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Georgia aging and disability resource connection expansion evaluation

Georgia Health Policy Center

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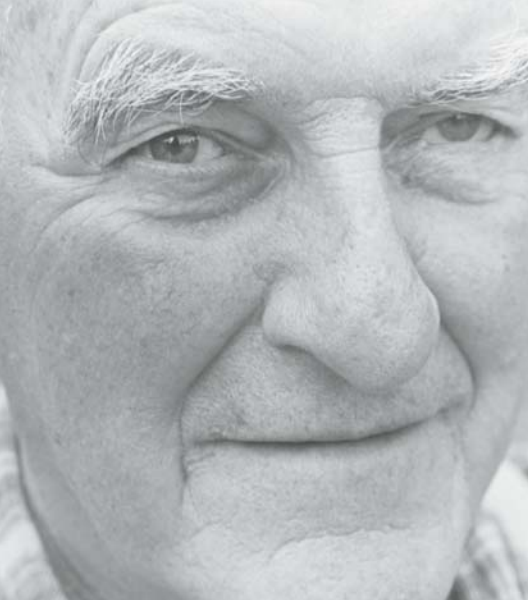

Georgia Aging and Disability Resource Connection Expansion Evaluation

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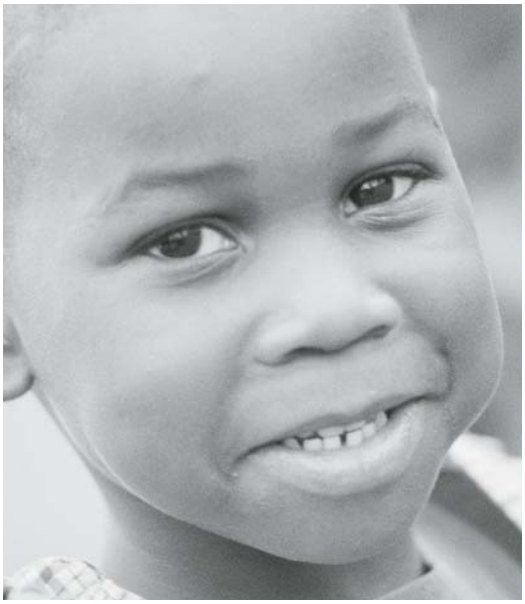
Division of Aging Services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Georgia Aging and Disability Resource Connection Expansion Evaluation

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The Georgia Department of Human Resources
Division of Aging Services

By

The Georgia Health Policy Center

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Background

In 2003, the Federal Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) launched the Aging and Disability Resource Center (ADRC) grant initiative. The ADRC initiative has as its mission to provide a citizen-centered "no wrong door" approach to accessing the long-term care system in local communities. Central to the mission of the ADRC is the recognition that the elderly and individuals with disabilities use the same long-term care services and face many of the same barriers and frustrations when attempting to access needed information, support, and services within the long-term care system. The ADRC seeks to provide consumers an integrated system of access that reduces confusion and duplication of efforts among service providers in local communities. ADRC grantees develop entry points within their communities through the implementation of three central ADRC functions: information and awareness, assistance, and access to public and private resources related to long-term care needs. [1]

The ADRC seeks to provide consumers an integrated system of access that reduces confusion and duplication of efforts among service providers in local communities.

In September 2004, Georgia was awarded a three-year ADRC grant from the Administration on Aging and the Centers for Medicare and Medicaid Services. The grant resulted in the development of two pilot site ADRCs, one serving the Atlanta region and the other serving the greater Augusta region. In the FY2007 budget cycle, the Georgia General Assembly appropriated $700,000 to expand the ADRC model to three additional regions encompassing both Area Agency on Aging (AAA) and Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) regions: Northeast Georgia, Coastal Georgia, and the Southern Crescent.

As described in a Statement of Need released by the Division of Aging Services, successful ADRC grantees are expected to create a visible and trusted source of information and support within their communities, streamline access to long-term supports, establish information technology systems to support the efficient functioning of the ADRC, and identify strategies and resources to sustain the program beyond the duration of the grant.

The Georgia Division of Aging Services (DAS) contracted with the Georgia Health Policy Center (GHPC) for an evaluation of the initial implementation of the ADRC model at the three expansion sites. For the ADRC expansion award, DAS requested the following evaluation services:

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[1]The Lewin Group. Aging and Disability Resource Center Technical Assistance Exchange Website. *The Aging and Disability Resource Center Interim Outcomes Report*, accessed on 7.17.07 at: http://www.adrc-tae.org/documents/InterimReport.doc

1. Uniform reporting impacts
2. Assessment of advisory board activity
3. Assessment of coalition activities and partnerships
4. Assessment of the relationship with MHDDAD
5. Explore cost/benefit and/or ROI of ADRC expansion

This report provides a description of the process evaluation findings related to ADRC implementation approaches in each of the three expansion sites, presents an initial evaluation of the role and functioning of the ADRC Coalition, and describes the formation of the collaboration between the AAA and the Regional Offices of MHDDAD at each expansion site. A framework is included to provide benchmarks for successful collaboration development, and the process of program logic modeling is discussed as an evaluation framework that might guide future process and outcome evaluations of the partnerships and collaborations that are instrumental to the effective functioning of the ADRC model in Georgia.

Data Collection Methods and Analysis Approach

In order to evaluate the implementation of the ADRC at the expansion sites in Northeast Georgia, Southern Crescent, and Coastal AAAs, evaluators collected primary and secondary programmatic data by the following means:

1. Review of relevant ADRC program materials from local sites, the Georgia DAS, and the federal AoA;
2. Observation of relevant ADRC state working group and quarterly partners meetings;
3. Review of expansion site proposals for stated vision, mission, values, goals, activities, and objectives;
4. Site visits and interviews with key informants from the two ADRC pilot sites in Atlanta and the CSRA;
5. Site visits and interviews with key informants from the three expansion sites in Northeast Georgia, the Southern Crescent and Coastal areas. Semi-structured interviews were conducted with ADRC personnel at each site as well as with selected ADRC Advisory Board members.

Program information collected from key informant interviews, through ADRC meeting observations, and through document review was analyzed by major thematic areas:

- Understanding of ADRC intent and vision
- Communication strategies
- Infrastructure to support ADRC mission
- Partnerships and collaboration
- Sustainability
- Challenges and expectations

- Technical assistance and support needs

Key findings under each thematic area were summarized and compared across each of the three expansion sites to identify shared and diverging patterns of experiences and perspectives. A synthesis of the key findings is presented below.

Overview of Program Approaches

Program models vary in organizational structure, and sites have implemented either a decentralized model or a blended model that combines elements of the centralized and decentralized approaches. In a centralized ADRC model, one organization has the primary responsibility to implement all of the ADRC services to all target populations. A centralized model partners closely with other community organizations that serve on the ADRC Coalition, help market the ADRC, and refer their clients to the ADRC.

Program models vary in organizational structure, and sites have implemented either a decentralized model or a blended model that combines elements of the centralized and decentralized approaches.

In a decentralized model, two or more organizations collaborate to deliver ADRC services, allowing consumers to access ADRC services through multiple entry points. Decentralized models standardize the intake and referral procedures and share data across organizations in order to ensure that consumers receive the same standard of information and referral. In both centralized and decentralized models, grantees work to simplify the process of accessing services and to impose consistency and uniformity across the intake and eligibility determination processes for long-term care programs[2].

The federal grant awarded to Georgia in 2004 resulted in the development of two pilot ADRC sites in the Atlanta and Central Savannah River Area (CSRA) regions. In the Atlanta region, the Atlanta Regional Commission (ARC) AAA partnered with the Atlanta Alliance on Developmental Disabilities (AADD) to implement a decentralized Resource Connection model, while the CSRA AAA implemented a centralized Resource Connection model. In the expansion sites, the DAS mandated that the AAA collaborate with the regional MHDDAD in the implementation of the ADRC. Funding is provided through the ADRC expansion grant and is supplemented by monies from the State Office of Developmental Disabilities to fund the ADRC staff positions within the regional MHDDAD offices.

The Southern Crescent region originally proposed a centralized ADRC model, but with the inclusion of its MHDDAD partner, it is now implementing a decentralized model. The Southern Crescent AAA provides information, referrals, and assistance through the existing

[2] The Lewin Group. *The Aging and Disability Resource Center Interim Outcomes Report*. Accessed online 7.17.07 at: http://www.adrc-tae.org/documents/InterimReport.doc

Gateway Program. The Southern Crescent's Gateway Center was developed to serve older adults and their caregivers seeking information and referrals to local resources and services. Gateway specialists receive training on resources and services available to the disability community, and information, referrals, and assistance are provided through the ADRC by utilizing existing Gateway staff and infrastructure. A state-level Memorandum of Understanding between Southern Crescent AAA and the MHDDAD regional office links the two agencies, and an ADRC Specialist within each organization serves as the point of contact for the collaborating agencies, partner organizations, and community stakeholders. The MHDDAD regional office also has access to a read-only version of the Enhanced Services Program (ESP) database in order to provide referrals to both aging and disability resources.

The Northeast Georgia AAA is implementing a decentralized ADRC model. A staff person from each of the AAA and regional MHDDAD offices is dedicated to the project and receives cross training on issues, needs, resources, and programs available to the elderly and persons with disabilities. Information and referrals provided through the ADRC come from staff located in each office.

In their proposal to DAS, the Coastal AAA described the planned implementation of a "blended" ADRC approach that combines characteristics of both the centralized and decentralized ADRC models. This blended approach calls for the central coordination of services by two cross-trained staff members, one located within the AAA office in Brunswick and the other located at the MHDDAD regional office in Savannah. The referral process remains decentralized, and consumers contact either agency that has historically provided information and referral supports to the elderly, persons with disabilities, or caregivers. Participating referral agencies agree to refer clients who need information and referral supports from multiple sources to an ADRC Coordinator at the AAA or MHDDAD regional office.

ADRC Coalition Activities

The Statement of Need issued by the DAS required that successful grantees have in place a Coalition to serve in an advisory role and provide guidance to the AAA and the MHDDAD regional office staff in the implementation of the ADRC in their region. For each of the three expansion sites, the local CARE-NET Coalition serves as the ADRC Coalition.

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Georgia has a network of twelve CARE-NETs across the State. The CARE-NETs, originally developed by the Rosalynn Carter Institute for Caregiving beginning in the 1990's, are collaborative networks of professional and family caregiver organizations that develop educational programs and support services for caregivers. In each

of the three expansion sites, the CARE-NET was established prior to the award of the ADRC grant.

Coalition Partner Views on the ADRC Mission

Most CARE-NET members interviewed at the three expansion sites were able to describe the mission of the ADRC. Many informants talked about a "one-stop shop" and a collaboration that will reduce duplication of services and "stop people from falling through the cracks." Most of the informants interviewed were able to speak to the importance of this core mission of improving people's experiences accessing information and referrals for long-term care services. A CARE-NET member from one site described the mission of the ADRC this way:

Most of the informants interviewed were able to speak to the importance of the core mission of improving people's experiences accessing information and referrals for long-term care services.

> *It is a gate-keeping mechanism for families who have a member who is aging and has a developmental disability or for aging parents caring for a child with a developmental disability. It limits the duplication and replication of services. Families are less likely to fall through the cracks because services are pulled together and families get the services that are most suited to their needs.*

The CARE-NET's Role in the ADRC Initiative

Informants interviewed at the three expansion sites consistently reported that the local CARE-NET has expanded its mission to incorporate the objectives of the ADRC. Informants at each of the three sites believe that bringing the ADRC under the "umbrella" of the CARE-NET encourages the CARE-NETs (which were more focused on the aging population) to expand their missions and focus on developmental disability issues as well.

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Informants across the three sites agreed that the CARE-NET is an appropriate entity to serve as the Coalition because it is an existing collaboration that brings together key partner agencies that are actively involved in providing long-term care as well as information to the ADRC's target populations. The creation of a formal connection between the ADRC and the CARE-NET enables local long-term care and caregiving agencies to receive regular information about the ADRC and its services. In addition, informants perceived that representatives from local community agencies are "meeting-ed out" and that adding an additional meeting to their already full schedules would be met with resistance. The fact that the CARE-NET Coalition is an existing group that is currently well attended by key partners is an additional advantage of using the CARE-NET as the ADRC Coalition.

Across the three sites, informants described the role of the CARE-NET as more of a partner to the ADRC than as an advisor. None of the informants interviewed characterized the CARE-NET as serving

in an advisory capacity or as a decision-making body. Informants reported that the activities of the ADRC are folded into general program updates or "report backs" during the agenda at the CARE- NET meetings. For many of the informants interviewed, the opportunity to share information with providers and caregiving agencies at the CARE-NET meeting is significant to the growth of the presence of the ADRC in the local community.

Level of Interest of CARE-NET Coalition Members

Informants reported varying degrees of interest in the ADRC among CARE-NET members. Program staff and CARE-NET members interviewed noted that those providers who had experienced the "overlap" in their own agencies (i.e. providing information or services to aging caregivers of children with developmental disabilities) or who had direct contact with consumers were more interested in the initiative. Most of the CARE-NET members who were interviewed were unaware of the ADRC's external communication efforts and collaborative partnerships or ADRC efforts to gather input from key stakeholders. Their knowledge of and interest in the ADRC was more focused on what they see to be its core mission of bringing together the Aging and developmental disability (DD) communities in order to streamline information and referral services for consumers.

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Constituencies represented on the CARE-NET Coalition: Who's there and who's missing

Informants at each of the three expansion sites reported that CARE-NET meetings are often well-attended. They perceive that participating agencies send "key" personnel to the meetings and that those who attend the meetings are highly motivated and often personally invested in the mission of the CARE-NET. When asked to list key representatives not attending the CARE-NET meeting, informants at all three sites reported a lack of representation from the DD community. Many informants perceive that the CARE-NET and the ADRC continue to "tilt towards Aging." Representatives from the local Division of Family and Children Services (DFCS) office also do not regularly attend the meetings. There is a feeling that because the CARE-NET is so oriented toward caregiving, critical partners may not feel they belong at the meeting or that the meeting is not worth their time because most of the information discussed is not relevant to their daily functions. Multiple informants also said that the Coalition membership should expand to include representatives from the faith-based community, local government officials, representatives from the physical disability and mental health communities, and family (non-professional) caregivers.

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Future Steps

In two of the three expansion sites, ADRC staff spoke of their desire to have an advisory body that is dedicated more exclusively to providing guidance to the ADRC. At one site, program staff discussed plans to convene an "ADRC Subcommittee" of the CARE-NET Coalition that will focus on issues related to the ADRC.

In summary, the informants agreed that the advantage to utilizing the CARE-NET as the ADRC Coalition is that the CARE-NET is an existing entity with a strong and active membership made up of agencies actively involved in caregiving in the local community. Folding the ADRC initiative into the CARE-NET mission ensures that key professional stakeholders are aware of ADRC functions and can communicate the initiative within their respective agencies and to other partners in the community. Informants across the three sites expressed the desire to see an expansion of the membership of the Coalition to include representatives from the mental health, DD, and physical disability communities, as well as from the local DFCS office and local government.

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ADRC Relationship: Collaboration between AAA and MHDDAD

The central goal of ADRC, as set forth in the Division of Aging Services' Statement of Need, is to create and sustain a "one stop shop" at the community level that will serve the long-term care needs of all individuals, regardless of age or disability. ADRC funding proposals submitted for consideration to the DAS were required to have the support and active participation of the regional MHDDAD office. The ADRC model is structured to focus on cross training between MHDDAD and AAA staff, the development of referral and cross referral protocols, and increased communication and linkages between the two agencies at the local level to ensure the seamless provision of information and referral assistance regardless of how consumers access the Information and Referral (I&R) system.

The ADRC model is structured to focus on cross training between MHDDAD and AAA staff, the development of referral and cross referral protocols, and increased communication and linkages between the two agencies at the local level.

Informants were asked to describe the nature of the partnership between the local AAA and MHDDAD agencies and the process of implementing the ADRC in collaboration. Program staff and CARE-NET members alike spoke at length about the importance of increased collaboration between the two agencies. They were clear that better communication and coordination between the two agencies will result in improved access for individuals seeking information about and referrals to long-term care services. Program staff are eager to continue to learn each others' "systems and processes" and report that cross trainings held with AAA and DD staff and attendance at provider meetings have increased familiarity with their respective systems and services. One informant described how the AAA had changed as a result of the implementation of the ADRC approach in the region.

> *Prior to the ADRC we [the regional AAA] vaguely knew the DD [developmental disability] system, we knew about some of the waivers, some of the phone numbers, but we didn't understand the process for getting DD services - didn't know staff or have contacts. In the last few months we have been to meetings with DD staff, DD providers, and they have seen how our Gateway system works. We now know who works where and have some contact names.*

Informants at each of the three expansion sites cited as a challenge to effective collaboration the delay in hiring the MHDADD project counterpart at the regional office. At each of the three sites, program staff described how the initial planning and implementation of ADRC functions were conducted primarily within the local AAA because there was not a dedicated staff member at MHDDAD to work on the ADRC.

Some informants expressed their concern about the "aging slant" that the ADRC may have at this early stage. Because the funding for the initiative is directed through the Division of Aging Services and because the CARE-NETs have traditionally focused more on caregiving issues among the elderly, these informants recognized the need for a more concerted effort to make the collaboration more equitable. Coalition partners at the three sites perceive less of a DD presence at the table during the CARE-NET meetings and expressed a desire to see more mental health and DD providers participating. Perhaps anticipating the need to proactively work toward inclusion, program staff at one site described their decision to implement a decentralized model:

> *We spoke with Atlanta and Augusta sites [two pilot ADRC sites in the State]. We felt that our model needed to be decentralized like the Atlanta model because if the entire ADRC were housed here in Aging then things wouldn't change. We needed equal staff at each entity - one cross-over person at each place.*

Informants described how the differences in organizational cultures and methods of operation present a challenge when building a collaborative initiative. Informants pointed out that the strength of the ADRC approach is also its greatest challenge. Most informants believe the ADRC should be a cultural and process change, not just the hiring of new staff members. They stress that in order for the ADRC to be successful, the Aging and DD communities must learn each other's systems and approaches to client interaction and care and work to integrate those different systems into a streamlined I&R process. One informant described the importance of viewing the ADRC as a process change:

Informants pointed out that the strength of the ADRC approach is also its greatest challenge. Most informants believe the ADRC should be a cultural and process change, not just the hiring of new staff members.

> *I am worried that if the ADRC is just a person, the services will be isolated again rather than integrated into a new way of doing things… We must be careful not to make the project just another government entity*

This "culture change" comes with challenges, and informants provided specific examples of some of those challenges the agencies face as they begin to bridge the gaps. One informant described the challenge of beginning to learn the highly complex waiver programs and eligibility processes for DD services. Another informant described how even the vocabulary that the agencies use is different and that "our names can get in the way." For example, the Aging community's "case manager" becomes the Developmental Disability community's "case expediter."

In addition to the "cultural differences" between the two agencies, informants mentioned physical and structural impediments to more effective collaboration. Each agency has its own local resource database and system for tracking and managing clients through the Information and Referral (I&R) process. Bridging the gap between the two information management systems may be a significant structural impediment to tracking ADRC clients across multiple agencies and effectively streamlining the I&R process. At one expansion site, informants reported that the MHDDAD staff have access to the Enhanced Services Program (ESP) database used by the local AAA, but only in read-only format. Thus, MHDDAD staff are unable to enter and track client data and actively manage ADRC clients between the AAA and MHDDAD agencies. Informants at another site spoke of the challenge of centralizing information and referrals and implementing standard protocols when the AAA and MHDDAD staff are working out of different offices.

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Informants recognize that the ADRC has been and will continue to be the impetus behind the increased collaboration between the AAA and the MHDDAD. Though informants described systemic and structural challenges to effective and efficient collaboration between agencies, project staff and coalition members expressed strong support for the ADRC approach to streamlining information and referrals for consumers and believe that increased collaboration will result in reduced duplication of services and prevent individuals and families from "falling through the cracks."

Informants expect a more streamlined information and referral system in which "people won't get the runaround anymore" or "fall through the cracks" between the two agencies.

ADRC Implementation and Sustainability: Challenges and Great Expectations

Informants were asked to talk about their expectations related to the implementation of the ADRC in their communities.

Better service to clients/consumers
Informants spoke most often of improved client experiences and outcomes as a result of the increased collaboration between AAA and MHDDAD. Informants expect a more streamlined information and referral system in which "people won't get the runaround anymore" or "fall through the cracks" between the two agencies.

Creative, local solutions that will reduce duplication of services
As state funding for health and human services in the State is reduced, it falls to local communities to better leverage existing resources to meet long-term care needs at the local level. There is a perception shared by multiple informants that resources are often left untapped because agencies are not communicating with each other and sharing resources to support their clients across the long-term care continuum. The ADRC encourages inter-agency collaboration that informants believe will result in better leveraging of existing services.

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Informants also described what they saw as the most significant challenges to effective implementation and sustaining the ADRC.

Leadership and direction from the State level
Informants at each of the three sites spoke of the challenge of bringing some key stakeholder groups and collaborating agencies to the table. At one site, informants described hesitancy on the part of local representatives of the DFCS office and the Board of Health because of their perception that long-term care services are not part of their scope of practice. A member of the program staff at this site stated that there needs to be a mandate from the State Department level and a show of solidarity with the ADRC concept across Divisions and Offices in order for local agency representatives to participate fully.

Time and resource limitations
Many informants perceive that local health and human service agencies are already stretched thin and are unable to take on more meetings or additional referrals. There is a sense among many informants that State funding to support health and human services will continue to diminish in the coming years and that agency workloads will become heavier without the accompanying resources to expand agency capacity to meet demand. In addition, informants at two sites fear that with less funding available at the local level, competition for limited resources and turf guarding among agencies will increase.

Evaluation Framework: Benchmarks for Successful Collaborations

The Georgia Health Policy Center has developed a set of benchmarks against which a developing coalition or community network can measure its level of functionality and progress towards sustainability. The benchmarks outline six dimensions of a functioning community network and provide a helpful framework through which the ADRCs can evaluate their own inter-agency efforts. It is these benchmarks that served as a framework for discussions with key informants.

Based on where a coalition falls along the benchmarks, it may be categorized as Beginning, Developing, or High-Functioning. The three expansion sites have achieved most of the benchmarks that would categorize them as Developing coalitions.

Benchmarks	Key Elements of Success	ADRC Expansion Sites: Progress to Date
Clear Vision and Intent	• Mission is understood and clearly communicated by members • Mission/vision statement is written and agreed upon by coalition members • Memoranda of Understanding (or other formal agreements) exist between partner agencies • Coalition activities represent stated goals and mission	ADRC program staff and the majority of CARE-NET Coalition members are clear on the mission of the ADRC. Informants interviewed are unified in their desire to streamline I&R processes for individuals seeking long-term care. Some CARE-NET members were unclear about the role of the CARE-NET with the ADRC. Program staff at the expansion sites reported that some key partner agencies had provided letters of support for submission with the ADRC funding proposal to DAS, but there did not appear to be formal Memoranda of Understanding signed between the AAA and partner agencies.
Culture of Caring	• Coalition activities improve access to services, increase efficiency and improve care of vulnerable populations • Coalition delivers integrated services in collaboration with partners	Informants report important strides in improving communication and collaboration among MHDDAD, the AAA, and other key referral agencies. Challenges exist in continuing to bridge the "cultural" and structural differences and between the two agencies to create a streamlined cross referral system for clients/consumers.

Benchmarks	Key Elements of Success	ADRC Expansion Sites: Progress to Date
Communication and Campaigning	• Community awareness of existence of coalition • Coalition engages in patient/client outreach and education activities • Coalition has regular mechanism for seeking out and using community input • The coalition engages in advocacy efforts with an eye towards sustaining activities and engaging additional external partners	Program staff interviewed reported that community outreach efforts are in their infancy at each of the three sites. Most of the CARE-NET Coalition members interviewed were unaware of any efforts to gather input from community stakeholders. Program staff and CARE-NET members are aware of the need to identify local resources through local partnerships to sustain the ADRC in the long term, but at this phase of implementation they have not engaged in active advocacy efforts.
Infrastructure to Support Mission	• The coalition has sufficient staff to realize key program activities • Member agencies have sufficient resources dedicated to the realization of program activities • Existence of an effective information management system to track eligibility, enrollment and referrals at a minimum	The hiring of the MHDDAD position dedicated to the ADRC was delayed significantly at each expansion site. Challenges exist in creating a unified client management and I&R database that can track clients across AAA and MHDDAD.
Sustainability Based on Demonstrated Value	• Coalition is developing a sustainability plan • Coalition members contribute resources or in-kind • Coalition is collecting data that are specific, measurable and demonstrate key intermediate and impact outcomes	A few informants identified the need to collect additional program data that will clearly illustrate improved client experiences with I&R.
Technical Assistance	• Coalition members know how to identify and seek out other projects to gather input and access technical resources • Coalition can effectively communicate lessons learned to peers and feels willing and comfortable serving as a peer mentor to a new network	Program staff reported speaking with ADRC staff at the Georgia ADRC pilot sites and DAS as well as accessing the Lewin Group's Technical Assistance Exchange website for tools and information related to the implementation of the ADRC. Quarterly ADRC meetings among the ADRC sites and DAS facilitate the exchange of information and best practices among the five sites.

The Logic Modeling Process

As part of the process evaluation currently in process, evaluators have begun to work in collaboration with program staff at each of the three expansion sites to develop ADRC program logic models. A program logic model is a visual representation of the relationship between program resources, planned activities, and intended outcomes and impacts. A basic logic model provides a picture of how program staff believe the ADRC program works.[3] The development of a program logic model allows program staff to continuously evaluate their activities to ensure that program resources (human, financial, organizational and community input to the program) are being effectively and appropriately leveraged to realize program activities, and that the program activities contribute to the intended outcomes.

Resources (Inputs)	**Activities**	**Outputs (Evidence of Activities)**	**Outcomes**		**Impact (Program Goals)**
What is invested in project (human, financial, organizational, and community resources)	*What the program does (processes, tools, events, technology, actions that form the implementation)*	*Direct product of program activities (e.g. number of trainings, meeting attendance, clients reached, referral time)*	**Short-term**	**Long-term**	*Overarching goals of ADRC*
			What the short-term results are	*What the long-term results are*	

GHPC evaluators proposed that creating a basic program logic model would help program staff identify measurable program outcomes. Evaluators provided program staff with a basic overview of the logic model process and drafted initial program logic models by extracting expected program resources, planned activities, and program outcomes from each expansion site's ADRC funding proposal. This initial draft was used as a starting point to facilitate a directed process of identifying the key outcomes of interest at each site and ensuring that planned activities align with those outcomes. This exercise has been helpful in identifying how current activities may or may not lead to the intended program results. The logic modeling process has also encouraged program staff to revisit their original program plans and intended outcomes after the initial phase of program implementation to make necessary revisions, as well as determine what is appropriate and feasible to measure over the next year of program implementation.

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[3] W.K. Kellogg Foundation. The Logic Model Development Guide. December, 2001.

Observations - Big Picture Issues

The CARE-NET as the ADRC Coalition

As described above, the CARE-NET is serving as the ADRC Coalition at each of the three expansion sites. Informants perceive that one advantage of utilizing the CARE-NET as the ADRC Coalition is that the CARE-NET is a previously chartered inter-agency working group that has active participation from many partnering agencies. In addition, informants believe that it is not advisable to add additional meetings to the already very full schedules of their collaborators. They perceive that folding the ADRC into an existing group makes it more likely that local agencies will participate.

However, there may be some drawbacks to utilizing the CARE-NET as the ADRC Coalition. Because of its primary focus on caregiving and historical focus on the aging community, the CARE-NET may not attract ADRC stakeholders and partner agencies who do not view caregiving as part of their scope of practice. Some informants described the challenges of getting important ADRC partner agencies like DFCS and the school system to the table because they do not see a connection between the CARE-NET mission and their agency.

At least one expansion site has begun to explore the possibility of forming an ADRC subcommittee within the CARE-NET that would serve a more direct advisory function. Creating an advisory group either within or outside the CARE-NET that focuses primarily on advisement may encourage partners and stakeholders not currently involved in the ADRC effort to come to the table. Also critical to the success of the ADRC Coalition is buy-in and active support from leadership across the Divisions within the Department of Human Resources. Local Division representatives may come to the table when they see the ADRC as a process change mandated by State-level leadership.

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Lessons from the ADRC Expansion Sites

The ADRC expansion sites provided useful recommendations that can assist emerging ADRCs as they begin planning. They include the following:

The ADRC expansion sites provided useful recommendations that can assist emerging ADRCs as they begin planning.

- Coalition membership should expand to include representatives from the faith-based community, local government officials (DFCS), representatives from the physical and developmental disability and mental health communities, and family (non-professional) caregivers.
- MHDDAD staff could perhaps seek out and recruit DD representation to the ADRC Coalition.

- Effective cross-training might help to break down barriers such as language and terminology among the ADRC partner agencies.
- Bridging the gap between MHDDAD and Aging information management systems may significantly improve tracking ADRC clients across multiple agencies and effectively streamline the I&R process.
- There needs to be a mandate from the Department level and a show of solidarity with the ADRC concept across DHR Divisions and Offices in order for local agency representatives to participate fully.
- Formal memoranda of understanding across partner agencies may strengthen collaboration.
- There is a need to identify local resources through local partnerships to sustain the ADRC in the long term.
- The logic modeling process is helpful in identifying how current activities may or may not lead to intended program results. The logic modeling process also encourages program staff to revisit their original program plans and intended outcomes after the initial phase of program implementation to make necessary revisions, as well as determine what is appropriate and feasible to measure over the next year of program implementation.

Process Change and Policy Alignment

Major process and policy changes are not fully actualized unless there is alignment at the local, state, and national levels across public and private organizations. In the case of ADRC, the concept has been adopted and promoted as the future direction of national policy efforts through CMS and AoA to promote a "no wrong door" approach to long-term care information, access, and referral. Considerable national resources have been allocated to promote the ADRC concept. Those resources have flowed through the Division of Aging Services down to the local level at AAAs and MHDDAD offices, where the ADRC is operationalized; however, from discussions at the local level there is a perception that not everyone at the state level is "on the same page" regarding implementation of ADRC.

The philosophical, organizational, and operational alignment that must occur across Georgia to realize the goals of ADRC is a significant process change. Historically, the Aging, DD, Physical Disability, and Mental Health communities have competed for the same limited resources. Each community, supported by different state infrastructure across Departments, Divisions and Offices, has developed different management information systems, consumer philosophies, service packages, and cultures. The paradigm shift that must occur to ensure ADRC's success is not insignificant.

The paradigm shift that must occur to ensure ADRC's success is not insignificant.

Alignment may be catalyzed by commitment that is demonstrated by members of the Department of Human Resources Leadership Team and put into practice throughout Divisions and Offices. A system where all players (state and local) are "on the same page" regarding the ADRC "no wrong door" approach will literally open doors to further collaboration and streamlining at the local level as the ADRC concept matures. Without alignment within and throughout the Department, the ADRC's full potential may not be completely realized.

Appendix A
ADRC DEVELOPMENT
DISCUSSION GUIDE

Name of ADRC: _____

Contact Person: _____

Clear Vision and Intent

1. In your own words, please briefly describe the ADRC project and what it is trying to accomplish.

2. Does your ADRC have a mission and/or vision statement? (If yes) Tell me about the process for creating them.

3. Does your ADRC have a strategic (work) plan? (If yes) Tell me about the process for creating it. Describe any assessments you have conducted in order to set goals and objectives.

4. How is your ADRC structured? Describe your governing body and any by-laws or charter you have in place. Do most partners of the governing body attend meetings?

5. Do you know of other communities who have approached similar projects? Are you adapting a model used by another community? If so, did you examine the indicators for the effectiveness of their model?

6. Tell us about the partners of your ADRC. Can you talk about the process of bringing coalition partners together? What kind of coordination does your ADRC do with other partners? What is your role?

7. Do you have written MOUs with partners?

Communication and Campaigning

8. What are the relative levels of interest and contribution of the ADRC partners? Do most members of the partnership attend your meetings? Do the leaders of your partner organizations attend your meetings or do they send a representative?

9. Has the number of partners grown since the implementation of the ADRC?

10. Have you gotten input from the key stakeholders in your community that will be impacted by your ADRC? How? or Why not? or Do you have plans for this type of effort? If so, how do you use that information?

11. Are there stakeholders that should be at the table who are not? Who?

12. How are you communicating to those outside your ADRC? Does this include advocacy efforts?

13. What kinds of ADRC education activities do you conduct with consumers, if any? Other partner organizations?

14. Describe your ADRC's attempts to document the value of its activities.

Technical Assistance

15. What aspect of your ADRC are you most excited about?

16. What part of your ADRC development presents the greatest challenge?

17. What expertise do you need to implement your ADRC that is not available within the members of your consortium? How do you plan on getting the help you need?

Appendix B
ADRC COALITION PARTNER
DISCUSSION GUIDE

Name of ADRC: _____

Contact Person: _____

1. In your own words, please briefly describe the ADRC project and what it is trying to accomplish.

2. Can you talk about the beginning of the CARE-NET's role in the ADRC?

3. Tell us about the partners of your ADRC. What kind of coordination does your ADRC do with other partners? What is your role?

4. Do you think the CARE-NET is the right entity for the job? What do you think is the most valuable contribution the CARE-NET can make to the development of the ADRC?

5. What are the relative levels of interest and contribution of the ADRC partners? Do most members of the partnership attend your meetings? Do the leaders of your partner organizations attend your meetings or do they send a representative? Has the number of partners grown since the implementation of the ADRC?

6. Who are the key stakeholders in your community that will be impacted by your ADRC? Have you gotten their input? How? or Why not? or Do you have plans for this type of effort? If so, how do you use that information?

7. Are there stakeholders that should be at the table who are not? Who?

8. How are you communicating to those outside your ADRC? Does this include advocacy efforts?

9. What aspect of your ADRC are you most excited about?

10. What part of your ADRC development presents the greatest challenge?