Can a Unified Service Delivery Philosophy Be Identified in Aging and Disability Organizations? Exploring Competing Service Delivery Models Through the Voices of the Workforce in These Organizations

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ABSTRACT

Services for older adults and younger people with disabilities are increasingly merging, as reflected in the creation of Aging and Disability Resource Centers (ADRCs). Using ADRCs to coordinate services is challenging, primarily because these fields have different service delivery philosophies. Independent Living Centers, which serve people with disabilities, have a philosophy that emphasizes consumer control and peer mentoring. However, the aging service delivery philosophy is based in a case management or medical model in which the role of consumers directing their services is less pronounced. Using institutional logics theory and a qualitative research design, this study explored whether a unified service delivery philosophy for ADRCs was emerging. Based on focus groups and questionnaires with staff from ADRCs, findings revealed that competing service delivery models continue to operate in the aging and disability fields.

Introduction

The rapid aging of our society is now well known, with policy makers and analysts forecasting enormous increases in the numbers of people living longer with chronic illness and disabilities (Administration on Aging, 2015). During this same time of rapid growth, services for older adults and younger people with disabilities—historically separated by different funding streams, service systems, and workforces—are increasingly merging (Putnam, 2007). In the past 13 years, the movement to coordinate services for older adults and younger persons with disabilities has accelerated as a result of federal funding in 2003 to create a new hybrid organizational entity: Aging and Disability Resource Centers (ADRCs) (O'Shaughnessy, 2011; Putnam, 2011). Preliminary evidence suggests that the use of ADRCs as the principal organizational strategy to coordinate aging and disability services has proven

challenging for many states for a number of reasons. Primary among these is that aging and disability organizations have different histories and service philosophies (DeJong, 1979; Kane, 2007; Putnam & Stoever, 2007). In particular, Independent Living Centers (ILCs; also referred to as Centers for Independent Living), which emerged in the 1970s as a core agency for people with disabilities, have a service philosophy that emphasizes "consumer control," characterized through self-help, advocacy, and peer models to guide services (McDonald & Oxford, n.d.). In contrast, within the aging world, the concept of consumer control is a more recent philosophical shift. Historically, the formal system of care for older adults, organized around Area Agencies on Aging (AAAs), has emphasized the protection and safety of older adults (Simon-Rusinowitz & Hofland, 1993).

In this case study research, I examined the experiences of Massachusetts in establishing ADRCs to coordinate aging and disability services using institutional logic theory. My primary objective was to assess whether a unified organizational philosophy for people who work under the umbrella of ADRCs could be identified. Case study research in public policy is a qualitative research method that is used to understand the policy-making process. It can be an important tool for gaining insights into how public policy is designed and implemented (Pal, 2005).

The Massachusetts Executive Office of Elder Affairs was funded by the Administration on Aging in 2009 to create national standards and build competencies for the workforce of options counselors through the development of a new cross-training program. Focus groups were held to gather input on the knowledge, skills, and values needed to understand consumer control, choice, and direction, which would serve as the foundation for the content created for the new training program. After these focus groups, the course entitled "An Options Counselors Guide to Consumer Control, Consumer Choice, and Consumer Direction" was launched with the same participants who were involved in the focus groups, along with many other options counselors across the state (findings on the training program are forthcoming in a separate article). This article reports on the focus group findings as they relate to the challenges and opportunities in coordinating aging and disability services and in understanding consumer control, choice, and direction.

Background and significance

In 2003, Massachusetts was one of the first 12 states funded to develop an ADRC. Due to its initial success, Massachusetts received a 2-year continuation grant from the Administration on Aging in 2006 to expand the ADRC model to other regions of the state. In 2009, Massachusetts received an additional 3-year ADRC grant to develop a 5-year strategic plan that evolves

its ADRCs to a "fully functional" status (Executive Office for Elder Affairs, 2010). The main mission for ADRCs is to take a complicated system of long-term services and supports and streamline access for consumers under one umbrella—to embrace a "no wrong door approach" (O'Shaughnessy, 2011). While the goal for ADRCs is to promote and develop stronger coordination between aging and disability organizations, one complicating factor is that ADRCs are not freestanding organizations where staff from both organizations share a common work environment. The majority are located within existing organizations that have long served the aging communities: AAAs, which serve adults older than 60 and their caregivers, while a smaller percentage are located in ILCs, which serve people with disabilities of all ages. In fact, in Massachusetts there are 11 ADRCs, of which 9 are located in AAAs and only 2 are located in ILCs (Executive Office for Elder Affairs, 2011). It is important to understand the varying service delivery philosophies of each organization and how this impacts the target populations they have traditionally served.

Aging programs and the delineation of services for older adults were enacted in public policy in 1965 through the Older Americans Act (OAA). The OAA authorizes a wide range of service programs through a national network of 56 state Agencies on Aging, 629 AAAs, nearly 20,000 service providers, 244 tribal organizations, and 2 Native Hawaiian organizations representing 400 tribes (Administration on Aging, 2016). The key services provided by AAAs are information and referral, case management, intake and assessment, development and implementation of individual services plans and reassessment of needs, protective services (investigations of abuse and neglect of elders), caregiver support, and nutrition services (Community Resources Information, Inc., 2013).

Inherent in these services is that the case manager will address the service needs of the older adult through a series of assessments and planning and the role of consumers directing their services is less pronounced, with the belief that the professional has more experience and can plan services with more skill and expertise than the consumer (Kunkel & Nelson, 2006). However, in the past 20 years there has been a shift in aging services, primarily through the Cash and Counseling Demonstration program, which provides older adults and younger people with disabilities the option of managing a budget to hire and direct their personal assistant services rather than having the agency deliver these services (Mahoney & Simone, 2006). This model has proven to be effective for those adults who want to manage these services and has been critical in helping to reenvision the delivery of care in aging organizations (Mahoney, Doty, Simon-Rusinowitz, & Burness, 2016). Previous research has examined how case managers in aging organizations have responded to consumer-directed services, and many describe challenges with letting go of managing services, in particular in the areas of quality of

care and right to risk, as safety and services provided by "professionals" to protect the well-being of older adults has long been at the heart of aging services (Kunkel & Nelson, 2006).

While the aging service delivery philosophy has traditionally been based in a medical model of care rooted in a case management professional orientation, services for people with disabilities have long been associated with a model of consumers being in control of their services and supports (DeJong, 1986; Putnam, 2002; Simon-Rusinowitz & Hofland, 1993). In 1979, Gerben DeJong published a seminal article on moving from a medical model to the independent living paradigm and the differences within each model. A summary of his work is that the medical model defines the problem as physical or mental and believes that the individual needs to be "fixed" by medical or professional interventions in which the provider is the expert. Comparatively, the independent living paradigm states that the problem is a dependence on professionals and a "hostile" environment that creates barriers to community living. The independent living movement is not founded in the belief that professionals are the solution to the problem; rather the solution lies in individuals having "consumer control over options and services" while working with peers or by becoming involved in self-help or advocacy roles to be their own expert (DeJong, 1979).

Contemporary perspectives on the service delivery models for people with disabilities became more distinct as the independent living movement came into being (Scotch, 1989). Through this movement, the definition of disability began to change from a deficit-based perspective to a strong consumer voice determined to have the same rights as people without disabilities (McDonald & Oxford, n.d.; U.S. Department of Labor, 2010). The independent living movement provides the primary service philosophy for ILCs throughout the country (Scotch, 1989). By the mid-1970s, organizations were being formed that put the independent living philosophy and concepts into operation. The core services provided by ILCs are peer support, information and referral, individual and systems advocacy, and independent living skills training, all of which are operated under a "strict philosophy of consumer control, wherein people with all types of disabilities directly govern and staff the organization" (National Council on Independent Living, 2013).

In 2003, the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services funded the national initiative to develop ADRCs, which was designed to create a "seamless" network of information, referral, and assistance for older adults and people with disabilities of all ages, specifically, a "no wrong door" approach to accessing services and supports (ADRC Technical Assistance Exchange, 2013; O'Shaughnessy, 2011; Putnam, 2007). As this effort moved ahead, a new accompanying workforce called "options counselors" was also created to work in ADRCs. Options counselors' main responsibilities are to assist older adults and people with

disabilities in making informed choices about setting, services, and financial resources that will best meet their long-term support needs (ADRC Technical Assistance Exchange, 2013). Currently there are 467 ADRCs around the country delivering services to older adults and people with disabilities (Administration for Community Living [ACL], 2014).

Almost 10 years since the original funding for ADRCs, the federal ACL was created in 2012 and combined the efforts and goals of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, the U.S. Department of Health and Human Services Office on Disability and, more recently in 2014, the National Institute on Disability, Independent Living, and Rehabilitation Research. Similar to the mission of ADRCs, ACL strives to promote services and supports that will enhance the well-being of older adults and people with disabilities and ease access to long-term services and supports (ACL, 2014).

The decision to coordinate the efforts of these organizations is multi-faceted and includes reasons such as streamlining services, easing access for consumers, and pooling resources (ACL, 2013; O'Shaughnessy, 2011), yet there are also challenges that often stem from the differences in public policy for older adults and people with disabilities (Putnam, 2007). Some of the challenges in cross-network collaborations, as stated by Putnam, are "variance in organizational mission, distinctive professional training, competition for program funding, and lack of investment in common goals" (2011, p. 328). Efforts to create professional standards and cross-training for options counselors are underway, as evidenced by the funding support to Massachusetts in this project to create a new training program and through other training initiatives recently funded by ACL, yet more work remains in how best to break down some of these organizational silos.

Through this review of service philosophies for aging organizations and ILCs, it is clear that there are differences in orientation, beliefs, and approach between these two broad types of organizations, represented at the community level by AAAs for older adults and their caregivers and ILCs for people with disabilities. Now, in a major policy shift, federal agencies are promoting initiatives to coordinate and streamline services for older adults and people with disabilities. Whether these differing service philosophies can be successfully integrated and how these new policies impact the workforce serving both populations is a critical policy issue and the focus of this research.

Theoretical framework

To analyze and compare the service philosophies of AAAs and ILCs, I used institutional logic theory to determine whether distinctive institutional logics could be identified for each organization. The main concept in institutional logics theory is that each institution has its own set of logics or principles that

guide work and activity and it is these logics that prevail in an organizational field (Friedland & Alford, 1991; Hinings, 2012; Lounsbury, 2001; Marquis & Lounsbury, 2007; Scott, 2001; Skocpol, 1991; Thornton & Ocasio, 1999). Logics shape behavior and organizational actors can influence how logics develop and change over time (Thornton, 2004; Thornton & Ocasio, 2008). Guiding logics are based in symbolism, organizational structure, and policies. In order for organizational change to happen there must be new institutional logics, or models to guide them, and new symbols and behavior need to be created (Friedman & Alford, 1991). Institutions can be interdependent while struggling between differing institutional logics in an effort to determine which logic should be dominant.

Many authors have tackled the issue of how to manage competing logics (Kitchener, 2002; Marquis & Lounsbury, 2007; Reay & Hinings, 2009). Previous research has examined whether logics can coexist or whether one logic will be dominant over the other (Marquis & Lounsbury, 2007; Lounsbury, 2007; Zilber, 2008; Reay & Hinings, 2009). Pache and Santos (2010) stated that, "organizational members who have been socialized or trained into a specific institutional logic are likely to be committed to defending it in case it is challenged" (p. 16). Some research has shown that when there are differing logics, ultimately one will become dominant over the other or "individuals give the appearance of accepting the new logic but continued to act in accordance with the old logic" (Reay & Hinings, 2009, p. 632). The guiding concern is whether micro-level actors in the field can manage competing logics from the macro systems in which they work. Reay and Hinings (2009) identified four mechanisms to manage competing institutional logics: (1) creating formal decision-making roles; (2) including both stakeholders in the decision-making process; (3) finding a common connection between the two groups; and (4) working together in joint projects to create collaborative programs. They found that diverging logics could coexist if the different parties collaborated with an understanding that not one logic would dominate the other; this is referred to as a "pragmatic collaboration."

The previous section described the differences in service delivery philosophies in the aging and disability fields. These and other differences between these two types of organizations suggest that differing and competing institutional logics can be identified for each group because of the historical differences in how services have been delivered and the variation in the core value systems propelling these service delivery systems. In this study, a central focus is whether a single institutional logic will become dominant and can bring together disparate service philosophies for the workforce located in a "hybrid organization"—that is, an organization that has multiple institutional logics governing their work (Lounsbury, 2007; Thornton, 2004). Inherent in the creation of ADRCs is the notion of collaboration, as these two organizations are now charged with working together to deliver

streamlined services to both populations. Federal policy makers are working jointly to create and refine the services that are offered under ADRCs (ACL Strategic Plan, 2013), but the question is whether the aging and disability organizations can accept a coexistence of competing logics or whether the implementation will be challenged because one logic, or group, wants to be dominant.

Methods

Data from this study were gathered from a larger funded program, which was conducted from 2009 to 2012, to create a cross-training program that would develop the competencies for options counselors working in ADRCs in Massachusetts. The purpose of the research for this paper was to analyze and compare the institutional logics of AAA and ILC directors and options counselors to determine whether distinctive institutional logics can be identified for each group and to assess similarities and differences between them. To assess the service philosophy of directors, a focus group was held with ILC directors and an online questionnaire was distributed to AAA directors from ADRCs in Massachusetts. The purpose of this analysis was to provide a comparison of institutional logics between the two groups of agency directors. A limitation of this study is that we did not hold a focus group with AAA directors, as it was not part of the larger funded project, and as a result we were only able to gather their input via an online survey, therefore hindering our ability to have a deeper dialog with the AAA directors.

A convenience sample of ILC directors in Massachusetts were recruited for the focus group. An email was sent to Massachusetts' ILC directors ($n = 14$) and they were asked whether they would like to participate in a focus group to discuss the knowledge, skills, and values needed in the areas of consumer control, choice, and direction for options counselors in ADRCs. ILC directors who were interested signed up to participate in these focus groups; no other workers were invited to participate. One focus group was held with five ILC directors, three women and two men, for approximately 2 hours. As a complementary analysis, a questionnaire was distributed via SurveyMonkey to AAA directors ($n = 12$) who are part of an ADRC in Massachusetts. Eight completed the questionnaire; all of whom were women.

Two focus groups were held with options counselors who work in ADRCs. An email was sent to directors of AAAs and ILCs and they were asked to inform their options counseling staff that focus groups were being held to gain a better understanding of how consumer control, direction, and choice are understood by this workforce and how this impacts their work with older adults and persons with disabilities. A convenience sample of options counselors signed up to participate in these focus groups; no other workers were invited to participate. The first focus group had 12 participants (all women)

and the second focus group had 15 participants (only 2 men). The focus groups lasted approximately 2 hours and were held at different regions in Massachusetts to capture the diversity of the population being served and the options counselors themselves.

A structured focus group protocol was developed in consultation with the Massachusetts Options Counseling Training Advisory Group (this group was created for the larger federally funded project), which included key stakeholders in the aging and disability communities in the state, including representatives from the Executive Office of Elder Affairs, Massachusetts Rehabilitation Commission, ILCs and AAAs, options counselors, and consumers. I created the first draft of focus group questions based on initial meetings with the advisory group. This draft was reviewed and finalized by the advisory group for face validity (see Appendix A for the focus group protocol).

Focus groups were not held with AAA directors, as this was not part of the scope of the larger federally funded project. As a secondary analysis for this research, I decided it would be important to gain the perspective from AAA directors on the topic of consumer direction and control. I created an online questionnaire, which was reviewed by my advisors to assess the appropriateness of the questions and whether these questions would achieve the aim of my study and accurately assess institutional logics. I included some of the same questions used for the focus groups as they had already been reviewed and revised by the advisory board for face validity (see Appendix B for the questionnaire used with AAA directors).

The focus groups were led by me and one other cofacilitator was present for all sessions. As I conducted the focus groups, I included probes to allow some flexibility in the responses, which allowed the conversation to move in a natural progression, but I would always bring them back to the specific questions from the protocol to have consistency across the focus groups. The same questions/probes were used during the focus groups with both ILC directors and options counselors from ILCs and AAAs. The focus groups with ILC directors and options counselors were audiotaped and transcribed for analysis. The average length of focus group transcripts across the three groups was approximately 40 pages. The transcripts were reviewed by both focus group facilitators for accuracy. Copies of audio recordings were not allowed off the premises and were kept in a locked office accessible only to myself. All focus group data and questionnaire results were stored in a restricted-access folder on a highly secure server. All names, if mentioned during the focus group, were removed from the transcripts and all that remained was the response.

I independently analyzed the focus group transcripts and questionnaire responses to look for common themes surrounding how consumer control, direction, and choice are understood by this workforce, in addition to

examining any other presenting service principles or logics. During this first reading, it was important to familiarize myself with the data by actively reading each transcript and taking notes as I went along. I used a grounded theory technique of line-by-line coding to find themes to support the research questions while remaining open to other themes that emerged (Charmaz, 1999; Glaser & Strauss, 1967). This was achieved through sorting the data into similar components, comparing data across the three focus groups and questionnaire responses, and identifying similarities and gaps (Charmaz, 2006).

Transcript notes and questionnaire responses were read twice, with the first reading focusing on a detailed description of each line, and during the second reading I collapsed the ideas into larger themes. All themes were reviewed by my advisors until we had consensus on the major themes and a coding structure. I manually coded all the data and sorted them under the appropriate themes, such as "consumer control" or "case management." This analysis provided information as to how different staff members in AAA and ILC organizations understand the terms consumer control, choice, or direction and how these different philosophies might guide their work.

Results

There were five participants in the focus groups with ILC directors, three women and two men. Eight AAA directors completed the online questionnaire; all were women. In the first focus group with options counselors, there were a total of 12 participants, of whom four participants were from ILCs. The remaining participants were from AAAs. All participants were women. The second focus group held had 15 participants, 13 of whom were women. Five participants were from ILCs, and the remaining 10 were from aging organizations. The average time options counselors had been working in this position was 10 months. However, out of the 27 options counselors, on average they had worked in the fields of aging and disability for 13 years, and 13 out of the 27 options counselors had previously held the job of case manager or other human services manager. This speaks to the newness of this occupation, yet many of the people occupying these positions have been in the human services field for a while and have likely been oriented into logics dependent on their background and work experience. It is also relevant to note that most options counselors ($n = 27$) worked more with older adults (63%) and less with persons with disabilities (33%).

The following themes were identified by directors and options counselors at ILCs and AAAs and are organized under five categories: (1) terminology/ language; (2) professionalization; (3) risk versus safety; (4) organizational orientation; and (5) organizational resources and financing. As shown in

Table 1. Themes Identified by Directors and Options Counselors.

Themes	ILC directors and options counselors (n = 14)	AAA directors and options counselors (n = 30)
Terminology/language	Consumer control	Consumer direction
Professionalization	Peer workers	*
	Anti-certification	
Dignity of risk vs. safety	Right to risk	Balancing risk vs. safety
Organizational orientation	Independent living model	Case management model
Organizational resources and financing	Not equal partners	**
	Financing imbalance	

Note. ILC = Independent Living Centers; AAA = Area Agencies on Aging.
*This theme was not identified by AAA directors or AAA options counselors.
**This theme was not identified by AAA directors.

Table 1, directors and options counselors expressed different belief systems on the same general topic.

Contrasts in terminology and use of language: Consumer control versus consumer direction

Very different professional logics emerged between ILC and AAA staff in the use of language and terminology. From the outset, and before we could go any further in the discussion, all ILC staff across focus groups (*n* = 14) were very clear that we should be talking about consumer control, not consumer direction. As pointedly stated below:

> We don't use consumer direction, we use consumer control. Consumer direction is a bastardization of consumer control developed primarily by agencies that take care of people. So consumer control is very simple: It's that the individual has a right and a responsibility to make his or her decisions on her own with information and informed choices and options. (ILC director)

The importance of language and how language embodies the guiding philosophy of ILCs was repeatedly stressed by all the ILC staff. Another important distinction on language is described below:

> There is a big push on person-centered planning. But for an independent living person, person-centered planning is really an affront to consumer control because it does not give the individual true control of the choices, decisions, and settings that they seek. It pretends to give some kind of credence to that, but control is an issue that needs to be dealt with. And I say, "My staff are not going to be certified in person-centered planning. My staff are independent living services folks. They don't need to be person-centered planning trained." So that's where that word gets us really caught up, because if you start saying consumer directed, how does that differ from person-center directed, person-centered planning? See, I don't think

they can go down that path because it's either one model or the other. (ILC director)

In contrast, the professional logic related to language and terminology that emerged from all staff at aging organizations (n = 26) is more accurately described as consumer direction, not consumer control. When aging staff are asked whether the philosophy of consumer control is embraced by the organization's structures and practices, many responses are clearly not as strong as those from staff from the ILCs, as articulated below:

Consumer control is not embraced, but we are definitely trying to move towards it. (AAA director)

Consumer control is not recognized organizationally, and it is a learning curve for a few individuals who are longtime employees. (AAA director)

These statements confirm that the professional logic of consumer control is a logic that AAAs would like to better understand, but this has not yet been realized by aging organizations; perhaps there are some obstacles of entrenched old logics within the aging system that hinders this goal. What is important to note is that staff at AAAs acknowledge that this professional logic is not yet "embraced"; therefore, the important work ahead is moving toward finding mechanisms to help these organizations in adopting a new unifying logic.

Themes related to professionalization

Staff professionalization came up in the focus group with ILC directors, but this theme was not present in the findings from the AAA directors or options counselors from either organization. One issue repeatedly identified by all ILC directors was the concern that decisions are made without the consumer being present, especially when these decisions are being made by "professionals" who might not know the consumer very well and who might not even understand the issues being faced. One clear example of this is in the role of peer counselors; this is a central staffing position in ILCs, but these types of positions are not widely used in aging organizations. Below an ILC director describes the role of peer counseling:

Because our model is a peer role, peer consumer-driven model, a paraprofessional model. Because any time you create certification, you create power. You create control, the people aren't equal. And the epitome of consumer control is equality. Now, the individual, the consumer, has just as much right to screw up or succeed as you and I do. And that's a lesson that's very hard to train and transmit into traditionally trained individuals. That poster right there says it best. That has to be the core of where we're at, and that's what says it the best. *Nothing about us without us.*

This guiding philosophy of "nothing about us without us" is central to the disability rights movement in that all policies, programs, and services should be designed and carried out by people who have a disability or within an organization in which the majority of the board is controlled by people who self-disclose that they have a disability (National Council on Independent Living, 2013).

ILCs are not using degree attainment as a prerequisite to securing a job, whereas AAAs might be more likely to hire a social worker or someone who has a similar degree. This variation in professionalization creates a stark difference in the workforce under the ADRC umbrella and could lead to varying types of consumer interactions and outcomes. Below an ILC director states the differences between a "professional" and a peer:

> It won't even make sense. You can't sit in a room and understand what we just talked about if you've never experienced it. You can't, it's just words. To say independence, to say control. The definition of control to someone coming off the street would be completely different from what we're talking about here.

The issues of experiential learning and anti-professionalism are central to the institutional logics of disability organizations. ILC directors connect the concepts in the language they use to real-life experiences and state that this type of life experience is far more important than any type of professionalization or certification.

Contrasts in professional logics related to risk: Right to risk versus balancing risk and safety

Most ILC and AAA directors and options counselors articulated guiding professional logics in the area of risk, although with distinct differences between their views. All ILC staff firmly stated that consumers have the right to take risks and stressed that this is a key tenet of the guiding philosophy of consumer control, as described by the following:

> It includes the right to fail. If they make the wrong choice, it's still their choice. I mean, I think sometimes when people start getting into the case management, they don't take that step until they almost are sure that there's a perfect result. The dignity of risk does not guarantee a perfect result, but it's the path of the person deciding. (ILC director)

One corollary of this theme deals with the importance of the providers' willingness to give up controlling the situation. This issue really brings to light some of the differences in guiding professional logics between aging services providers and independent living staff, as articulated below:

> The second we sit down with any of the partners [who] are coming from the elder side, and we mention the right to fail, it's almost like the air has been taken out of

the room. There's this gasp there, and they don't want to give that up. And it's very significant. We need to stress that people have that right. The ability to let go has to be there. (ILC director)

Many aging staff in the focus group discussed their struggle with balancing the right to risk and safety, as this is a real shift in their organizational culture and upbringing in the aging world, as noted below:

Anybody think big can of worms here? I mean, I'm scared by it, quite frankly … sometimes the choices are so vast, or even so narrow that they [consumers] either feel pressured to make the right decision, or they feel overwhelmed because there are so many different choices to make. So I get a little nervous. (AAA options counselor)

I think the issue of risk and safety really varies agency to agency. And it can vary with who your supervisor is, it can vary with who your director is and who your executive director is. (AAA options counselor)

This last quote clearly states that organizational philosophies vary across agencies, supervisors, and directors and that issues of safety and responsibility are very complex and unsettling for aging services staff as they confront life and death issues. There are clear differences between staff in ILCs and AAAs in issues surrounding safety and the dignity of risk. AAA staff had safety as a paramount concern when supporting consumers in their wishes. ILC staff would often stress that dignity of risk, in particular, that "quality of life" supersedes "quantity of life," stating that this should be a central focus of those working in ADRCs. What becomes clear is that these differences are deep and evoke passion on both sides, as dignity of risk is central to consumer control and ILCs, while consumer safety is a driving force for those working in AAAs. The question is how these differences impact the workforce and the people they serve under the ADRC umbrella. It seems logical to assume that staff will guide their work and decisions based on the guiding philosophy of the agency in which they are located, but it is clear that there are differences in approach between AAAs and ILCs. The reconciliation of these varying professional logics seems necessary in order for the ADRC workforce to ground themselves in a guiding work ethic or value so they can provide quality, unified services to older adults and people with disabilities.

Independent living model versus case management model

One of the more striking differences in professional logics between the aging organizations and ILCs emerged in the focus groups as the independent living model and case management model; these appeared to supersede or encompass all of the other logics identified. Many of the staff located in the aging organizations were case managers in their previous jobs, so they

continue to hold onto some of their original organizational orientations, as stated below:

> I think it's a bit of a switch, especially with the elder population, where in the past I think it's kind of been "this is what you need and here's how you get it." So it really is about listening to what somebody wants and, in my view, being able to go with that. And it's not about what I think you should be doing. It's about, if this is what you want to do, let's take a realistic look at that. (AAA options counselor)

While there seems to be some variation of professional logics among aging organizations, the logics of ILCs from the independent living movement are clear and uniform across all these agencies, as stated below and echoed by all staff at ILCs:

> Well, these are the tenets of independent living. Consumer control, where the consumer is in control, the consumer determines what is going to happen with their life. The consumer has the ability to say, yes, this is what I want; no, I this is not what I want; this is where I'm going to go; this is what I'm going to do; this is how I'm going to achieve what I want to achieve in my life. Self-determination and dignity of risk. I'm going to do this this way, and I may succeed or I may fail, but this is how I'm going to go about doing it. (ILC options counselor)

Many of the AAA staff acknowledge that there are different organizational philosophies between ILCs and AAAs and admit to challenges in moving toward a true model of consumer control, while a few AAA staff wonder whether there could be a role for both logics:

> We're a big agency and there's a lot of people so it takes time for all that change. But I know that is what's being promoted, that it's consumer driven, consumer choice. No more going in and saying, "This is what you need." And despite that, though, there's still the state home care system, which is the case management model. And I think there can—there still is a role for both. And I think that that's important to acknowledge, too. I mean, can there be—is there a case management model that might be helpful if someone wants the help? I don't know. I kind of feel like it would be nice if we were sort of on an equal par in terms of having both options for those who want it. (AAA options counselor)

Also, many options counselors discussed that cross-collaboration and coordinating work between the ILCs and AAAs would make their work more efficient and help options counselors feel that they are working together toward a common goal with a unified mission:

> Whether you're new to the elder world or the disability world. Cross-collaboration needs to definitely happen because when I started, I was only elder. I didn't really know anything until meeting up with an options counselor from an ILC. (AAA options counselor)

It was clear that the options counselors from both ILCs and AAAs wanted to be more unified and wanted to collaborate in their work together. They enjoyed the opportunity to be together at the focus group and share ideas

and feelings; many said that the time spent together in the focus group helped to bring cohesion and made them feel as though they were not alone in their struggles to do the difficult work they encounter in options counseling.

Themes related to organizational resources and financing

Several related themes emerged in the analysis of the focus group with ILC directors and options counselors pertaining to funding, resources, and shared decision making that underscore the challenges in managing competing institutional logics between the aging and disability systems. This did not come up in the survey with AAA directors. Most ILC directors described the imbalance in resources and financing between the aging and disability systems and how this impacts the development of a uniform organizational philosophy for ADRCs. When thinking about ADRC staffing and leadership, the fact that ILCs are outnumbered by aging organizations is of major concern to the ILC directors, as they are concerned that the sheer number of aging organizations will result in the workforce being indoctrinated into the aging logics and that there will not be an equal opportunity for the ILCs' overarching logics to be dominant or even considered.

All ILC directors and many options counselors from ILCs discussed the concern that they are not considered "equal partners" at the table. They have less staff, fewer agencies represented under the ADRC umbrella, less funding: All of this leads to underrepresentation and the need to be outspoken so that their values and organizational philosophies are being heard. Below, an ILC director discusses the lack of formal decision-making roles and how that leads to feelings of inequities:

> I mean, it's ironic that we've been in ADRCs for going on four or five years now and still the "D" in ADRC fades a lot. And it's not because we're not trying. It's because we're outnumbered. I have five [options counselors]. I'm going down to three now. Not because I wanted to, because the AAAs decided this and they told elder affairs so elder affairs said sure. They never talked to me. It affects ADRCs, but the "D" was never consulted. It was a decision made outside of my interest, apparently. And it affects me.

The issue of inequitable distribution of resources between aging and disability organizations was frequently mentioned. There are differences in how much money each organization is allotted and this leads to genuine feelings of inequities. These themes surrounding funding, resources, and shared decision making are important to consider in this analysis, as they speak to whether a truly equitable and collaborative relationship can occur when there is imbalance between the two organizations. It is worth consideration that the theme of inequity might be the place to begin in order to

move toward either a unified institutional logic or at least a hybrid logic that is agreed upon by both members based on a shared process. It is also worth noting that aging organizations are aware that they have greater organizational representation under the ADRC umbrella but, at least in this case study, have not acknowledged that this discrepancy could impact the potential for equitable collaboration or that it has led to feelings of imbalance between the two types of organizations. Privilege and power are important considerations and until power is acknowledged it will be challenging to change discourse or behavior as those in power continue to underestimate their position and downplay any feelings of oppression felt by those with less power or privilege (Dei, Karumanchery, & Karumanchery-Luik, 2004).

Discussion

The variations in how themes are expressed by the staff at AAAs and ILCs confirmed that there are differences in professional logics at these organizations and that ADRCs lack an overarching logic to guide the important work of this umbrella organization. The policy initiative to coordinate care of older adults and people with disabilities under a "no wrong door" approach makes sense at a macro level, as both populations might need similar types of services. However, this research exemplified some of the challenges of policy implementation at the local agency level. There can be contradictions in job expectations that impact the delivery of services, which stresses the utility of a "bottom-up" approach to understanding policy implementation for those who are actually in the field implementing the new policy initiatives, better known as "street-level bureaucrats" (Elmore, 1979; Lipsky, 1971). Street-level bureaucrats, such as social workers or other human service workers, are allowed much discretion in how their services are delivered and how policies are implemented; therefore, they often have a more direct impact on people's lives than those making policy (Lipsky, 2010). This research provides insight into the implementation of the "no wrong door" policy through the role of options counselors, as street-level bureaucrats, and should be a consideration for policy makers as they reflect on the intent of this policy and gain a better understand of how this is executed on the ground.

A hybrid organization, such as an ADRC, would seem a natural direction for coordinating services, as it is not unreasonable to assume that the professional logics would be similar for both organizations. What became apparent is that the professional logic in aging emulates more of a case management professional logic, with concerns about safety outweighing risk, while the ILC staff were motivated by the social movement crusaded by leaders in the disability field who fought for dignity of risk and control dictated by the consumer, not a professional. While these professional logics are at odds, it became clear that it would be beneficial to have shared decision

making and collaborative projects that educated each profession about the belief systems that guide their work.

An important move to ensure the success of ADRCs would be to work together toward creating a new overarching logic for this hybrid organization. This will require defining new standards of operation, with cooperative discussions aimed at creating a revised industry logic. Aging and disability stakeholders need to collaborate to find common ground in order to adopt a new logic that will ultimately be translated to the workforce in the field. Before this happens, each agency needs to be willing to change as the creation of this logic will inevitably entail some compromise in each field as new logics, language, guiding principles, and structures emerge.

It was also clear from this research that a strong theme emerged in the analysis that addressed ILC organizational constraints due to funding/resource issues. It seems that the imbalance in resources and financing between the aging and disability systems may affect the development of a uniform organizational philosophy and could be related to obstacles in managing competing institutional logics. While theorists have stressed the importance of shared decision making, collaborative processes, and working on joint projects as being key in negotiating varying institutional logics, this analysis revealed that who holds the power and money is a key consideration in how logics are managed. Having all the funding flow down from the Executive Office of Elder Affairs creates a power differential that is hard to overcome when working on creating a unified organizational logic, as one of the professions—namely the aging side—holds more control through their resource dominance.

The term "institutional demands" describes pressures put on organizations to conform, which can lead to "conflicting" institutional demands to operate within multiple institutional logics (Pache & Santos, 2010). Oliver (1991) describes five strategies to deal with institutional demands: (1) acquiescence, (2) compromise, (3) avoidance, (4) defiance, and (5) manipulation. According to my research, the aging and disability organizational members are responding differently to the conflicting professional logics or institutional demands. Workers from AAAs are trying to find a compromise to the demand of adhering to the new logic of consumer control by exhibiting behavior that balances their understanding of how to work with the consumer driving the process. The ILC workers are resisting the case management model inherent in AAAs by dismissing and attacking this logic, as they will only accept the logic they know as consumer control. This struggle impacts the move toward hybridity and the ability to operate with multiple institutional logics.

What is interesting is that while ILCs are resource-dependent on the Executive Office of Elder Affairs under the ADRC umbrella and have less

representation, their defiance to adhere to the overarching logic that comes from aging organizations is very strong. This is not what we would expect to see, as usually the group that is less powerful would likely acquiesce to the more dominant group (Greenwood & Hinings, 1996; Kim, Shin, Oh, & Jeong, 2007; Pache & Santos, 2010). What is it about these members that make their reaction different? From the focus group analysis, it is clear that the journey through fighting for equal rights and protection under the law for people with disabilities has made this group of actors powerful and united.

Reay and Hinings (2009) state that the first step toward a "pragmatic collaboration" that could lead to a unified organizational logic is including both stakeholders at the table, then giving stakeholders from each group a role in decision making. While I agree that a pragmatic collaboration is important, I would also add to this that the collaboration must be driven by common values and equal resources with shared power between the two groups. Therefore, I argue that there needs to be fifth step added to Reay and Hinings' work: the need for equal resources and power in order for collaboration and new models of care to be fully realized in ADRCs. The lack of this dimension was critical in hampering the full development of an overarching logic for aging and disability organizations, as resources are so intricately tied to power domination, and this kept breaking down the ability to fully identify an overarching logic.

Study limitations

One of the main study limitations was that this was an applied study based on a larger federally funded project; therefore, some of the data collection methods were predetermined, which led to variation in these methods. In particular, this was apparent in the funder's decision to not hold a separate focus group with AAA directors. As a result, the data collected on the opinions of AAA directors were collected via an online questionnaire in order to provide a comparison to the information gathered in the focus groups with ILC directors. Even though the questionnaire was open-ended, the results from the AAA directors might have been more robust had they had equal opportunity to participate in a focus group with their peers the way the ILC directors did. This difference is evident in the rich quotes from the ILC directors, as focus groups provide an opportunity for deeper dialog while the online questionnaire with AAA directors did not allow for this type of communication.

It is possible that there were also limitations to holding "mixed" focus groups with options counselors from both ILCs and AAAs. Would the results have been different if the options counselors from each organization were only with their peers? Would they have shared more about the opportunities

or challenges in organizational embodiment of consumer control? However, while it is important to note this limitation, this might have also been a strength, as the options counselors in the focus groups spent a lot of time educating each other about the varying professional logics and describing very complex practice situations and concerns about how to adopt new logics in these scenarios. The time spent together in the focus groups seemed to help the options counselors from AAAs and ILCs feel more connected, and many stated how much they learned from each other during that time.

Additional limitations pertain to the generalizability of the study. This research was conducted in Massachusetts, and there may be geographic differences across the country. For example, Massachusetts is known to have a vocal group of disability advocates that are prominent in Washington, DC, and who were active during the disability rights social movement. Had this research taken place in another state with fewer vocal disability advocates, an unanswered question is whether there would have been such pronounced differences in professional logics.

Conclusions and suggestions for future research

This research provided important information on the workforce tasked with working between two target populations consisting of older adults and people with disabilities. ADRCs and the job of options counselors were created in an effort to support independence and choice to live in the community longer and to embrace a "no wrong door" philosophy (ADRC Technical Assistance Exchange, 2013). Currently, there are multiple professional logics guiding the work for this workforce. This research contributes to the knowledge needed to provide services to both older adults and people with disabilities, while identifying challenges associated with the organizational differences of AAAs and ILCs in providing services within a hybrid organization, namely ADRCs.

Future research should examine efforts across the country to see how other states are faring in the coordination of aging and disability services under the ADRC umbrella. This study could be replicated in other states using similar methods, with the exception of the online questionnaire used with AAA directors. Future research could include focus groups with AAA directors and ILC directors. In addition, because the focus groups served as a mechanism to bring the two organizations together, one could consider holding one focus group for both types of directors as we did for the options counselors in this study. While this might have led to some hesitation to share fully, it did seem to meet the goal of helping each group develop a better understanding of each other's organizational philosophy and professional orientation.

Future research should continue to find ways through collaborating on projects or through cross-training efforts to create more unification between the workforces serving older adults and people with disabilities. Training is an

ongoing challenge in the geriatric field as a result of shortages of trained professionals, retirement of older workers who have experience in working with older adults, and a lack of emphasis on aging in schools (Institute of Medicine, 2008; Whitaker, Weismiller, & Clark, 2006). Recent efforts are underway to build the competencies of students in schools of social work to understand the paradigm shift that has occurred over the past 20 years from a model where the professional "knows best" to a model of empowerment and person-centeredness (Mahoney et al., 2016). This is an important step forward; however, it is critical to continue to build on initiatives in the field as many of the staff employed at AAAs and ILCs may not have a social work education or subscribe to formal certifications because peer models are dominant in disability organizations. Therefore, training through their organizations might be the best opportunity for creating a more unified workforce with shared logics.

Future work in this area should focus on creating a new industry logic for ADRCs. It is clear that these hybrid organizations need an industry logic to reflect the diversity of issues and the people who will likely utilize the services being offered. While it was important for staff in aging organizations to understand how consumer control guides the work of ILCs, it would be equally important in future work to examine whether there might be another dimension of this logic that could be considered as there are concerns about how a fully embraced logic of consumer control might work for frail older adults or with their caregivers. In essence, it might be best to consider a logic that is more fluid and meets the consumers where they are rather than using one logic to fit all types of consumers.

In addition, resource allocation is an important mechanism to managing competing logics. Power and money need to be equal in order for a true collaboration to occur within ADRCs; otherwise the dominant logics seem to emanate from the one who holds the most resources, which leads to feelings of inequities. Federal funding for ADRCs has focused on building the capacity of these organizations and workforce. It would be important for funders to consider adding a funding stipulation that builds on a model of shared decision making and equal representation. In order for ILCs and AAAs to work successfully under the umbrella of ADRCs, policy makers should be cognizant of how the money flows down to each organization. Money being directed to AAAs and their representatives being involved in policy initiatives without proper representation from ILCs will continue to promote the existence of multiple logics, and it could be that the professional logics associated with the aging profession are more dominant, therefore breaking down the potential for true collaboration between these organizations. Further funding should continue to focus on collaborative programs to build a new industry logic that could ultimately lead to increased cohesiveness among the workforce and ideally enhance interactions and services for older adults and people with disabilities.

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Appendix A: Focus Group Protocol

These questions were created to gain a better understanding of consumer control, direction, and choice and how this impacts or guides the work of directors and options counselors in AAAs and ILCs. The questions were the following:

(1) What do the terms consumer control, direction, and choice mean to you?
(2) How do consumer control, direction, and choice affect your work and what you do? (Can you give examples?)
(3) How do you work with consumers to support them in the processes of consumer control, autonomy, self-determination, and dignity?
(4) What information and knowledge do options counselors need to know to work effectively with consumers in applying consumer control, direction, and choice?

    (4a) What are the skills and abilities that options counselors need?
    (4b) What are the attitudes options counselors need?

(5) What is your level of professional or personal experience with consumer control, direction, or choice within your agency or community?
(6) What are some of the barriers or challenges you face in supporting consumers in consumer control, direction, and choice?
(7) How do you support consumer control, direction, and choice when working with families of consumers? (Probe: What happens when there is a conflict between what a consumer wants and what a family wants? What do you do?)

Appendix B: Questionnaire on Service Delivery Philosophy for AAA Directors

The following questions were asked of AAA directors regarding overarching service delivery philosophy and their understanding of consumer control, direction, and choice.

(1) What is the main service philosophy guiding your organization?
(2) What is the main service philosophy that guides you in the services you provide to older adults and people with disabilities?
(3) What do the terms consumer control, direction, and choice mean to you?
(4) Does the philosophy of consumer control, direction, or choice guide your work? Please explain the ways in which this impacts your work within your agency.
(5) If consumer control is a new concept to you, how likely are you to adopt the philosophy of consumer control?
(6) Are there barriers or challenges to adopting the philosophy of consumer control?
(7) Is the philosophy of consumer control embraced by the organization's structures and practices? Please explain.
(8) As a staff member at an [Aging and Disability Resource Center (ADRC)], what seem to you to be the most confusing or challenging aspects of your organization's mission and goals?
(9) Is there consensus and clarity about how ADRC staff will accomplish the organizational goals? Please explain.