

INTRODUCTION AND BACKGROUND

This Toolkit, *New Tools that Span the Generations: A Guide to Developing a Point of Entry in your Community*, is based on Fulton County's 25 years of experience in developing, implementing and fine-tuning the Central Assessment and Placement Program (CAP), a point of entry (POE) into their long term care system.

The creation of CAP, which began in 1980, was the result of a five-year effort on the part of both county agencies and providers in Fulton County to tackle the problem of a fragmented long-term care system and make it possible for residents to easily access appropriate long-term care services. *New Tools that Span the Generations* highlights what was accomplished by all the entities in the County coming together to work smarter. The goal of this Toolkit is to provide a resource for other counties in establishing a POE.

This manual has been developed to both document the Fulton County POE experience and to offer help to others through the process of establishing a POE. Fulton County may be viewed as a pilot project that can serve as a model for other groups to use in developing a POE system that fits into their local long-term care system.

The Story of the Central Assessment and Placement Program in Fulton County

The idea of a POE is not a new one. Beginning in the 1970's, the Administration on Aging funded a number of demonstration projects, including The Monroe County Access Program based in Rochester, NY (Eggert, Bowlyow & Nichols, 1980). The Access Program became recognized as one of the model programs for the nation (Zawadski, 1984).

In 1980, New York State Department of Social Services (DSS) announced an intention to develop Community Alternative Systems Agencies (CASAs) under a three-year contract with the U.S. Department of Health and Human Services' National Long -Term Care Channeling Demonstration Program. There were to be nine demonstration sites. There was an expectation that every county in the state would have some type of channeling and assessment agency or POE (Lane & Falotico, 1984).

Beginning in late 1980, the Fulton County Public Health Committee and the County Planning Department began to work toward the development of a Long-Term Care Task Force. The need for change was driven by a number of issues that were common in many counties throughout New York, including:

- ? a high number of alternate level of care days in hospitals;
- ? hospital closings;
- ? more community based care was needed and agencies were competing for increased role as providers;
- ? Medicaid costs were climbing for the county;
- ? high nursing home placement rates existed;
- ? high rate of adult protective calls;
- ? escalating disagreements between community agencies and county departments, (including social services, aging, department of health and the county nursing homes).

In March 1981, the Fulton County Board of Supervisors appointed an ad hoc committee to form this Task Force. The members Task Force were drawn from the Fulton County Office for Aging (OFA), Local Department of Social Services (LDSS), the Fulton County Nursing Service (Nursing Service), the hospitals and other community providers. Technical assistance was provided by the County Planning Department. The Task Force adopted the following definition of long-term care, which continued to guide the development of services in the County from this time forward:

Long-term care includes all forms of services, both institutional and non-institutional, that are required by all people with chronic conditions. Such conditions may be experienced by any age, as recurrent or persistent symptoms, illnesses or disabilities or impairments of a physical or mental nature (Dept. of Health, Education and Welfare, 1980, p. 15).

Two points in this definition were emphasized. First, long-term care was not associated with a specific age group and, second, source of payment was not to be considered a factor in the development of long-term care services.

The Task Force was divided into two groups: the committee on institutional problems and the committee on non-institutional problems. In March 1982, the Task Force released a final report entitled *Alternative Ways to Improve Fulton County's Long-Term Care System*. The report looked at the following areas:

- ? Inadequate in-home services
- ? Inadequate transportation services
- ? Lack of unsupervised housing units for the elderly
- ? Inadequate number of supervised housing units
- ? Lack of a comprehensive outreach program
- ? A shortage of nursing home beds
- ? The under-utilization of adult home beds
- ? A lack of a multi-disciplinary planning approach
- ? Excessive and burdensome State and Federal regulations

There were a number of specific action recommendations under each section. By the end of the year the Task Force decided to change their name to the Council on Long-Term Care (Council). During the following March the Council adopted a formal goal statement: "The goal of the Council on Long-Term Care is to cost effectively improve the quality of long-term care services being offered in Fulton County."

In December 1983, the Director of the Office for Aging and the Director of the Nursing Service sent a proposal to legislators and other directors and commissioners. In this document the two department heads proposed the development of a formal, county-operated central assessment and placement system with joint client assessments to be completed by nurse and social worker teams. The important point is that, prior to working on this central assessment project, the two departments had no history of working together. This proposal represented a major extension of the cooperative work that had been going on between the two agencies for some months.

In response, the proposed following steps were generated:

- ? Discussion among all the key agencies, OFA, DSS and the Nursing Service began in February 1984 with a focus on the creation of a formal central assessment or POE mechanism.
- ? In October 1984, the Board of Supervisors contracted with the Health Systems Agency of Northeastern New York (HSA/NENY) to assess the feasibility of developing a central assessment system for the County. In December, a *Report to the Fulton County Board of Supervisors on the Development of a Coordinated Long-Term Care System* was completed by HSA/NENY (1984).
- ? The HSA/NENY, (1984, p. 25) recommended "the employment of a coordinator for long-term care services by the Department of Social Services" to coordinate services and to work in "concert with a Long-Term Care Advisory Council."

The Central Assessment and Placement Program and the Long-Term Care Council

In February 1985, a resolution from the Fulton County Board of Supervisors formally established the Fulton County Central Assessment and Placement (CAP) unit within the Local Department of Social Services. The CAP unit was established "to improve the coordination of available services to the elderly (and younger persons with disabilities) in order to allow more people to safely stay in their homes" (Harazin, n/d). The job description for the position of coordinator of the CAP unit offers the best single statement of the unit:

This is an administrative and supervisory position for the Central Assessment Unit which coordinates long-term care services (assessment, placement, monitoring, and direct care) provided by the County of Fulton through the Department of Social Services, Fulton County Nursing Service, Office for Aging, Mental Health, and the Infirmary (via shared services supported by contracts and memorandums of understanding) to provide a *single point of entry* [emphasis added] into the service delivery system for those in need of long-term care. . . The services of this unit will be available to every Fulton County resident with long-term care needs.

On June 4, 1985, the Long - Term Care Council (Council) held its first meeting since the establishment of CAP (Minutes, June 4, 1985). Since 1985, the Long - Term Care Council has continued to meet on at least a quarterly basis. In 1994 the two subcommittees disbanded and the organization reverted to a single Council format, which exists today.

Between 1987 and 2005, CAP made a total of 12,505 assessments, with an average yearly caseload of 473 clients. At the beginning of 2005, CAP was carrying a caseload of 506 clients. Referrals have been made from the certified home health agencies, families, Office for Aging, Nathan Littauer Hospital, and physicians, among other sources. CAP serves both Medicaid and non-Medicaid clients. For example, in 2004, CAP received 271 referrals for clients who were qualified for Medicaid, out of total of 702 referrals. CAP continues to meet the long-term care needs of county residents of all ages.

Lessons Learned From the Experience of Fulton County

By reviewing the history of the development of a POE in Fulton County, a number of lessons can be learned from their experience. Keeping in mind that there are always some unique variations between counties, several things are clear:

- ? Political support from county government is crucial.
- ? You cannot control many of the problems or changes you encounter, but you can control how you will respond to them.
- ? It takes multiple agencies working together to address and solve complex problems.
- ? A long-term care council or coalition is essential to the success of a POE.
- ? The long-term care network in Fulton County developed a vision of what they wanted to do and then began to talk about how to fund their vision.
- ? “You don’t have to reinvent the wheel” – there are a number of models, so steal the best ideas from them and build a system that works for you.

- ? When major changes come you will be ready because you have a working system in place.

A DESCRIPTION OF CAP

This section describes CAP in terms of financing, physical location, staffing and supervision. In keeping with the goals of this toolkit, issues have been put into a context, lessons learned from the Fulton County experience are offered and a set of steps, in the form of an action plan to aide readers in the development of a POE, are presented. When asked to describe how the CAP agency is designed to function, Kathryn Leitch (2005), the former Director of the Fulton County Office for Aging, said, “one call does it all.”

By the early 1980s, counties around the state were beginning to look at ways to reduce the number of persons waiting in hospitals for nursing home placement, to deal with a perceived shortage of nursing home beds, and to both develop and improve access to home care services. As part of the Federal channeling to address these issues, New York State began an initiative known as Community Alternative Systems Agencies, or CASA (NYSDSS, 1982).

Although Fulton County did not develop a CASA, it did develop the Central Assessment and Placement (CAP) unit that still serves the County today. Even though the unit is physically located in the LDSS, the CAP unit was developed with a more inclusive focus than many envisioned a Medicaid-focused CASA program. That is, CAP is specifically charged to serve all persons in need of long-term care, including disabled children, regardless of payment source.

Financing the Fulton County Experience

The financing has always been a cooperative among all the agencies that have funding streams.

- ? CAP was created by shifting personnel from the principle cooperating agencies and by creating one new position, that of Long Term Care Coordinator of the unit.
- ? The Fulton County Nursing Service (FCNS) provided one nurse, while the LDSS furnished the first caseworker. The caseworker was part of the old Medicaid personal care caseworker system.
- ? CAP was physically located in LDSS because they had electronic access to the Medicaid system. This linkage remains crucial for the determination and approval of eligibility so that services could be started quickly (Harazin, 2005). Today, with advent of the Internet, access may be gained from a wireless location in the home of a client.

- ? When the Expanded In-home Services for the Elderly Program (EISEP) was created, OFA used funding from this program to fund an assessment caseworker through this program.
- ? When the FCNS withdrew their nurses from CAP, a new cooperative arrangement was developed. Nurses are now employed by OFA under a contract from LDSS.
- ? Based on extensive interviews, it is clear that the cooperative shared funding strategy is a workable one that can support a POE over an extended period of time. If agencies are willing to cooperate and support a common goal, it is an approach that offers the flexibility to incorporate new funding opportunities.

Physical Location

The process of choosing a physical location for a POE would seem to be an extremely important issue to resolve. However, there is very little discussion of choosing the physical location of a POE unit in the literature. The literature that does exist is generally focused on either examining the geographic variables to aid in the selection of large industrial concerns (Empower Geographics, 2005) or on issues of site selection and economic development (Bizspeed, 2004).

There are, however, a number of questions that should be considered:

- ? Do you want a walk-in center or do you want to rely on telephone, in-home visits and the Internet?
- ? Where is there available space?
- ? Where is staff currently located?
- ? Is there public transit to and from the site and sidewalks for accessibility by pedestrians?
- ? Is there available parking for both staff and clients?
- ? Where is the local Medicaid eligibility done?

To many of the stakeholders and partners the physical location will represent ownership or control. Research by Goodstein, Nolan, & Pfeiffer (1993) indicates for programs to be successful, the site chosen must be viewed as both reasonable and, if at all possible, neutral. In some models, both staffing and location are directly related and the location will follow the staff or vice versa. In other models, there may be no connection between the location and staffing. For example, a call center that is never physically accessed by clients could be the answer, especially if the POE serves a large urban or extremely isolated rural area.

Lessons Learned from the Fulton County Experience

In Fulton County, the location of the CAP is a result of the availability of space within the key partner agencies, the OFA, the LDSS and Nursing Service. These were the agencies that were working together in 1985 when CAP opened. For Fulton County, there have been several advantages for having the CAP unit located in LDSS:

- ? CAP caseworkers are able to work closely with DSS staff in qualifying clients for Medicaid;
- ? There is quick access to adult protective services, when necessary;
- ? Good access to other providers and agencies is readily available;
- ? The POE office is in close proximity to Lexington Center, the developmental disabilities service site for the County;

Disadvantages noted, include:

- ? Some clients will not want to come to DSS because of the association with welfare.
- ? The DSS location may create some problems in convincing non-Medicaid clients that the POE is there to serve their long-term care needs.

Action Checklist – Physical Location

The following are considerations in making the decisions concerning the physical location and staffing of the POE unit:

- ✍ Consider locating a single point of entry unit in its own space-not within an existing agency's office.
- ✍ The CAP unit in Fulton County is located in LDSS. Since few clients actually come to the office, this location has not represented any problems. Clients in Fulton County do not view CAP as simply a Medicaid only program because it is physically located in a LDSS office.
- ✍ Pick the most accessible location for the office. Advertise the location to encourage potential clients to walk-in.
- ✍ The final decision on the location may be a very practical one. That is, is there a sponsoring agency in the community that has both the space and ability house the new unit?

Staffing and Supervision

In states where a POE system has either been developed, or is under construction, the subject of assessments is generally discussed in terms of the content and form. Who will perform the actual assessment is left unspecified. The literature does not speak to the issue of supervision.

Developing a Professional Staff

In order to develop a professional staff for CAP, caseworkers and nurses would need to be moved from different agencies into the unit. This need to develop a CAP staff generated situations that needed creative solutions. CAP may be physically located in LDSS but it is not their unit. The staffing of CAP represents a cooperative effort of both OFA and DSS, using funding streams that are controlled by both agencies.

- ? **How do you move personnel from one agency to another when each agency has separate civil service hiring lists?** This problem was solved in 1987-88 by creating a single hiring list, one for caseworkers and one for registered nurses (RN), with similar job requirements and pay rates across all county agencies.

As referrals increased, OFA added a caseworker using Expanded In-Homed Services for the Elderly Program (EISEP) funding while another caseworker from the Medicaid unit was shifted to the CAP unit. The Fulton County Nursing Service (FCNS) also moved a second nurse into the unit.

- ? **How can you resolve the issues of direct supervision and oversight when staff is working in one unit and being funded by another agency?** This issue was resolved by having the direct supervisor handle the supervision of personnel in the CAP unit. However, in all other ways, CAP staff is treated as employees of the agency that funds their position. For example, those CAP staff members who are employed by OFA may attend OFA staff meetings in addition to meetings of the CAP staff. This means that the Director of OFA signs the time cards and handles all other personnel issues for OFA funded employees, while LDSS does the same for their employees.

In Fulton County there is no direct billing of clients for assessments. An assessment is not a billable function; it is a staffing function reimbursed by various funding streams supplied by different agencies. Medicaid administrative costs can be used to cover assessments beyond determination of financial eligibility. The costs associated with assessments can also be covered under some aging programs such as EISEP.

Throughout the life of CAP, the Fulton County Office for Aging has provided strong support and has expanded the funding base. Grant monies have been combined and used in creative ways to fund the POE. It takes the effort of one or more dedicated and committed individuals to make sure that a partnership like this succeeds; cooperation and collaboration are keys to developing and sustaining a POE.

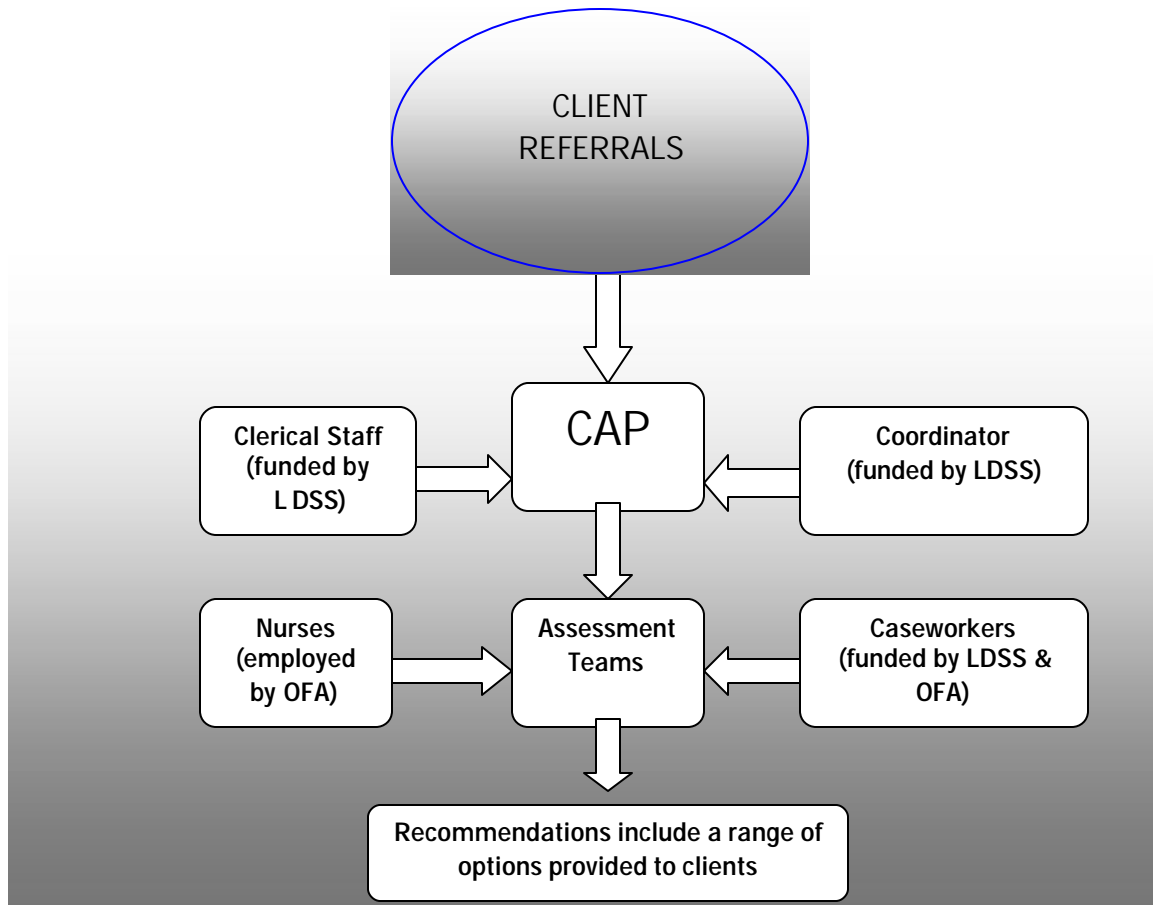
Lessons Learned from the Fulton County Experience

- ? In counties where agencies such as OFA and LDSS **provide direct** service, it is possible to move personnel into a common POE unit.
- ? In counties where agencies such as OFA and LDSS **do not provide** direct services, a POE can be established through the contract process.
- ? The POE gives counties an opportunity to gain more control over money.
- ? By sharing personnel lines, a county can design the system that is most cost effective for its situation.
- ? The hard questions always revolve around “turf issues” and getting people to really plan, both of which can be overcome if win-win situations are created for all parties.

Organization of the CAP Staff

An organizational chart, indicating funding sources for each position, appears below.

Central Assessment and Placement Organization of Staffing and Funding Sources



To summarize, the general strategy used in Fulton County has been to move existing staff into positions in CAP from OFA and DSS. Since 1985 only two new positions, that of the Coordinator and a caseworker, have been created using local funding sources.

Advantages to Inter-Agency Cooperation on Staffing a POE

There are a number of advantages to agencies cooperating to share the staffing of a POE unit:

- ? Pooling the resources of several agencies maximizes all available funding streams.
- ? Staffs from different agencies are all “inside the same firewall” and this results in fewer HIPAA issues.
- ? This arrangement is the most efficient way to meet the goal of improving access to services.
- ? Sharing staff helps to alleviate the “turf” issues, which can be among the most difficult to resolve.
- ? Sharing staff encourages planning across agencies
- ? In more populous, urban counties, the larger agencies can always encourage more cooperation among providers by changing the way contracts are written

It is important to note that all services are authorized by an assessment. Caseworkers and nurses complete all required forms for service assessments, care planning, and case management and authorization of services and payment. Subcontractors provide services. Nurses are involved in assessments and are never involved in providing “hands-on” nursing care. By the same token, social caseworkers conduct assessments and do not provide “social work services” to clients.

IDENTIFYING BARRIERS AND GAPS IN SERVICES

Identifying Barriers

The greatest barrier to implementing a POE may be resistance to change. Change and barriers go hand in hand. At first glance, creating a POE can seem like an insurmountable task. The best way to overcome barriers is to plan for them. Use the natural resistance as a tool to gather information and data that will help support the process of change. There is much to be learned by asking the question “why?” Why is there resistance?

Barriers to Creating a Point of Entry System

Although each community’s experience will vary, there appear to be a set of common barriers that may inhibit the process of creating a POE. The Fulton County experience clearly demonstrates that concerns can be successfully overcome so that a POE can be developed that serves clients of all ages and disability groups who are funded by a wide variety of payment sources.

Change is threatening. Stakeholders concerns about a POE include:

- ? Agencies fear losing control over their clients care plan

- ? Administrators believe the new system will limit the business agencies now receive and clients will be diverted to other services
- ? Agencies are concerned that a POE may put them out of business
- ? Local Department of Social Service offices may be concerned that Medicaid costs will increase
- ? “If my agency doesn’t authorize its own services, clients will receive services for which they are not eligible.”

Given that the population is aging, far from losing clients under a POE, this type of system will be a major tool in managing the increasing number of clients entering the system over the next few years.

Organization Structure. When creating a POE, it is important to consider that a long-term care system consists of both multiple agencies and multiple levels of care. The following are some of the structural barriers:

- ? The current long-term care system has multiple funding sources that have resulted in separate and conflicting eligibility requirements and program designs.
- ? There has been difficulty working with union job titles and getting non-union and union organizations to work together.
- ? Health Insurance Portability & Accountability Act (HIPAA) will not allow agencies to share information

Lack of Resources. Cost is one the most commonly voiced concerns where the implementation of a POE is proposed. With Medicaid costs mounting, many county governments have been downsizing staff and attempting to minimize Medicaid costs. The Fulton County experience demonstrates that a POE can be both initiated and maintained by CAP by sharing staff that are occupying existing positions.

Climate. Currently, simultaneous changes are being made on both the federal and state levels. These changes will support and even insist on the creation of a POE to all long-term support services.

Additionally, in response to limited resources, local governments are seeking to operate more efficiently. This effort may include consolidation of departments and a search for innovative solutions, including collaborative arrangements that can deliver services within constrained budgets.

Lessons Learned from the Fulton County Experience

Fulton County encountered all of the above barriers listed. However, barriers that are solved will sometimes re-appear. New barriers arise as there are changes in health care legislation, in clients, in service agencies and in key players that may pose a threat to the continued viability of a POE. The Fulton

County POE has exhibited the flexibility to meet all of these new challenges. Through continuous planning, cooperation, innovation and planning, barriers can be converted into challenges for which solutions can be developed.

When Fulton County began to develop their POE, few models existed to replicate. Although New York State was experimenting with the CASA program that targeted Medicaid clients, Fulton County was seeking to develop a more comprehensive POE that would serve all clients regardless of payment source. Fulton County reduced the threat posed by change in several ways:

- ? Development of the Long Term Care Task Force, which became the Long Term Care Council (Council). The Council is an inclusive group that allows for every agency and provider to have a voice in the planning;
- ? There was careful and comprehensive planning, including, if possible, a study by an outside evaluator;
- ? There was strong support and encouragement from the Board of Supervisors. Political support that supported change put everyone on “safe ground”;
- ? The CAP unit was only put in place after extensive discussions had been conducted. Since there were few existing models, those discussions were somewhat protracted;
- ? The agencies that controlled the major funding sources, especially LDSS and OFA were willing to commit resources once the major structural barriers was eliminated;
- ? Common job titles were developed for nurse assessor and social caseworker. This means that staff can be moved from an agency into the CAP unit without violating civil service regulations or with any change in the rate of pay or seniority.

Action Checklist

According to Bell and Smith (2003), there are a number of elements for success in coalition building. These elements can be somewhat modified to form an action checklist for overcoming barriers to POE development.

- ✍ **Set common goals.** What is the desired change? Broad goals can be set in the beginning as they will be refined during the development process.
- ✍ **Establish clear lines of communication.** Working with a number of different agencies, and even different systems such as the aging network and intellectual/developmental disabilities, terms and concepts must be understood. Everyone must work from a common language, a common set of terms and concepts.
- ✍ **The input of every member must be considered as valuable.**
- ✍ **Conduct efficient and effective meetings.** Consider developing sub-groups and committees but meet often and on a regular basis.

- ✍ **Everyone must be willing to bring something to the table.**
- ✍ **Resistance is not necessarily a negative concept** (Zaltman, G. & Duncan, R. (1977). Resistance can be a tool for change, as it may force those who are proposing the change to support their ideas with information to “make their case.”

Defining Gaps in Services

Before proceeding with the development of a POE, it will be necessary to get a “lay of the land”. You will need to find out the shape and structure of the current long-term care network, the service needs in the community, and the gaps in services. While you may know the answers to these questions based on experience, you will need formal answers through research to meet the needs of decision makers. This usually begins with a needs assessment.

In order to gather the necessary information to plan, develop, and implement a POE, reliable data are required. Much of the information you will need may be readily available online through:

- ? The U.S. Census Bureau web site (www.census.gov);
- ? Needs assessments that have been conducted by both government and private organizations;
- ? The NYS Department of Health (www.health.state.ny.us);
- ? The NYS Office for the Aging (www.aging.state.ny.us) website may also have information that you need.

Methods/Categories of Data Collection Used to Determine Gaps in Services

Needs Assessments

“Needs assessments are those studies that attempt to gain information about the extent of some felt need, to obtain an accurate picture of available resources and to assess the fit between what is available and what is needed” (Schneider & Kropf, 2000, p. 105). A full community needs assessment can be very costly, time consuming and, in most cases, can be avoided. What you are looking for is a “snapshot, a point in time” concerning the long-term care system in your county or region (Washington County, MN, 2001).

Needs assessments will use some combination of standard research methods (McKillip, 1987), including questionnaires, interviews, and focus groups (Rouda & Kusy, 1996). These, and a number of other techniques, will be discussed in this section. For the Real Choice Systems Change Grant in Fulton County, it was decided that a needs assessment using an extensive telephone or mailed questionnaire survey was unnecessary. Several agencies, including OFA, had

completed needs assessments for their programs and this data were sufficient to proceed with the grant.

Public Forums

The public forums described below represent major activities conducted during the grant.

- ? **Recognition breakfast:** The purpose and goals of the Real Choice Systems Change grant were introduced followed by comments from a representative for the NYSDOH and NYSOFA.

- ? **Fall forum –“Crossing Network Lines”:** The purpose of this forum, entitled “*Crossing Network Lines*,” was to look at ways to facilitate partnerships across the continuum of service networks to improve service delivery. Two keynote speakers addressed issues of collaboration between the aging and disability networks, one from the aging perspective and the other from the disabilities perspective. Following these two presentations, the 43 attendees were divided into five working groups. Each group addressed three questions (see the box below) built around the theme of developing a common agenda between the aging and disability service networks, including the assessment process.

Discussion Questions for the 2004 Fall Forum

1. **What do you feel the aging and disability service networks have in common?**

2. **What are some barriers that may impede the aging and disability networks from working together?**

3. **Building on their common interests, what are four concrete steps that you could to bring the networks closer together?**

- ? **Final Forum –** An outline of the Toolkit, as well as, the results of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of both CAP and the long term care system in Fulton County was presented. A Train the Trainers workshop expanded upon the issues addressed at the morning session.

- ? **The Forums as a Data Collection Opportunity.** At the recognition breakfast, the Long term Care Council meetings, and on several other occasions the following brief, three-item questionnaire was used to gather basic data on strengths, weaknesses, and perceived changes that could be made in the long term care system.

Brief Questionnaire

- 1. What is the greatest strength of the current long-term care system in Fulton County?**
- 2. What is the greatest gap in the current long-term care system?**
- 3. What would be the most valuable change that could be made to the current long-term care system?**

Interviews

Face-to-face interviews were conducted with 20 key members of the long-term care system, including current directors, commissioners, administrators, and supervisors, as well as, several who had retired or moved from the County. These interviews were usually held in the offices of the respondents and lasted from 30 minutes to over one hour in length. Five basic questions were used with every respondent and are listed in the box below:

Questions Used in All Key Informant Interviews

- 1. Could you please describe to us how the current long-term care system works in Fulton County?**
- 2. Please describe Central Assessment and Placement (CAP) to us.**
- 3. What do you see as the greatest strength of the current CAP system?**
- 4. What do you see as the greatest weakness?**
- 5. If you could make one change in CAP, what would it be?**

SWOT Analysis

Ferrell, Hartline, Lucas & Luck (1998) offer an excellent definition and description of a SWOT analysis:

SWOT analysis is a basic, straightforward model . . .It accomplishes this by assessing an organization's strengths (what an organization can do) and weaknesses (what an organization cannot do) in addition to opportunities (potential favorable conditions for an organization) and threats (potential

unfavorable conditions for an organization). The role of the SWOT analysis is to take the information from the environmental analysis and separate it into internal issues (strengths and weaknesses) and external issues (opportunities and threats).

STRENGTHS	WEAKNESSES
OPPORTUNITIES	THREATS

In addition to data gathered through the forums, interviews with key members of the long-term care service network; the following five-item questionnaire was distributed to members of the Long term Care Council. One specific focus group, which will be discussed below, was also used in developing the SWOT analysis for CAP.

A Five-Item SWOT Analysis Questionnaire

- 1. Strengths: What are the greatest strengths of the long term care system in Fulton County? List up to three.**
- 2. Weaknesses: What are the greatest weaknesses of the system? List up to three.**
- 3. Opportunities: What programs, services, or other initiatives should Fulton County be pursuing right now, given your personal understanding and assessment of the current situation in the County? List up to three.**
- 4. Threats: What are the biggest threats to the viability of the long term care system in the County? List up to three.**
- 5. Gaps in Services: What would you say is the single greatest gap in the long-term care system in Fulton County today?**

Focus Groups

A focus group is a small-group discussion guided by a trained leader. According to Krueger and Casey (2000) “A focus group isn’t just getting a bunch of people together to talk. A focus group is a special type of group in terms of purpose, size, composition, and procedures. The purpose of a focus group is to listen and gather information. It is a way to better understand how people feel or think about an issue, product or service.”

As part of the needs assessment/evaluation of the CAP program, five focus groups were conducted:

- ? CAP staff, including all caseworkers, nurses and clerical staff. (The Long Term Care Coordinator was not present.)
- ? Office for Aging (OFA) staff. All staff members, including the clerical staff were included (The Director was not present.)
- ? Community focus group consisting of professionals (senior center director, investment counselor, minister, manager of a physician's office, two pharmacists who sell durable medical equipment and a real estate agent).
- ? Health care and social services professionals group (a mix of seven nurses and social workers from various agencies in the County).
- ? Caregivers (eight caregivers, all women).

Based on information found in the *Community Tool Box* (n.d.) and Krueger and Casey (2000), the following are the basic steps in setting up a focus group. This is an area where you may want to seek outside help from faculty at a college or university near you or a trained professional.

- ? **Identify the major objective of the focus group.**
- ? **Select a convenient time and location.**
- ? **The size of the group can range from 6 to 10.**
- ? **Develop about 8-10 good questions.**
- ? **Set an agenda.**
- ? **Take very good notes.** Audio or video is generally recommended. We found that having an assistant with good typing skills taking notes on a laptop computer works well. After the session, the facilitator/moderator and an observer went over the notes and filled in blanks and made corrections.
- ? **Moderating a focus group takes some skill and training.** .
- ? **The purpose or intent of your project should be the focus of your analysis.** For a full discussion of data analysis see Krueger and Casey (2000, pp. 125-142).

Sample Focus Group Questions

- 1. How would you describe the Central Assessment and Placement (CAP) unit to someone who is not familiar with it?**
- 2. What do you see as the greatest strength of the current CAP unit?**
- 3. What do you see as the greatest weakness of CAP?**
- 4. What would be the most valuable change that could be made to the current CAP system?**

5. **Are there any reasons why someone might not want to use the services provided by CAP?**
6. **One of the major goals of the Real Choice grant is to assess the gaps in service needs that exist in the county. What do you see as any gaps in service in the county today?**
7. **Another goal of the grant is to improve the visibility and marketing of the CAP unit. Do you have any suggestions about how we might get the word out to those we might be missing in the community?**
8. **The grant is also designed to bring the aging and disability communities, including disabled children, more closely together under CAP. Do you have any suggestions as to how we might accomplish this goal?**
9. **Is there anything that we missed? Is there anything that you came wanting to say that you didn't get a chance to say?**

The Fulton County Experience in Defining Service Gaps

The development of the CAP unit in Fulton County began in 1980 with the recognition that there was a set of problems related to the long-term care system. Over a period of five years, the following steps were taken:

- ? The Long term Care Task Force was organized in 1981, with a chairperson appointed by the Board of Supervisors.
- ? The Task Force conducted needs assessments and a report, *Alternative Ways to Improve Fulton County's Long term Care System*, was issued. It was decided that the Task Force would continue to meet.
- ? The Task Force began to focus on developing programs, such as adult day care, to fill the gaps identified in the needs assessments.
- ? Late in 1983 the creation of a POE was suggested. In 1984 a formal proposal was made to the Board of Supervisors (Board) to create such a unit. The Board funded a study by outside consultants.
- ? In December 1984, the consultants issued a report that strongly supported the Fulton County concept and recommended that they proceed with the implementation of a POE. In February 1985, the Board of Supervisors created the Central Assessment and Placement (CAP) unit.

- ? In 1987, the Board of Supervisors again contracted with consultants HSA to evaluate CAP. The evaluation was very positive.
- ? The Council has continued to address gaps in the system and support individual agencies as they have conducted individual needs assessments and evaluation research on the effectiveness of their programs.

Action Checklist for Conducting a Gap Analysis

- ✍ Review the relevant literature.
- ✍ Review census data.
- ✍ Examine previous state and local reports and studies.
- ✍ Determine what needs assessments have been completed recently pertaining to your long-term care network.
- ✍ Develop questionnaires (both mailed and distributed at specific events or locations).
- ✍ Conduct interviews with persons in key positions and/or with specific knowledge.
- ✍ Observe programs directly.
- ✍ Conduct focus groups.
- ✍ Analyze your data and report it widely.
- ✍

WHAT DOES CAP DO?

What Does CAP Do? The Fulton County Experience

In Fulton County, referrals come into CAP from all the providers in the community, including the hospital, adult homes, and nursing homes, as well as from families, friends and neighbors. The CAP approach is built around an in-home assessment by a team composed of a caseworker and a nurse assessor. Service plans are developed and case management is provided. Clients are followed overtime and service delivery is monitored. Re-assessments are also conducted.

From the outset, CAP was designed to serve all clients in the County, regardless of age, disability or payment source. The services that are authorized by an assessment and coordinated by CAP include the following:

- ? **Expanded In-home Services for the Elderly Program (EISEP).** This program is funded through the Fulton County Office for Aging (OFA) and provides personal care to clients aged 60 or over. OFA funds one of the caseworker positions at CAP.
- ? **Personal care services.** These services are made available to clients through contracts with one of the two licensed home care agencies in the

County. They can be funded through Medicaid, long-term care insurance or private funds.

- ? **Consumer Directed Personal Care.** CAP manages the Consumer Directed Personal Assistance Program (CDPAP) for the County through contracts with two agencies who serve as fiscal intermediaries in the community. CDPAP is a Medicaid funded program.
- ? **The Long-Term Home Health Care Program (LTHHCP).** The LTHHCP is another program that CAP authorizes for Medicaid eligible clients after a home assessment is completed.
- ? **Social Adult Day Care.** CAP does the home assessments of social adult day care. The staff also makes referrals to medical day care programs, which must conduct their own assessments for entry into the program. Funding sources include private pay, OFA funding, waived funds through the LTHHCP and Medicaid.
- ? **Medical day care.** CAP makes referrals to the Wells Nursing Home Adult Medical Daycare, which has both private pay and Medicaid clients.
- ? **Adult home, assisted living and skilled nursing home.** CAP completes the assessment and PRI/SCREEN for admission to all of these living arrangements in the County. All the County facilities accept Medicaid and SSI, as well as long term care insurance funded and private pay clients.
- ? **Private duty nursing program.** CAP makes referrals to this program for both children and adults in need of home care who are eligible for Medicaid.
- ? **Home delivered meals and all other programs aging programs.** These are funded through OFA and staff at CAP completes assessments to determine eligibility for these services.

Data Collection and Reporting Function

In Fulton County, CAP is responsible for maintaining a database on clients regardless of age or need. The Long Term Care Coordinator compiles and issues quarterly and annual reports used by both the LDSS and Aging that include:

- ? intake statistics
- ? referral sources
- ? case management information

- ? statistics on the numbers of clients dementia, psychiatric disorders and developmental disabilities
- ? alternate levels of care
- ? disposition of client placement
- ? assessments for nursing home placement.

The development of new or additional services is the responsibility of the Long Term Care Council and individual providers.

Program Support and Oversight

One of the most important features of the POE in Fulton County has been the continued existence of the Long - Term Care Council. In addition to working with CAP, the Council has also been the focal point for identifying needs and gaps in the long-term care system as well as for the development of new programs and services. It is an inclusive long-term care council that will serve as the guide for the development, sustainability and some degree of oversight of the POE.

Long - Term Care Coalitions and Councils

As the POE begins to develop, it is important to establish a long-term care council with a formal set of bylaws and a process to resolve issues including who will be voting members on the council. Strongly consider having the Council formally created by the county legislative body at the time the POE program is formally established. This has been one of the most important factors in the sustainability of the Fulton County program.

Using a Council for Oversight and to Expand Services

One issue that will need to be resolved is the degree of oversight your council will have over the activities of the POE. Many agencies have advisory boards with extensive duties that have been established through regulations. Such advisory boards may act as governing boards. Their activities may include such things as evaluating the performance of an agency director and reviewing of all financial matters. It is assumed that, in most cases, activities such as these will be the responsibility of directors and commissioners who, in turn, are responsible to elected officials.

Therefore, the oversight function of a council would include at least the following duties:

- ? Providing a forum for regular updates from the Coordinator of the POE to the entire long-term care community.
- ? Working with the staff to help them deal with referral and organizational issues to keep the program running smoothly.

- ? Ensuring that the POE is being utilized for all clients, regardless of payment source.

Long-term care councils also serve a number of functions, including:

- ? helping to identify gaps in services;
- ? supporting agencies in their attempts to expand and improve services and;
- ? helping to present a unified voice of support for grant proposals.

Action Checklist for Developing Program Support and Oversight

The following are steps to consider in building a coalition that will lead to a long-term care council ((Lodl, K. & Stevens, G., 2002; University of Florida, 2002; and the Wisconsin Clearinghouse for Prevention Resources, n.d.):

- ✍ **Establish a working group.** Most of the group dynamics literature indicates that groups with a maximum of 11 people works best. Make sure that all sides of the issues are represented.
- ✍ **One agency needs to take the lead.** Someone needs to act as a facilitator (calling meetings, setting date, time and location). The “lead” agency does not have a greater say over substantive decisions than any other member of the coalition.
- ✍ **Write a draft of a mission statement.** The mission statement should contain a concrete statement of the functions of the POE, including a definition of long-term care.
- ✍ **Set realistic goals and objectives for the POE.** The goals must be believable, attainable within a reasonable length of time, tangible and capable of being revised, set up within a timetable or workplan and create a “win-win” situation for all parties involved.
- ✍ **Keep the county legislators or board of supervisors informed.** The CAP program in Fulton County has been successful, in part, because it was created and has continued to be supported by the Board of Supervisors.
- ✍ **Develop a plan for bringing other stakeholders into the process.** Seek to be as inclusive as possible.
- ✍ **Choose a name that clearly describes the POE.**

- ✍ **Keep the public informed.** Utilize the local media. Get input from consumers as the process continues.
- ✍ **Emphasize the positive aspects of the new POE for consumers and agencies alike.** Sell the POE as a time saver for caregivers and seniors, a way to improve services and as an innovative, forward-looking strategy that will benefit everyone in the county or region.

FUTURE PLANS

Planning for the Future: The Next Steps for CAP

Many of the major goals of the Real Choice Systems Change grant focused on planning for the future. This involved not only looking at CAP, but also examining both the long-term delivery system and the Long - Term Care Council. Among planning areas that were examined during the grant were:

- ? **marketing to the next generations of consumers;**
- ? **the use of technology;**
- ? **developing a new directory of services and;**
- ? **the development of a closer relationship between the aging and intellectual developmental disabilities networks.**

Marketing to the Next Generations of Consumers

During this project, a number of focus groups were conducted. At each group, participants were asked for suggestions about how we might reach the next generations of consumers. As expected, the social workers, nurses, and other professional staff from agencies across the County were all quite familiar with the concept CAP as a POE. However, responses from consumers indicated that while they did know about the central assessment system, they were unfamiliar with the name CAP. One participant who did know of the term said that her husband was reluctant to use the service because it had “placement” in the name; he did not want to be “placed” anywhere but at home.

Traditionally AAA’s have relied on such things as presentations at senior centers, newsletters, presentations to community groups, booths at health fairs and the distribution of brochures to market programs and services. But, these and other traditional venues may not reach the next generation of consumers. The “baby boomers” are likely to have a different set of interests and may be more inclined to visit a health club than a traditional senior center program or health fair (McKeage & Kaye, 2003). In addition, younger, middle-aged caregivers may be miles away and need different avenues for obtaining information that will help their aging parents, therefore, new avenues to reach this group must be developed if the public is to become aware that a POE is in place in a county.

As McKeage and Kaye (2003) have pointed out, many see marketing to be the same as advertising and something that service providers should avoid. However, that is not the case: marketing is built on the idea that understanding your client is the best way to provide the services they both want and need. “When done properly, better marketing insures that an agency’s services will be used effectively” (Kaye, 1995 quoted in McKeage and Kaye, 2003, p. 92).

The Fulton County Experience

When CAP began to serve clients in April of 1985, its opening followed sustained local press coverage of the planning process over the previous five years. This was an enormous help in the launching of the program. From the late 1980s to 1999, CAP used a basic brochure listing all the services. It was decided that while the information was what they wanted in their brochure, the type was too small. Therefore, during 1999-2000 CAP revised their brochure. It is now printed on a single, oversized (8 ½ X 17), tri-fold brochure in a single color. It includes a type of mission statement under the heading of “what is central assessment and placement,” a section entitled “who can central assessment and placement help” and a brief statement on how to obtain services. The brochure opens to a full-page table. Ten major categories programs are listed.

Reference Guide to Central Assessment Services

The Long Term Home Health Care Program	Personal care
Nursing home/adult care placement	Private duty nursing
Care at home	Case management
Adult day care	Home care
EISEP program	Shared aide program

Consumer focus groups indicated that residents liked the information provided in the brochure and thought it was very useful. However, they were not as positive about the size of the brochure and thought it had a lot of “open space on the back.” We determined that some redesign is necessary.

CAP issues quarterly reports, as well as an annual report, which are made available to the provider community. These data give insight into the referral sources CAP receives. Over the past few years, the largest number of referrals has come from family members. Friends rank last as a source of referrals. One problem with this reporting system is that the “other” category, which includes sources located outside the County, now ranks as the second leading source of referrals. It was recommended that system be reevaluated so that the largest sources of referrals are removed from the “other” category and placed in

individual categories the categories that now provide few referrals be collapsed into the “other” category.

Since family ranks number one, it would appear that many County residents have some degree of familiarity with CAP.

Marketing Lessons Learned from the Fulton County Experience

- ? Traditional marketing methods have worked well over the years and should be continued as part of any updated marketing plan.
- ? Brochures need to clearly demonstrate the range of long-term care services that potential clients can gain information about through a contact with CAP.
- ? Marketing a POE is not simply the responsibility of the agency, but also needs to involve every provider in the community. As providers make referrals to the POE, the word continues to spread among relatives, friends, and neighbors about how easy it is to obtain information and to access long term care services.

Using Information Technology

Over the past 25 years, there has been an explosion in the use of information technology (Friedman, 2005). Since the inception of CAP, the explosion in information technology has touched all areas of our lives. The next generation of consumers, as well as many in the current generation, will use the Internet for everything from shopping, to planning vacations, to gaining health care information on a regular basis. They are giving up their slow dial-up connections for high-speed DSL access.

Fulton County has a website for all agencies. The Fulton County OFA maintains its own well developed website that lists and describes all the long-term care services available throughout the County. The OFA plans to expand this website. The final version of this toolkit is scheduled to become available through this website. The County is well positioned to begin to take greater advantage of information technology in the future.

There will always be a need for the traditional marketing materials (brochures, posters, flyers) and personal contacts and informational presentations that have been a hallmark of the Fulton County OFA. But, every agency needs to begin to think in terms of how to get materials onto a well designed, user-friendly website. The basic cost of everything from computer hardware and software to assistance with website construction has decreased over the past five years. Knowledge management through the use of information technology needs to be at the forefront of your marketing plan.

Developing a New Directory of Services

One of the issues that emerged during the research was the need for a new service directory. This issue was discussed at the first two public forums. The main directory that was available when the project began was a small, phone directory format that also included agencies from other counties. It was decided that a new type of directory needed to be developed, one that focused on Fulton County and that would be useful for both professionals and consumers. Members of the Council took this on as a project.

The Council formed a committee chaired by a nurse from one of the certified home health agencies, a representative from OFA, and professionals from other agencies. The structure of this committee illustrates the value of a Council. As result of this inter-agency effort, the directory will appear in both print form and one-line. The on-line version will be available on various web sites, including the OFA site.

Crossing Network Lines: Bringing the Aging and Intellectual and Developmental Disabilities Networks Closer Together

“There are an estimated 500,000 older persons with developmental disabilities in New York State, and the population is expected to double by 2030.”

Jenny C. Overeynder and Kathleen Bishop, “Aging persons with developmental disabilities,” Project 2015, The Future of Aging in New York State.

Improving the coordination of service delivery between the intellectual/developmentally disabled (I/DD) service network and OFA was one of the goals of the Fulton County project. It was determined that there were two important reasons for bringing the I/DD and aging networks closer together in the County:

- ? **The aging of the disabilities population.** It is estimated that one of every 100 older Americans is someone who has an early onset developmental disability (Ansello, 2004, p. 3). We have the growth of the aging population coupled with the increased longevity of persons experiencing I/DD conditions (Putman, 2004).
- ? **Dual eligibility.** Every person with an I/DD condition who reaches age 60 becomes eligible for all the programs and services funded under the Older Americans Act. They, of course, are still eligible for all the services they have received over their life course from the disabilities network.

Because of the importance of this issue, DiAnn Baxley was invited to speak at one of the forums and she cited four reasons why the aging and disability networks need to “cross network lines” and cooperate on serving older persons with developmental disabilities.

- ? **Many older adults with I/DD could benefit from special services;**
- ? **There are many of the caregivers are older and could use help from the aging network;**
- ? **Working together saves time, money and staff effort and;**
- ? **Cooperation helps in planning for the future (developing community housing and support resources).**

Baxley (2004) has also pointed to a number of other potential benefits from collaboration between the two networks:

- ? **Coordinated approaches help both families and individuals;**
- ? **Collaboration can result in shared resources (staff, funds, equipment, and buildings);**
- ? **Collaboration also enhances communication between caseworkers;**
- ? **Agencies can conduct targeted training and share information and;**
- ? **The result of collaboration should be improved quality of life and consumer satisfaction of both older persons and their families.**

The Fulton County Experience

The Fulton County Experience has been marked by a willingness on the part of both the aging and disabilities networks to cooperate:

- ? The I/DD agency, the Lexington Center (Lexington), along with OFA, LDSS and the Council formed the Partnership Group that submitted the Real Choice Systems Change Grant, which funded this Toolkit.
- ? For the past 20 years, Lexington has remained an active member of the Council.
- ? Over the period of the grant, contact has increased between CAP and Lexington. CAP staff met with the newly appointed Medicaid service coordinator for Lexington. The two agencies are working to improve the coordination of these cases

Action Checklist for Bring the Networks Closer Together

Much of this action checklist is drawn from the work of DiAnn Baxley (2004).

- ✍ **Aging programs can include I/DD agencies in area resource guides for seniors**
- ✍ **Ensure that all POE staff know about the support that I/DD agencies provide and who the call for referrals**
- ✍ **Make sure that the disabilities network is represented on the long term care council.**
- ✍ **Begin to build informal coalitions between providers from the two networks.** Your long-term care council and/or POE can take the lead. Define who should participate, call a meeting, gain consensus on the needs, issues and approaches you want to take, meet and follow-up.
- ✍ **Support groups represent common ground and a good place to start.** Organize around “neutral topics,” such as financial planning or self-help. Provide respite support for the caregivers. Use the group’s success to demonstrate the viability and importance of working together.
- ✍ **Consider organizing a joint initiative between the two networks.** The Real Choice Systems Change Grant, which funded this Toolkit, was a joint venture between Lexington and the aging network. Lexington furnished the grant writer for the project. One goal of the grant was to begin to bring the two networks closer together.

APPENDIX A

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APPENDIX B

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Hugh Farley, New York State Senator, 44th Senatorial District
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Neal E. Lane, Director, New York State Office for the Aging
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David Verner, Demistified Technologies

Agencies and Business Organizations

Alcoholism & Substance Abuse Council
Alzheimer's Association of Northeastern New York
Ambulance Service of Fulton County Inc.
Caldwell Banker Arlene M. Sitterly, Inc.
Catholic Charities of Fulton County
City of Gloversville
City of Johnstown

Community Health Center Inc, of St. Mary's & Nathan Littauer Hospital
Cornell Cooperative Extension of Fulton & Montgomery Counties
David & Helen Getman Home
Del Negro Pharmacy/DME
Fulmont Community Action Agency, Inc.
Fulton County Adult Protective Services
Fulton County Board of Supervisors
Fulton County Mental Health
Fulton County Nursing Service
Fulton County Public Health
Fulton County Regional Chamber of Commerce & Industry
Fulton County Residential Health Care Facility
Fulton County YMCA
Fulton Friendship House
Fulton, Montgomery and Schoharie Counties Workforce Development Board, Inc.
Fulton Montgomery County Community College
Greater Johnstown School District
Holiday Inn of Johnstown-Gloversville, NY
Holy Trinity Parish
Home Health Care Partners
Independent Living Center of Amsterdam
Johnstown Public Library
Legal Aid Society of Mid-New York, Inc
Legal Aid Society of Northeastern New York
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Nathan Littauer Hospital Lifeline
Nathan Littauer Hospital Nursing Home
New State Office of Mental Retardation and Developmental Disabilities
New York State Office for the Aging
Palmer's Pharmacy
St. Mary's Hospital
Senior Center of Gloversville & Fulton Co, Inc
Staff of GoldenLane Associates, Inc.
Staff of Central Assessment and Placement
Staff of the Fulton County Office for Aging
Staff of the Lexington Center
United Cerebral Palsy Association of Fulton & Montgomery Counties, Inc.
Visiting Nurses Home Care
Wells House Skilled Nursing Facility
Willing Helper's Home for Women Inc.
WMHT Television