	.2675 .0604	-.1942 .1766	-.2438 .0879	-.1818 .2063	-.0863 .5510	-.0963 .5060	.0171 .9064	-.0347 .8107	.0200 .8903	.0247 .8648	-.0263 .8562

INCOME	.1735	-.2107	.1483	.1180	.0333	-.0880	-.0070	-.2895	.1866	-.2594	-.1352	.0529
	.2283	.1419	.3040	.4144	.8184	.5433	.9613	.0414*	.1945	.0689	.3493	.7152
AGE	.1268	-.1286	-.1924	-.2705	-.0429	.2844	-.0116	.3771	.1678	.5708	.1875	.1288
	.3804	.3849	.1807	.0574	.7672	.0453*	.9363	.0069***	.2441	.0000***	.1923	.3729
RURAL	-.1256	.2017	-.0013	.1204	.2256	-.0094	.2888	.2814	-.1382	.2329	.0945	.3922
	.3849	.1601	.9930	.4050	.1153	.9481	.0420*	.0477*	.3388	.1036	.5141	.0048***
RACE	-.1126	.0027	-.0847	-.1994	-.2656	.1456	-.2241	-.2201	-.1957	-.4347	-.1690	-.6438
	.4361	.9852	.5588	.1650	.0623	.3131	.1177	.1246	.1731	.0016***	.2406	.0000***

	GOV PARTY	LEGPROF	FISCH	INCOME	AGE	RURAL	RACE
GOVPARTY	1.000						
LEGPROF	.0204	1.000					
	.8882						
FISCH	.0637	.1911	1.000				
	.6602	.1838					
INCOME	-.0678	.3959	-.1855	1.000			
	.6397	.0044***	.1972				
AGE	.1591	-.0092	.2737	-.3430	1.000		
	.2698	.9494	.0545	.0148**			
RURAL	.0158	-.5084	-.0787	-.6540	.1592	1.000	
	.9132	.0002***	.5869	.0000***	.2695		
RACE	-.1327	.2738	.1172	.2277	-.2707	-.4242	1.000
	.3584	.0543	.4177	.1117	.0573	.0021***	

*** p< .01
** p<.025
* p<.05

Table 4.6 Results of the Bi-variate Logistic Regression
Testing Explanatory Variable Effect on ADRC Program Choice

State Choice of ADRC No Wrong Door Program Model	Odds Ratio	SE	P (Sig.)	Pseudo R2
Change in Institutional Spending	6.69	5.390	.313	0.0195
Skilled Nursing Facilities Per Capita	2.14	2.51	.306	0.0159
Change in Welfare Spending	3.49	6.47	.054*	0.0613
Government Structure				
2-Div. W/ Med. and Dis.	.9	.843	.910	
3-Div. W/ Dis.	1.35	1.379	.769	
4-Div. W/ Med.	1.8	1.286	.411	
5-Div.	1.35	1.379	.769	.0128
Division of Larger Agency	1.42	.839	.548	.0053
Housed with Medicaid	1.32	.7713	.634	.0033

N=50
*** p< .01
** p<.05
* p<.10

Table 4.7 Results of the Bi-variate Logistic Regression
Testing Control Variable Effect on ADRC Program Choice

State Choice of ADRC No Wrong Door Program Model	Odds Ratio	SE	P (Sig.)	Pseudo R2
Voter Turnout	1.03	.042	.474	.0076
Gubernatorial Party	.941	.546	.917	.0002
Legislative Professionalism	3.56	1.609	.020**	.1258
Change in Fiscal Health	.032	1.198	.215	.0242
Median Income	1.000	.000	.225	.0225
Per. Of Population 65+	1.148	.179	.377	.0119
Per. Of Population Rural	.176	.346	.377	.0116
Per. Of Population Nonwhite	1.997	.022	.433	.0093

N=50
*** p< .01
** p<.05
* p<.10

Table 4.8 Results of the Multi-variate Logistic Regression
Testing Effect on ADRC Program Choice

Variable	Odds Ratio	Std. Err.	P(Sig)
Change in Institutional Spending	55385	619916	.329
Skilled Nursing Facilities Per Capita	3.4	6.62	.727
Change in Welfare Spending	2.83	6.73	.361
Division of Larger Agency	1.182	1.011	.845
Voter Turnout	1.048	.0902	.586
Gubernatorial Party	.6328	.5138	.573
Legislative Professionalism	326676	193050	.032*
Change in Fiscal Health	.00315	.010734	.090
Median Income	.9999	.0001	.791
Per. Of Population 65+	1.209	.3377	.495
Per. Of Population Rural	.2442	1.153	.765
Per. Of Population Nonwhite	.0222	.1381	.539

N=50, Model chi-square = p<0.0809, -2 log likelihood= -24.3494, Pseudo R2 = 0.2841

* p<.10

** p<.05

Table 4.9 Results of the Bi-Variate Ordinal Logistic Regression
Testing Explanatory Variable Effect on Level of Integration

Variable	Odds Ratio	P(Sig)	Pseudo R2
Change in Institutional Spending	.0001	.091	.0252
Skilled Nursing Facilities Per Capita	7.05	.450	.0043
Change in Welfare Spending	1262.7	.617	.0019
Government Structure			
2-Div. W/ Med. and Dis.	.7110	.717	
3-Div. W/ Dis.	.3026	.142	
4-Div. W/ Med.	.3679	.126	
5-Div.	.5177	.452	.0256
Division of Larger Agency	.4152	.109	.0197
Housed with Medicaid	.6498	.413	.0050

N=50
*** p< .01
** p<.025
* p<.05

Table 4.10 Results of the Bi-Variate Ordinal Logistic Regression
Testing Control Variable Effect on Level of Integration

Variable	Odds Ratio	P(Sig)	Pseudo R2
Voter Turnout	.9558	.256	.0098
Gubernatorial Party	.6738	.445	.0044
Legislative Professionalism	.0568	.241	.0100
Change in Fiscal Health	.0264	.077	.0244
Median Income	1.000	.338	.0069
Per. Of Population 65+	1.079	.598	.0069
Per. Of Population Rural	.0941	.178	.0136
Per. Of Population Nonwhite	1.030	.174	.0147

N=50
*** p< .01
** p<.025
* p<.05

Table 4.11 Results of the Multi-Variate Ordinal Logistic Regression Testing Effect on Level of Integration

Variable	Odds Ratio	Std. Err.	P(Sig)
Change in Institutional Spending	.0002	.0014	.115
Skilled Nursing Facilities Per Capita	1.92	3.35	.861
Change in Welfare Spending	2.98	5.59	.198
Division of Larger Agency	.3490	.2355	.119
Voter Turnout	1.013	.0765	.858
Gubernatorial Party	.3406	.2312	.113
Legislative Professionalism	.0001	.0004	.016**
Change in Fiscal Health	.0009	.0027	.019**
Median Income	1.000	.0000	.778
Per. Of Population 65+	1.468	.3960	.155
Per. Of Population Rural	.0270	.1050	.352
Per. Of Population Nonwhite	1.067	.0443	.113

N=50, Model chi-square = p<0.0206, -2 log likelihood= -54.985, Pseudo R2 = 0.1789

* p<.10

** p<.05

Table 4.12 List of Partner Organizations within the ADRC Advisory Councils

Independent Living Center	Hospital Association
Area Agencies on Aging	State Health Insurance Program
Medicaid Agency	State Caregiver Assistance and Respite Program
Skilled Nursing Facilities	Money Follows the Person
Home Health Organizations	Veterans Administration
Hospitals	Mental Health
Community Center Boards	Substance Abuse
Consumers	Department of Rehabilitation Services
Adult Protective Services	State Unit on Aging
Developmental Disabilities	Intellectual Disabilities
Brain and Spinal Injury Association	

Note: The partners listed were sometime referred to by different names that identified states and respondents. These agencies were classified based on their function and included in the above list.

Table 4.13 Leadership factors influencing the ADRC design model

Responses
You really have to have, you need a strong leadership. And you need it to be consistent.
I think we've learned a lot of things but I think personally that the number one thing that I would say is that before we would pilot we would have at the state level the… more of the planning group or the advisory group so that all the departments would work together and then once we implement that it would be easier, you know, within the local communities to get those individuals to participate.
Probably the biggest lesson is that we have to take more of a leadership role. I think there was a reliance on the AAA since they are connected. They have their own trade organization, they talk to each other. There would be more cohesiveness there that they would work on that together and it doesn't happen organically, the state really does need to take a leadership role in setting consistent policies for expectations and reinforcing that all the time.
I think there's been a lot of growing and modeling happening at the federal level which has assisted at the state level, us to shape how we want to model and have leadership for the work that we are doing and how we want to coordinate stuff… You know a lot of these other initiatives, if they are not coordinated, then your kind of missing the opportunity. With this Part A grant, it really has been beneficial because we have collaborated and worked across divisions and bureaus more than any time before.
I think the lack of collaboration. The lack of guidance that were started. So they didn't receive any additional funding or guidance, so that was difficult that they could have met any sort of standards. The ADRC system, which is very much not how they were doing things before. It very much was just a call center. So policies in terms of processes are lot different now than they were before.
I think the easiest lesson learned would be something that would be easy to implement would just be to require everyone to use the same IT system. Really easy to implement that. An aegis makes a whole bunch of stuff a lot easier. Data collection, improving data collection, evaluating data etc. it just makes all lot easier if everyone uses the same system. It would just be a lesson learned.
Which I would argue that's what the planning grant is. It is also a systems or a potential systems it's an opportunity to do a systems change and hopefully there's implementation dollars multiyear implementation dollars, down the road. I guess the thing that would strike me the most as the takeaway is you really need the communication with and the buy in from the leadership at the top of the administrative chain, from the governor's office down and or from the legislative perspective down. You really need to have the buy in from people high enough up that they can keep you on track. And when you're crossing so many historically siloed segments you need someone above all those silos to keep the direction for you and to keep the flow and I think that if you really don't have that you'll have much less success and much more difficult road to pave.

Table 4.14 Conceptual Table of Qualitative Findings

1st Steps	ADRC Location	Advisory Groups	Strengths	Challenges	Lessons Learned
Website/Central Phone Number	SUA	None	Communication and Buy-in from AAAs	Territory Issues/ Mixing Clientele	Consistent Strong Leadership
Website/Central Phone Number/ Pilot Site in AAAs/AC	AAAs and Medicaid Offices	ILC, AAAs, Medicaid, SNF, HH, Hospitals, Consumers, CCB	ACs	Funding for young Disabled	State-Level Planning Group prior to piloting
Pilot Sites in Senior Centers	AAAs	ILC, SNF, Hospitals, APS	Staff/ Database	Updating Database	Core partnership with no target population
Website/Pilot Sites in AAAs	AAAs	None	Brokerage model of services	Lack of State Leadership	Regional ADRCs based on resources
Website/ Pilot Sites in AAAs	AAAs	DD, Brain and Spinal Injury Association, Hospital Association, Medicaid, SHIP, CARES, AAAs, ILC	Information Sharing from Disability	Recognition of ADRC	coordinate existing services
Pilot Sites in AAAs	AAAs	None	Communication and Staff	Consistency	State Leadership Role needed
Formalized core partnerships	Core Partnership	10 Partner Agencies, MFP and VA	Equal partnership	Lack of Shared Language	Equal partnership
Client tracking system/formal evaluation / logo	Local Nonprofits	Departmental partners, DD, MH, Substance Abuse, Elderly and Adult services	Overall model	Growing bigger/ recognition but limited resources	Coordinate other initiatives at the same time with ADRC
Formalized core partnership	Core Partnership	None	Technology / branding strategy	Technology Architecture	None
Call center	Local Nonprofits	Medicaid, DHS, DMH, DRS	AC/Workgroups	Partner flexibility	Starting with more guidance from Feds
Website/self-assessment tool	AAAs	ILC, DD, Medicaid	Partnership	Lack of shared IT Systems	None
AC/RFP'd for contractor to admin	Local Nonprofits	DD	Options Counseling	Funding	Assessment/ Add partners
Pilot Sites	Local Nonprofits	None	Partnership/ Communication	Options Counseling	Earlier engagement of partners
Website/Pilot Sites in AAAs/OC / standards	AAAs	SUA, AAAs, CIL, DD, ID, MH, VA	OC/ Website	Lack of equal partnership	Equal partners with disability
Pilot Sites	AAAs and Nonprofits	None	Staff	Political Restrictions	Standardized IT systems
Pilot Sites	Core Partnership	None	Partnership/ Cross training	IT Systems	Leadership

References

Administration on Community Living. 2015. National Family Caregiver Support Program. Accessed July 28. http://www.aoa.gov/AoA_programs/HCLTC/Caregiver/index.aspx

_____. 2015. Administration on Aging. Accessed April 10. http://www.aoa.acl.gov/

_____. 2015. ADRC Program. Accessed July 28. http://www.adrc-tae.acl.gov/tiki-index.php?page=PublicEnhancedOC

_____. 2014. State Program Reports. Accessed May 30. http://www.agid.acl.gov/Resources/DataSources/SPR/

Agranoff, Robert and Michael McGuire. 2001. Big Questions in Public Network Management Research. *Journal of Public Administration Research and Theory* 11, no. 3: 295-326

Agranoff, Robert. 2007. *Managing Within Networks*. Washington, DC: Georgetown University Press.

Administration on Aging. 2015. Alzheimer's Disease Supportive Services Program. Accessed July 29. http://www.aoa.gov/AoA_Programs/HPW/Alz_Grants/index.aspx

_____. 2015. Community Living Program Grants. Accessed July 29. http://www.aoa.gov/AoA_programs/HCLTC/NHD/index.aspx

Americans with Disability. 2015. About Olmstead. Accessed September 25, 2015. http://www.ada.gov/olmstead/olmstead_about.htm

Askim, Jostein, Anne Lise Fimreite, Alice Moseley, and Lene Holm Pedersen. 2011. One-stop Shops for Social Welfare: The Adaptation of an Organizational Form in Three Countries. *Public Administration* 89:1451-68.

Baggett, Sharon. 1989. *Residential Care for the Elderly: Critical Issues in Public Policy*. New York: Greenwood Press.

Berry, Frances Stokes and William D. Berry. 1990. State Lottery Adoptions as Policy Innovations: An Event History Analysis. *The American Political Science Review* 84 (2): 395-415.

Berry, William D. and Evan J. Ringquist, Evan J. 1998. Measuring Citizen and Government Ideology in the American States 1960-93. *American Journal of Political Science* 42 (1): 327-349.

Bingham, Lisa B., Rosemary O'Leary and Christine Carlson. 2008. Frameshifting: Lateral Thinking for Collaborative Public Management. In *Big Ideas in Collaborative Public Management*, ed. Lisa B. Bingham and Rosemary O'Leary, 3-16, New York: M.E. Sharpe.

Bode, Ingo. 2006. Co-governance within networks and the nonprofit-for-profit divide: A cross-cultural perspective on the evolution of domiciliary elderly care. *Public Management Review* 8 (4): 551-566.

Brown, Mitchell, and Kathleen Hale. 2014. *Applied Research Methods in Public and Nonprofit Organizations*. Hoboken: Wiley.

Bryson, John M., Barbara C. Crosby, and Melissa Middleton Stone. 2006. The Design And Implementation Of Cross-Sector Collaborations: Propositions From The Literature. *Public Administration Review* 66 (Special Issue).

Canon, Bradley C., and Lawrence Baum. 1981. Patterns Of Adoption Of Tort Law Innovations: An Application Of Diffusion Theory To Judicial Doctrines. *American Political Science Review* 75 (4): 975-987.

Center for Medicare and Medicaid Services. 2015. History. Accessed July 28. http://www.cms.gov/About-CMS/Agency-Information/History/index.html

_____. 2014. Medicaid Data Sources - General Information. Last modified March 19, 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/index.html

_____. 2012. MDS 3.0 for Nursing Homes and Swing Bed Providers. Accessed April 3. https://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Centers for Disease Control and Prevention. 2011. Life expectancy at birth, at age 65, and at age 75. Accessed September 22, 2015 http://www.cdc.gov/nchs/data/hus/2011/022.pdf

Cho, Ji Young and Eun-Hee Lee. 2014. Reducing Confusion about Grounded Theory and Qualitative Content Analysis: Similarities and Differences. *The Qualitative Report* 19 (64): 1-20.

Creek, Heather M. and Stephen Yoder. 2012. With a Little Help from Our Feds: Understanding State Immigration Enforcement Policy Adoption in American Federalism. *The Policy Studies Journal* 40 (4): 674-697.

Erkulwater, Jennifer L. 2006. *Disability rights and the American social safety net*. Ithaca, N.Y.: Cornell University Press.

Ervin, Naomi E. 2001. Assessing interagency collaboration through perceptions of families. *Journal of Community Health Nursing* 21 (1): 49-60.

Finn, Dan. 2000. Welfare to Work: the local dimension. *Journal of European Social Policy* 10 (1): 43-58.

Fisher, Louis. 2002. Biennial Budgeting in the Federal Government. In *Government Budgeting,* ed. Albert C. Hyde. United States: Wadsworth.

Gazley, Beth. 2008. Intersectoral Collaboration And The Motivation To Collaborate: Toward An Integrated Theory. In *Big Ideas In Collaborative Public Management,* ed. Lisa Blomgren Bingham and Rosemary O'Leary, 36-54, New York: M.E. Sharpe.

Gray, Barbara. 1989. *Collaborating: Finding common ground for multiparty problems.* San Francisco, CA: Jossey-Bass.

Gray, Virginia. 1973. Innovation in the States: A Diffusion Study. *American Political Science Review* 67: 1174-85.

Hackbart, Merl and James R. Ramsey. 2002. The Theory of the Public Sector Budget: An Economic Perspective. In *Budget Theory in the Public Sector,* ed. Aman Khan and W. Bartley Hildreth, 172-187, Westport, Connecticut: Quorum Books.

Hahn, Harlan. 2003 Accommodations and the ADA. In *Backlash against the ADA : reinterpreting disability rights*, ed. Linda Hamilton Krieger, 26-61, Ann Arbor: The University of Michigan Press.

Hale, Kathleen. 2011. *How Information Matters: Networks and Public Policy Innovation.* Washington D.C., Georgetown University Press.

Huxham, Chris. 1996. Collaboration and collaborative advantage. In *Creating collaborative advantage*, ed. C. Huxham, 1-18. Thousand Oaks, CA: Sage.

Hobbs, Frank and Nicole Stoops. 2002. Demographic Trends in the 20th Century Census: 2000 Special Reports. U.S. Census Bureau.

Holbrook, Thomas M. and Emily Van Dunk. 1993. Electoral Competition in the American States. *American Political Science Review* 87 (4): 955-963.

Hong, Sounman. 2015. Fiscal Rules in Recessions: Evidence from the American States. *Public Finance Review* 43 (4): 505-528.

Huang, Kun and Keith G. Provan. 2006. Resource Tangibility and Patterns of Interaction in a Publicly Funded Health and Human Services Network. *Journal of Public Administration Research and Theory* 17: 435-454.

Hwang, Sung-Don and Virginia Gray. 1991. External Limits and Internal Determinants of State Public Policy. *Political Research Quarterly* 44: 277-298.

Imershein, Allen W., Larry Polivka, Sharon Gordon-Girvin, Richard Chackerian and Patricia Martin. 1986. Service Networks in Florida: Administrative Decentralization and Its Effects on Service Delivery. *Public Administration Review* 46 (2): 161-169.

Isett, Kimberley R., Ines A. Mergel, Kelly LeRouxà, Pamela A. Mischen, and R. Karl Rethemeyer. 2011. Networks in Public Administration Scholarship: Understanding Where We Are and Where We Need to Go. *Journal of Public Administration Research and Theory* 21 (1): i157-i173.

Kagan, Sharon L. 1991. *United we stand: Collaboration for childcare and early education services.* New York: Teachers College Press.

Keehan, Sean P., Helen C. Lazenby, Mark A. Zezza, and Arron C. Catlin. 2004. Age Estimates in the National Health Accounts. *Health Care Financing Review* 1 (1): 1-16.

Kenis, Patrick and Keith G. Provan. 2006 The Control of Public Networks. *International Public Management Journal* 9 (3): 227-247.

Kettl, Donald F. 2002. *The Transformation Of Governance: Public Administration For Twenty-First Century America*. Baltimore: The Johns Hopkins University Press.

Kim, Soonhee, and Hyangsoo Lee. 2006. The Impact of Organizational Context and Information Technology on Employee Knowledge-Sharing Capabilities. *Public Administration Review* 66 (3):370-85.

Klase, Kenneth A. 2011. The Intersection of Flexible Budgeting and Cutback Management: Factors Affecting the Responses of Selected States to Recent Economic Recessions. *Public Finance Management* 11 (1): 197-230.

Krieger, Linda Hamilton. 2003. *Backlash against the ADA: reinterpreting disability rights*. Ann Arbor: The University of Michigan Press.

Kubiceck, Herbert, and Martin Hagen. 2000. One Stop Government in Europe. Results from 11 National Surveys. Bremen: University of Bremen.

Lienert, Judit, Florian Schnetzer, and Karin Ingold. 2013. Stakeholder analysis combined with social network analysis provides fine-grained insight into water infrastructure planning processes. *Journal of Environmental Management* 125: 134-148.

Medicaid. 2015. Balancing Incentive Program. Accessed July 29. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html

_____. 2015. Financing and Reimbursement. Accessed September 25, 2015. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/financing-and-reimbursement.html

Miller, Edward Alan. 2005. State health policy making determinants, theory and methods: A synthesis. *Social Science & Medicine* 61: 2639-2657.

Miller, Edward Alan and Lili Wang. 2009. The influence of national policy change on subnational policymaking: Medicaid nursing facility reimbursement in the American states. *Social Science and Medicine* 68: 1926-1934.

Mooney, Christopher Z. and Mei-Hsien Lee. 1995. Legislating Morality in the American States: The Case of Pre-Roe Abortion Regulation Reform. *American Journal of Political Science* 39 (3): 599-627.

Mossberger, Karen and Kathleen Hale. 2002. 'Polydiffusion' in Intergovernmental Programs. *American Review of Public Administration* 32 (4): 398-423.

National Association of State Units on Aging and Disability. 2015. HCBS Conference. Accessed May 6. http://www.nasuad.org/hcbs-conference#sthash.f3TBs9rR.dpuf

_____. 2014. Glossary. Accessed April 1. http://nasuad.org/hcbs/glossary#sthash.bxNfGwIU.dpuf

National Council on Disability. 2003. Olmstead: Reclaiming Institutionalized Lives. Publication date: August 19. http://www.ncd.gov/publications/2003/Aug192003#Decision

Northwestern Mutual. 2012. Cost of Long-Term Care Study. http://www.northwesternmutual.com/learning-center/studies-and-reports/cost-of-long-term-care-study.aspx accessed April 3, 2012

O'Toole , Daniel E. and James Marshall. 1988. Citizen Participation Through Budgeting. *The Bureaucrat* 17 (2): 51 – 55 .

O'Toole, Laurence J., Jr. 1997. Treating Networks Seriously: Practical and Research-Based Agendas in Public Administration. *Public Administration Review* 57 (1): 45-52.

Patton, Michael Quinn. 1990. *Qualitative Evaluation and Research Methods, 2nd Edition*. Newbery Park: Sage Publications.

Pew Research Center. Baby Boomers Retire. http://pewresearch.org/databank/dailynumber/?NumberID=1150 accessed April 3, 2012

Poddighe, Francesco, Alessandro Lombrano, and Mario Ianniello. 2011. Lean Production and One-Stop Shop for Municipal Services. Public Administration & Management 16 (1): 1-20.

Powell, Walter W., Douglas R. White, Kenneth W. Koput and Jason Owen Smith. 2005. Network Dynamics and Field Evolution: The Growth of Interorganizational Collaboration in the Life Sciences. *The American Journal of Sociology* 110 (4): 1132-1205.

Provan, Keith G., Kimberly R. Isett and H. Brighton Milward. Cooperation and Compromise: A Network Response to Conflicting Institutional Pressures in Community Mental Health. *Nonprofit and Voluntary Sector Quarterly* 33 (3): 489-514.

Provan, Keith G., and H. Brinton Milward. 1995. A Preliminary Theory of Interorganizational Network Effectiveness: A Comparison Study of Four Community Mental Health Systems. *Administrative Science* 40 (1): 1-33.

Provan, Keith G. and Brinton Milward. 2001. Do Networks Really Work? A Framework for Evaluating Public-Sector Organizational Networks. Public Administration Review 61 (4): 414-23.

Provan, Keith G. and Patrick Kenis. 2008. Modes of Network Governance: Structure, Management, and Effectiveness. Journal of Public Administration Research and Theory 18 (2): 229-252.

Reed, Charley. 2012 A Matter of Balance: Washington and Oregon States' Long-Term Care System Model. *Generations* 36 (1): 59-63.

Roberts, Bridget. 2012. Interprofessional relationships in dual diagnosis discourse in an Australian State: are we respecting each other yet? *Mental Health & Substance Use: Dual Diagnosis* 5 (2): 148-159.

Roger, Eleanor Jo, Corinne Jorgensen, George D'Elia. 2005. Partnerships and Collaboration among Public Libraries, Public Broadcast Media and Museums: Current Context and Future Potential. *The Library Quarterly* 75 (1): 42-66.

Rogers, Everett M. 2003. *Diffusion of Innovations (5th ed).* New York: Free Press.

Rubin, Herbert J. and Irene S. Rubin. 1995. *Qualitative Interviewing: The Art of Hearing Data*. Thousand Oaks, Sage Publications.

Sapat, Alka. 2004. Devolution and Innovation: The Adoption of State Environmental Policy Innovations by Administrative Agencies. *Public Administration Review* 64 (2): 141-150.

Shelley Ii, Mack C., and Seongyeon Auh. 2008. Aging and Disability Online Service Delivery: A Global Perspective. *Conference Papers -- Midwestern Political Science Association, 2008 Annual Meeting*: 1-27.

Steves, Laura, and Ted Blevins. 2005. From Tragedy to Triumph: A Segue to Community Building for Children and Families. *Child Welfare* 84 (2): 311-322.

Switzer, Jacqueline Vaughn. 2003. *Disabled Rights: American Disability Policy and the Fight for Equality*. Washington, DC, Georgetown University Press.

Thomson, Ann Marie, James L. Perry and Theodore K. Miller. 2007. Conceptualizing and Measuring Collaboration. *Journal of Public Administration Research and Theory* 19: 23-56.

The Lewin Group. 2011. Aging and Disability Resource Centers 'Just the Facts.' *National Aging and Disability I & R Symposium*.

U.S. Department of Health and Human Services. 2005. Long-Term Growth of Medical Expenditures — Public and Private. Accessed July 29. http://aspe.hhs.gov/health/medicalexpenditures/

Vai Daka-Mulwanda, Kathy R. Thornburg, Laura Filbert and Tanna Klein. 1995. Collaboration of Services for Children and Families: A synthesis of Recent Research and Recommendations. *Family Relations* 44 (2): 219-223.

Van Voorhees, Elizabeth E., Kim Hamlett-Berry, Dana E. Christofferson, Jean Beckham, and Jason A. C.Nieuwsma. 2014. No Wrong Door to Smoking Cessation Care: A Veterans Affairs Chaplain Survey. *Military Medicine* 179 (5): 472-476.

Walker, Jack L. 1969. The Diffusion of Innovation among American States. *The American Political Science Review* 63 (3): 880-899.

Ward, Robert B. and Lucy Dadayan. 2009. State and local finance: increasing focus on fiscal sustainability. *Publius: The Journal of Federalism* 39(3): 455-475.

Werner, Carrie A. 2011. The Older Population: 2010, 2010 Census Briefs. Accessed April 2, 2012 http://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf

Wetten, Roger and Megal Kimber. 1996. *One Stop-Shopping: Notes on the Concept and Some Australian Initiatives*. Center for Research in Public Sector Management at the University of Canberra.

Wiggan, Jay. 2007. Reforming the United Kingdom's Public Employment and Social Security Agencies. *International Review of Administrative Sciences* 73 (3):409-24.

Wildavsky, Aaron. 1961. Political implications of budgetary reform. *Public Administration Review* 21 (4): 183–190.

Williams, Christine B., Martin Dias, Jane Fedorowicz, Dax Jacobson, Sonia Vilvovsky, Steve Sawyer, and Michael Tyworth. 2009. The formation of inter-organizational information sharing networks in public safety: Cartographic insights on rational choice and

institutional explanations. *Information Polity: The International Journal of Government & Democracy in the Information Age* 14 (1/2):13-29.

Appendix A-Table of Variables

Variable	Source	Measure	Time Frame
Public Welfare Spending	Census State and Local Government Data2005-2008 Annual Surveys of State and Local Government Finances; US Census Bureau	Of total State budget, % of spending towards public welfare programs	2005-2008
Long-term Care Infrastructure	CMS Form 64 Financial Management Report And Older American Act Expenditure Report	Percentage of all long-term care spending directed to institutional care	2005-2008
Long-term Care Infrastructure	Centers for Disease Control and Prevention Trend Table 101	Number of Skilled Nursing Facility beds per state	2000
Long-term Care Infrastructure	2002 Economic Census	Number of registered Home Health organizations per state	2002
Bureaucratic Structure	State Unit on Aging –State Plan on Aging 2004-2008		2008
Voter turnout 2004	U.S. Census Bureau, Statistical Abstract of the United States: 2006. U.S. Census Bureau.	Percentage of voting age population that cast a vote in the Presidential Election of 2004	2004
Gubernatorial Party	National Governors Association	Party of Governor 2004 1-Democrat or independent 0-Republican	2004
Legislative Professionalism	Squire's Index of Legislative Professionalism		2003
Population 65+	2000 Census	Percent of population aged 65 and older	2000

	Data		
Population in Rural Area	2000 Census Data	Percent of population living in Rural area	2000
Median Income	2000 Census	Median household income	2000
State Fiscal Health	2005-2008 Annual Surveys of State and Local Government Finances; US Census Bureau	Ratio of total state revenue minus total state spending: to total state spending	2005-2008
Race	2000 Census	Percentage of non-white	2000
ADRC Program Design	ADRC Technical Assistance Exchange Website	Measure of State combined selection of Program Design Elements: Single Point of Entry No Wrong Door Virtual ADRC Single Assessment Tool Decentralized Eligibility	9/5/12-Date that data was pulled from TAE site.

Appendix B: Interview Questionnaire State Aging and Disability Resource Center Directors

Date: _____
Agency Code: _____

Background Experience:
_____
_____
_____
_____

Section 1: Aging and Disability Resource Center Grant Processes

I am interested in how your state has chosen to implement the Aging and Disability Resource Center grant. How do you see the grant being implemented by your state? What changes have been made to the way clients received long-term care information? What changes have been made to how your agency works with other long-term care agencies in your state?

Follow up: What were the first changes that took place after receiving the initial grant?

Your state has reported that it has a (single-point of entry approach/no wrong door approach), how would you describe what this means in your state?

Some states have chosen to implement certain tools, such as a web portal that client can access information from and a screening or standardized intake tool that can help identify client needs as well as eligibility for services. Your state indicated that it had
_____,
can you describe these tools and how they were implemented in your state.

Probe: If your state has developed a single assessment tool available for clients covered by an ADRC, how would you describe this tool and who uses it?

Probe: If your state has a web portal for clients to obtain LTC information, how is the database of information maintained? Is this portal used by only clients or is it used by ADRC professionals as well?

Follow up: Do ADRC personnel assist clients in signing up for needed services? Do they help them enroll in services outside of your agency, such as Medicaid or disability services?

Other Program Tools:

You mentioned additional elements of your ADRC program. Can you describe these in more detail?

Has your state chosen to modify the ADRC program since the first grant was received?
If so, how was it modified and why?

Probe: What years did these changes take place?

Section 2: Organizational Information
Since a major goal of the ADRC grant is to provide long-term care information to both aging and disability communities, how would you describe your agencies relationship with the disability agencies in your state?

Follow up: Were these agencies asked to assist with implementing the ADRC grant in any way?

Probe: Did they attend meetings prior to or after the implementation of the ADRC grant? Can you describe the purpose of the meetings as well as what agencies were represented?

In your opinion, how involved are other long-term care agencies in making ADRC program decisions?

Follow up: Has the amount of involvement by other agencies, such as Medicaid or disability agencies, changed since the first ADRC grant?

Would you say that your agency has a history of working with these agencies and if so, do they assist in making program decisions for your agency?

As the ADRC program manager, did you have a role in the planning of the ADRC program for your state?

Probe: Has there been multiple program managers since the initial grant?

If you were a part of ADRC planning, can you tell me how the size of the ADRC grant or other funding has influenced your program design?

Probe: Was funding by other agencies considered in how the ADRC program would be implemented?

Your agency is (a division of _____/a stand-alone state department), can you tell me if your agency position in your state government has changed in the last ten years? Has other state long-term care agencies consolidated within the last ten years?

In your opinion, do state policy decision makers understand the ADRC/no wrong door philosophy?

Section 3: Home and Community Based Services

I understand that providing all available long-term care options to clients is a major focus of the ADRC grant. Excluding Older American Act and Medicaid Waiver services, are there any other state supported Home and Community Based Services in your state? Can you describe these programs and how they are funded?

Were the Home and Community Based Options in your state a consideration when designing your state's ADRC program? If yes, then how?

Since receiving the first ADRC grant, has there been any increase or decrease in Home and Community Based Service programs in your state?

Section 4: National perspective
Did your state unit on aging participate in national conferences prior to grant application that had an ADRC component?

Probe: What was the name of the conference?
Probe: What was the agenda?
Probe: Who were the main participants?

To your knowledge, did anyone from your state unit on aging meet with ADRC program or State Aging personnel from another state prior to grant application or program design? If so, which states?

Section 5: Strength and Weaknesses

What do you believe is the most effective element of your ADRC program?

Has there been any challenge in implementing the ADRC program design that has led to changes in your state's approach?

What would you consider to be your state ADRC's greatest strength?

Have you learned anything in the process of implementing the ADRC grant that would influence future program design for similar grants?

In this study, coordination is defined as the effective interaction and partnership between stakeholders within a network or collaboration? How would you describe the level of coordination between your state ADRC program and other state organizations that share an interest in long-term care?

Appendix C: Informed Consent Form

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INFORMED CONSENT
for a Research Study entitled
"State Implementation of Aging and Disability
Collaboration for Improved Long-Term Care"

You are invited to participate in a research study to *evaluate state Aging and Disability Resource Center programs.* The study is being conducted by Jessica Gratz, graduate student, under the direction of Dr. Kathleen Hale in the Auburn University Department of Political Science. You were selected as a possible participant because you are identified as the Aging and Disability Resource Center grant manager for your state and are age 19 or older.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete a phone interview. Your total time commitment will be approximately one hour.

Are there any risks or discomforts? The risks associated with participating in this study are minimal and may include the risk of breach of confidentiality. To minimize this risk, we will code all information from your interview and will not report any identifying data.

Are there any benefits to yourself or others? If you participate in this study, you will receive a summary of results which will include information on trends and best practices associated with grant processes, state aging and disability organizational structure, home and community based services as well as any strengths or weaknesses associated with state Aging and Disability Resource Center program designs. I cannot promise you that you will receive any or all of the benefits described.

Will you receive compensation for participating? The researcher is unable to provide any compensation for your participation.

Are there any costs? There are no costs associated with this study other than the time you spend completing the interview.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Political Science or any federal grant agency.

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Your privacy will be protected. Any information obtained in connection with this study will remain confidential. Information obtained through your participation may be used to fulfill an educational requirement, published in a professional journal and presented at professional meetings.

If you have questions about this study, *please ask them now by* contact Jessica Gratz at 334-294-6031 or Dr. Kathleen Hale at 334-844-6155. A copy of this document will be given to you to keep.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR SIGNATURE INDICATES YOUR WILLINGNESS TO PARTICIPATE.

_____

_____

Participant's signature Date

_____

Printed Name

_____

_____

Investigator obtaining consent Date

_____

Printed Name

_____

_____

Co-Investigator Date

_____

Printed Name

Appendix D: Qualitative Response Tables

Table D.1 State responses to first steps to implementation

State Code	Responses
S1	They developed a website and its's not as useful as it could be…central phone number and it comes into our (SUA) office, I think it forced the AAAs to talk with the CIL and disability constituents
S2	The whole idea is that there is one place that they can call and get information and assistance. We have a 1800 number for individuals to call and when they call that number, they enter the zip code of where they need services and they are directed to their local ADRC. A pilot site in one county was set up in a AAA and an advisory council which helped to develop the ADRC, to market the ADRC. We worked with 211 to develop a resource database.
S3	Right, before then we had two sites they were both grant funded back in 2003. (We) were one of the original 12 states that got the first ADRC grant. Then we got, after the first two years, there was a supplemental funding grant that came out that we applied for and received to expand services. The original ADRCs that were grant funded, that only served a couple counties, were actually located in the senior centers in the county aging providers and were operated by them.
S4	There was a …. website that was developed when the ADRC first started but it really it is pretty limited. ADRCs were housed in the AAAs and were expanded from pilot areas to statewide coverage.
S5	I would say that we have changed somewhat as we've grown. You know we've certainly started out with the idea a of kind of being the one stop shop and now we have moved into the no wrong door kind of organization, where we're working to develop access points outside of the area agency on aging. We have an abbreviated database … for seniors that is on our state website. Right now is a query system you can go to the state ADRC website.
S6	I think the very first ADRC grant was piloted in 2 or 3 AAA, I know area 2 was one of the pilot. But I think their first go around was to pilot in a couple areas and they developed the tools and readiness review checklist before it rolled out in. Well I think from our perspective, as I remember them rolling out the program at the AAA level. The things I was hearing and seeing didn't really match up. I think a lot of our AAAs looked at ADRC and maybe still do, as kind of a beefed up version of I & A, information and assistance. They've all done that for years and it is key function that they perform at the AAA. So for a lot of them, ADRC meant just adding staff to their I & A department or doing more of the initial workup and intake on waiver clients in your I & A department. It wasn't. So it ended up being just add some staff on or you now have a little department that you call ADRC and I think they missed the point. The money and the investment was supposed to be more about transforming your whole agency into an ADRC and connecting it to a network and so we missed the boat with a lot of that and so a result as the grant ended and the money dried up, we had a lot of AAA that were really lost with that saying how are we supposed to fund the people that I hired, because they missed the sustainability part of it, in that you transformed your agency and your focus and you met all the requirement of being and ADRC and then you made that into a network, and we didn't do that
S7	Well the majority of our partners have a 1800 numbers or major I & A lines. So they

	contact the partner agencies by phone or in person or by email. In S7 we have a no wrong door system. It's been that way since its inception in 2005. It's crossed into a disability and it has been since its inception. It was built on the infrastructure of existing organizations. And we, all of those partners have a mission and a vision and our role in the community for providing the core functions of what's the ADRC is expected to provide.
S8	So back in 2003, we were one of the first 12 to get an ADRC grant and we focused the majority of our grant dollars on some of the infrastructure and formalization of aging and disability resource center work. So we utilized the funding to procure a client tracking system. We formalized our evaluation process across each of the offices. We branded by creating the …. logo. We currently have 8 contracts and those local agencies implement a scope of work. That includes what we call core services, which includes all of the ADRC functions that the administration on community living have identified as ADRC functions and that includes information and referral, options counseling, person centered counseling, our (offices) also administer our family caregiver supports through the OAA.
S9	We organize ourselves into four channels of information. The first channel is the phones. And so each of the (partners) has a toll-free number. And then the second channel is a website. And then the 3rd way is throughout in person assistance that I mentioned. And then the 4th channel is a print strategy. *** back in about 2000 made a strategic decision to align a number of activities into a single brand and not to have sort of separate silos of funding and support the strategies…board on aging holds the designation for the ADRC but our ADRC is made up of the linked (partners)… So the board is simply the designation. They hold the designation and then our ADRC model, we call it the (network) and we have about two thousand users in the network that have (a software) product installed, which is secured chat and they can also take call transfers from (other organizations). We have a lot of people in the system, so there is no reason for us to set up like a new program or a new service, we are very service rich, and what we needed and the call for our ADRC was communication. So we really embraced the NWD approach from day one.
S10	Okay, so we had what they called an ADRC until a few years ago, it wasn't really. It was like a very limited call center situation, I mean almost nonexistent. It certainly didn't meet the qualification of what nationally we're expected to do.
S11	We applied for another grant through the Federal gov't to create an ADRC. Now the first one was given to S11, was given to the University***, not to us. But we had some involvement in it but it was all before I got here. Yeah you know I think that in 2009 that was probably the main goal of the grant was to establish kind of like a virtual ADRC is what they called it. That was the perspective backed then, was that we're gonna put all our eggs in that one basket and that was gonna be it. From people's perspective if they're going to look for resource than they are going to go to this virtual ADRC. We have that it's still an objective if you look at our website. We have a self-assessment tool where people they can answer a questionnaire and from the questionnaire filters services for them. So that is a piece of it. I think back then it was a little bit more the whole pie but for us right now is a piece of it. We're still working on that.
S12	We formed an ADRC advisory council. We RFP from people who would be willing to set up (an ADRC). We got four people who said that they wanted to do it and we had an independent panel choose who that might be. What they did with the 200,000 is they

	hired… 2 to 3 options counselors through this whole process. And they have a couple of volunteers people who do phone intake when he will call in.
S13	Okay, so originally I would say that the design was fairly ambiguous. And we established our 3 pilot sites and we said to the pilot sites that you have to offer information and referral, benefits counseling and options counseling but we didn't have really any guidance to what that all meant. How we originally said to the sites was, you know, we're giving you funding to enhance what you are already doing and collect data on what you were already doing. So it was very ambiguous. So these sites work independently of each other because they are all different organization but what we've done at the state level, is try to standardize some processes so we have like a standard operations manual, we have a standardized intake form, standardized options counseling assessment and that sort of thing.
S14	You know I think initially our whole plan, the plan from the very beginning with the first grant was to expand statewide, while we started with the pilots, the plan was always to go to nine. And then with the second options counseling grant, we were able to disburse those funds to help folks get started. With our very first grant we started out with three pilot areas which were AAAs so they did both the OAA programs and the Medicaid programs, in one house…so that's how we started out and the funding went to the AAAs. We had to create this whole ADRC process and those were the three areas or the 9 counties is what we started with and that was back in 2010. We started at the beginning just defining what I& A would look like and how it would look different in the ADRC. We created our own options counseling training that is still in existence. We started developing we developed statewide standards for the ADRC that are in place right now. We also purchased our software program. Its call *** which is the name of our vender and it provides our public facing website and on the backend is a call module and a resource database for our I&A staff.
S15	So in S15 an aging and disability resource center is a one stop shop, where any individual who is over the age of 18, who is experiencing any issues where the aging or disability or maybe someone that they care for has an issue with the aging and disability
S16	So we got a grant in 2003 and then we put together the (ADRC) and those are the bricks and mortar ones and pretty much did their thing and nothing really happened for several years and then there was an opportunity to do sort of an expansion grant.

Table D.2 Qualitative Responses to ADRC Location

State Code	Responses
S1	Centralized phone number and it comes into our (SUA) office and we are woefully understaffed…we refer those calls out to the AAA's and the centers for independent living for direct service in the county.
S2	Housed within the AAA's and other Medicaid offices
S3	We moved the ADRCs into the area agencies on aging in ***. In *** the area agencies on aging do not provide any direct services whatsoever. They just monitor and funnel the money…So each of the agencies opened an ADRC which were located in their AAA and then they had to open at least one satellite somewhere in their region just to increase accessibility and availability of the service.
S4	Six ADRCs are housed in AAAs.
S5	Then we have of course all of our area agencies on aging that also serve as the ADRCs and then we contract with developmental disabilities where we have four staff to serve as liaisons between developmental disabilities and the AAA's.
S6	We have ** AAA and all ** are currently labeled as certified ADRC. We don't have any ADRC that are not part of the AAA network. It's kind of they are one in the same for us. It lacks the real characteristic of a network. It really is ** individual ADRC. There is not a real network identity at this time.
S7	So there are 10 core partners which make up the **** ADRC.
S8	So our ADRC program is implemented through contracts with local (nonprofit) agencies.
S9	Well the board holds the designation but the ADRC itself is a little bit of a different model. It has the three (partnerships) and it also has in person assistance which is delivered by people out in the community as well. In the community, there are local organizations, that are the AAAs, the CIL or our veterans (organizations)
S10	And we have six centers across the state that can be reached by going into the facility or center, they can be called by our geolocation 1800 number, they can be accessed through the website which is a resource database that is public facing and also used by the staff. What we call our *** centers. And we use that term in order to separate what we were doing, what was already going on in terms of ADRCs in our state. Well sort of both, they are contracted out to nonprofits through the planning and development commissions, which is also where the AAAs are located. There are 10 across the states.
S11	Well right now, we designated six AAAs in our area as ADRCs.
S12	Contract with nonprofit to provide statewide coverage
S13	In our state we do not have AAAs and so our ADRC program administered and run by our SUA through sub grants to local community organizations. And we have 7 ADRC sites throughout the state and those go through a competitive grant cycle every 2 years
S14	Actually now we have broke it out state wide. We have 9 ADRCs across the state, in various regions/locations, housed in AAAs.
S15	Regional centers, some are integrated with aging offices and some are not.
S16	Well we have a dual approach. We still have the existing 2, the originally bricks and mortar ADRCs that we started with the original ADRC grant that we got in 2003. But over time have morphed or developed into one statewide system which we call in S16, *** to aging and disability resources. We do a network approach to implementing ADRC. So instead of designating specific agencies or creating new ones to be the ADRC, we

network together or link together or group together under a specific structure the agencies or organizations at the local level to collectively fulfill or work together collaboratively, to collectively fulfill the requirements of a fully functioning ADRC system.

Table D.3 State and Local Advisory Groups

State Code	Responses
S1	None
S2	Independent living centers, the AAAs, the single entry point, the nursing facilities, the home health agencies, the hospital discharge planners, consumers and community center boards were all involved. I think the thing that got the highest rating when we did our evaluation was the advisory council that was set up because there was a true coordination of service within that county for one of the first time. Now seeing this at the state level with the new No Wrong Door grant.
S3	I have a no wrong door council, I have an ADRC Council. Those are my two councils but there are representatives from other state disability agencies on those. But different programs have different counsels. (At the local level) we work closely with the center for independent living but we're not still collocated with them. And nursing facilities we've built a lot of relationships up with the nursing homes. Hospital admissions, so we have some relationships with the hospitals and adult protective services we have a pretty good relationship with.
S4	It's gonna be the ADRC advisory council and is not fully formed. We're still on the process of forming that committee and setting up??? No it will include because we are limiting The number of committee members, what we wanna do is include both established ADRC executive directors from both the AAA's and ILCs and then also include the developing ADRC Partnerships and again one of the things I think being from my perspective …When I look it aging disability its really, and what we had in our an advisory committee in **** was, developmental disability was part of our advisory Committee and really engaged At our subcommittee level. When we started there was this whole thing around universal assessment and one of the subcommittee which included aging ILC, DD, Medicaid staffs, it was a pretty robust representative across state agencies. And then our partners when they said we can't do a universal assessment. Let's start with a uniform intake. So DD was at the table help building that. What I see in **** I don't see DD as being really actively engaged in the process. It's kind of like they sit on the committee but it's not really being truly integrated at an ADRC level. So the hope from the advisory committee is to really engage them and make them an invested partner in this and the same thing with veteran services. So not to have them just on the committee just to say oh we have DD and VA But to truly have them being active participants.
S5	Developmental disabilities, brain and spinal injury association, the hospital association, the department of family and children's services the Medicaid entity that actually manages the application and eligibility for Medicaid, we have partners with our state Health Insurance program, the cares program. I mean on the state advisory council we do have representation we have a couple AAA directors that serve on the council, we have local program staff for developmental disability that serve on the council. I would say our main partners…we have the centers for independent living representatives individuals with disabilities and also one of our strongest council members is the parent of an adult with a disability. So that I think we have a pretty well rounded advisory council.
S6	No, we are clearly moving that way, our advisory work group for the NWD planning

grant includes all of those agencies. So we realizing that we need to work together in concert on that. But that had not been done anytime previously.

S7 We have (an) advisory board which is comprised of both stakeholders at the provider level and consumer level, that we consider kind of our advisory group. And then our core partners have their own boards which in many are comprised of at least 50% consumer and their involved at the core partner level. And we first started this initiative we started with an overload of an advisory council that the state and local level. But given the size of S7 it was just way too much because you saw the same faces around the table multiple times and it was just asking few to do too much. So we have built in our advisory through our state level advisory board as well as our local partner boards. But we have utilize what we call our ADRC leadership team as our core focal group and they have been working together on a monthly basis of the 10 partner agencies with the state, MFP program and our veterans administration. We've been working at that level and it's really kind of the workhorses, the leadership of our partners as well as the other entities. That has kind of been the focal point for where all the work is to be done. And then we take that up to the advisory board to do a check end just to be sure that they are in support of or in line with the direction that we're going.

S8 Well at the state level we have government in the form that's still being development in a formal way but we have coming to the table our client service entity which does all of the eligibility functions and assessment functions for the dept. we have been coming to the table, we have teaching, we have DD and community MH, as well as substance abuse and child protection, you know all coming to the table. Well the physical disabilities would be handled across all bureaus, but the bureau of elderly and adult services, between them and the community mental health and developmental services, it covers physical disabilities. We do have a center for independent living in S8 just like every other state. And we do have a partnership with them but it's not necessarily in the form of state level governance. Definitely at the local level with our contractors, there are MOU's and business agreements and things like that in place with our CIL. So there are partnerships at the local level as well, with community mental health centers and our agencies that do developmental disabilities in the local areas. And they meet on a regular basis. We do have an advisory group, just for ADRC, which focuses more on grant activities, but also on the state level we do an infrastructure for governance, which includes at the highest level, what we call executive sponsors. So we have at the commissioner level people who get together every other week and we go over any decision making that has to happen or present information and vet it through them and have them inform certain things. And under that we have an advisory group that includes all of those internal DHHS groups that we talked about.

S9 It's just not something we need. In addition, the board on aging, provides the technology infrastructure for these, like the CIL that do the disability and for the senior and the veterans, so all of this is sitting on a single server that is hosted by the board on aging. You know we don't really work that way here. That would probably not add a lot of value. We have a group called the home and community based partners' panels. And some of those folks sit on the partners' panel as well as providers and associations that represent providers and consumers and that panel, we work a lot with them. So that would be more like our advisory council. But we generally go through our partners and seek a lot of advice but we just don't have a council. You know here, council's just kind

of causing problems if you don't really take the time meaningfully support them and you don't have a staff for them and those kinds of things. So we don't really do it in that way but we meet with them a lot and we do get their advice and support and feedback.

S10 We sort of have two. We have one that…I don't know if it would be considered formalized, it's certainly a group of select people, representatives from each agency. Primarily they are the people that are responsible for the waivers and so representatives from each of these agencies including Medicaid, department of human services, department of mental health, department of rehab services. We work closely with representatives from each of those in order to move forward with this. And so that smaller group it probably includes about maybe 25 people. Not all of them have attended all of the meeting we've had because we've had so many. But that smaller group of about 25 people is who are involve in the RFP process and who have attended extensive amounts of meetings since then, trying to coordinate some of this. There is also a larger group of stakeholders that we call the *** work group. And that's probably 100 people, maybe more. 100 people so that includes people from all the different agencies that are named as well as ***, doctors, different organizations like the arc. Just all the different representative, anyone who is interested in our cause are welcome to come to our meeting and play a role in the decision making process.

S11 You know I think that's probably one of our strongest attributes. Each one of them participated. I held an ADRC stakeholder feedback session and all three of the centers for independent living directors were there. Also partnerships that we have with the new ADRC grant as required by ACL is the state independent living council and the adult council on developmental disabilities and Medicaid. So the four of us are working together on the new no wrong door grant. And as I was mentioning before I'm almost certain that there's four center for independent living that have MOUs with the AAA's. I sit on the DD Council and also the state independent living council and I think we partner quite a bit, not necessarily just on the ADRC projects but on other projects as well. We've gotten a lot of support from them. I think when you look at what we inherited it was a trust issue people were afraid that they were going to be taken over they kept all of their processes to themselves but I think over the last couple years people are getting and especially with the changes that the Federal level people are seeing that yeah it is not efficient we need to make some changes.

S12 Well if you think of it as siblings, we are close. We work together very closely, we attend each other meetings, and we collaborate on projects. We have an ADRC advisory council and they are both of them are heavily involved. They assist in the decision making process where the ADRC is concerned. So we have…one of my coworkers here in the aging division, is on the governor's council for DD. So we try to work together, back and forth. We try to know what each other is doing and how we can help and how we can partner.

S13 None

S14 Within our ADRC they are required, they have a governance or a leadership counsel within each ADRC and we delineated the core partners for that, the people who need to be involved in that leadership level are (SUA) office, AAAs, and CIL. Those were the core three that we started with. But now as the feds are starting to expand the program they will be bringing the DD and ID. They will be bringing in mental health, veterans. Some are already bringing in drug and substance abuse programs and trying to keep up

	with what we see coming from the feds, ACL and they feds. And comply with what they are identifying as the ADRC partners. Right, so there's this leadership counsel and we also require them to have an operations counsel that should be made up of core partners and 50% consumers as well. And that operations counsel really drives the operations of the ADRC and how they deliver services.
S15	We do not…we have an advisory council but it's mainly staffed with different…I don't think DVR is on that. We do have the board on aging and LTC, on that advisory council. The LTC advisory council, but there are a lot of providers on that council or provider association. (At the local level) The governing board, needs to have representation of target groups that are served by the ADRC, so they need to have individuals who represent people with physical, developmental disabilities and aging. And then the governing board is the one of the organizations that monitors the effectiveness of the ADRC. So the board has some extent on what it needs to look like, but the statutory requirements also specify what the board needs to do to determine that the ADRC is effective. Now I don't know if you know that we are in the midst of a new budget cycle and there are statutory changes proposed to aging and ADRCs. So some of the changes, would change what I am telling you, so but they are not enacted yet, so I am just telling you what we have now.
S16	I would say that's true. the types of meetings and organization that goes on at the state level between these groups either they might jointly administer a little bit of they might pool a little bit of money to jointly administers some funding opportunities or at the local level aging offices and intellectual disability or behavioral health or intellectual disability offices to do some joint training or programming or those kinds of things. Or we sponsor a joint conference once a year and that kinds of stuff. But we're not doing true administrative level we are not at the state. Aging does their thing, the department of human services does their thing.

Table D.4 Strengths

State Code	Responses
S1	Probably forcing the conversation. In recognizing the interconnectedness of the services in the community. The desire and the buy in from the AAAs
S2	It would be our advisory councils
S3	I would think the staff most of the staff that I have been with me since day one in 2007 so I think that is really an asset to us. And I think just having senior staff that's been around so long that really understand the services and support is really beneficial to us. Our think our resource database is really good to all though I wish I had some help keeping it up to date.
S4	It's interesting because I think um again going back to when I was in *** I looked at S4 and said hey they really got it and they are developed the ADRC and I want to use this. Having seen where they are now, they put together a brokerage model in terms of looking at services and really selling it to hospitals and managed care plans. Which I think is a strength but not every ADRC is there and they bring a good bit of collaboration to the table.
S5	I think the integration between aging and disability. With some of that state funding that I mentioned earlier that we have, we've used some of that and paid the salary for four staff in the disability department to serve as liaisons to our AAAs, and we have consistently done that since the beginning of that funding and so that is a really strong partnership. And I would say that some of the work that we've been able to do just in bringing disability resources into our database and then having individuals within the disability community work with us closely.
S6	I think most of the AAA their strongest point is their local connections to local resources and organizations. They haven't formalized those with MOU to the extent they should. They haven't captured them in databases the way they should and so it's largely knowledge that gets lost with the person. When they have staff turnovers they don't have relationships with. All the relationships are very personal in nature and so there's some strengths they but overall it makes us very ineffective
S7	I think very early on just the fact that we did not phase in partnerships. We started from the very beginning with equal partnerships across our various networks including the aging and disability networks. And I think that that fundamentally was a critical strategy because what I've personally seen in other states is when you have the aging network sort of initiating all of this and then adding and disability afterwards, there's this perception that that their sort of just tacked on at the end and a sense of the quality is not the same. So we really very cognizant of ensuring that we brought in all of our disability partners at the same time. We are also very transparent in how we do our grant funding so that all of our partners get in equal base of grant funding. And then depending upon the various activities or the type of things that were involved and some of our partners may receive additional funds. And everybody knows that and everyone supportive of it. All of our partners get the same base and then some additional funds based on activities. And that goes a long way in building trust and in building appreciation for the fact that they're all in this together.
S8	I guess I would just have to say, the overall model and how we've implemented it statewide. And infrastructure.

S9	I think where we're unique is our technology infrastructure. I don't think anyone has what we have yet, maybe they will get there but they don't have it yet. So that makes us unique. I wouldn't say that's my favorite but it is definitely something that makes us different from the rest of the world. The other thing that makes us different is that we have a very purposeful branding strategy.
S10	None of this would be possible if we didn't have the work group that we have that has been able to increase positive working relationship. We have much been relationship with people from all the different agencies. To my understanding before I came into this job, there were not very many healthy relationship among all of the different agencies and now we work very closely with Medicaid. With rehab and with mental health and are able to all make decisions together. Which has been hugely helpful.
S11	I think the partnerships. I think that we everybody wants to see, everyone has a shared vision. When I established my stakeholder meeting back in early December everybody was super eager to get together and work on this and all of us have this shared vision that people are accessing these long-term care resources and that their accessing them in a streamline manner. So I would probably say that that is our strongest attribute.
S12	Probably our options counselors and the way that they work. You know they are very very busy and they provide statewide services, regardless of the fact that they are in two locations themselves.
S13	I'm thinking the most effective part of our ADRC, I think it has been bringing together partners and opening up conversation.
S14	I think our options counseling is probably working well. I think you know while we don't have a lot of users on our website as far as consumers I think that is the backbone of our system. Our resource database, our website, that old module um were gonna see more people using the website. I think people will age into it. Most of our consumers still, the first contact is via phone but we are see that might grow as well. But I would say the options counseling and the website database are our two critical pieces.
S15	I think that the conversations, the individuals are well trained in how to have conversations with people. How to listen, how to get at the real issue. Sort of like a root cause analysis but done in a very people centered way. So that people are not wasting their time by contacting the ADRC. You know we have challenges in getting people to talk to the ADRC. And getting our name out there more but we don't want, you know the last thing we want is for people to feel like they wasted their time in contacting the ADRC. Our evidence seemed to suggest that if they do contact the ADRC they are getting good information and that is from that person listening and getting the key components out.
S16	Definitely the partnership development and I would say that includes that cross training piece right. the ability for them to work together and at the local level has probably had the biggest impact on the residence of Pennsylvania and on the individuals who work at the local agencies in terms of having more training and more support and more options themselves and so that's probably yeah even though it's hard to measure on some level, if someone can help me figure out how to really measure I would love to figure that out.

Table D.5 Challenges

State Code	Responses
S1	territory issues, mixing the clientele
S2	funding for young disabled
S3	You know I think we've struggled with the documentation piece of harmony some staff have it down pat really really well some not so much. I think we struggled with keeping the resource database up-to-date although I think it's a great directory and with the budget cuts we still have to look at, we used to have a lot more staff, and when somebody would call the ADRC like we had live people answering the phone and you used to get assistance right away.
S4	So the development phase of each one is so individualized rather than there being some consistency across and again I think in states where I've talked to or seen where the ADRC has been really driven from the state level, with staff-that have staffed it that have really done the development and participated it seems like they've gotten further rather than taking the approach of at the state level we would do the grant, we would do the allocation but really it's been more of I think a hands off approach. so to me I think there's a happy medium between allowing for the flexibility for ADRC to really develop at a local level but from a consistently standpoint across the state yes you have that designation criteria it seems like Historically Involvement at the local level has been pretty hands off . That 10 years plus we only have six ADRCs in *** that's huge. And again I think one of the challenges for **** is not only the turnover in the program staff but really having it And that's me is the big one that's been a personal challenge for me because I know ADRC from an ***** standpoint but coming in and stepping in to a program that you got the long history of it but then the fact that its transitioned from aging to agency and has come back. That's been difficult as well and I think with some of our AAA's they are moving forward in spite of the fact that there isn't funding for ADRC. knowing and feeling that there's a commitment that this is the right thing to do so we're gonna do it anyway, but still having partnership that say well where's the money. Well it's not about where's the money but it's looking at the current infrastructure and how you can streamline the process and move forward with something like this it is not an easy thing to do.
S5	I don't know that there is anything that we are still struggling with now, you know there are probably still people out there that don't really understand the aging and disability resource connection, they don't understand the integrating and streamlining, but I think it probably always gonna be that way. You know there are a lot a people out there that don't even know that aging services exist or disability services exist. So you know I would say we've had improvement in that area but I think there's always gonna be a little bit of that there.
S6	Consistency. Really we are hammering that at them all the time that we have to get ourselves to a point where there's consistent consumer experience no matter which ADRC they get in touch with.
S7	Well as think one of the challenges that that we still struggle with is that particularly with our it intellectual and developmental disability partners, it's still a model whose language and whose terminology and whose audience often is does not resonate with our partners. Even though they fundamentally believe in our concept and they are doing what we

believe is a options counseling and what we believe is Person-Centered assistance, the world that they work in and the language that they use and the fact that they work a lot with parents and families, is often very divergent from our aging partners and agencies, and even at the Federal level the language that's learned or used in the forms and the expectations. So we've had to work very hard to ensure that that we modify or make adjustments to accommodate the differences and really the population that they worked with and the framework in which they work to support the consumers.

S8 Yeah, I think it's just the growing pains that we struggle with. You know the…you know over the years, expanding and enhancing means getting bigger, more volume, more staff, more infrastructure and making sure that there are sufficient resources to support growing. You know sometimes the growing happens before the resources and that is tough.

S9 The technology architecture is challenging. You know *** does not have the kind of penetration of broad band that I wish we had. I think that is something that we could really benefit from if the feds did a little bit more purposeful Wi-Fi access around the world. That would be good. And you know just in general, some of these small shops that are doing a lot of work, that are doing a lot, I'm talking about the little food shelf inside the church in the little town. You know we have a lot rural areas in ***. And that's whose really keeping it together for the people. Are these little small providers, well those folks don't have technology. So how do you engage them and make sure people know about them. And maybe they don't want to be known about. So I think that is an interesting challenging that we have.

S10 Sure, I think that my answer about what has been the most helpful has also been the most challenging because nobody wants to change what they've been doing. Everybody wants to make things easier but change is very difficult and everybody has had to compromise in that department. So everybody lack of flexibility has certainly been a challenge in the past and continues to be challenge in the future as we work with these agencies and the planning and development districts. Our lack of funding is also extremely concerning. It would be really unfortunate to lose all of the work that we have done, the planning and development districts could not pay for all for all of the max centers should the federal funding run out, which it's going to.

S11 I think what they wanted to see at the national levels that we had shared systems and I think that's probably been the most challenging. Medicaid has a certain way of doing things and we have a certain way of doing things. I think those kind of conversations can be somewhat sensitive…you know all agencies have invest a lot of money into their application systems and to change those or to adapt those to others it is difficult it is just a difficult thing of changing and having everyone use a similar system or have access to only a piece of a system. There's just a big difficulty with identifying is there one no wrong door system that everybody can have access to parts and pieces of. Instead of investing in their own silo system. There's a lot of silos that are out there

S12 Got to be funding. On so many levels.

S13 For us we are struggling and it has been a struggle, in terms of options counseling. Implementing options counseling, getting our local sites to see how it's different than the regular I&R assistance and also getting the community buy in for what it can do for our state.

S14 I would say we struggle because of our structure here and the idea that the AAAs are the

	in charge that they are the ADRC sort to speak. Our Aging and people with disability field offices are crucial to that relationship and I think we struggle with that. ADRC is AAA is *** is CILs and making sure that everybody understands that they need to be equal partners with the ADRC. It would seem to me when you look at the whole premise of the ADRC if they were really creative, they would be figuring out how to share I and A staff and how to share options counseling and how kind of cohabitate in the same building and really maximize their resources, and if they came together as a team they could it seems to me they could do a lot more. But it's really difficult to get them to look at the ADRC in that perspective. Maybe it comes down to territory I don't know. Dollars, dollars, dollars.
S15	I think the biggest challenge, with every pro there is a con. There are all sorts of pros for linking up with counties to provide ADRC services, the con there is that counties are independent governmental agencies. So you know there's just a whole political aspect there that is hard. 72 different independent political entities. You know with their own elected officials. The and there are a lot of pros two organizing… to linking up with counties because of the statutory requirements that they serve certain people because of the aging units etc. but boy it's got some cons to.
S16	Sure everyone uses a different information management system. Our biggest challenge is that most of the organizations that participate as part of the ADRC, we don't really have any administrative authority over. So they're doing it out of in essence goodwill or pressure from their own administrative entity because we've asked them to pressure them. So administratively that makes it difficult. If it would be if there was funding available it would be much easier to have a number of bricks and mortar sites across the state that really have their own staff and those staff identified themselves as ADRC staff.

Table D.6 Lessons Learned

State Code	Responses
S1	You really have to have, you need a strong leadership. And you need it to be consistent.
S2	I think we've learned a lot of things but I think personally that the number one thing that I would say is that before we would pilot we would have at the state level the… more of the planning group or the advisory group so that all the departments would work together and then once we implement that it would be easier you know within the local communities to get those individuals to participate.
S3	I would just say that when we first got started we really had this envisionment of these physical location where people could walk in all the time and we took the money we had and we built, we didn't actually build them, we rented building space. So I guess I had this envisionment that we had to be this separate entity, but it was just that's all we did was the ADRC, and I guess as we got more involved in the system, we were just going to do aging and disability, you had to be 18 and old with a physical disability or you had to be over the age of 60. That was kind of all the resource information we had up front, that was what we were used to working with, those were the populations we had familiarity the resources. And then we started getting calls from people that were seniors but they were raising grandkids with disabilities. Or we were working with someone with a physical disability who also had a mental health disability. We really quickly found that we couldn't specify a very specific population that you are going to serve because within that population are other needs and populations that need the service. And it really not possible for one person to know everything.
S4	So in the discussion with other states and some of the existing ADRCs it's really looking at we need a look at a regional ADRC. There's gonna be some areas and state that will not have the bandwidth to do an ADRC. so was really kind of looking at how to map out of regions, the capacity and really taking a totally different approach rather than for every area agency in a county and the counties are current and well the interesting thing is with **** County when you look at the area agency for that county you've actually got six or seven counties that bleed over. So she has one establish county that has established an ADRC and she has two more counties that she's developing Into an ADRC. And so it's a big challenge to look at and as you look at her area and say well if I do a regional then I have three ILC's sitting in one region. So just mapping it out looking at the local level is challenging.
S5	You know I think initially, there was this and a lot of this was coming right before I came here, but We received a nice chunk of funding to get the ADRC started and the plan was to start it slowly with only five areas and we threw a lot of money at those areas, and in retrospect, I don't know if we needed to. Because we have been able to accomplish the same thing with all the remaining areas and to get them on board with much less money. And part of it I think I felt like if we had used the approach that yes of course some level of funding is necessary and helpful but a lot of this is what we should be doing anyways and it's not that significant of a change in your day to day work. I would say the biggest change, certainly you have to learn more about disability and understand the etiquette and your call volume is going to increase. And the volume of the services that you provide but this need to just put all this money out to organization and it ends up being spent on marketing items that I'm not sure if beneficial. I just feel like, yes it does take money to

sustain it, and probably where we need a lot of funding is on paying for additional staff positions so that we improve our services and improve our marketing and outreach and the call volume increases and you want to provide really good quality service. But outside of that this is a program I think, that it doesn't cost that much to operate.

S6 Probably the biggest lesson is that we have to take more a leadership role. I think there was a reliance on the AAA since they are connected. They have their own trade organization, they talk to each other. There would be more cohesiveness there that they would work on that together and it doesn't happen organically, the state really does need to take a leadership role in setting consistent policies for expectations and reinforcing that all the time.

S7 Yeah I think that one of the areas that we are looking to expand to is behavioral health. And we very much want to bring in our community of mental Health Partners but it's a matter of the right timing. Their very taxed right now financially and otherwise. But I think that the lessons learned that we've taken from the equal partnership and engagement and transparency would be the same approach and strategy that we would want to take with new partners going forward. We believe that that's a critical and successful way of doing that. But we also believes very strongly that we don't want to impact the efforts to date over the last 10 years of our current partners, and in a new partner in a new grant kind of an extension of what we're doing would need to be within the full vision and commitment of what our partners have laid out, so that the integrity of what we have been trying to do any integrity of the services and the expectations that the partners have put out would be held to the same standard for any new person or group coming in. Knowing that there's going to be a learning curve and that there's going to be training and a process of familiarizing, but ultimately they need to be holding themselves to the same standard to be considered a partner.

S8 I definitely have, with this grant in particular, you know there's a lot of, I think there's been a lot of growing and modeling happening at the federal level which has assisted at the state level, us to shape how we want to model and have leadership for the work that we are doing and how we want to coordinate stuff… You know a lot of these other initiatives, if they are not coordinated, then your kind of missing the opportunity. With this part a grant, it really has been beneficial because we have collaborated and worked across divisions and bureaus more than any time before.

S9 None

S10 That's a hard question for me to answer since I wasn't involved in the planning. I think the lack of collaboration. The lack of guidance that were started. So they didn't receive any additional funding or guidance so that was difficult that they could have met any sort of standards. And the lack of person center thinking is sort of a new way of doing things from what I gather. The ADRC system that is very much not how they were doing things before. It very much was just a call center. So policies in terms of processes are lot different now than they were now. Otherwise I would probably need to talk to somebody else about what we learned from our original.

S11 None

S12 Yes we have really, one of the thing we have learned is having a standardized assessment would be really helpful, and we were, it was actually kind of in systems start when we first began as to which data elements we wanted and needed to report on, having that settled is really important and I think also taking into consideration the other agencies in

	the state that you could really work with, not just partner with but work with.
S13	I think I would say currently the lesson learned is early engagement of broader group of stakeholders. Which is something we have tried to correct with the NWD planning grant.
S14	I think they all ??? like with the 1800 number you would go to the AAAs. Again, it's all set up to have them. Like I said hind sight is 20/20 cause that has really been problematic for our system. Because they do think they are in charge they do think that they make the call because they have the money because that's how we set it up. I think we are finally turning the corner but it has been difficult. One of the things I wonder not having been immersed in this for very long, specifically with our state having 17 AAAs and yet we only decided to have 9 ADRCs and just the way our state is laid out population wise for our central and eastern part of the state, we are talking huge miles and huge territories for those ADRCs, and two of the ones that are struggling the most are in those areas, and we're talking border to border, north to south are included in one ADRC. And even being rural each one of those counties is probably unique and different in and of its self and then bring them together as one ADRC has been one of the biggest challenge. We are making strides, no question about it, but that would be something, that I would have thought twice about. That's the other thing, when we were deciding what the ADRC regions would be, we had the AAAs, they have an association and they kind of laid out how it should look, and again, hind sight that probably wasn't the best way to go. The way they laid it out, it has that whole eastern region, maybe we should have done it a little bit different it may have made things a little bit easier. When you have vast miles between offices, like 2 hours driving distance, it is problematic, no matter what you do. Those little AAAs they need to be condensed down into something else, they just are not able to…its very problematic in that they don't have the capacity to do the work and finding people to do the job is very difficult as well.
S15	I think the easiest lesson learned would be something that would be easy to implement would just be to require everyone to use the same IT system. Really easy to implement that. An aegis makes a whole bunch of stuff a lot easier. Data collection, improving data collection, evaluating data etc. it just makes all lot easier if everyone uses the same system. It would just be a lesson learned.
S16	Which I would argue that's what the planning grant is. It is also a systems or a potential systems it's an opportunity to do a systems change and hopefully there's implementation dollars multiyear implementation dollars, down the road. I guess the thing that I would that would strike me the most as the takeaway is you've really need to is the communication with and the buy in from the leadership at the top of the administrative chain, from the governor's office down and or from the legislative perspective down. You really need you need to have the buy in from people high enough up that they can keep you on track. And when you're crossing so many historically silo'd segments you need someone above all those silos to keep the direction for you and to keep the flow and I think that if you really don't have that you'll have much less success and much more difficult road to pave and if you do have that it's amazing what kinds of things you can get done

Appendix E: Fully Functioning ADRC Criteria

Aging & Disability ResourceCenter
An initiative of the U.S. Department of Health and Human Services
TECHNICAL ASSISTANCE EXCHANGE

Core Components and Criteria of a Fully Functional Aging and Disability Resource Center (ADRC) At-A-Glance

Updated March 2012

Information, Referral and Awareness (I&R/A)

- Formal Marketing Plan for All Ages, Income Levels, Disability Types
- Marketing to and Serving Private Paying Populations
- Systematic I&R Processes Provided Across all Operating Organizations
- Follow-Up on I&R Services
- Online Comprehensive Resource Database, Public and Searchable

Options Counseling and Assistance

- Formal Standards and Protocols Guiding Delivery to All Income Levels and Disabilities
- Short-term Support in Crisis/Urgent Situations (Preventing Institutionalization)
- Follow-Up on Options Counseling Services
- Futures Planning for Long Term Service and Support (LTSS) Needs

Streamlined Eligibility Determination for Public Programs

- Coordinated/Integrated Process for Financial and Functional Eligibility
- Standardized Intake and Screening Across all Operating Organizations
- Uniform Criteria to Assess Risk of Institutionalization
- Functional Eligibility Determined On-Site or Through Seamless Referral Process
- Personalized Assistance in Financial Application Completion
- Financial Eligibility Determined On-Site or Through Electronic Exchange
- Applicants Tracked through Determination Process; Follow-up with Ineligible Individuals

Person-Centered Transition Support

- Formal Agreements with Critical Pathway Providers and Protocols for Providing Transitions Support, Referral Processes, and Staff Training
- Local Contact Agency Designation (MDS 3.0 Section Q)

Consumer Populations, Partnerships and Stakeholder Involvement

- Staff with Capacity and Training to Serve All Ages and Disability Types
- Consumer Involvement in Program Design, Operation, and Quality Improvement
- Formal Partnership Agreements, Protocols, or Contracts with:
  - Critical Aging and Disability Organizations
  - Medicaid
  - State Health Insurance Assistance Program (SHIP), Adult Protective Services (APS), and 2-1-1
  - Veteran's Administration (VA) Medical Center(s)

Quality Assurance and Continuous Improvement

- Formal Sustainability Plan with Diverse Funding Sources
- Adequate Staffing and Management
- Continuous Quality Improvement Plan and Procedures in Effect
- IT/MIS Supports All Program Functions
- Routine State Level Performance Tracking
- Routine Local Level Performance Tracking