

2014

Can a service philosophy be identified in aging and disability resource centers? A study of institutional logics as applied to the creation of new hybrid organizations

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BOSTON UNIVERSITY
GRADUATE SCHOOL OF ARTS AND SCIENCES

Dissertation

**CAN A SERVICE PHILOSOPHY BE IDENTIFIED IN AGING AND
DISABILITY RESOURCE CENTERS? A STUDY OF INSTITUTIONAL LOGICS
AS APPLIED TO THE CREATION OF NEW HYBRID ORGANIZATIONS**

by

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Submitted in partial fulfillment of the
requirements for the degree of

Doctor of Philosophy

2014

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DEDICATION

I would like to dedicate this dissertation to my loving husband Peter, my wonderful children Sophia and Anabelle, and my parents for their collective support, love, and encouragement.

ACKNOWLEDGEMENTS

As I embarked on this journey five years ago, I thought it would be a lone journey accompanied by few companions, but as I come to the end, I realize that while I was walking this path alone I had many guides and supports along the way to help me navigate this uncharted territory. I would like to begin by thanking my dissertation committee for their guidance and intellectual support. Scott Miyake Geron, my first reader, who holds many roles for me – my boss, my mentor, my friend, and my guide. For over 10 years we have shifted between these varying roles while holding true to the core value of the work we do together and a deep belief in each other’s strengths. Scott, your support, intellectual guidance, and compassion for me in my multi-faceted roles have been unparalleled and constant throughout. I truly would not be here had you not taken a chance on me after graduating with MSW/MPH over 10 years ago – you believed in me and allowed me to grow with you. For this, I will be forever grateful. To Emily Barman who opened my mind up to new theories that have captured my interest in a way I didn’t think was possible and who pushed me to think deeper about theoretical comparisons and outcomes, I thank you for your thoughtful comments and reassuring presence. To Sally Bachman whose practical advice of how to survive a doctoral program with young children and who pushed me further by asking challenging questions, I thank you for the support and challenge. And, to Rob Hudson, who is an inspiration for anyone interested in aging policy, I thank you for always taking great interest in my development as an aging scholar. The very reason I came to BU was to

work and learn from aging experts such as Scott and Rob and to have the both of you serve on my committee has made this journey worth every sacrifice.

I want to thank the amazing people that I worked with on the Advisory Committee from the Executive Office of Elder Affairs, Massachusetts Rehabilitation Commission, Independent Living Centers, Area Agencies on Aging, and Options Counselors across the state of Massachusetts. I was so fortunate to be able to work with such a diverse group of people whose mission is to improve the lives of older adults and people with disabilities. This project opened my world up to a place I never knew before, that is, the culture of disability rights. I have been forever changed through this project by a few pivotal disability rights activists who pushed me to uncomfortable places where I was able to reflect on my positions and grow to heights I didn't know of because of these challenges.

All the while, I was working full-time at BU at the Institute for Geriatric Social Work (now the Center for Aging and Disability Education and Research) and the support of my co-workers has been unwavering. To all the meetings I missed because I was at class or allowing me to “steal” Scott away from important Institute business to guide me in my dissertation work – this was not unnoticed. In particular, Kathy Kuhn, my co-worker of almost 10 years who has seen me through all of these times and has always encouraged me along the way to keep going. She is always the first one to announce my accomplishments to a public audience while I'm too modest to tell anyone about what I am doing. I am grateful for her continued belief in me.

How do I begin to thank my family for all of their love and encouragement? It's overwhelming to think of all the years, months, and days that have gone by with everyone by my side. This is really where the journey begins and ends; they were with me in the beginning and will be with me as I begin the next stage in my life. I could not think of anyone else I would want be my side. To my parents who have given me the love of learning from a very young age and who have always believed that I could do whatever I wanted in life. To my father, a true educator and defender of rights for those who may not hold the strongest voices. I have watched his crusade to educate children in the poorest districts and fight to get them a fair chance in their life pursuits. He has changed the lives of many of his students, but none as great as what he has done for me throughout my life. To my mother, whose intellect and strength has humbled me at moments and who has motivated me to honor the tradition of strong women in our family. She has always challenged me to be the best that I can and to think deeply about life. Her love of words and language flow through me in ways I never knew and are undeniably a part of her influence. I am honored to be her daughter and to watch her instill these core values in my daughters and continue the legacy her mother began.

To my husband and children who have intimately supported me through each step of the way. Through the tears and frustration met with love and understanding and through small victories met with celebrations – they have been there throughout. Peter, you have sacrificed so much for me – you have put your future on hold to keep a secure job, you have been a dedicated father and a constant figure, and you have cheered me on during my darkest moments. I am lucky to have you for my life partner. To my

daughters, Sophia and Anabelle, it has been a long journey for you and I can finally tell you we are almost there! To Sophia, who at a young age is wise and compassionate beyond her years, and who has understood my journey in ways I never expected. To Anabelle, who was only five when I began the program, and whose inquisitive and thoughtful presence has been a source of comfort and unconditional love through what has been half of your life. The two of you have grounded me through my toughest moments and helped me to realize that my most important job in life is being your mother. I will forever hold this title higher than any other I earn in life.

**CAN A SERVICE PHILOSOPHY BE IDENTIFIED IN AGING AND DISABILITY
RESOURCE CENTERS? A STUDY OF INSTITUTIONAL LOGICS AS APPLIED
TO THE CREATION OF NEW HYBRID ORGANIZATIONS**

(Order No.)

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ABSTRACT

The aging of our society is well known, with policy makers and analysts forecasting enormous increases in people living with chronic illness and disabilities (AoA, 2009). Less well known is that services for older adults and younger people with disabilities – historically separated by different funding streams, service systems, and workforces – have increasingly merged (Putnam, 2007). The movement to combine services for older adults and younger persons with disabilities is reflected in the creation of a hybrid organization – Aging and Disability Resource Centers (ADRCs) – designed to combine services for both populations (O’Shaughnessy, 2011; Putnam, 2011). Using ADRCs as the principal organizational strategy to combine aging and disability services has been challenging, primarily because these organizations have different histories and service philosophies (Kane, 2007; Putnam & Stoever, 2007; DeJong, 1979). Independent living centers, who serve people of all ages with disabilities, have a service philosophy that emphasizes ‘consumer direction’, characterized by consumer control, advocacy, and

peer models. While the aging service delivery philosophy is based in a medical model of care where care plans are developed by medical providers and services are provided by professionals in order to protect the well-being of older adults (DeJong, 1986; Simon-Rusinowitz & Hofland, 1993).

The purpose of this dissertation is to examine the experiences of ADRCs to combine aging and disability services. The study employs institutional logics theory and a mixed-methods design to assess whether a unified organizational philosophy for these services can be identified. In this dissertation, I found that there were competing logics between directors located at aging organizations when compared to directors at Independent Living Centers. These competing logics were also present among their staff in these organizations. As a mechanism to manage the co-existing logics, I found that the joint activity of collaborating in creating a training program to describe overarching service philosophies helped to unify the two organizations. Additionally, I found that the workers located at aging organizations who took the training had increases in their understanding of the professional logic of consumer control, which is dominant in the disability organizations; therefore, this training helped in managing the co-existence of logics.

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LIST OF ABBREVIATIONS

AAA	Area Agencies on Aging
ACL	Administration for Community Living
ADRC	Aging and Disability Resource Centers
AoA	Administration on Aging
DMH	Department of Mental Health
EOEA	Executive Office of Elder Affairs or Elder Affairs
ILC	Independent Living Centers
MRC	Massachusetts Rehabilitation Commission
OAA	Older Americans Act

CHAPTER 1: INTRODUCTION

It is obvious why disabilities of all sorts and the aging community would want to come together: politically, we are much stronger as one unified voice than we are as separate voices asking for the same thing. Divided, we are easily conquered as well. So, we need to step back, and listen. We need to tear apart our misconceptions, our silos. Oh—I know how trite this sounds as we have all heard the silo speeches before. But in fact, even in the dearest community to me, I saw how separate we all are, the aging services, disability services, medical services, technical services. It absolutely astounds me to keep going to meetings and conferences and hear all the same stories told in different ways, with great ideas that somehow are not—still!—uniting. So much potential in all of it, especially now. And now is the time to come together and act. – ILC Options Counselor

The rapid aging of our society is now well known, with policy makers and analysts forecasting enormous increases in people living with chronic illness and disabilities (AoA, 2009). Less well known is that services for older adults and younger people with disabilities – historically separated by different funding streams, service systems, and workforces – have increasingly merged (Putnam, 2007). In the past ten years, the movement to combine services for older adults and younger persons with disabilities has accelerated and is now reflected in federal policy as well as the creation of a new hybrid organizational entity – Aging and Disability Resource Centers (ADRCs) – designed to combine services for both populations (O’Shaughnessy, 2011; Putnam, 2011). Using ADRCs as the principal organizational strategy to combine aging and

disability services has been challenging for a number of reasons. Primary among these is that aging and disability organizations have very different histories and service philosophies (Kane, 2007; Putnam & Stoeberl, 2007; DeJong, 1979). In particular, independent living centers who work with people with all disabilities have a service philosophy that emphasizes ‘consumer direction’, characterized by consumer control, self-help and advocacy, and peer models to guide services (<http://www.mtstcil.org/skills/il-3-standards.html>). Consumer directed choice is a philosophical shift in how providers care for older adults and as a result implementing this new service delivery model can be challenging for aging service providers (Simon-Rusinowitz & Hofland, 1993).

The purpose of this dissertation is to examine the experiences of Massachusetts in using ADRCs to combine aging and disability services. The study employs institutional logics theory and a mixed-methods research design to assess the state’s efforts to develop a unified organizational philosophy for these services. Specific research aims are the following:

1. To analyze and compare the institutional logics of Area Agencies on Aging (AAA) directors and Independent Living Centers (ILC) directors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them. I will also determine whether a clear institutional logic/service philosophy for ADRCs can be identified.
2. To analyze and compare the institutional logics of AAA Options Counselors and ILC Options Counselors to determine whether distinctive institutional logics can

be identified for each group, and to assess similarities and differences between them. Do Options Counselors understand the service philosophy of consumer direction and what are the challenges or barriers in implementing this practice?

3. To examine whether there are differences in the depth of the knowledge gained in the logic of consumer direction depending on whether a worker is located in an ILC or AAA. Specifically, can a training program designed to orient all Options Counselors – whether located in an AAA or ILC – impact the adoption of a new institutional logic? What are the effects of methods to orient or socialize the new workforce tasked to work in these hybrid organizations?

The three research aims in this dissertation are organized through data collected in three smaller projects that were gathered and analyzed using different methods. Chapter 5 presents the results from focus groups with Independent Living directors and the responses to open-ended questions from a survey of directors from Area Agencies on Aging. The aim of this chapter is to analyze and compare the institutional logics of AAA directors and ILC directors to determine whether distinctive institutional logics can be identified for each group. Chapter 6 presents the results of the focus groups conducted with Options Counselors at AAAs and ILCs on the topic of consumer direction to determine whether distinctive institutional logics can be identified for each group and to analyze how Options Counselors understand the service philosophy of consumer direction and the challenges or barriers in implementing this practice. Lastly, Chapter 7 will report on findings from the statewide training program on consumer direction and discuss the impact of the training program on Options Counselors based on pre- and post-

training competencies. The analysis will look at the changes in scores based on organizational settings, AAAs compared to ILCs, to examine whether there are differences in the depth of knowledge gained in the logic of consumer direction. The purpose of this chapter is to determine whether a training program can impact the adoption or understanding of a new institutional logic.

In addition to contributing to our knowledge of the implementation of a major new policy affecting thousands of older adults and people with disabilities, this dissertation will contribute to the research on institutional logic theory, and will assess the utility of institutional logic theory to explain the differences in the identification and adoption of a uniform or multiple institutional logic by directors and Options Counselors within AAAs and ILCs. As an example of a hybrid organization – ADRCs – this study will inform research on organizational hybridity; specifically, what happens when service organizations move towards hybridity through the experience of the organizations' members via different types of engagement with the dominant institutional logic?

CHAPTER 2: BACKGROUND AND SIGNIFICANCE

This chapter will provide demographic information on the two populations – older adults and people with disabilities. I will review the overarching service delivery philosophies for both the Area Agencies on Aging (AAA) and Independent Living Centers (ILC) to provide background information on the how these organizational delivery philosophies have historically differed. The significance of how these populations are viewed and how services have been traditionally delivered are important to consider as the two organizations merge together to combine streamlined services.

The baby-boom generation (individuals born between 1946 and 1964) began to turn 65 in 2011. By 2030, about 19 percent of the population – approximately seventy-two million people – will be 65 years old or older (AoA, 2013). By 2050, the “oldest old” population, which is defined as 85 years or older, is expected to increase by 377% and will be the fastest growing segment of the population (Center for Health Workforce Studies, 2006). This population is more likely to be comprised of women who are widowed, divorced or never married and often have higher levels of institutionalization (Population Reference Bureau, 2011).

According to a 2010 Census Bureau report, this generation of older Americans will live longer and healthier lives, but because of increased longevity, will also be prone to chronic illnesses such as heart and respiratory disease, diabetes, and dementia as they enter their late seventies and eighties (U.S. Census Bureau, 2010). The Administration on Aging (AoA) estimates that there will be an increase in disability in older Americans by 2040, particularly for persons with lower incomes (AoA, 2009).

The Americans with Disability Act (ADA), which was passed in 1990 and most recently amended in 2008, defines a person with disability as someone who has a "physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment" (Americans with Disabilities Act, 2013; U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 2005). The World Health Organization (WHO) defines disability as any change in health that has the potential of causing people to function less well in their usual everyday environment (WHO, 2010).

According to the 2010 U.S. Census Bureau report, approximately 12% of the non-institutionalized population has a disability. Ten percent of the population between the ages of 18 to 64 has a disability and 37% of the population over the age of 65 has a disability. Of the 18 to 64 age group, the most common disabilities reported in order of prevalence are ambulatory, cognitive limitations, and an independent living difficulty (American Community Survey, 2007). For people age 65 and over, the most common disabilities reported are ambulatory issues, independent living challenges, and hearing difficulties (American Community Survey, 2007).

In the past ten years, there has been a movement to combine services for older adults and younger persons with disabilities under one service umbrella (Putnam, 2007). The main reason for this motivation is to take a complicated system of long-term care and fold it under one umbrella to ease navigation for consumers – a “single point of entry” and to embrace a “no wrong door approach” (O’Shaughnessy, 2011). In 2003, the U.S.

Administration on Aging and the Centers for Medicare and Medicaid Services funded a national initiative to create Aging and Disability Resource Centers (ADRCs), designed to create a “seamless” network of information, referral, and assistance to older adults and people with disabilities of all ages (O’Shaughnessy, 2011; Putnam, 2007). In that same year, Massachusetts was one of the first 12 states funded to develop an ADRC. Due to its initial success, Massachusetts received a two-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 three-year ADRC grant to develop a five-year strategic plan that evolves its ADRCs to a “fully functional” status (EOEA, 2010, internal report).

The development and implementation of ADRCs has been challenging for a number of reasons. Primary among these is that aging and disability organizations have differing service philosophies guiding their work and organizational mission. Another major complicating factor is that ADRCs are not free standing organizations – the majority are located within existing organizations that have long-served the aging communities: Aging Service Access Points or Area Agencies on Aging (ASAPs/AAAs), which serve adults over age 60, while a smaller percentage are located in Independent Living Centers (ILCs), which serve people with disabilities of all ages. In fact, in the state of Massachusetts there are 11 ADRCs of which 9 are located in AAAs and only 2 are located at ILCs (Executive Office for Elder Affairs, 2011).

As the national initiative to create ADRCs moved ahead, a new accompanying workforce called ‘Options Counselors’ was also created to work in these hybrid settings.

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 website, <http://www.adrc-tae.org>). Among the challenges for Options Counselors, who are working with both older adults and people with disabilities, is the adoption of the service philosophy of consumer-directed services (EOEA Internal Report, 2010). This concept is core to the independent living movement, but it is still a growing concept for the aging network. Furthermore, Options Counselors who are located at AAAs are often surrounded by other aging service providers who may not understand or subscribe to the philosophy of consumer-directed care, which could impact the success of implementing these types of services. To provide greater background on how these organizations varying service philosophies and target populations have evolved, the next few sections will describe the historical background on these organizations and the people they serve.

Historical Perspectives on Service Delivery for Older Adults and People with Disabilities

Social construction theory provides a context for understanding differing perceptions in aging and disability and how that is influenced by societal norms and values (Bengtson, Burgess, & Parrott, 1997). Schneider and Ingram (1993) discussed the importance of the social construction of target populations in public policy and the influence this has on policy officials and the design of programs. Traditionally, issues surrounding the elderly have been thought of as being aligned with a positively constructed, advantaged group with a strong base of power (Schneider and Ingram,

1993). Although, several writers have noted that the social construction of a “deserving” older adult could change over time as perceptions are switching to viewing older adults as “greedy” or receiving resources at a rate that is disproportionate to children or other “needy” populations (Simon-Rusinowitz & Hofland, 1993; Gonyea, 2005).

Historically, increasing age has been thought of as the end of productivity – a detachment from meaningful, productive life (Estes, 2001). Research has shown that older adults are often associated with images of incapacity, senility, and lacking value and worth to society (Gubrium & Holstein, 1999). Estes states that “the major problems faced by the elderly in the United States are, in large measure, ones that are socially constructed as a result of our conceptions of aging and the aged ... In an important sense, then, the major problems faced by the elderly are the ones we create for them” (Estes, p.29, 2001). Lynott & Lynott (1996) also stated that while the passing of the Older American’s Act in 1965 was important in maintaining the independence and well-being of older adults, it also created a dependency on a state-supported system. Based on this belief, what becomes important is continuing to create a need for older adults to depend on a system of care. The interconnectedness between political economy and social construction of age developed when old age was defined as a problem that needed economic solutions; hence, the creation of Social Security where eligibility for benefits were linked to age (McMullin, 2000).

The history of services for people with disabilities has some similarities to that of older adults; although one distinct difference is the history of the civil rights movement for people with disabilities. Schneider and Ingram (1993) classified people with

disabilities in a dependent category with a positive construction, a weak power base, and an orientation toward a government disinterested in their issues. According to Gadacz (1994), “disabled individuals might be conceptualized as a disadvantaged or minority group in that they are treated and reacted to as a category of people much like the aged, blacks, women, the poor and other pariah and deviant groups” (p. 45). Older adults, while they may or may not be productive members of society in later life, are assumed to have been productive when they were younger. Conversely, the social construction of disability is often based on the idea that people with disabilities have never been able to contribute to society or be economically productive (Putnam, 2007). This contrast is evident in the way public policy treated the two populations and why people with disabilities had to become their own advocates.

Early federal programs for older adults and people with disabilities date back to war pensions given to soldiers from the Civil War when the United States government provided either disability-related pensions or old-age pensions (Skocpol, 1991; Orloff, 1998). There was a difference between the two types of pensions in that one was for disability caused through working conditions and the other was due to old age (Putnam, 2007). This division early on foreshadowed the separate political agendas to come for older adults and people with disabilities. According to Putnam (2007), “even at this early juncture, segmented political agendas often related back to the perception of disability as a normative part of growing old, and an abnormal part of being young or middle-aged” (p. 8).

Healthcare policies for the two populations followed a similar pattern of construction. Putnam (2007) states that, “the mix of social, economic, political, and scientific factors drew parallels between aging and disability while at the same time distinguishing them as different phenomena” (p. 9). Both populations were seen as vulnerable and at risk, and care, whether supportive or rehabilitative, was seen through a medical lens with the goal of “curing” the negativities associated with aging or disability. Gadacz (1994) maintains, “it is difficult to escape the conclusion that the disability category is not only socially created, but, as something that can be manipulated, also serves as an administrative and political tool” (p. 36). As a result, some of the major social policies were passed such as Social Security, Medicare, Medicaid, and Social Security Disability Insurance (Putnam, 2007; Skocpol, 1992).

The Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 were a result of the strong voices in the disability movement – a movement that was virtually void of the voices of older adults (Putnam, 2007). Another important milestone for disability groups came out of the 1999 Supreme Court decision in *Olmstead v. L.C.* where it was ruled that services for people with disabilities must be provided in the most “integrated setting” as possible (Olmstead, 1999). The Olmstead ruling made it clear that states were not complying with the intent of the ADA and that this was in violation of federal law. The Olmstead case recognized the problems of implementing the law: institutional care of one kind or another has been embedded in our philosophy of care for people with disability since its beginnings. People questioned, what are the alternatives for caring for people who have never experienced life on their own terms? Some states

had neither the economic assets nor the desire to permit the “disabled” to live freely in the community in spite of the ADA. Although disability advocates have fought for equal treatment under the law for decades, they have been losing some of their individuality as a group since the creation of the ADRCs in 2003 and the inherent merging of populations and service delivery philosophies under one umbrella.

Area Agencies on Aging and Independent Living Center Service Delivery

Philosophies

While both older adults and people with disabilities might require some of the same services, it is clear that historically these populations have been treated differently and programs have been designed with these differences in mind. It is important to review how these services were developed, what types of services are offered by both organizations, and the main values that drive the provision of service delivery.

Aging programs and the delineation of services for older adults were enacted in public policy in 1965 through the Older Americans Act (OAA). This act was passed to “help people age 60 and older maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for the vulnerable elderly” (National Health Policy Forum, 2011). The OAA authorizes a wide range of service programs through a national network of 56 State agencies on aging, 629 area agencies on aging, nearly 20,000 service providers, 244 Tribal organizations, and 2 Native Hawaiian organizations representing 400 Tribes (AoA, 2010). This dissertation focuses on Area Agencies on Aging (AAA), in particular those located in Massachusetts.

The key services provided by AAAs are: information and referral; interdisciplinary 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). At the core of these services are care management, development and reassessment of service plans, and coordinating needed services. Inherent in these services is that the worker at an AAA will direct 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, as the assumption is that the professional has more experience and can plan services with more skill and expertise than the consumer (Kunkel & Nelson, 2006).

The aging service delivery philosophy is based in a medical model of care where consumers are referred to as patients and considered dependent upon the care plans developed by medical providers (DeJong, 1986; Simon-Rusinowitz & Hofland, 1993). Aging service delivery models often align more closely with the medical model rooted in care management (Putnam, 2002). Safety and services provided by professionals in order to protect the well-being of older adults has been at the heart of aging services (Kunkel & Nelson, 2006).

The service delivery system adopted by AAAs, which is grounded in the belief that older adults need to be taken care of and that care and services should be directed by the health care provider, not the consumer, is vastly different from that of Independent Living Centers. The following chart captures the differences in the medical model,

which aligns more with the principles of aging organizations, as compared to the independent living paradigm (Developed by Gerben DeJong, 1979; adapted by Maggie Shreve, 2002).

Table 1. The Medical Model and Independent Living Paradigms

	Medical Model and Rehabilitation Paradigm	Independent Living and Disability Paradigm
Definition of Problem	physical or mental impairment; lack of vocational skill (in the VR system); lack of abilities	dependence upon professionals, family members & others; it is the attitudes & environments that are hostile & need fixing
Locus of Problem	in the individual (individuals are sick and need to be "fixed")	in the environment; in the medical and/or rehabilitation process itself; disability is a common part of the human condition
Solution to the Problem	professional intervention; treatment	<ol style="list-style-type: none"> 1. civil rights & advocacy 2. barrier removal 3. self-help 4. peer role models & peer support 5. consumer control over options & services
Social Role	individual with a disability is a "patient" or "client"	individual with a disability is a "consumer," "customer" or "user" of services and products
Who Controls	Professionals	"consumer" or "individual"
Desired Outcomes	maximum self-care (or "ADL" - activities of daily living); gainful employment (in the vocational rehabilitation system)	independence through control over ACCEPTABLE options for everyday living in an integrated community

As articulated in the above chart, the independent living movement's core belief is that the root of the problem lies within society, professionals, and the environment in that barriers are put up that prohibit successful independent living for people with

disabilities. This is at the crux of the independent living movement – to break down these barriers and put the control back in the lives of the people who have the disability.

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 powerful 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, 2010b).

The independent living movement provides the primary service philosophy for Independent Living Centers throughout the country (Scotch, 1989). This philosophy states that ‘consumer control’ is the core driving value that embodies models of consumer direction, self-help, and peer relationships to guide services (McDonald & Oxford, n.d.). Centers that receive federal assistance are defined as “consumer controlled, community-based, cross-disability, non-residential, and private non-profit agencies” (<http://www.ncil.org/about/aboutil/>). In this context, consumer controlled means that the “power and authority” to make decisions, arrange for services, and manage independent living are vested in the individual.

By the mid-1970s, organizations were being formed that put the independent living philosophy and concepts into operation. In Berkeley, California, students from the University of California founded the first center for independent living in 1972 as a means of creating independent living options within the Berkeley community (DeJong, 1979). The core services provided by Independent Living Centers are: peer support;

information and referral; individual and systems advocacy; and independent living skills training – all of which is 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).

The services for ILCs are not in alignment with the main functions of aging services, which are focused on assessment, care planning, and re-evaluation. In fact, it appears that it is not just the services that are misaligned between these two organizations, but that the value judgments behind these services are very different. In particular the philosophy of consumer control that drives ILCs is based on “the idea that people with disabilities are the best experts on their own needs, having crucial and valuable perspective to contribute and deserving of equal opportunity to decide how to live, work, and take part in their communities, particularly in reference to services that powerfully affect their day-to-day lives and access to independence” (National Council on Independent Living, 2013).

Whereas, aging workers are professionals trained to assess and deliver services while independent living workers are often “peers” who join consumers for support during the journey of determining what life choices they want to make. There is often a stigma associated with aging professionals, who are viewed by disability advocates with a level of mistrust, as they assume the role of “professional” and expert while they develop service plans for the person with a disability, which counters the philosophy of advocates who state that they are their own life experts (Kane, 2007). Furthermore, consumer direction is a philosophical shift in how providers care for older adults and as a

result implementing this new service delivery model can be challenging for aging service providers (Simon-Rusinowitz & Hofland, 1993). Therefore, the merging of AAAs and ILCs under ADRCs could prove difficult due to the variations in service delivery philosophies between these two organizations.

Merging of AAA and ILC Service Philosophies and the Creation of Aging and Disability Resource Centers (ADRCs)

In 2003, the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services (CMS) funded a national initiative to develop Aging and Disability Resource Centers (ADRCs), designed to create a “seamless” network of information, referral, and assistance to older adults and people with disabilities of all ages (O’Shaughnessy, 2011; Putnam, 2007). Aging and Disability Resource Centers were created across the country with a mission to “promote the integration of long-term care information and referral services, benefits and option counseling, and access to publicly funded and privately financed services and benefits for those in need of long-term supports and their families” (Aging and Disability Resource Center 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, 2014). It is important to remember that these ADRCs are housed within either aging or disability organizations – they are not free-standing organizational entities (Aging and Disability Resource Center Technical Assistance Exchange, 2014).

Almost 10 years later since the creation of ADRCs, a new federal administration, the Administration for Community Living (ACL), was created in 2012 and combined the

Administration on Aging with the Administration on Intellectual and Developmental Disabilities and the Office on Disability. ACL's mission is to "maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers" (Administration for Community Living, 2013). Together ACL, CMS, and now the Veteran Health Administration (VHA) have come together to further develop ADRC's impact and ease access to long-term living services and supports (Administration for Community Living, 2014).

The decision to merge these entities together is multi-faceted, and includes reasons such as streamlining services, easing access for consumers, and pooling resources (Administration for Community Living, 2013; O'Shaughnessy, 2011; Putnam, 2007). In the ADRC Strategic Plan for Massachusetts dated March 31, 2011, they cited many advantages to the collaboration between aging and disability organizations. As stated in their plan, some of the advantages include (Executive Office of Elder Affairs, 2011):

- Increased consumer access to a broader array of options for living independently
- Shared or compatible vision and mission
- Networks are local non-profits with local consumer-controlled boards
- Access to various funding bases
- Shared commitment to serving individuals in the settings and manner of their choice, and to diverting individuals from institutionalization and/or transitioning individuals out of institutions and into home and community-based supports

- An opportunity for aging and disability networks to advocate together on legislation and policies that enhance the ability of individuals to live independently in the community

The benefits to having one service delivery model are clear in that services can be streamlined and funding sources can be shared, yet there are also challenges which often stem from the differences in public policy for older adults and people with disabilities (Putnam, 2007). According to Simon-Rusinowitz and Hofland (1993), “extreme heterogeneity both within and between the aging and disabled communities can limit consensus about an aging or disability agenda; let alone a unified agenda for both groups” (p. 160). This has far reaching implications for organizations and workers serving both groups. Putnam (2011) stated that some of the challenges in cross-network collaborations are “variance in organizational mission, distinctive professional training, competition for program funding, and lack of investment in common goals” (p. 328).

As ADRCs merge AAAs and ILCs into a hybrid organization that seeks to address the needs of both older adults and people with disabilities, Massachusetts and other states implementing ADRCs have begun to identify the needs of these organizations and their constituencies. For example, during a 2012 cross training initiative held by the Massachusetts Executive Office of Elder Affairs, an internal document stated that, “It is not until the ASAP/AAA adopts a consumer-direction philosophy across their programs and services that the ASAP/AAA will be able to effectively implement new consumer-directed programs. This means new models of service delivery, but before that, it means a new approach to how we do business (regardless of elder eligibility, the program, the

provider, or the role of ASAP/AAA staff)” (EOEA Internal Training Program, *Shifting the Paradigm: Increasing Opportunities for Elder Choice and Control Through Consumer-Direction*, 2008). Therefore, it is important to consider if these two different service delivery models and subset of workers can come together to accept a uniform orientation to service delivery in these hybrid organizations.

Through a review of divergent views of older adults and people with disabilities in society and the differing service principles for aging organizations and independent living centers, it is clear that there are substantial differences in orientation, beliefs, and approach between these two broad types of organizations. This dissertation focuses its analysis to two prominent and distinctive organizations within each sector: AAAs and ILCs. The following chapter will discuss how institutional logics theory provides a framework for thinking about how these two different service philosophies might impact the unification of their work together.

CHAPTER 3: CONCEPTUAL FRAMEWORK/THEORY

In the previous chapter I documented how popular views of older adults and people with disabilities in society have shaped different service philosophies for each and led to divergent service systems – represented at the community level by AAAs for older adults and ILCs for people with disabilities. Now, in a major policy shift, the U.S. is promoting an important policy initiative to combine these two service sectors into one hybrid organization – Aging and Disability Resource Centers (ADRC). The U.S. Administration of Community Living (ACL) and Centers for Medicaid and Medicare Services (CMS) have committed millions of dollars to transforming the service system serving both populations (ACL Strategic Plan, 2013 – 2018). 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 dissertation. To study the development and success of ADRCs, this dissertation will apply institutional logic theory and explore the effects of organizational hybridity on the workers in these organizations.

Institutional Logics Theory

Scott (2001) states that institutional logic “refers to the belief system and related practices that predominate in an organizational field” (p.139). Specifically, logics guide an organizational field and organizations are part of a larger overarching system (Hinings, 2012). Logics shape behavior and organizational actors can influence how logics develop and change over time (Thornton, 2004; Thornton & Ocasio, 2008). Marquis and Lounsbury (2007) summarized that institutional logic refers to “broad cultural beliefs

and rules that structure cognition and fundamentally shape decision making and action in a field” (p. 799). Logics are structured through the larger overarching institutions and sectors of society. For example, previous literature has distinguished market logics, state logics, corporation logics, professional logics, industry logics, religious logics, and family logics (Friedland & Alford, 1991; Thornton & Ocasio, 1999).

The main concept in institutional logics is that each institution has its own set of logics or principles that guide work and activity, e.g., the institutional logics of capitalism or states (Lounsbury, 2001; Thornton & Ocasio, 1999; Friedland & Alford, 1991; Skocpol, 1991). These differing guiding logics are based in symbolism, organizational structure, and politics. 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. According to Friedman and Alford (1991), this is necessary for organizational change to be successful; they maintain that “when institutions are in conflict, people may mobilize to defend the symbols and practices of one institution from the implications of changes in others” (p. 255). Institutions can be interdependent while struggling between varying institutional logics in an effort to determine which logic should be dominant.

The previous chapter documents 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. This dissertation will aim to assess whether these differences are pronounced among the

workforce and assess methods of how these workers might reconcile these differences, or competing institutional logics.

Competing Institutional Logics

Many authors have tackled the issue of how to manage competing logics (Reay & Hinings, 2009; Marquis & Lounsbury, 2007; Kitchener, 2002). Previous research has examined whether logics can co-exist or whether one logic will be dominant over the other (Marquis and Lounsbury, 2007; Lounsbury, 2007; Zilber, 2008; and Reay and 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). For example, Reay and Hinings (2009) identified two competing logics in the health care field: a *business-like health care* logic and the logic of *medical professionalism*, with the former focusing on cost-effectiveness and the latter honoring the status of doctor-patient relationships where physicians determine care, not business managers. The two logics at odds in this example are market logics and medical logics in that health care professionals felt pressure to focus on cost containment compared to the logic of medical professionalism where patient care is decided because of medical factors – the concern about these competing logics could be that the type of care provided to patients could be sacrificed as decisions were now being made based on business logics rather than medical logics (Scott, Ruef, Mendel, & Caronna, 2000; Reay & Hinings, 2009). Similarly, competing logics have also been studied in the publishing field where there was a shift from an editorial logic to a market

logic, also articulating a change in that industry with market and business values driving the field (Thornton, 2004).

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 co-exist if the different parties collaborated with an understanding that not one logic would dominate the other; this is referred to as a “pragmatic collaboration.”

Staffing levels and composition of staff are also important indicators as to whether a new practice or logic is being fully adopted and diffused throughout the organization (Lounsbury, 2001). Lounsbury (2001) examined two levels of staffing as a telltale sign about adoption practices: (1) status creation and (2) role accretion. His research provided evidence that when new staff positions are created that the diffusion of new programs went beyond the ceremonial and had a substantive effect on the logics of the organization.

Aging and disability organizations have created a new staff position called an Options Counselor, whose role is 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 website, <http://www.adrc-tae.org>). This represents a public policy commitment that ADRCs should have dedicated staff that serves both older adults and people with disabilities. Determining which logic to follow might be challenging as Options Counselors could be affiliated with either aging organizations or independent living centers resulting in different professional identities dependent upon organizational affiliation and physical location. Therefore, while new positions have been created it might lack a connection to a unified, overarching logic and might not translate clearly to workers in the field.

Many researchers believe it is not just a single organization's logic that needs to change, but the overarching logics that guide the field (Scott, 2001; Hinings, 2012). Industry logic is described as identities and structures that are related to a particular industry and when industry logics change then the organizational field will also change (Thornton & Ocasio, 1999). Additionally, societal-level logics, which represent a macro-level view, influence the industry-level logics, which is more focused on the micro picture (Thornton & Ocasio, 1999); although, some research has shown that institutional logics are not always easily passed down to organizations from "higher-order institutions" (Schneiberg & Clemens, 2006).

In this study, a central focus is whether a single institutional logic will become dominant and can bring together disparate service philosophies for workers in the field who are located in a hybrid organization. ADRCs are an example of a 'hybrid organization' – that is, an organization that has multiple institutional logics governing

their work (Barman, in progress). Inherent in the creation of ADRCs is the notion of collaboration as these two organizations are now charged in 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 – 2018), but the question is whether the aging and disability organizations can accept a co-existence of competing logics or if the implementation will be hampered because one logic, or group, wants to be dominant.

Power and Actors in Institutional Logics

Power is critical to influencing institutional logics and builds on the issues discussed previously concerning competing logics in the aging and disability service delivery models. Whether the dominate logic in an organization changes often has to do with who has power and ultimately who will be listened to by others to effectuate change. According to Gaventa (1980), the relationship between power and change can be conceptualized through multiple mechanisms, such as who has decision-making authority, how action is thwarted because of fear of sanctions from those in power, and how power influences the social construction of meanings or symbols to the point where people act in a way that is to their own detriment. Similarly, Brint and Karabel (1991) also argued that power structures in society can shape an organization; although, they believe that organizations can have their own distinct logic that is different from the larger society. These factors are critical to examine when thinking of how power impacts institutional logics.

Another important concept in institutional logics is the role of organizational actors (Jackall, 1988; March & Olsen, 1989); specifically, the concept of institutional entrepreneurs (Hwang & Colyvas, 2011). This is described as “actors who serve as catalysts for structural change and take the lead in being the impetus for, and giving direction to, change” (Leca, Battilana, & Boxenbaum, 2009, p. 3). The focus on actors in this role is a shift from earlier theories where actors were agents of the organization and did not wield much power, whereas in this light, actors are forceful agents of change. In fact, according to Hwang and Cloyvas (2011), “actors, rather than being the creatures and derivatives of larger institutional forces, are creators, maintenance workers, and destroyers of institutions” (p. 63). Inherent in this is a tension between the individual and the institutional environment, which becomes a challenge to resolve especially in a highly embedded organization.

Leca, Battilana, and Boxenbaum (2009) analyzed potential circumstances that can lead an actor to become an institutional entrepreneur and offer two circumstances that impact whether an individual assumes this role; they are (1) field-level conditions and (2) the actor’s social position. Field-level conditions deal with seismic changes or crises that “disturb the socially constructed field-level consensus and contribute to the introduction of new ideas” (p. 7). The actor’s social position addresses how the actor is perceived in the field by diverse stakeholders and whether the person has tangible or intangible resources available. Further, the organizational environment is also relevant because the more heterogeneity in the actor’s institutional arrangements along with a lack of organizational structure can lead to tensions that make the environment ripe for an

institutional entrepreneur to make large scale changes in institutional logics. To that end, Battilana and Casciaro (2012) contend that “structural holes” in a network make the environment more open to change that diverge from overarching institutional logics.

The character traits of the actor are also important to consider, such as mastery in managing a wide array of constituencies, evoking empathy and cooperation, and attaching value to the social cause in order to impact change. All of these traits are necessary as the institutional entrepreneur must mobilize the masses to make radical change, in addition to finding creative ways to leverage resources. When aging and disability stakeholders come together to discuss change, the representatives for the disability groups are often those living with a disability while the aging stakeholders are often state officials or front line workers. There are stark differences in the emotions evoked by disability advocates in comparison to aging bureaucrats in that the disability actors convey value in the reasons for change, it does not come from a market or economic impetus.

Discourse and Institutional Logics

The relationship between discourse and institutional logics is important to consider as institutions provide workers with a vocabulary that identifies their place in the organization and society – “a sense of self” (Friedland & Alford, 1991). Specifically, there is power in discourse and this impacts individual action. In fact, “actors rarely, if ever, remain silent as they make policy ... they think, meet, argue, make claims, define options, conduct studies, tell stories, and generate discursive output, including reports,

interviews, minutes, and newspaper commentaries” (Schneiberg & Clemens, 2006, p. 210).

Organizational discourse is critical in organizational change of logics as it explicates how language impacts the social construction of organizations and how power and stakeholders can shape the reality of organizations through language (Grant & Marshak, 2011; Grant, Michelson, Oswick, & Wailes, 2005). Discourse can impact change and create new logics in organizations. Hardy (2001) states “organizational discourse theory focuses on the constructive effects of discourse – how discourses bring reality into being by making social relations and material objects meaningful” (p. 29).

Five levels of discourse analysis can be used to examine organizational change in institutional logics; they are: (1) intrapsychic, (2) micro, (3) meso, (4) macro, and (5) meta-level discourses (Grant & Marshak, 2011). The intrapsychic level of discourse focuses on the cognitive frames of language used in an effort to make sense of a situation – it relates to the internal stories that individuals create. This level of analysis has been less used in organizational change research. Discourse analysis at the micro level deals with the language used by organizational actors. The meso level of discourse analysis goes beyond mere language and looks at how discourse impacts social order in the organization – this is critical in understanding change at the organizational level. Macro-level discourse focuses on how language changes institutional practices and procedures. Lastly, meta-level discourse is when discourse is changed at the societal level and institutional domains (Grant & Marshak, 2011). This dissertation focuses on aging and disability stakeholders who are working at the macro and micro level to impact change

and create collaborative relationships through examining institutional discourse and guiding logics. Analysis of institutional logics through discourse can use some of the following methods to examine the content, meaning, and change by using data sources such as focus groups, interviews, archival documents, and various other texts (Thornton, 2004; Philips & Hardy, 2002; Scott, Ruef, Mendel, & Caronna, 2000; Haverman & Rao, 1997).

Applying institutional logics to the current study, one of the key research objectives will be to ascertain whether AAAs and ILCs, now providing services under the umbrella of ADRCs, are found to operate with a uniform institutional logic (service delivery model), or whether both maintain separate institutional logics. As both the AAAs and ILCs adapt to the presence of ADRCs within their organizations, both may need to embark on a journey of organizational change to alter logics as applied to care and services. The two types of agencies could come to a “pragmatic” arrangement to maintain differing institutional logics, which may make sense to agency directors or policymakers, but might make less sense for Options Counselors who work in the field and desire clear standards of operation. There is an opportunity to create new standards of practice and guiding professional logics for ADRCs as these newly combined organizations are still in their infancy; although the challenge is that they are housed within are more established AAAs and ILCs and those organizations may resist change.

This dissertation will contribute to the research on institutional logic theory, and will specifically assess the utility of institutional logic theory to explain the differences in the identification and adoption of a uniform or multiple institutional logics by directors

and Options Counselors within AAAs and ILCs. The study will consider mechanisms to reconcile these differences and the importance of collaborative processes to managing co-existing logics. This research will also examine whether a training program can bring together disparate logics for workers in the field who are located in a hybrid organization.

CHAPTER 4: METHODOLOGY

This research study used a mixed-method design to examine institutional logics in aging and disability organizations and the extent to which directors and Options Counselors identify an institutional logic to guide their work. The three research aims in this dissertation are organized through data collected in three smaller projects that were gathered and analyzed using different methods. This chapter describes the specific aims of the study, participant recruitment and settings, data collection and analysis, and ethical considerations.

From April of 2011 through October of 2012, I was the Project Director for the Options Counseling Training Program for the Center on Aging and Disability Education and Research (CADER) at Boston University (formerly the Institute for Geriatric Social Work). I worked with the Massachusetts Options Counseling Training Advisory Group, which included Options Counselors from the ADRCs, leadership and program staff from the Executive Office of Elder Affairs (EOEA), Massachusetts Rehabilitation Commission (MRC), and the Department of Mental Health (DMH), as well as other experts and consumers from the aging and disability networks to conduct focus groups and develop an online course titled *“An Options Counselor’s Guide to Consumer Control, Consumer Choice, and Consumer Direction.”*

The sequencing of this project is important in the discovery of the institutional logics and how these logics flow down through the organization and key players. The analysis begins at the director level of the organization, moves to the member level by examining the workers, and wraps up with an intervention, the online training program

described above, to determine if this can impact institutional logics. Further, the methods in this dissertation reflect the chronological order of this collaboration and offers insight into how the relationships unfolded.

The project began with funding from the Administration on Aging to the Executive Office of Elder Affairs with the goal of creating national standards and building competencies for the new workforce of Options Counselors tasked to work between two agencies in a hybrid organization. The focus group with directors and workers was the first step in developing the training in an effort to gain consensus on what the training program should consist of based on the needs of the workforce. The curriculum development occurred afterwards and was a collaborative process leveraging the Massachusetts Options Counseling Training Advisory Group. After months of meetings and many revisions to the curriculum to gain consensus among this representative group, the training program was launched with many of the same participants who were involved in the original focus groups. The methods for this dissertation reflect an applied research project and provide three different snapshots of how institutional logics present with members of Aging and Disability Resource Centers (ADRCs).

Specific Aims

The purpose of this dissertation is to examine the experiences of Massachusetts in using ADRCs to combine aging and disability services. Specific research aims are the following:

1. To analyze and compare the institutional logics of Area Agencies on Aging (AAA) directors and Independent Living Centers (ILC) directors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them. Through this analysis, determine whether a clear institutional logic/service philosophy for ADRCs can be identified.
2. To analyze and compare the institutional logics of AAA Options Counselors and ILC Options Counselors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them. To analyze how Options Counselors understand the service philosophy of consumer direction and the challenges or barriers in implementing this practice.
3. To examine whether there are differences in the depth of the knowledge gained in the logic of consumer direction depending on whether a worker is located in an ILC or AAA. Specifically, can a training program designed to orient all Options Counselors – whether located in an AAA or ILC – impact the adoption of a new institutional logic? What are the effects of methods to orient or socialize the new workforce tasked to work in these hybrid organizations?

The following table summarizes each research aim along with the sample and data collection method for each aim.

Table 2. Sample and Data Collection

Research Aim	Sample	Data Collection Methods
To analyze and compare the institutional logics of Area Agencies on Aging (AAA) directors and Independent Living Centers (ILC) directors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them.	<ul style="list-style-type: none"> • ILC directors • AAA directors 	<ul style="list-style-type: none"> • Focus Group with ILC directors • Questionnaire with AAA directors
To analyze and compare the institutional logics of AAA Options Counselors and ILC Options Counselors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them.	<ul style="list-style-type: none"> • Options Counselors 	<ul style="list-style-type: none"> • Focus Groups with Options Counselors
To examine whether there are differences in the depth of the knowledge gained in the logic of consumer direction depending on whether a worker is located in an ILC or AAA.	<ul style="list-style-type: none"> • Options Counselors 	<ul style="list-style-type: none"> • Pre and Post Competency Questionnaire

Sample Recruitment

Research Aim 1: To analyze and compare the institutional logics of Area Agencies on Aging (AAA) directors and Independent Living Centers (ILC) directors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them.

The assessment of the first research aim was analyzed through a focus group held with ILC directors and an online questionnaire 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. The focus group with ILC directors was held to gather information to create an online training course on consumer direction, which will be used to train Options Counselors across the state of Massachusetts. The questionnaire distributed to AAA directors was collected after the focus groups as an additional comparative analysis for the purposes of this dissertation.

A convenience sample of Independent Living Center (ILC) directors in Massachusetts was recruited for the focus group. An email was sent to Massachusetts's ILC directors (n=14) who have Options Counselors on staff and they were asked if they would like to participate in the focus group. 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 for approximately two hours. All participants were offered coffee and muffins. This study protocol was approved by Boston University's Institutional Review Board (#2554E). An amendment for secondary analysis was submitted to the IRB and approved prior to data analysis.

As a complementary analysis, a questionnaire was distributed via Survey Monkey to AAA directors who are part of an ADRC in Massachusetts. The questionnaire and consent form were embedded into the online training course taken by Options Counselors and directors across the state of Massachusetts. All participants (n=115) taking the training were asked to complete an open-ended questionnaire about service delivery philosophies that guide them in their work with older adults and people with disabilities. Of the 115 participants, 12 were AAA directors and 8 completed the questionnaire. All

participants were told that the questionnaire would take approximately 15 minutes to complete. This study was approved by Boston University's IRB (protocol #2938X).

Research Aim 2: To analyze and compare the institutional logics of AAA Options Counselors and ILC Options Counselors to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them. To analyze how Options Counselors understand the service philosophy of consumer direction and the challenges or barriers in implementing this practice.

To assess the service philosophy of consumer direction, focus groups were held with Options Counselors. An email was sent to Options Counselor leads at AAAs and ILCs from the Massachusetts Executive Office of Elder Affairs director of Options Counseling and they were asked to inform their Options Counseling staff that focus groups were being held on the topic of consumer direction. Options Counselors who were interested signed up to participate in these focus groups; no other workers were invited to participate.

Two focus groups were conducted with Options Counselors. The first focus group had 12 participants and the second focus group had 15 participants. The purpose of these focus groups was to gain a better understanding of the meaning of consumer direction and provide an opportunity for Options Counselors to articulate the challenges or barriers in implementing this service philosophy with both older adults and persons with disabilities. The focus groups lasted approximately two hours. Similar to the focus group with ILC directors, all participants were offered a coffee and muffins in the morning and lunch in the afternoon. This study protocol was approved by the IRB

(#2554E) and an amendment for secondary analysis was approved prior to any data analysis.

Research Aim 3: To examine whether there are differences in the depth of the knowledge gained in the logic of consumer direction depending on whether a worker is located in an ILC or AAA. Specifically, can a training program designed to orient all Options Counselors – whether located in an AAA or ILC – impact the adoption of a new institutional logic?

To assess whether there are differences in the depth of the knowledge gained in the logic of consumer direction depending on whether a worker is located in an ILC or AAA, I compared a pre- and post-training assessment of competencies with a population sample of Options Counselors in Massachusetts (n=115). Of the 115 enrolled participants, 85 (74%) completed both the pre- and post-competency assessments. Options Counselors in Massachusetts were recruited for the training program from their agencies by the director of Options Counseling from the Executive Office of Elder Affairs (EOEA). Agency directors located at ADRCs across Massachusetts received an email from EOEA stating that a new training program on consumer direction had been created for Options Counselors and that all options counseling staff would be required to take the training. EOEA's director of Options Counseling sent the training participant list to the Online Training Manager at CADER who then sent a welcome letter to the participants with instructions about how to access the online training program. This analysis examined the results of a new online training course on consumer control, direction, and choice for Options Counselors working with older adults and persons with

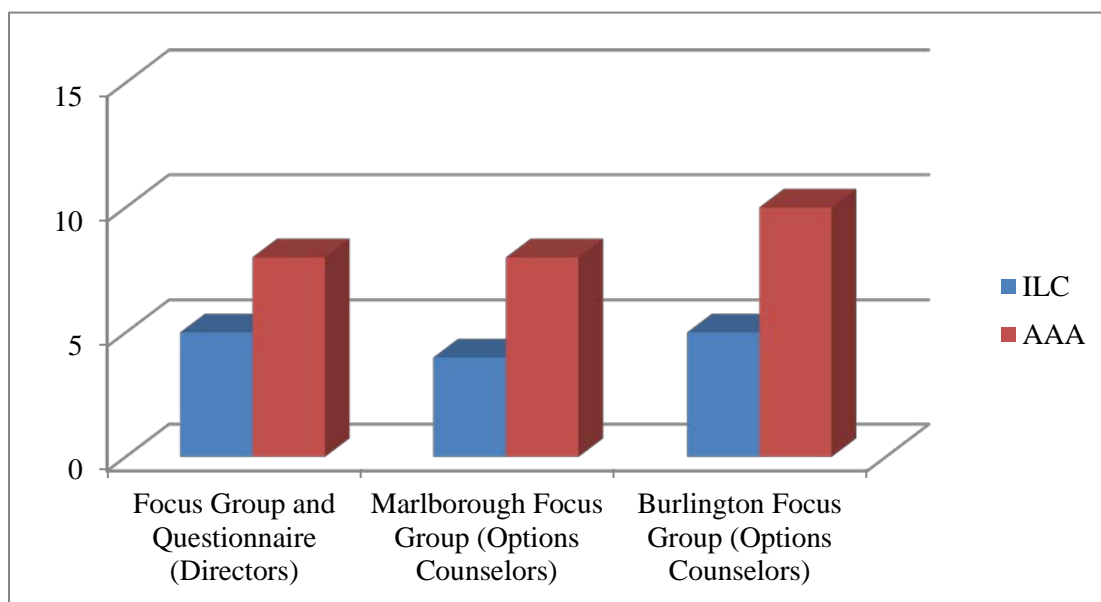
disabilities in Massachusetts to assess the impact of the training on developing a unified logic of consumer direction.

Setting and Participants

The focus group with ILC directors was held in Worcester, Massachusetts for approximately two hours. There were five participants; three of whom were women and two men. Eight AAA directors completed the online questionnaire; all of whom were women. Options Counselors were given two opportunities to participate in the focus groups depending on geographic location and topic. Each focus group met for 90-120 minutes; there were 12 participants (all women) in the first focus group and 15 participants (only two men) in the second focus group held with Options Counselors. The purpose of the focus groups was to identify the Options Counselors' learning needs on the topics of consumer control, direction, and choice training. The focus groups were held at different regions in Massachusetts to capture the diversity of the population being served and the Options Counselors themselves. The first focus group with Options Counselors took place in Marlborough, Massachusetts. This region is in the Metro West area of Boston and the agencies represented spanned geographic areas as far South as Cape Cod and as far West as the Berkshires. The second focus group was held in Burlington, Massachusetts. This area is North of Boston, and included agencies from the City of Boston to the North Shore area of Massachusetts.

The following chart summarizes the participants included in the focus groups and questionnaire by organizational setting (AAA or ILC).

Chart 1 - Organizational Settings for Focus Group and Questionnaire Participants



The online training program was available to all Options Counselors in the state of Massachusetts through a contract between the Executive Office of Elder Affairs (EOEA) and BU's Center for Aging and Disability Education and Research (CADER). The inclusion criteria were the following: (1) job title is an Options Counselor and (2) the place of employment is an Aging and Disability Resource Center (ADRC) in Massachusetts. All other aging and disability workers were excluded from this study. The training was delivered in an online course format and participants had up to six weeks to complete the course.

Data Collection

The data collection methods used for this dissertation included conducting three separate focus groups: one held with Independent Living directors and two focus groups of Options Counselors, and distributing an open-ended questionnaire to Area Agencies on Aging directors. Additionally, Options Counselors in the online training program

completed an online questionnaire prior to beginning the training and again after the training to assess competencies in the service philosophy of consumer control. Each of these data collection methods are described in more detail below.

Focus Groups with Independent Living Directors and Options Counselors

A structured focus group protocol was developed in consultation with the Massachusetts Options Counseling Training Advisory Group, which included key stakeholders in the aging and disability communities in Massachusetts, including representatives from the Executive Office of Elder Affairs, Massachusetts Rehabilitation Commission, Independent Living Centers (ILCs) and Area Agencies on Aging (AAAs), Options Counselors, and consumers in Massachusetts. 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. As I conducted the focus groups on consumer direction, I included specific 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 Independent Living directors and Options Counselors. These questions were created to better understand the professional logic of consumer direction, choice, and control and to gain information on how this logic impacts or guides the work they do whether as a director or an Options Counselor. The questions were the following:

1. What does the term consumer direction mean to you?

2. How does consumer direction affect your work and what you do? (Can you give examples?)
3. How do you work with consumers to support them in the process of consumer control, autonomy, self-determination and dignity?
4. What resources about consumer direction do Options Counselors need to know in order to better serve their consumers?
5. What information and knowledge do Options Counselors need to work effectively with consumers in applying consumer direction?
 - a. What are the skills and abilities that Options Counselors need to work effectively with consumers in consumer directed care?
 - b. What are the attitudes Options Counselors need to have to work effectively with consumers in consumer directed care?
6. What are the most important topics that should be covered in the new course on consumer direction? What would best meet your learning needs around these topics? (Probe: face-to-face, learning in groups, visual, auditory, written?)
7. What is your level of professional or personal experience with consumer directed programs and services within your agency or community?
8. What are some of the barriers or challenges you face when providing consumer directed services to consumers?
9. How do you support consumer directed options 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?)

10. Did you have a burning question about consumer directed services or resources you hoped would be answered today? Was it answered or been covered?
11. What are your suggestions to us as we move forward with this curriculum?
12. Have we missed anything?

Open-ended Questionnaire with AAA Directors

Focus groups were not held with AAA directors as this was not part of the scope of the overall contracted project with Massachusetts. As a secondary analysis for my dissertation, I decided it would be important to get the perspective from AAA directors on the topic of consumer direction and control. I created an online questionnaire, which was reviewed by my faculty advisors to assess the appropriateness of the questions and whether these questions would achieve the aim of my study and accurately assess institutional logics.

The eight aging directors from AAAs were asked questions regarding their service delivery philosophy and how that applies to their work with older adults and people with disabilities, along with questions surrounding the definition and meaning of consumer control. I also 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.

The following open-ended questions were asked to AAA directors:

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 does the term consumer control mean to you?

4. Does the philosophy of consumer control guide your work? Please explain the ways in which this impacts your work within your agency.
5. If this 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 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.

Pre- and Post-Training Competency Assessment on Consumer Control, Choice, and Direction with Options Counselors

The analysis on the training program was conducted to determine the impact of the training on the adoption of the institutional logic of consumer choice and control. The purpose of this analysis was also to determine if differences existed in the depth of the knowledge gained in the professional logic of consumer direction depending on whether a worker is located in an ILC or AAA.

I worked with the Options Counseling Training Advisory Group to create the course content and competencies on consumer control, direction, and choice. Integral to the development of curriculum was the involvement of the Advisory Group at critical junctures throughout the project. The Advisory Group reviewed beta versions of the

course and provided detailed feedback to ensure that the finished product accurately reflected the outline, and thus met the learning goals of the intended audience. Each individual section draft went through several stages of review, culminating in a thoroughly vetted preliminary draft that formed the basis for the course.

The following additional steps were taken to ensure that the course met the objectives for this project and represented the consensus of the participants in this collaboration:

1. The competencies and curriculum developed were reviewed, revised, and, ultimately, approved by the Advisory Group consisting of key stakeholders in the aging and disability communities in Massachusetts.
2. A beta version of the course was reviewed by the Advisory Group and their feedback incorporated into the live (finished) version of each course.
3. The revised version of the “*An Options Counselor’s Guide to Consumer Control, Consumer Choice, and Consumer Direction*” course was pilot-tested with Options Counselors and agencies across the state.
4. The results of the pilot tests, including self-reported skill and knowledge gains, were reviewed, and feedback from participants about the utility and applicability of the online training was incorporated in another round of revisions.

The Advisory Group was responsible for reviewing and vetting the core competencies. Nineteen competencies were created with approximately 5-10 listed under each category: knowledge, skills, and values. The competencies are based on the core knowledge and skills necessary to understand and practice consumer directed care as

perceived by aging and independent living directors, Options Counselors, subject matter experts, and other key stakeholders working in the aging and disability fields. This review and analysis provided face validity on the competency measure. The analysis of the core competencies related to consumer direction will provide a deeper understanding as to whether the training program had an impact on the depth of knowledge gained in the institutional logic. The competencies used were the following:

Knowledge

- Understand the history of the Independent Living Movement
- Describe the evolution of Independent Living Centers and the model for services
- Define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services
- Explain the right of choice and risk to consumers
- Understand the core roles and functions of Options Counseling
- Understand the difference between a case manager and an Options Counselor
- Understand the history of Disability Rights Legislation
- Identify legal and ethical considerations that are involved when working with consumers and families

Skills

- Describe how to recognize personal bias and judgments in an Options Counseling session
- Recognize needs, values and preferences of consumers

- Demonstrate the difference between case management and Options counseling
- Develop strong interpersonal communication skills to support the consumer in the decision-making process, including decision making support, effective ways to ask questions while providing resources, active listening, and paraphrasing
- Demonstrate creative ways to research services and supports as an Options Counselor
- Determine how to effectively support family members' interest in participation and assist with the problem-solving and resources

Values

- Understand the consumer's right to consumer control, consumer choice, consumer direction, dignity of risk, and self-determination
- Recognize the importance of respecting strengths, values and preferences of consumers
- Recognize the impact of one's own values and biases on one's ability to provide quality options counseling related to aging and disabilities
- Understand the value of cultural inclusion and cultural humility when working with consumers
- Understand professional sense of self, the importance of self-care, and the boundaries and limits of Options Counseling

Before collecting any data, Options Counselors created a secure web account through Boston University in order to access the online learning management system.

Once the account was created, the Options Counselors were directed to a participant profile form that all CADER training participants are asked to complete. There is an informed consent form embedded in the registration manager system that explains why CADER is collecting this demographic information. The participant profile form was approved by BU's IRB under protocol #1235X. Once training participants completed the online registration and the participant profile, they were then prompted to link out to Survey Monkey to complete the pre-training competency assessment. Participants were asked to provide their BU user identification on the questionnaire in order to match the pre- and post-training assessments. The link to identify them was deleted immediately after the data has been matched. Participants were given another link to Survey Monkey at the end of the course for the post-training assessments.

The following demographic information was collected for the online training analysis: age, gender, race, educational background, years of experience working with older adults or people with disabilities, type of organizational setting (specifically whether they are at an AAA or ILC), and percent of their job that involves working with people with disabilities or older adults. Identifying information, such as name and address, was not included in this analysis. This data was collected prior to beginning the training program.

Data Analysis

The focus groups with Independent Living Center directors and Options Counselors were audiotaped and transcribed for analysis. 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 Boston University School of Social Work file server. In order to access this data, individuals had to be explicitly granted permission to access this folder. They then had to securely log onto machines on the BU network using strong authentication via a unique, personal login and complex Kerberos password. All names, if mentioned during the focus group, were removed from the transcripts and all that is remaining in the transcripts is the response.

I analyzed the focus group transcripts and questionnaire responses to look for common themes surrounding the service philosophy of consumer direction, along with any additional guiding service principles or logics that showed up through the focus groups or questionnaire responses. I used a grounded theory technique of line by line coding to find themes to support the research questions (Charmaz, 1999; Glaser and 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. This analysis provided information as to how different staff members in AAA and ILC organizations understand and feel confident in their ability to implement or adopt the new service delivery philosophy of consumer direction.

The data from the online training questionnaires was downloaded into SPSS, and all data was analyzed using SPSS version 19. I ran frequencies on the demographic data stratified by organizational setting (AAA or ILC) to report baseline differences or similarities in the training population of Options Counselors. I also examined to what extent the agency location of the worker, specifically whether they are located in either an AAA or ILC, influences the implementation of the institutional logic of consumer direction and control in the ability to serve the needs of both older adults and people with disabilities. This was measured via a self-assessment questionnaire of knowledge, skills, and values on consumer direction based on competencies from the online course, as measured pre and post training. Participants were asked the same set of questions before and after taking the training and rated their competency in these areas using a self-rated scale ranging from 0 = no skill at all to 4 = expert skill. To determine significance, pre- and post-training data were matched for each participant and analyzed for change using paired t-tests. To compare agency differences in means at pre- and post-training an independent samples t-test was used to analyze the groups, which were categorized as either AAA or ILC.

Ethical Considerations

Consideration of ethics should always be prominent in conducting research with human subjects. As such, all research methods were reviewed carefully by my committee and by Boston University's Institutional Review Board. An ethical concern I grappled with throughout this research was the duality of my role: I was both a doctoral student collecting data and an employee of the Center managing a project. It was

important for me throughout this work to ask myself the question: “Which hat am I wearing today?” This question would help to ground me in my objective for the moment and determine my direction and behavior. Another important part of managing this process was that I was completely transparent in my dual roles with the Massachusetts Options Counseling Training Advisory Group throughout this project and this led to open discussions based on trust and created a supportive atmosphere. It was validating to note that people were pleased to be a part of this project and believed that this work could have a meaningful contribution to the objectives of moving forward in having a unified identity within the Aging and Disability Resource Centers.

**CHAPTER 5: RESULTS ON INSTITUTIONAL LOGICS AS DESCRIBED BY
INDEPENDENT LIVING CENTER DIRECTORS AND AREA AGENCIES ON
AGING DIRECTORS**

The following three chapters will present results from the research conducted in this dissertation. Chapter 5 presents the results from focus groups with Independent Living directors and the responses to open-ended questions from the questionnaire of directors of Area Agencies on Aging. The aim of this chapter is to analyze and compare the institutional logics of AAA directors and ILC directors to determine whether distinctive institutional logics can be identified for each group. Chapter 6 presents the results of the focus groups conducted with Options Counselors at AAAs and ILCs on the topic of consumer direction to determine whether distinctive institutional logics can be identified for each group and to analyze how Options Counselors understand the service philosophy of consumer direction and the challenges or barriers in implementing this practice. Lastly, Chapter 7 will report on the findings from the statewide training program on consumer direction and discuss the impact of the training program on Options Counselors based on pre- and post-training competencies. This chapter looks at the changes in scores based on organizational settings, AAAs compared to ILCs, to examine whether there are differences in the depth of knowledge gained in the logic of consumer direction. The purpose of chapter 7 is to determine whether a training program can impact the adoption or understanding of a new institutional logic.

The ordering of the results chapters is important in the discovery of the institutional logics and how these logics flow down through the organization and key

players. The analysis begins at the director level of the organization, moves to the member level by examining the workers, and wraps up with an intervention, namely the training program, to determine if this can impact institutional logics. Further, the presentation of results in this dissertation reflects the chronological order of this collaboration and offers insight into how the relationships unfolded. The project began with funding from the Administration on Aging to the Executive Office of Elder Affairs with the goal of creating national standards and building competencies for the new workforce of Options Counselors tasked to work between two agencies in a hybrid organization. The focus group with directors and workers was the first step in developing the training in an effort to gain consensus on what the training program should consist of based on the needs of the workforce. The curriculum development occurred afterwards and was a collaborative process leveraging the Massachusetts Options Counseling Training Advisory Group made up of officials from Elder Affairs, directors from aging organizations and Independent Living Centers, and Options Counselors from both primary organizational locations. After months of meetings and many revisions to the curriculum to gain consensus among this representative group, the training program was launched with many of the same participants who were involved in the original focus groups. These results chapters articulate the journey of how each group has differing professional logics, which are very pronounced at the beginning in the focus groups, and how 12 months later after the training program and collaborative work, there is a new understanding of how best to manage these potentially competing logics.

Professional Logics Identified by Independent Living Center Directors and Area Agencies on Aging Directors

This chapter reviews the results from focus groups with directors of Independent Living Centers (ILC) and the responses to open-ended questions from the questionnaire of directors of Area Agencies on Aging (AAA). There were five participants in the ILC focus groups; three of whom were women and two men. Eight AAA directors completed the online questionnaire; all of whom were women. Throughout this chapter, I will compare and contrast the professional institutional logics that emerged from the themes in the analysis of these data. The main concept in institutional logics is that “each institution has its own set of logics or principles that guide work and activity” and it was apparent in my analysis that the ILC directors and AAA directors expressed very different professional institutional logics in a number of important ways.

The themes that were identified and organized under four categories were: a) terminology/language; b) professionalization; c) risk versus safety; and d) organizational resources and financing. As shown in the following table, both groups of directors expressed different belief systems on the same general topic.

Table 3. Themes Identified by Directors

Themes	ILC Directors	AAA Directors
Terminology/Language	Consumer Control	Consumer Direction
Professionalization	Peer Workers Anti-certification	*
Dignity of Risk vs. Safety	Right to Risk	Balancing Risk vs. Safety
Organizational Resources and Financing	Not Equal Partners Financing Imbalance	*

** This theme was not identified by AAA Directors*

The variations in how themes are expressed by the directors confirm that there are differences in service delivery systems and professional logics at the director level of these organizations. The policy initiative to merge care of older adults and people with disabilities into a “single access point” or “no wrong door” approach seems to make sense at a macro level as both populations might need similar types of services. Further, it is not unreasonable to assume that the professional logics would be similar for both organizations; therefore, the hybrid organization of ADRCs would seem a natural direction. What became apparent is that the professional logic of aging directors emulates more of a medical professional logic with concerns about safety outweighing risk; while the ILC directors 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 medical professional. While these professional logics are at odds, it became clear that it was beneficial to have shared decision-making and collaborative projects that educated each profession about the belief systems that guide their work.

It was also clear from the qualitative analysis 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 service 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 a key in negotiating varying institutional logics, the analysis through the focus groups with directors 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 Office of Elder Affairs to the ILCs rather than having the funding split between the two organizations creates a power differential that is hard to overcome when working on creating a unified professional logic as one of the professions, namely the aging side, holds more control through their resource dominance. The following sections describe how each theme relates back to their guiding professional logics and the differences between the two organizations.

Contrasts in Terminology and Use of Language: Consumer Control vs. Consumer Direction

Very different professional logics emerged between ILC directors and AAA directors in the use of language and terminology. From the onset, and before we could go any further in the discussion, all of the ILC directors in the focus group (n=5) were very clear that we should be talking about consumer control, not consumer direction. As

pointedly stated by one of the ILC directors who has a disability and has been a vocal advocate for people with disabilities for most of his life:

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. And we're not the ones responsible to make decisions for people or on behalf of people. At least that's how I see it. –

ILC director

The importance of language and how language embodies the guiding philosophy of all ILCs was repeatedly stressed by the ILC directors. In fact, it was so important that we could not begin the formal focus group protocol until this was discussed at length. Additionally, one of the ILC directors gave me articles on the meaning of language and another lengthy article that described the independent living paradigm as compared to the medical paradigm. This was a striking indoctrination for me as I was beginning to understand the varying institutional logics of the aging and disability worlds. What also became apparent rather quickly is that the language and definitions are confusing to those who are not in this organizational setting and for those who do not practice these core philosophies on a daily basis. Another important distinction on language is described below:

There was 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. – ILC director

The emphasis on consumer control is further stated by another ILC director in the room who has been a director for the past couple of years and who does not have a disability.

It should be consumer control. I think that's what happened, even during training [note: during a previously held Options Counselor Orientation training], not to be so bold. But person centered planning was part of the presentation. Actually more time for that than ILC, but that's a different model. And that's where, I think, all of us really were up in arms when person-centered planning was rolled out to us as a model. And I get a lot of pressure from DMH about that. 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? You know, we get caught up. See, I don't think they can go down that path because it's either one model or the other. – ILC director

The description about the difference between consumer control and person-centered planning continues as another ILC director wants to be sure I understand the history. The importance of understanding history and the journey of disability rights is always in the forefront of our interactions. They must be sure I understand this well.

People with disabilities usually are not given full control of what they need for services or activities or environments or choices. And no amount of nice person-centered or even consumer direction is really ... the provider has to be willing to give up controlling the situation. And that's key to anything to really get to something as fundamental as consumer control. – ILC director

Another critical point was not just being able to translate and recite the terminology of consumer control, but really being able to operationalize it and understand

it deeply. Many of the ILC directors in the focus group believe it is only possible to do this through direct and personal experience, not trainings. This issue comes up again in the institutional logic related to the professionalism of staff that is address in the next section. One of the ILC director states:

So I would say it really is helping people to understand, if you're an Options Counselor, here's the words, here's what consumer control is, here's how it's different from this. Here's what it means to be an Options Counselor embodying what consumer control is about. But here's how it translates. So I think it's taking these words and at least helping connect it to how. And then really, like we all said, an internship experience, experiential, job shadowing. – ILC director

In contrast, the professional logic related to language and terminology that emerged from the directors from aging organizations is more accurately described as consumer direction. Basically, AAA directors, in their characterization of what they do, the role of Options Counselors, and their agency's overall service philosophy, give less autonomy to consumers than ILC directors. When asked about the definition of consumer control, the AAA directors imply that the worker is driving the process by empowering the individual – note the language is not as strong and the word “control” is absent from the definition. As stated below by AAA directors:

The consumer preference is a priority and the consumer takes the lead and his/her preferences are what matter. – AAA director

Consumer direction is empowering the individual. It means that everyone has a right to influence and manage their own lives, whether they have a disability, are aging, or not. – AAA director

The consumer is driving the direction of services and of the options desired. – AAA director

One particular AAA director struggles with why the word “choice” is not strong enough and an ILC director attempts to educate the aging director on the differences, but there is confusion on the semantics and the terms get very muddled for this director, as noted below.

I get discombobulated with it [control], because I think of choice in a very similar kind of a way, that I have choices in my life and the choices that I make determine how I live my life. – AAA director

The ILC director tries to clarify the difference between choice and control in an example stated below.

You're a salesman. You always want to give two choices so that your person buying a car or buying whatever you're selling chooses something. So what is the sales technique if you offer two choices, “So, would you like to have a ham sandwich or are you going to bring your lunch?” And the person has two choices, and you have just limited. He's either having a ham sandwich or they're going to have a lunch. That's what I think is the difference. You know, another way, consumer choice. You could either have the nursing home in Windham, New Hampshire that has a nice facility, meaning a Dementia unit and this and this, or you can have the assisted living place in Middleton. There are two choices, but it's not ... [consumer control] – ILC director

When directors from AAAs are asked about the main service philosophies that guide their organization, it is also clear that the language and terminology they use is more consistent with consumer direction or person-centered planning rather than consumer control.

Competent elders have the right to self-determination – AAA director

Listening to the consumer's needs, wants, and wishes and respecting these. – AAA director

Consumer centered care – AAA director

Person-centered planning, utilizing consumer preferences, and offering resources – AAA director

It is interesting to note that person-centered planning is one of the guiding organizational philosophies for aging organizations, yet this logic is antithetical to consumer control, according to the ILC directors, and is not a model they embrace at their organizations. When aging directors are asked whether the philosophy of consumer control is embraced by the organization's structures and practices, their responses are clearly not as consistent or strong as those from the ILC directors. Four out of the eight AAA directors addressed this issue as follows:

Consumer control is not embraced, but definitely moving towards it. – AAA director

Not organizationally, but it is a learning curve for a few individuals who are long time employees. – AAA director

The care management system makes it difficult, but respecting consumers and their choices is still the goal. – AAA director

The word choice is something that we use in the aging network both. And I think that because this module [course], I mean we're working towards consumer control. That is ultimately the goal. We're not there yet. – AAA director

These statements confirm that the professional logic of consumer control has not yet been realized by aging organizations and that there are some obstacles of entrenched old logics within the aging system that hinders this goal. What is important to note is that these AAA directors acknowledge that this professional logic is not yet “embraced”; therefore, the important work ahead is moving towards finding mechanisms to help these organizations in adopting this new logic.

Themes Related to Professionalization as Described by ILC Directors

The institutional logic of staff professionalization came up in the focus group with ILC directors, but this theme was not present in the findings from the AAA directors. Professionalization was mentioned in the context of creating training for the newly emerging workforce of Options Counselors and the ILC directors wanted to be very clear where they stand in their position on creating certification or professionalization of workers. One issue repeatedly identified by ILC directors concerned workers making decisions 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, as only a person who has walked in those steps can really understand.

One clear example of this is in the role of peer counselors; this is a central staffing position in independent living centers, but these types of positions are not widely used in aging organizations. Below an ILC director describes the evolution of peer counseling:

In fact, it grew out of Northeast Center ... and the fact is the mental health community, the survivor community, and so forth, has taken the IL model of peer counseling, peer support, and influenced that into providing recovery learning

*centers for people with mental health as their primary disability. Which is great, but the struggle I see is they've also bought into the practice of certification and professionalism. They're going after peer support certification. One of my counselors went to that. And I supported them going to that. Because you have a lot of skill sets in the mental illness community. But it's interesting how that community has already bought into a professionalism model, whereas the IL community has rarely gone to that belief that we need to be certified or professionally trained. Because our model is a peer role, peer consumer-driven model, a paraprofessional model. Because any time you create power or 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.** - ILC director*

This guiding philosophy of “*nothing about us without us*” is central to the Disability Rights Movement in that all policies, programs, and services need to 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 (<http://www.ncil.org/about/aboutil/>). It is further stressed that any type of professionalization or certification is an affront to consumer control and the principles of independent living. This particular ILC director targets the profession of social work in the statement below.

When we first started, we had a FTE and we hired a brand new social worker out of grad school and she was malleable. So that was my first ever time agreeing to

hire a social worker. Nothing against social workers, but I generally hate them [laughter] or their profession. – ILC director

This has a direct impact on the new profession of Options Counselors as they are a unique group of workers ranging from having no degree to having a social work degree or other higher education degree. ILCs are not using degree attainment as a prerequisite to securing a job as an Options Counselor, whereas an aging organization might be more likely to hire a social worker or someone who has a similar degree. This variation in professional logics and standards creates a stark difference in the workers depending on their organizational setting and could certainly lead to varying types of consumer interactions and outcomes. Below the ILC director continues to state 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. – ILC director

If you develop curriculum for consumer control, then you first need to have people who practice this doing the training. And when you do a training about consumer control, you'll have to do a training on the disability rights movement, because it's nothing-- it's not even these sayings. The reality is discrimination, social isolation, the stigma of being a person with a disability as a result of that and the movement that came out of that, is what created consumer control. It's what created independent living centers. – ILC director

Formal training is not important to the ILC organizations; rather, being a peer or a person with a disability holds more weight than any degree or credentialing.

Understanding first hand through personal lived experience what consumer control is carries far more importance.

If we're going to be talking about independent living philosophy and we're going to teach it truly, it's got to be taught by people that truly understand it and people that truly experience it every single day. – ILC director

Additionally, the same ILC director continues to state the involvement from the people working in Independent Living Centers should not be superficial or peripheral – their input should be central to the process of creating and revising this training program on consumer control, direction, and choice as they know and understand this philosophy on a daily basis.

There needs to be involvement from this community after the course is developed... there has to be input throughout the entire process. And if there's going to be a shift in what's done, that input has to come directly from us, the people that deal with it and the people that work in it every single day. – ILC director

Another ILC director discusses the challenges of hiring staff who have not previously worked at an Independent Living Center or been a consumer of these services. The ILC director describes frustration on both the part of the new Options Counselor and the director in attempting to get the new person up to speed with the organizational philosophy.

And we had kind of an interesting experience because we brought an Options Counselor on who was there for a very, very short time. One of the things that I could sense was a bit of frustration in the short time that she was there because-- and I think where that came from-- it was, "All right, here's your job. Figure it

out.” And then the person that we have right now was very different and very much being full of the drive and being willing to find the resources and do that. But this was also a person that came from within our organization and understood the IL philosophy before switching over to become an Options Counselor. The other person came from an outside agency coming into our organization and didn't necessarily understand where we were with that. So from day one, it was sitting down with the person and talking about IL philosophy and history and doing those type – discussing where we came from. And I have a bit of a sense that that was part of the frustration and why the person didn't stay for a very long period of time. Because this is something that we see. And again, you're asking where do we start with a new person. – ILC director

The issues of experiential learning, anti-professionalism, and deeply understanding the language of the independent living movement is core to the institutional logics of this social movement. 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 in being successful as an Options Counselor than any type of professionalization or certification.

Contrasts in Professional Logics Related to Risk: Right to Risk vs. Balancing Risk and Safety

Both ILC and AAA directors articulated guiding professional logics in the area of risk, although with distinct differences between their views. All ILC directors firmly stated that consumers have the right to take risks, and stressed that this is an important component of consumer control. As described by the ILC directors, this is a human rights issue and a key tenet of the guiding philosophy of consumer control. In this view,

all competent adults deserve the opportunity to exercise their right to risk. This is described by two of the ILC directors as the following:

It also 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. This does not guarantee a perfect result, but it's the result of the path of the person deciding. – ILC director

Independent living, it's all about opportunities to learn from your failures, your successes, your fellow peers. It's about learning the skills that we supposedly all acquire as we develop into adulthood to be responsible individuals in this society. And people with disabilities have been either stigmatized or excluded from that participation. – 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 logic between aging providers and independent living workers.

The second we sit down with any of the partners that 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. Traditionally in human services, we get assigned a consumer and now that's our person for life. And so the ability that once you made the referral to let go. That's part of the problem, and that's what's real hard about options counseling, is the dependency issue. – ILC director

Aging directors struggle with balancing the right to risk and safety. This is a challenge for many in the aging community to reconcile as it is a real shift in their

organizational culture and upbringing in the aging world. As noted below by three out of the eight AAA directors:

Some professionals have difficulty with level of risk consumers may chose. – AAA director

The only challenges are getting by-in and understanding from other aging professionals that are still risk averse. – AAA director

The medical community is often too focused on "safety" for the consumer. – AAA director

The following statements come from two out of the five ILC directors about how the aging and disability systems are set up differently:

It's the ideology and the systems and the elder systems deal with safety that's a paramount issue. – ILC director

The systems are set up differently. We take care of the elderly. You know, we make things safe for them. It's just very different. It's the penalty that their systems would place on them if they did that. They could lose their job. – ILC director

The dialogue below is illustrative of how a director from an aging organization and a director for an independent living center are not able to find common ground on the issue of safety and risk. They ultimately agree to disagree, and if it were not the case that these two organizations are now charged with combining services in a unified way, it might be acceptable to agree that they have differing guiding beliefs in such core issues, but this variation in professional logics could challenge the goal of creating a unified organizational mission with a shared vision and workforce.

AAA director: *I think what we have to keep reminding ourselves of the goal of the course, which is on consumer control, so that if we want to use an example about somebody who has Alzheimer's or Dementia, I would say it would be a case example of how does consumer control work maybe with somebody who is frail or who has Dementia. They don't have the choices left unless this is how their life has always been.*

ILC director: *Well wait, yes they do. I'm going to disagree. They always have the right to take the risk, unless there is a court that says that they don't have the right to make the decision. And until the aging community understands that, as the mental health community finally got in the case about antipsychotics years ago, until the aging world gets that under its gut anything we do in here is worthless, because then there is no consumer control. So, when we're talking about risk, that's from a cost factor or a legal cost factor. Talking about risk from a person's choice, it's whatever they are willing to take the risk for unless they are told by a court they may not make that decision, and that is a competency issue in the legal arena. And that's where we butt heads.*

AAA director: *We're going to continue to butt heads right there.*

ILC director: *But that's the law.*

AAA director: *Not the only law.*

ILC director: *Yes it is, it absolutely is. And you may have your license issues that you have to worry about, that in this case you may have to make sure that there is someone watching me, because you know I'm not going to be safe. If I tell you to get out of my house you better get a lawyer, call your legal people, if you don't leave my house because you think I'm unsafe, because you're invading my home. And that's a licensure issue. But that's the law. Read the guardianship steps.*

AAA director: *That's not the only law.*

ILC director: *Well I'd like to see the other law. I fought decades and I'll keep fighting.*

What becomes clear through this exchange is that these differences are deep and evoke passion on both sides about the subject of dignity of risk as being core to consumer control. Again, this disagreement is occurring between two different directors, one from the aging world and another from the disability world. The question remains, how does this difference impact the worker? It seems logical to assume that the workers will guide their work and decisions based on the guiding service 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 Options Counselors to ground themselves in a guiding work ethic or value so they can provide quality, unified services to older adults and people with disabilities.

Themes Related to Organizational Resources and Financing

Several related themes emerged in the analysis of the focus group with ILC directors pertaining to funding, resources, and shared decision making that underscore the challenges in managing competing institutional logics between the aging and disability system. ILC directors uniformly described the imbalance in resources and financing between the aging and disability systems and how this affected the development of a uniform service philosophy. Being outnumbered by aging organizations is of major concern to the ILC directors as they are concerned that just the sheer number of aging organizations will result in many Options Counselors 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.

The other issue we look at, quite frankly, is there are 11 independent living centers and there's how many elder service agencies coming into this and we're bringing the majority of folks that are coming in that don't have the IL history and philosophy background. There's a large majority there and it's like so how do we address that, and what do we do to turn-- so to say-- turn the tide on that. And there's a big difference in how we do our training. The example that I've been frustrated with a lot recently is I supervise my Options Counselor directly. So we work together, we talk to each other every day of the week on different issues. Over at the agency across the street [an aging organization], which literally is literally across the street that happens to be one of our ADRC partners, that Options Counselor is five to six people down deep within the organization. So my Options Counselor comes to me and she gets the word directly from me ... it's not the same as far as how the – what the word is that's getting to people. And so if we're going to be talking about independent living philosophy and we're going to teach it truly, it's got to be taught by people that truly understand it and people that truly experience it every single day. And I don't believe that that's happening now. – ILC director

ILC directors discuss the concern that they are not considered “equal partners” at the table. They have less staff, less agencies represented under the ADRC umbrella, less funding, which is held by the Executive Office of Elder Affairs – all of this leads to underrepresentation and the need to be outspoken so 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.

It will still be an interesting challenge, though, because of the differences between the ASAPs and the centers. I mean, it's ironic that we've been in ADRCs for going on, what, four or five years now and it's still a-- 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 ASAPs decided this and they told elder affairs so elder affairs said sure. They never talked to me. It affects metro west ADRC, but the D was never consulted. It was a decision made outside of my interest, apparently. And it affects me. – ILC director

It is clear that all of the ILC directors in the focus group feel that they are not involved in critical conversations and are often brought to the table after a decision has been made. This perfunctory role is transparent and only angers the disability stakeholders, as noted below by two ILC directors.

You get that feeling when you have multiple partners within the ADRC. And in the beginning, I didn't feel it and the more we get into our meetings and into our partnership, it's clear that when we go to a meeting, there have been so many conversations among the other four that decisions have really actually already been made, but they're just going to be polite and try and wrap us around it and it's causing more and more friction now. So it's a horrible position to be in. When you're trying to be an equal partner. – ILC director

I think where some frustration is coming, too, is, at least on my side where I'm seeing frustration, is it seems like many, many times even a focus group like today, the decision's already been made at elder affairs. And we're expected to rubber stamp it. That's not how we work. I'm going to be honest with you about it. The fact that that's the way it's working right now is really frustrating the hell out of me. And I have to ask why would I want to continue this type of relationship at times. – ILC director

The issue of inequitable distribution of resources between aging and disability organizations was frequently mentioned. Clearly, there are differences in how much money each organization is allotted and this creates a rift between the organizational directors and leads to genuine feelings of inequities.

The money went from elder affairs to MRC (Mass Rehab Commission). MRC, which is our traditional funder where all of our IL money, state and federal, each of us got a contract for \$90,000 and our deliverables were to MRC. So our money was being controlled by our partners, right? We could be equal. Well, two years into it, we still don't know what happened, but we were told that wasn't going to continue. And that the money had to flow through that lead agency of the ADRC, which ironically were all ASAPs (AAAs). And when we asked the commissioner of MRC about it, he gave an answer that my insight, since I've known the commissioner for years, is that he got told what to do. And that he had no choice in it, that he couldn't continue being separated like that. Whether elder affairs didn't like it, whether EOHHS didn't like it, I don't know. But something said this can't continue. So now that money I get for options counseling is as a result of a subcontract with one of my ASAPs in my ADRC. How does that make me an equal partner? It doesn't. And all the other ASAPs, they don't have a problem with it. But for me, it's a huge obligation that I quite frankly can't piss off my lead ASAP because they hold the purse strings to \$65,000. And it would jeopardize my options counseling position. I just find this frustrating because it puts us into no longer capital D, we're lower case D. And I realize that the centers are much smaller than the ASAPs and that we don't necessarily represent the same number of people, but I don't find that it's an equitable situation and I think the only equitable situation is when you have one-on-one. And even then, you're not contracted through MRC. You have to get money from your ASAP partner. So it's been baffling to us why that's happened. And the only response we get is, "Well,

you guys should have decided in your ADRC to be the lead agency.” – ILC director

These themes surrounding funding, resources, and shared decision making are important to consider in this analysis as it speaks to whether a truly equitable and collaborative relationship can occur when there is so much imbalance between the two organizations. It is worth consideration that these themes 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 a greater number of organizations and workers coming from the field of aging but, at least in this 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.

Summary

The analysis conducted from the focus groups with ILC directors and the questionnaires from AAA directors revealed very different guiding professional logics of services in the two types of organizations. In particular, consumer control is clearly articulated as a central institutional logic in Independent Living Centers while aging organizations seem to align more closely with consumer choice or person-centered practice approaches. It is interesting to note that AAA directors acknowledged that they are attempting within their organizations to move toward an overarching organizational philosophy of consumer control, but they are not there yet. The mission of ADRCs to

combine services from these two organizations provides an opportunity for each organization to learn from one and other, but that requires working together to find common ground and language, and can only happen through breaking down the silos between the organizations and creating more formal collaborations.

The results from this analysis contributes to the theoretical research in that it highlights that changes in institutional logics are challenging for those higher up in the organization and for those who are potentially more entrenched in the macro field level logics. Comparatively, the upcoming results chapter with Options Counselors will articulate that change might be more plausible at the micro level of workforce especially for those who are newer to the field and are “growing up” in this hybrid organization.

CHAPTER 6: RESULTS ON INSTITUTIONAL LOGICS AS DESCRIBED BY OPTIONS COUNSELORS

This chapter presents the results from focus groups with Options Counselors who are either located at an Independent Living Center (ILC) or in an Area Agency on Aging (AAA). Throughout this chapter, I will compare and contrast the themes that have emerged from the ILC and AAA Options Counselors focus groups while linking this analysis to how institutional logics can impact the organization's mission and guide the work of this occupation.

Professional Logics Identified by Options Counselors

The following table summarizes the main professional logics that were identified in this analysis. The themes identified are organized under four main categories: (1) terminology/language; (2) risk vs. safety; (3) contrasting organizational orientations; and (4) organizational resources and financing. There was one theme that was identified in the focus groups with Options Counselors that did not emerge from the focus groups with the directors described in the previous chapter – this was related to professional orientation in the two organizations. Overall, two very prominent and distinct professional logics emerged between the Options Counselors located at the different organizations: one is the independent living model for ILCs and the other is a care management model present in aging organizations, with the former coming from the now well-established social movement to improve the civil rights of people with disabilities and the latter emanating from a medical professional logic.

Table 4. Themes Identified by Options Counselors

General Categories/Themes	ILC Options Counselors	AAA Options Counselors
Terminology/Language	Consumer Control	Consumer Direction
Dignity of Risk vs. Safety	Right to Risk	Balancing Risk vs. Safety
Organizational Orientation	Independent Living Model	Care Management Model
Organizational Resources and Financing	Not Equal Partners Financing Imbalance	*

** This theme was not identified by Options Counselors in AAAs*

Participant Profiles

In Marlborough, MA there were a total of 12 participants of which four participants were from ILCs. The remaining participants were from AAAs. All participants were women. The second focus group was held in Burlington, MA with 15 participants, 13 of whom were women. Five participants were from Independent Living Centers and the remaining 10 were from aging organizations. The following charts describe the focus group participants in the context of how long they have been Options Counselors and what population they mostly serve in their work.

Chart 2. Length of Time Working as an Options Counselor

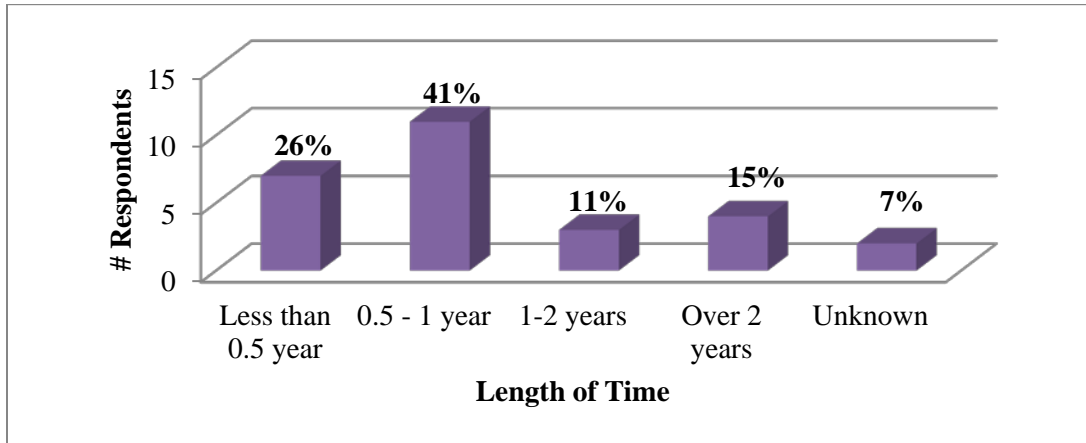


Chart 3. Percentage of Current Work with Older Clients

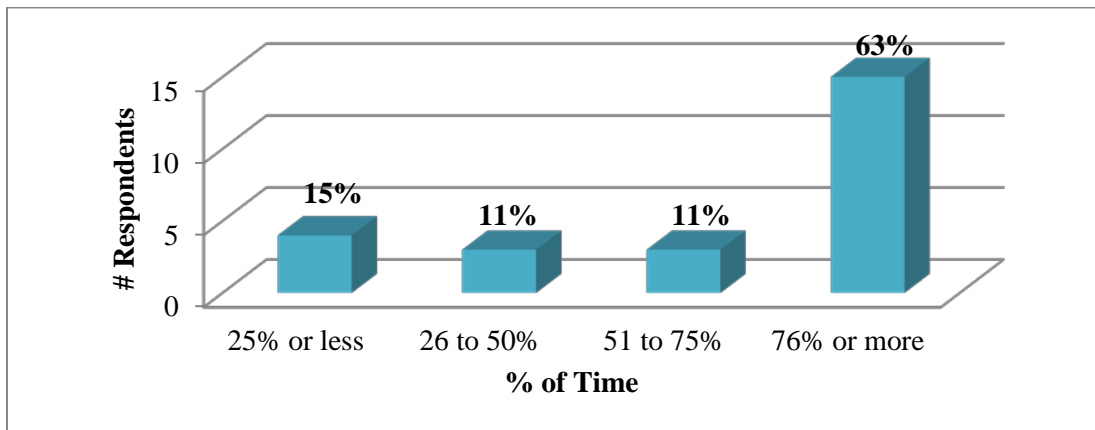
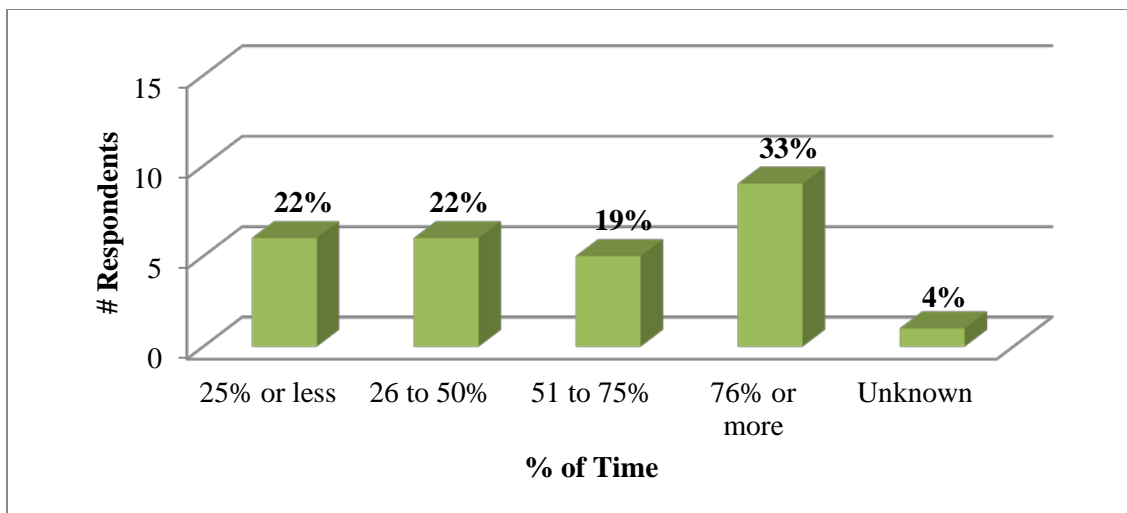


Chart 4. Percentage of Current Work with People with Disabilities



As noted in Charts 2-4, most of the Options Counselors were relatively new in their job with the majority only holding this position for about a year. This speaks to the newness of this occupation and the importance of creating clear professional standards. It is also relevant to note that most Options Counselors work more with older adults (63%) and less with person with disabilities (33%). This finding supports the notion that there are fewer Options Counselors working in Independent Living Centers and gives credence to the assumption that the aging organizations' guiding philosophies may be more dominant.

Contrasts in Terminology and Use of Language: Consumer Control vs. Consumer

Direction

The general response from focus group participants is that the definition of consumer direction is slightly different among Options Counselors from AAAs as compared to ILCs. I heard some of the following responses from workers in both organizational settings when asked how they define consumer direction:

It's empowering the consumer to kind of decide what and how the options counseling will go, empower them to make their own decisions. – AAA Options Counselor

It's allowing the consumer to set the agenda. – AAA Options Counselor

A belief that people have the right to make their own decisions, people have the right to fail. – ILC Options Counselor

The tenets of independent living are consumer control, autonomy, self-determination and the dignity of risk – ILC Options Counselor

Options Counselors at aging organizations use language such “empowering” or “allowing,” whereas ILC Options Counselors are more emphatic in their statements and use statements such as “have the right,” which references the role disability advocates had in fighting to attain equal rights. As the focus group discussion continues, the differences in institutional logics between workers in an ILC and AAA become more apparent, as stated below.

I think it's easier for me, actually. It sets that boundary for me so I can take myself out of it and having to feel responsible or guilty, or I didn't do enough. It's kind of like, okay, this is what you want? This is what I'm going to give you. This is the pros and cons. These are the consequences. I can live with myself with that; it's easier for me, personally for me. – AAA Options Counselor

I think this whole consumer direction that we're going on, while it might be beautiful in the perfect world, it's not going to be necessarily easy to administer. – AAA Options Counselor

I think consumer direction is consumer choice. And when you present them with options, you're giving the ability to make their own decisions. But the old model, if they didn't follow what we told them to do, they were non-compliant. The current model is, we also tell them what their choices are, if they don't do things, or if they choose certain options, but then we also identify what the consequences are. So then they're making a good, educated decision on what are the flaws with this decision, and what are the positives with this choice. – AAA Options Counselor

In contrast, an ILC Options Counselors disagrees with her counterpart on her definition of the terms, and states the following:

I'm not so sure that consumer direction and consumer control are synonymous. Working with the ASAPs, sometimes consumer direction means something else. Yes, the consumer can decide that, yeah, they want to live someplace, some town or something, but then the elder agency, for safety issues or whatnot – and I'm not saying it's right or wrong – but for whatever reason the elder agency decides that that's not going to be the best for you, okay. Whereas, the consumer control issue comes from, No, you're not going to sway me from what I want to do, and my decision is my decision if I'm 90 years old and I want to live at home. That's the consumer control of it. And to me, the direction work comes with the 90-year-old that wants to live at home, but somebody decides that the safety issues are paramount to freedom. Then that, to me, is more– it's not exactly clear in my mind that the two are synonymous, is what I'm trying to get at. I think it's really important– if I live to be 90 years old, I don't want anybody telling me that I have to go into a nursing home for any reason. I want to die at home. I know that now. And I've thankfully got enough support at my organization that they know it. And I would do everything that I can to make sure that somebody had that. Now, that to me is the difference between maybe consumer direction and consumer control. And I would always, for me, myself personally, I'm always going to want to go freedom over safety. I mean, life is not safe, period, anyway. So consumer control would be freedom. Because there is the consumer choice, consumer direction and consumer control. And as a new Options Counselor, even as a new person getting into this field and starting to read about it, these terms get a little blurry sometimes. – ILC Options Counselor

This dialogue really brings to light that there are three different terms – consumer choice, consumer direction, and consumer control – all of which carry different meanings. During the focus group, I probed to determine if Options Counselors recognize a difference between these terms. I asked the participants which of these terms that they, or their organization, were more oriented toward.

I think choice is more of a decision thing, and consumer direction is more of them kind of holding on to something and steering the ship. Where choice is, you give them something, they pick. Consumer directed is kind of them steering the ship more so, instead of just having choices. – AAA Options Counselor

The confusion between terms even occurs within aging organizations, as two AAA workers state differences in which logic guides their work.

Consumer choice is the focus of the work of an Options Counselor. – AAA Options Counselor

Consumer direction, that's what we do, that's what we're all about. – AAA Options Counselor

It is important to consider that while these AAA Options Counselors believe that consumer choice (or direction) is the focus of their work, this would be considered the most watered down level of consumer control according to an ILC worker. In their view, this guiding logic only provides the consumer with a fixed laundry list of choices from which to choose from, as compared to consumer control where the consumer defines the set of options and makes a decision based on his or her preferences and needs. The semantics are subtle, but the differences in life choices and outcomes are dramatic.

Contrasts in Professional Logics Related to Risk: Right to Risk vs. Balancing Risk and Safety

Similar to the focus groups with ILC directors and the opinions from AAA directors, the right to risk and giving up control is complex. This is particularly challenging for Options Counselors in aging organizations as stated below.

Anybody think big can of worms here? I mean, I'm scared by it, quite frankly, because they might— I mean, certainly, they have every right, if they live in the United States, to make their own decisions. But sometimes the choices are so vast, or even so narrow that they either feel pressured to make the right decision, if it's just a few choices, or they feel overwhelmed because there are so many different choices to make. So I get a little nervous. – AAA Options Counselor

Yeah, I think it definitely leads to curiosities about a person's follow-through. When you put it in their hands, just where will they take it? And you worry. – AAA Options Counselor

It's like your own loss of control. – AAA Options Counselor

So then when they make a decision to fail, they know they're going to fail. But that's okay, because we've done our job. It's an informed failure. – AAA Options Counselor

I think also the kind of informed choice is the hardest part, actually, of consumer-led decisions, because my experience with people who are developmentally disabled, quite often they don't even understand what their choices are. – AAA Options Counselor

This dialogue among the Options Counselors from the AAAs brings to light the issue of losing control and concerns that the person they are working with will make a choice that puts them at risk, but more striking, that the Options Counselor has failed. Some of the ILC workers attempt to bring comfort or clarity on the right to risk to the Options Counselors in aging organizations. It is clear that there are two very different opinions between the workers who are in different organizational settings. As noted:

I think for me it means that whatever label there is, whether it's— [loudspeaker announcement] that it doesn't take away your right to be able to make your own

choices. And whether that's a label of a mental illness, or whatever it's a label of you're 90, and so everyone thinks they know better, what's best for you because everyone's worried about your safety. – ILC Options Counselor

Consumers have the right to go into the community, just like everyone else with or without a disability; they have the right to succeed and they have the right to fail. – ILC Options Counselor

AAA workers are very concerned about safety and, through their organizational indoctrination, believe this is paramount when working with older adults and people with disabilities. There are concerns about legal responsibility in supporting consumers who they believe are choosing an “unsafe” alternative.

There's a question of the person's ability to make good decisions. It's when somebody's got that early sign of Alzheimer's, or a severe brain injury where really they can't go home, but because of their cognitive problem cannot make a safe choice. And that's where it gets really difficult. – AAA Options Counselor

One Options Counselor in an aging agency articulated the struggle she has with the decisions a consumer is making and how she still feels that her role is critical in the decision-making process and that it is not solely that of the consumers.

This is what they want to do ... it's not what you want for them....And I struggle, still, sometimes, am I doing the right thing? Am I giving them the right resources? Can this person really make it out there? And I know that are they're allowed. I know all of that! I know all of that, but still, I still, inside myself, struggle with, am I making the right decision. – AAA Options Counselor

Another AAA worker provides an example from her work experience to illustrate this point and an ILC worker validates that she has done the right thing in the spirit of

upholding consumer control. The AAA worker states that this becomes even more challenging because organizational philosophies differ across agencies and how to choose the correct course of action can be complicated and varied in the absence a clear, unified service philosophy to guide their work. The example given is provided below:

AAA Options Counselor: *I was called into an individual who was a young, I think he was 62, and he's a Vietnam vet. And he had been in the nursing facility for 15 years because he was homeless. He lost his wife, things fell apart and he went to a homeless shelter. At that time, they just wanted to get him housing so they put him into a nursing facility because he did have some medical need. He was there for 15 years. Didn't want to be there, but nobody stepped up and said, Hey, there's other places to go, there's other options for you. I mean, I was green to the options counseling as I could be when he started our program in September. I went out there, I met with him. We got him into congregate housing because all he wanted to do was cook. He used to be a chef in the military. And he was there for three months and he passed away, because the new doctor he had been set up with stopped his pain medication he'd been on for pain for years. Stopped it and, I don't know, something funny happened. But at least he got the right to be on his own and that ability to cook. That's what he wanted. That was his choice. He got that choice. But at the same time, then you go back and you look and you're like, hmm, would he still be here today if he was in the nursing facility, if he didn't go into the community?*

ILC Options Counselor: *He had quality of life.*

AAA Options Counselor: *I think it's an interesting point, that sort of if a plan is sort of supported and/or presented by an Options Counselor, and let's say that it may be the consumer's choice, but it may not be what we would think as being the best choice if we were going to take that paternalistic look at things. I think all of us have agency differences in terms of how our agency views that. Does this in*

turn cause our agency to be supporting an unsafe plan? And I think at individual agencies, that varies. I've worked in state home care in a timeframe when it was like, "We are not supporting this, we are not providing any services," kind of like the AMA thing, "because that would be unsafe." And where I work now, they're much more realistic in terms, "Okay, let's see what we can do. Let's try and bring certain pieces." But I think that 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. And so, I think that that's an interesting piece that maybe we need to think about in terms of what our role is and how does that affect us.

This last quote from the Options Counselor at the aging organization clearly states that organizational philosophies vary across agencies, supervisors, and director, and that issues of safety and responsibility are very complex and unsettling for the worker as they confront these life and death issues. Additionally, it can become even more complicated in a situation where there is a guardian. The issue of balancing safety with family members and guardians is challenging as the Options Counselor must decipher who their client is and from whom they should be getting direction from.

But I guess what I was getting at, too, I feel like it sort of muddies the role for me a little bit, because— and I've had this a little bit more with some of my pure options counseling. But in terms of when you have somebody with an activated healthcare proxy or a guardian, still including that consumer in the care process, the decision-making process, yet the final decision is not theirs. So I think that's where some— I've had a little bit of these issues come into play. And again, these seem to be residents of nursing homes. I think it's very easy to activate a healthcare proxy and guardianship when people are in nursing homes. And I have had several activated healthcare proxy clients as well, where there's different agendas. Daughter loves mom, loves her very, very much and is scared for mom to be out in the community, is the healthcare proxy and decision maker. But mom

wants to be out. It's a hard role. And try and figure out, making sure you're identifying your client. Giving decision support to someone who's not making the decision. You really have to do it two-fold; you have to work with both. – AAA

Options Counselor

Once again, an ILC Options Counselor tries to help the AAA Options Counselor with this struggle between safety and risk by providing the following example.

I think sometimes with family members, too— once there was a man who had MS and he was in short-term rehab. The short-term rehab actually thought that he could go home, but his wife did not. And that was a really difficult situation, because in the short-term rehab, he was physically not doing well. They weren't allowing him to walk because he was a fall risk. So they had him in a wheelchair with an alarm that would go off every time that he stood up, which he did numerous times just to show me that it worked. [Laughter] Then he was a behavioral problem. And then he was saying, "I don't want to live anymore." And so then the psych eval comes in. Then it gets into this huge mess and his wife was saying that he's incompetent. She's divorcing him so that she can get him on MassHealth for long-term care. And it just went on and on. And then consumer control, I talked to him, and he did end up leaving and he came to the IL Center. And it was such a difficult situation though, too, because we do face that. I saw the survey afterwards, too, and I knew which one it was, because the wife said, "She listened to him, she didn't listen to me." And I said, good! Yay! I was happy to get a bad survey that day. – ILC Options Counselor

Personal bias can also get in the way of putting consumers first and allowing them to make their own decisions.

I find it difficult not to be biased in a particular situation like we're talking about. For instance, I have a woman who really, really wants to go back home. I personally don't feel it would be safe for her. I think she'd be isolated. Her

mobility is really poor. She has money to maintain herself at home for a limited amount of time. She would run out of money. But she's adamant about going home. So we're trying to set up services for her to go home. But I feel as though I'm not– I'm really urging her in the direction of staying where she is and not really giving her as many options as she could to go home. And I'm not highlighting those, I'm highlighting more staying in place where she is. And it's difficult. It's the balancing act that I have a hard time dealing with in terms of truly respecting her wishes and saying, Okay, we can get you home and this is how we're going to do it. And it's difficult to balance that and pull back with my own biases and my own desires to see her safe. – AAA Options Counselor

Below an ILC worker explains how personal bias cannot enter the equation when working at an ILC. From the very first day on the job these workers are indoctrinated into a very clear professional ethic about the dignity of risk and the right to fail, as described below.

I think from an independent living center perspective, these are the fundamental basics that are drove into our heads from day one. The individuals that we start working with from day one, no matter who they are, have the ability to go out into the community and, just like anybody with or without a disability, they have the right to succeed and they have the right to fail. Nobody wants to see anybody else fail, but I think if you look at it from a perspective of, if I were in that individual's shoes and I wanted to go out into the community– a perfect example is an older gentleman, before the options counseling program was fully instituted in our center, there was an older gentleman, wanted to get out of the nursing home, and for years was in this institution. And he wanted to have that consumer control. Now he got out into the community and he passed away six months later. But right before he passed away, his last words were, "I am so happy to be able to have this experience." So it's not always about what the best situation is for somebody. It's giving them the options, just like anybody else with or without a disability or

mental health, or whatever's going on. I think always keeping in mind that quality of life is sometimes better than quantity. And that person you've been talking about got to go home. He got to have his own place. And that, it doesn't matter if he lasted two days, or six months, or five years. He was happy. – ILC Options Counselor

Throughout this section, there were clear differences between ILC and AAA Options Counselors in issues surrounding the right to fail and the dignity of risk. AAA Options Counselors had safety as a paramount concern when supporting consumers in their wishes. For example, they [or one] struggled with how dying at home could be considered a good outcome when there could have been additional interventions; albeit, these interventions might have included institutional care. ILC Options Counselors spent a good deal of their time during these exchanges encouraging and consoling AAA Options Counselors in the choices that consumers made and the difficult outcomes that sometimes occurred as a result. They often would stress that “quality of life” supersedes “quantity of life” and that this needs to be a central focus of the work of Options Counselors.

Contrasts in Professional Logics Related to Organizational Orientations:

Independent Living Model vs. Care Management Model

One most striking differences in professional logics between the aging organizations and independent living centers emerged when the Options Counselors were discussing the basic orientations of both organizations. I have labeled these contrasting themes as the independent living model and the care management model and these appeared to supersede or encompass all of the other logics identified. It is noteworthy

that these logics did not appear in the results with the directors. This may have to do with the organizational training and previous work experience of this group, as many of the Options Counselors are new to their jobs and some of the workers that are located in the aging organizations may have been a Care Manager in their previous job so they may 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

It goes back to that same old question that you were talking about, the differences between agencies, difference between experience, supervisors. Being able to share and understand that there are some people that are alone out there working at an agency without a lot of support, and then there are people like you that have wonderful supervisors. – AAA Options Counselor

While there seems to be some variation of professional logics among aging organizations, the logics of Independent Living Centers from the independent living movement are clear and uniform across all these agencies, as stated below.

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 that 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, that autonomy. I'm going to be

doing this. This is how I'm going to go. I'm going to steer my own ship here. These are the tenets of independent living. And this is how we go about doing this. –

ILC Options Counselor

What also becomes challenging is that often an Options Counselor holds more than one role at the agency. For example, it wasn't uncommon to hear that an Options Counselor at an aging organization was also holding a Care Management position. These two positions are very different and the ability to switch back and forth is not done easily as articulated below.

... to make the paradigm shift from being a case manager to an option counselor; shifting where you get your direction from. – AAA Options Counselor

So in practice, for a case manager, I think this is going to be really hard to work out. But for an Options Counselor, this whole program is about the consumer making the goals very clear to us, and then we help them get there. We give them information they need to get there. But I like being an Options Counselor much better than case management, because I don't have to— at the end of the road, 'Here's your information, god bless you, here you go.' But in terms of seeing it into practice, I think this whole consumer direction that we're going on, while it might be beautiful in the perfect world, it's not going to be necessarily easy to administer. Or it's going to be beyond hard to administer, I think. – AAA

Options Counselor

I would imagine, especially for people that are care managers and care advisors prior to consumer direction being in home care, I mean the whole paradigm shift, that we've worked with consumer direction all along, but it's just something that gets reinforced about how you look at that. And if you're doing joint roles, like [name] does joint roles in our agency, he's doing for lots of people and then he's

got to sort of step back and let them direct. And so, it's keeping that in check. –

AAA Options Counselor

It is evident that the Options Counselors in the aging organizations are still struggling with the true implementation of consumer control. In some respects, the professional logic of the care management model is similar to the professional logics in the medical field. In the discussion below the Options Counselor from the AAA is still talking about making decisions *for* the consumers, not that the consumer is driving the process and making his/her own decisions.

I sometimes struggle with me, am I making the right decision for this person. Well, I struggle with making the decision as opposed to asking because I'm saying, Well, I really don't want to be responsible for this, or something happens to them, I was struggling with that. Then I'm going to feel bad because that person came out of the nursing home, or wherever he was, and died, like you said. I would feel terrible! So I'm really thinking, is this the right thing to do? Am I doing the right thing? And then I have to retrain myself and say, This is what they want to do, it's not what you want for them. So I find myself having to talk back to myself and say – but to just say, this is what the consumer wants to do. It's not your choice. This is what they want to do for them. And I struggle, still, sometimes, am I doing the right thing? Am I giving them the right resources? Can this person really make it out there? And I know that they're allowed to. I know all of that! I know all of that, but still I still, inside myself, struggle with, Am I making the right decision? Am I giving them the right information? Is it okay for them to come out of that nursing home? Will they be able to find an apartment after I give them this information? – AAA Options Counselor

As the focus group was winding down and people were feeling freer to communicate openly there was a fascinating dialogue between an Options Counselor at

an ILC and AAA. The discussion had reached a point where there was an acknowledgement of the different organizational philosophies and the struggle to walk between these two worlds. These Options Counselors stated that if there was a greater understanding of the differences and more collaboration among them then it might be possible to impact a change across the organizations to make the work of Options Counselors more clear and unified.

I just have a comment. I think consumer choice and direction comes from the IL world. That's really the foundation. And I guess maybe some acknowledgement of how maybe if there's a conflict within the ASAPs when you kind of try to promote that. I know we talked about some agencies are better than others. Just some discussion on that point. Maybe working in the medical model, just kind of acknowledging maybe the different thought process, I don't know. If you go into a nursing home and you're working with people there and you're doing options counseling, you're dealing with the medical model. Within your agency, that agency may be a medical model, more of a controlling type of philosophy. And kind of acknowledging that, coming from an Options Counselor, how do you counteract that to do your job so that it's consumer choice and direction. – ILC Options Counselor

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 homecare system, which is the case management model, which is very different from the traditional case management model. You are using contracted providers by that homecare agency. I mean, there is much more of that paternalistic sort of view. So I think though within that, I really have seen a lot of shift and a lot of change in the ASAP [aging] system. And I think

there can– but there still is a role for both. And I think that that's important to acknowledge, too. – AAA Options Counselor

The same Options Counselor from the AAA further explains how she believes there could be a role for both organizational philosophies and professional logics.

I feel like there's definitely a role for both. And I do wish there was even a little bit more– on some level, I wish we were closer to being on even par, where we each offered both in an equal way. You know what I'm saying? Because for example, I referred a person to an ILC a couple of times. And that person has never followed up, never followed through. And I talk with them, and when I talk with them, they're still in the chaos, they're still in the mess, and they're still saying they want the help. Refer them back again, they still don't follow through. So I've had a conversation with the ILC. And then only to find out, too, that they had been referred by other professionals as well. So if we know that this person has been referred four or five times now, and they're not following through, is there another system? I mean, can there be– is there a case management model that might be helpful if she's saying she wants the help. I don't know. And the same token, I wish we had more consumer direction available for the elders. You know what I mean? 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

Many of the 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 towards 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 if you only have– because when I started,

I was only elder. I didn't really know anything until meeting up with [an ILC Options Counselor] and prior to her, the counselor, to figure out what they provide for services, and then to learn it enough that I could talk it. So like you, don't give the fluff. I can actually tell them what the programs are. – AAA

Options Counselor

Well, isn't that also a differentiation between the ILCs and the ASAPs? Because we have a database system that we're putting the goals in, but I don't know what the ILCs have. So that may be the differentiation there. But there's not continuity between both groups that are doing the same work. – AAA Options Counselor

And so, I just think it would be nice if we were all up to speed on sort of the— if we had some nice, general information for the whole entire population serve, and then work to making sure that we have good relationships to talk to each other when we need to kind of go a little bit more back-and-forth to each other. You know what I mean? But like having sort of a good base for everything, everyone that we're supposed to serve, but then still also make sure we're really coordinating together, like between ILCs and ASAPs. – AAA Options Counselor

While it was important to acknowledge that the focus of the work was constantly shifting, in part because Options Counselors received directions from multiple and conflicting sources, it was also clear that these Options Counselors 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

The Options Counselors, similar to the ILC directors, are also aware that the funding is not equal among the agencies, which contributes to feelings of an unbalanced partnership. This sentiment – of being outnumbered by the aging staff – resonated throughout the focus groups by both ILC workers and directors. It is therefore not surprising that this has an impact on the organizational culture and the perceived power within the system in which they are working, which explains in part [or perhaps] why many of the ILC staff are vocal about their history and their guiding philosophy, as articulated in an exchange below.

ILC Options Counselor: *Well, the ASAPs, you have a lot more to offer than we have. We just ...*

AAA Options Counselor: *We have a different funding system.*

ILC Options Counselor: *We do not have nearly a fraction of what you do.*

AAA Options Counselor: *No, I understand that, you're right.*

ILC Options Counselor: *We don't have case managers. We have a few peer counselors. And I have a PCA program. And that's about it, that's all I can offer. And information referral. So it is, it's hard.*

AAA Options Counselor: *Them or us.*

ILC Options Counselor: *Three ASAPs to one ILC or something.*

Unfortunately, this power dynamic may be difficult to change due to the variation in funding and the fact that there are more aging providers in the community than independent living groups. This means that mechanisms to rebalance the power will need

to start internally within the different organizations, such as having more joint meetings to discuss common issues and gain consensus or find ways to collaborate by seeking out additional funding. The initiatives to bring aging and disability organizations together to streamline care and create a “no wrong door” approach to accessing services is being articulated through new national efforts, in particular in the creation of the U. S. Administration for Community Living. The issues articulated by these Options Counselors are not just a local issue; they are occurring at the top level of policymaking with the goal that there will be widespread systems change in the near future.

Summary

Similar to the findings from AAA and ILC directors, the analysis conducted from the focus groups with Options Counselors revealed very different guiding professional logics of services in the two types of organizations. What was different in these findings became apparent in the discussion of varying organizational orientations, in particular the independent living paradigm as compared to care management. Inherent in these professional logics are the core differences in language and practice related to consumer control and consumer direction, but most important in this is who is controlling decisions, care, and, ultimately, the life of consumers. Control over life choice is at the crux of the independent living model with absolutely no qualification permitted in this statement, whereas the care management model might be thought of as similar to the medical model in health care in which the medical provider has control over the care provided to consumers (DeJong, 1979; Simon-Rusinowitz & Hofland, 1993; Kane, 2007). The challenge lies in how these hybrid organizations can come to common ground on these

institutional logics and what mechanisms can help to orient Options Counselors to these new logics. The next chapter on the training program will reveal one particular mechanism that might prove useful in this challenge (or opportunity) to bring these groups together.

CHAPTER 7: RESULTS OF THE OPTIONS COUNSELOR TRAINING PROGRAM

This chapter describes the findings from the Options Counselor training program. The objective of this chapter is to assess whether there are differences in the depth of knowledge in the professional logics of consumer control, choice, and direction depending on whether a worker is located in an ILC or AAA. Results will be presented from pre- and post-course competency assessments to see if the training program had an impact on Options Counselors' competencies. This analysis will be used to examine whether the training program had an impact on the overarching logic for Options Counselors, and whether the training in a new logic, specifically consumer control and direction, will alter Options Counselors' perceptions and engagement with the logic and their level of readiness to adopt the new logic.

Course Development Process

From April of 2011 through October of 2012, I worked with the Massachusetts Options Counseling Training Advisory Group representing those in the aging and disability communities to develop a course that was intended to meet the goals of the project in the most balanced and effective way possible. Members of the Advisory Group included Options Counselors from the ADRCs, leadership and program staff from EOEA, Massachusetts Rehabilitation Commission (MRC), and the Department of Mental Health (DMH), as well as other experts and consumers from the aging and disability networks. These individuals provided a wide range of viewpoints necessary for an inclusive and diverse curriculum. For the project, it was critical to widen the scope of

curriculum design and review so that content would not align disproportionately with either older adults or persons with disabilities, yet would also be consistent with ADRC principles and options counseling standards. This course was an important step towards the effort of creating a unified institutional logic for these hybrid organizations.

The process for developing this course, which included hosting focus groups with Options Counselors and directors from the aging and disability networks (described in earlier chapters), as well as multiple reviews from the Advisory Group, was designed to ensure that the learning objectives and the curriculum content met the high standards of the participating stakeholders. Integral to the development of curriculum was the involvement of the Advisory Group at critical junctures throughout the project. Having assisted in the development of the curriculum outline and competencies, the Advisory Group reviewed beta versions of the course and provided detailed feedback to ensure that the finished product accurately reflected the outline, and thus met the learning goals of the intended audience. Each individual section draft went through several stages of review, culminating in a thoroughly vetted preliminary draft that formed the basis for the course.

It is relevant to note that this project helped to build bridges between members on the Advisory Group who come from different organizations, specifically ILCs and AAAs, to work together toward a common goal. This journey was an integral part of the process as it provided a structure that required working together to find common language and understanding around differing logics in order to guide organizational members. As a result of this successful collaboration, the Advisory Group gave

unanimous support to the creation and delivery of the online training course. In the process of creating the course, I utilized many strategies to bring diverging groups together and ultimately to bring conflicting service philosophies or institutional logics closer into alignment. One of the most important decisions was to include representation from groups who held decision-making authority from both ILCs and AAAs from the beginning to the end of the process.

The consumer control, choice, and direction course was designed to help Options Counselors more fully understand the definition and meaning of consumer control, consumer choice, and consumer direction and the practice of this approach and philosophy within the context of options counseling. This course reviewed historical developments of consumer control, legal mandates, and provided case examples to show what consumer control, choice, and direction means in practice, and specifically in the context of options counseling. The content in this course are an accurate reflection of the themes that emerged from the focus groups.

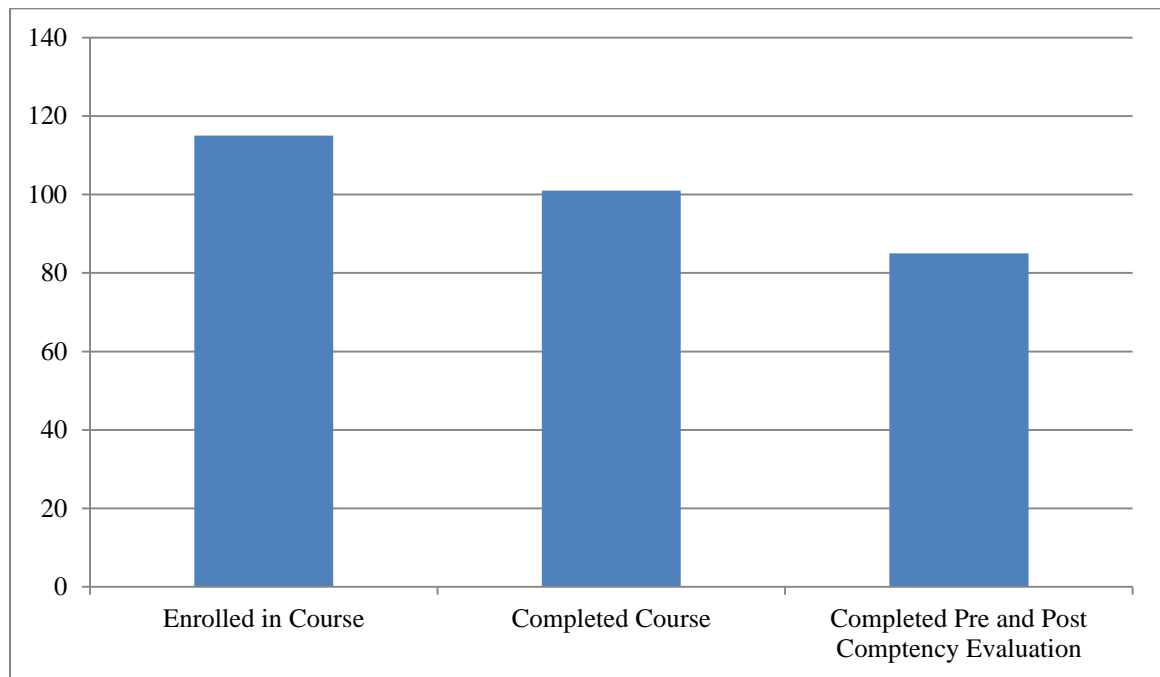
The remainder of this chapter provides information about whether the online course developed helped Massachusetts Options Counselors gain a better understanding of the varying language, terminology, and guiding organizational orientations (or logics) that impact the daily work of this workforce.

Participant Demographics and Completion Rate

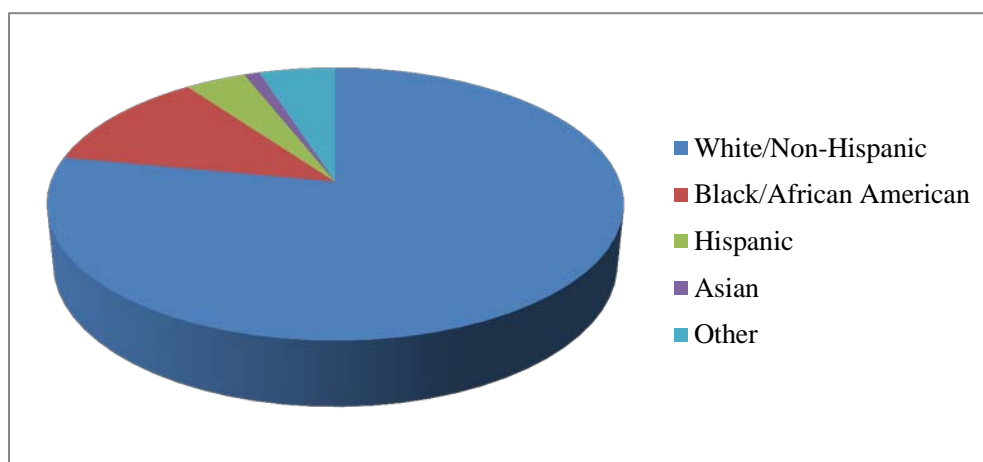
Demographic information was collected on participants and course completion rates were calculated. There were 115 participants who enrolled in the online course; 16 people withdrew from the course due to job changes and personal issues. Of the 115

enrolled participants, 101 (88%) completed the course, and 85 of the 115 (74%) who completed the course answered both pre and post competency assessments (see Chart 5).

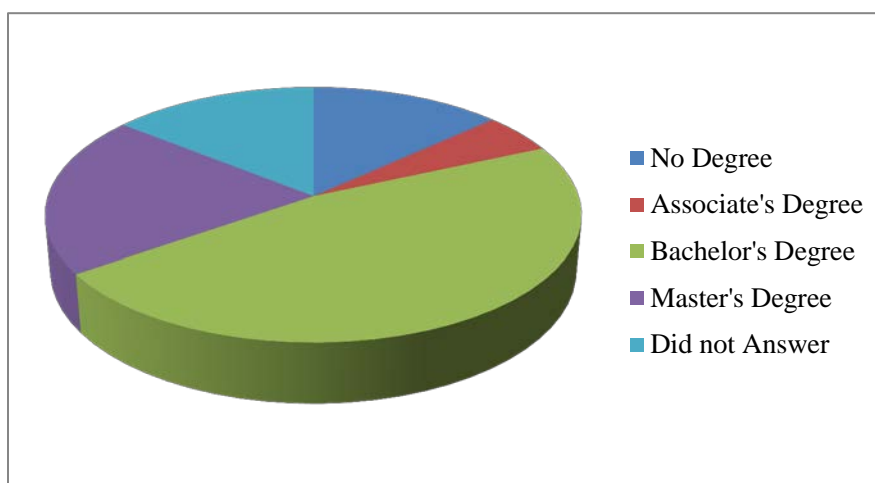
Chart 5. Online Course Completion Rates for Options Counselors



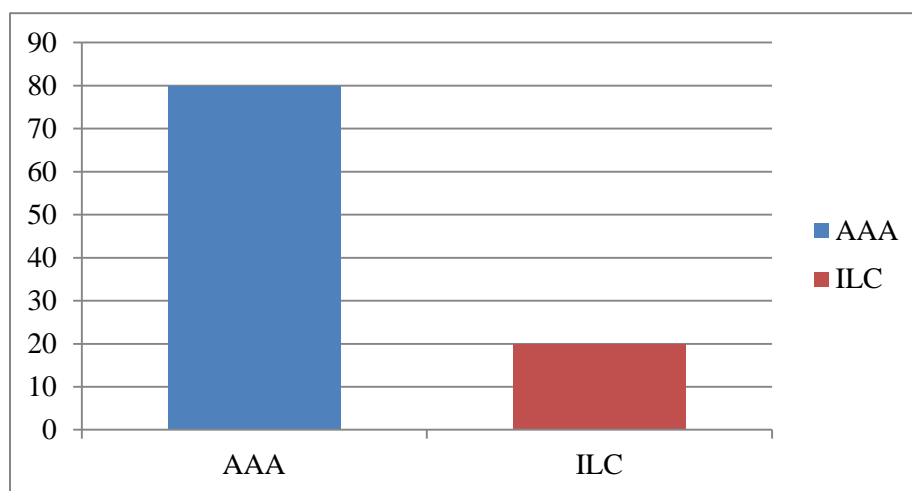
Of the enrolled participants: 78% self-identified as White/Non-Hispanic; 12% identified as Black/African American; 4% identified as other; 4% identified as Hispanic/Latino; 1% identified as Asian; and 1% did not respond (see Chart 6 below). Most of enrolled participants (96%) identified as female, and the average reported age was 43 years old.

Chart 6. Race/Ethnicity

As shown in Chart 7 below, education levels varied with 46% having a Bachelor's Degree; 20% holding a Masters; 13% having no degree; 5% having an Associate's; and 2% having a Ph.D.; and 14% not answering the question. There was no difference in educational level as analyzed by chi-square based on agency setting. While there is no significant difference, it is interesting to note that out of the 13 participants holding a degree in social work, only two were located at an Independent Living Center and they both held BSWs, while the remaining were MSWs and worked at aging organizations. This finding seems to support some of the strong feelings about anti-professionalization and certification that were brought up in the focus groups with ILC directors.

Chart 7. Education Level

For agency settings, 80% of enrolled participants worked for in an aging organization, which could be either an Area Agencies on Aging (AAA), an Adult Day Care, or a private care management company (see Chart 8 below). Twenty percent (20%) worked for Independent Living Centers (ILC). This difference in the number of Options Counselors from the two distinct organizations justifies the sentiment of feeling “outnumbered” that Options Counselors and directors from ILCs continued to stress throughout the focus groups. This belief contributes to why workers from ILCs want to be sure that their organizational philosophy of consumer control is not lost in the more dominant service philosophy presented in the aging organizations.

Chart 8. Agency Setting

Pre- and Post-Course Competencies

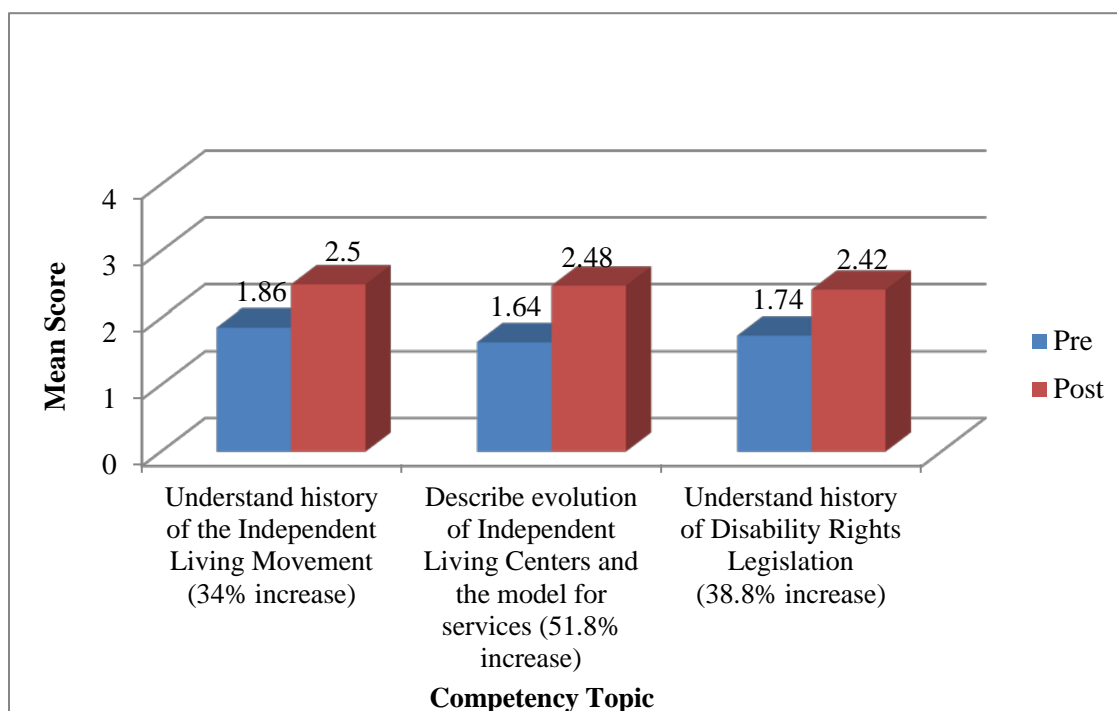
Pre- and post-course competency assessments were measured before and after the training to gauge whether participating Options Counselors increased their understanding of the logic of consumer control covered in the course. Participants rated their competency in these areas using a scale ranging from 0 = no skill at all to 4 = expert skill. Further, at the end of the course, participants were asked to complete a quantitative and qualitative evaluation of the course, which included asking them questions about whether they felt the training benefited them and whether it had an impact on their practice. Participants rated their satisfaction level on these questions using a five-point scale of strongly disagree; disagree; neutral; agree; or strongly agree.

The course had 19 competencies, created by the Advisory Group, which focused on content areas related to the domains of knowledge, skills, and values of consumer control; a common framework for understanding competency in adult learning theory (Kirkpatrick, 1998). For the participants who completed both the pre- and post-course

competency assessments, there was a significant increase in self-reported levels for all competency items when comparing pre- and post-test scores (paired samples t-test, $p < .000$). The average increase in competencies was 17.7%, with increases in individual competencies ranging from 6.4% to as high as 51.8%. The increase in all competencies for this course suggests that Options Counselors increased their knowledge of concepts, terminology, and competence in the professional logic of consumer control and direction.

Knowledge Domain in Consumer Control, Choice, and Direction

This domain consisted of eight statements regarding participant knowledge in areas such as history of the Independent Living Movement and Disability Rights Legislation, as well as important terms, such as the definitions of consumer control and consumer choice. The scale ranged from 0 = no skill at all to 4 = expert skill. At pre-test, the mean overall score in this domain was 2.28; at post-test, the mean overall score for this domain was 2.78, an average increase of 23.9%. Chart 9 shows the three largest item increases from pre-test to post-test within the knowledge domain to illustrate the areas where the most change occurred.

Chart 9. Three Highest Increases in Knowledge Competencies

A paired t-test was used in this analysis to examine differences between matched pre and post scores for each competency item to explore whether there were significant changes in the scores after the training occurred; all changes were statistically significant ($p < .000$). To further explore these competency gains, an independent samples t-test was conducted for each item based on assessments taken before the course and then again on assessments taken after course completion. The grouping variable was agency setting; that is, whether the worker was located in an ILC or an AAA. The goal of this analysis was to see if workers in different groups had the same level of understanding of competencies related to consumer control and direction before the training began, and to compare their understanding of competencies after taking the online course. This analysis provided insight into whether a training program can impact institutional logics. In

particular, this analysis examined whether a training course in the logic of consumer control and direction provided participants a deeper understanding of the main concepts in consumer control and explored whether this understanding is related to agency setting (ILC compared to AAA). Table 5 below shows the means table from the t-test for each group at pre and post assessment for the knowledge domain.

Table 5: Means Table for Knowledge Domain

Group Statistics for Knowledge Domain					
	Agency Setting	N	Mean	Std. Deviation	Std. Error Mean
Pre: Understand the History of the Independent Living Movement	AAA	68	1.57	.676	.082
	ILC	17	3.00	.707	.171
Post: Understand the History of the Independent Living Movement	AAA	67	2.31	.583	.071
	ILC	17	3.24	.664	.161
Pre: Describe the evolution of Independent Living Centers and the model for services	AAA	68	1.37	.771	.093
	ILC	17	2.71	.849	.206
Post: Describe the evolution of Independent Living Centers and the model for services	AAA	68	2.31	.652	.079
	ILC	17	3.18	.636	.154
Pre: Define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services	AAA	68	2.29	.774	.094
	ILC	17	3.12	.600	.146
Post: Define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services	AAA	68	2.76	.626	.076
	ILC	17	3.06	.748	.181

Pre: Explain the right of choice and risk to consumers	AAA	68	2.46	.700	.085
	ILC	17	3.00	.612	.149
Post: Explain the right of choice and risk to consumers	AAA	67	2.91	.690	.084
	ILC	17	3.18	.529	.128
Pre: Understand the core roles and functions of an options counselor	AAA	68	2.78	.770	.093
	ILC	17	3.00	.791	.192
Post: Understand the core roles and functions of an options counselor	AAA	68	3.15	.718	.087
	ILC	17	3.00	.791	.192
Pre: Understand the difference between a case manager and an Options Counselor	AAA	68	3.00	.733	.089
	ILC	17	2.94	.748	.181
Post: Understand the difference between a case manager and an Options Counselor	AAA	68	3.21	.682	.083
	ILC	16	3.06	.772	.193
Pre: Understand the history of Disability Rights Legislation	AAA	68	1.53	.762	.092
	ILC	17	2.59	.939	.228
Post: Understand the history of Disability Rights Legislation	AAA	67	2.27	.592	.072
	ILC	17	3.00	.866	.210
Pre: Identify legal and ethical considerations that are involved when working with consumers and families	AAA	68	2.10	.883	.107
	ILC	17	2.59	1.064	.258
Post: Identify legal and ethical considerations that are involved when working with consumers and families	AAA	68	2.68	.657	.080
	ILC	16	2.94	.680	.170

Based on the independent samples t-test, statistically significant differences between the groups were found for the three highest competencies listed in Chart 9 above before the online course was taken, with workers from the ILC group demonstrating

stronger competency scores ($p < .000$). This suggests, not surprisingly, that workers in ILCs had a greater level of understanding of these important competencies related to consumer control and direction before taking the online course. When comparing the means across the two groups, it is apparent that competency scores increased for Options Counselors in AAAs for these items, but there were still significant agency differences evident through an independent samples t-test between the levels of understanding in these concepts and overarching guiding principles related to consumer control and direction, with ILC workers still scoring significantly higher (see Table 6 below).

Table 6. Independent Samples T-Test for the Three Highest Knowledge Competencies

Knowledge Items		Levene's Test for Equality of Variances	Sig.	t-test for Equality of Means	df	Sig. (2-tailed)
		F		t		
<i>Pre:</i> Understand the history of the Independent Living Movement	Equal variances assumed	1.592	.211	-7.711	83	.000
	Equal variances not assumed			-7.504	23.854	.000
<i>Post:</i> Understand the history of the Independent Living Movement	Equal variances assumed	.215	.644	-5.662	82	.000
	Equal variances not assumed			-5.234	22.652	.000
<i>Pre:</i> Describe the evolution of Independent Living Centers and the model for services	Equal variances assumed	.064	.801	-6.275	83	.000
	Equal variances not assumed			-5.919	23.042	.000
<i>Post:</i> Describe the evolution of Independent Living Centers and the model for services	Equal variances assumed	.621	.433	-4.928	83	.000
	Equal variances not assumed			-5.005	25.111	.000
<i>Pre:</i> Understand the history of Disability Rights Legislation	Equal variances assumed	1.622	.206	-4.884	83	.000
	Equal variances not assumed			-4.306	21.564	.000
<i>Post:</i> Understand the history of Disability Rights Legislation	Equal variances assumed	.834	.364	-4.112	82	.000
	Equal variances not assumed			-3.292	19.957	.004

As shown in Table 7 below, two additional items in the knowledge domain – (1) *define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services*, and (2) *explain the right of choice and risk to consumers* – showed statistically significant differences between groups on these items from the pre-course assessment as measured by a t-test ($p < .000$; $p = .004$). These differences were no longer statistically significant when comparing these competencies between the groups after training; these findings suggest the intervention of the training may have had an impact on how well the AAA organization workers understood these competencies related to the logic of consumer control and direction (see Table 7). Similarly, the focus groups analysis revealed themes that closely matched these two competencies, which were categorized earlier on in this dissertation as language and right to risk. In the focus groups, the AAA workforce was struggling to understand the definitions of consumer control and direction and how to balance risk and it is relevant to note that through this training the differences between ILC and AAA Options Counselors began to dissipate. More importantly, these items are directly linked to the logic of consumer control and direction and suggest that training can have an impact on institutional logics.

Table 7. Independent Samples T-Test on Language and Right to Risk

Knowledge Item		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
<i>Pre:</i> Define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services	Equal variances assumed	2.211	.141	-4.085	83	.000
	Equal variances not assumed			-4.755	30.788	.000
<i>Post:</i> Define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services	Equal variances assumed	.458	.501	-1.666	83	.099
	Equal variances not assumed			-1.496	21.936	.149
<i>Pre:</i> Explain the right of choice and risk to consumers	Equal variances assumed	6.631	.012	-2.932	83	.004
	Equal variances not assumed			-3.180	27.475	.004
<i>Post:</i> Explain the right of choice and risk to consumers	Equal variances assumed	.705	.404	-1.480	82	.143
	Equal variances not assumed			-1.733	31.423	.093

The remaining items in the knowledge domain did not show significant differences between groups at pre- and post- assessment based on the t-tests (see Table 8 below). These items are primarily related to job functions and responsibilities and are less related to institutional logics that guide the work of an Options Counselor; therefore, the fact that these items are not significantly different between groups is not as relevant to the development and implementation of the logic of consumer control and direction.

Table 8. Independent Samples T- Test for Non-Significant Knowledge Items

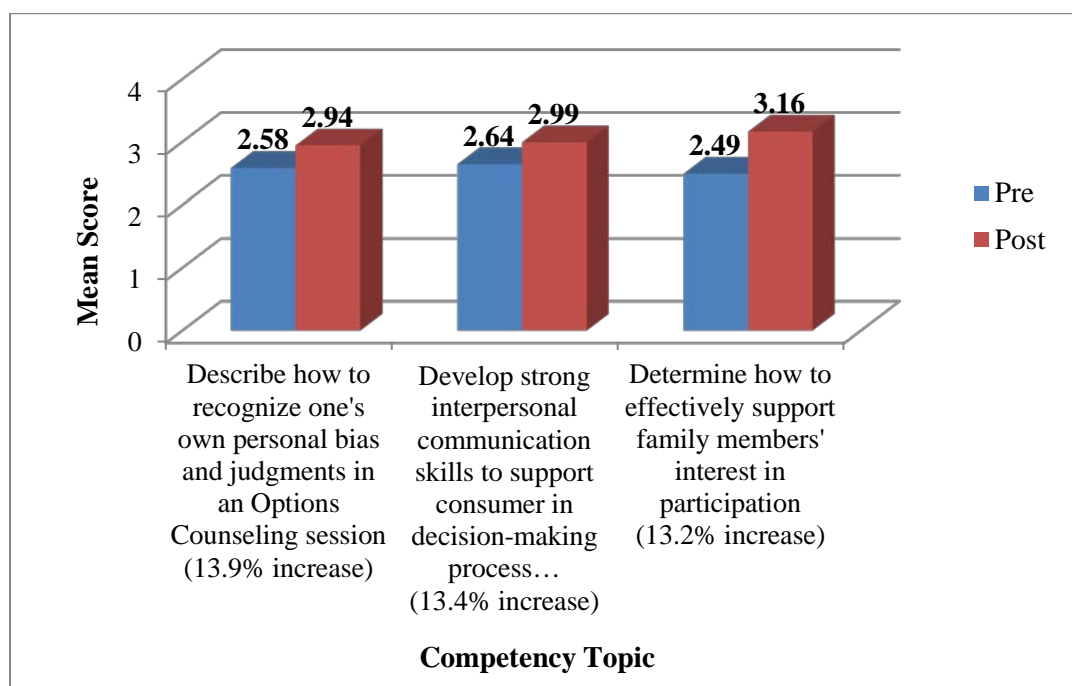
Knowledge Item		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
<i>Pre:</i> Understand the core roles and functions of an options counselor	Equal variances assumed	1.175	.281	-1.051	83	.296
	Equal variances not assumed			-1.034	24.157	.311
<i>Post:</i> Understand the core roles and functions of an options counselor	Equal variances assumed	.705	.404	.740	83	.461
	Equal variances not assumed			.698	23.043	.492
<i>Pre:</i> Understand the difference between a case manager and an Options Counselor	Equal variances assumed	.116	.734	.295	83	.769
	Equal variances not assumed			.291	24.282	.773
<i>Post:</i> Understand the difference between a case manager and an Options Counselor	Equal variances assumed	.590	.445	.738	82	.462
	Equal variances not assumed			.683	20.850	.502

Pre: Identify legal and ethical considerations that are involved when working with consumers and families	Equal variances assumed	.892	.348	-1.943	83	.055
	Equal variances not assumed			-1.737	21.833	.097
Post: Identify legal and ethical considerations that are involved when working with consumers and families	Equal variances assumed	3.826	.054	-1.421	82	.159
	Equal variances not assumed			-1.390	22.063	.178

Development of Skills Domain in Consumer Control, Choice, and Direction

The skills domain consisted of six statements regarding skills development related to options counseling and consumer control, choice, and decision making. The scale ranged from 0 = no skill at all to 4 = expert skill. At pre-test, the mean overall score in this domain was 2.65, and at post-test, the mean overall score was 2.96, an average increase of 13.2% from pre- to post-test. All items in the skills domain showed statistically significant change ($p < .000$) as measured by paired t-tests using pre- and post-course assessments. Chart 10 below shows the three largest increases in competencies from pre-test to post-test to illustrate the areas where the most change occurred.

Chart 10. Three Highest Increases in Skills Competencies



The increase in the skill competency of *recognizing one's own personal bias and judgments in an Options Counseling session* is an important competency gain as throughout the focus groups with Options Counselors this conflict was presented in the differing themes of safety versus risk. This was particularly difficult for the Options Counselors in AAAs who struggled with injecting their own personal bias about safety when working with consumers.

While these three competency items had the highest increases in pre- to post-course assessment based on the paired t-test analysis ($p < .000$), these competencies were not significantly different by agency setting when analyzed using an independent samples t-test. The following means table shows the item scores of ILCs and AAAs at pre and post training (Table 9 below).

Table 9: Means Table for Skills Domain

Group Statistics for Skills Domain					
	Agency Setting	N	Mean	Std. Deviation	Std. Error Mean
Pre: Describe how to recognize one's own personal bias and judgments in an Options Counseling session	AAA	67	2.55	.784	.096
	ILC	17	2.71	.686	.166
Post: Describe how to recognize one's own personal bias and judgments in an Options Counseling session	AAA	68	2.94	.751	.091
	ILC	17	2.94	.827	.201
Pre: Recognize needs, values and preferences of consumers	AAA	67	2.75	.659	.081
	ILC	17	3.12	.781	.189
Post: Recognize needs, values and preferences of consumers	AAA	68	3.00	.712	.086
	ILC	17	3.18	.636	.154
Pre: Demonstrate the differences between case management and Options Counseling	AAA	68	2.75	.870	.106
	ILC	17	2.76	.752	.182
Post: Demonstrate the differences between case management and Options Counseling	AAA	68	3.13	.710	.086
	ILC	17	2.88	.928	.225
Pre: Develop strong interpersonal communication skills to support the consumer in the decision-making process, including decision making support, effective ways to ask questions while providing resources, active listening, and paraphrasing	AAA	68	2.59	.758	.092
	ILC	17	2.82	.728	.176
Post: Develop strong interpersonal communication skills to support the consumer in the decision-making process, including decision making support, effective ways to ask questions while providing resources, active listening, and paraphrasing	AAA	68	2.97	.732	.089
	ILC	17	3.06	.748	.181

Pre: Demonstrate creative ways to research services and supports as an Options Counselor	AAA	68	2.56	.608	.074
	ILC	17	2.71	.772	.187
Post: Demonstrate creative ways to research services and supports as an Options Counselor	AAA	67	2.88	.708	.086
	ILC	17	3.06	.748	.181
Pre: Determine how to effectively support family members' interest in participation and assist with problem solving and resources	AAA	68	2.46	.656	.080
	ILC	17	2.65	.786	.191
Post: Determine how to effectively support family members' interest in participation and assist with problem solving and resources	AAA	68	2.84	.704	.085
	ILC	17	2.76	.831	.202

Based on an independent samples t-test, both groups – ILCs and AAAs – did not have statistically different means between groups at either pre- or post-course assessment on all skills items except for one item related to recognizing the needs and values of consumers (see Table 10 below). These findings suggest that the groups are not much different in the skill sets related to recognizing biases, engagement, and family involvement. Many of the competencies in this domain are related to job functions and while there may be differences in how these skills are implemented based on the workers organizational affiliation and job training, the self-rated assessment of competencies related to these skills is not perceived as different between the two groups.

Table 10. Independent Samples T-Test for Non-Significant Skills Items

Skills Item		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2- tailed)
<i>Pre:</i> Describe how to recognize one's own personal bias and judgments in an Options Counseling session	Equal variances assumed	1.284	.260	-.739	82	.462
	Equal variances not assumed			-.800	27.627	.430
<i>Post:</i> Describe how to recognize one's own personal bias and judgments in an Options Counseling session	Equal variances assumed	.001	.971	0.000	83	1.000
	Equal variances not assumed			0.000	23.040	1.000
<i>Pre:</i> Demonstrate the differences between case management and Options Counseling	Equal variances assumed	1.215	.274	-.064	83	.949
	Equal variances not assumed			-.070	27.751	.945
<i>Post:</i> Demonstrate the differences between case management and Options Counseling	Equal variances assumed	2.152	.146	1.218	83	.227
	Equal variances not assumed			1.038	20.929	.311
<i>Pre:</i> Develop strong interpersonal communication skills to support the consumer in the	Equal variances assumed	2.050	.156	-1.154	83	.252

decision-making process, including decision making support, effective ways to ask questions while providing resources, active listening, & paraphrasing	Equal variances not assumed			-1.183	25.407	.248
Post: Develop strong interpersonal communication skills to support the consumer in the decision-making process, including decision making support, effective ways to ask questions while providing resources, active listening, & paraphrasing	Equal variances assumed	.247	.620	-.442	83	.659
	Equal variances not assumed			-.437	24.267	.666
Pre: Demonstrate creative ways to research services and supports as an Options Counselor	Equal variances assumed	.602	.440	-.844	83	.401
	Equal variances not assumed			-.731	21.228	.473
Post: Demonstrate creative ways to research services and supports as an Options Counselor	Equal variances assumed	.417	.520	-.917	82	.362
	Equal variances not assumed			-.887	23.803	.384
Pre: Determine how to effectively support family members' interest in participation & assist with problem solving & resources	Equal variances assumed	.561	.456	-1.032	83	.305
	Equal variances not assumed			-.926	21.908	.365
Post: Determine how to effectively support family members' interest in participation & assist with problem solving & resources	Equal variances assumed	.828	.365	.371	83	.711
	Equal variances not assumed			.336	22.084	.740

The one item where the differences between groups from pre to post training changed was in the following item: *recognize needs, values and preferences of consumers*. There were statistically significant differences between groups at pre-training as measured by an independent samples t-test ($p=.049$), but these differences were not statistically significant after training; therefore, the intervention of the training may have had an impact on this item between groups (see Table 11 below). These findings suggest that this training enhanced Options Counselors ability to recognize the needs and preferences of consumers through gaining a better understanding in the logic of consumer control, as central to this logic is recognizing and valuing what the consumer wants and allowing the consumer to set the direction of his or her life choices.

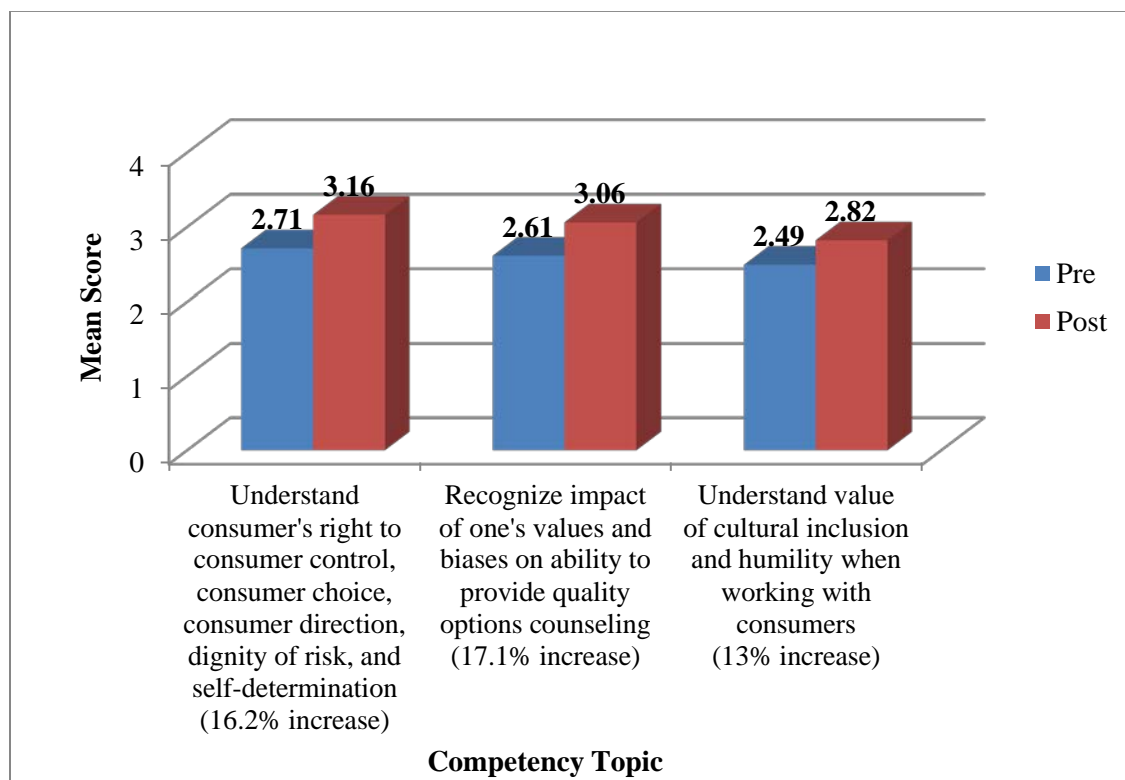
Table 11. Independent Samples T-Test on Recognizing Needs and Values of Consumers

Skills Item		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
<i>Pre</i> : Recognize needs, values and preferences of consumers	Equal variances assumed	.042	.838	-1.997	82	.049
	Equal variances not assumed			-1.804	22.130	.085
<i>Post</i> : Recognize needs, values and preferences of consumers	Equal variances assumed	.010	.920	-.932	83	.354
	Equal variances not assumed			-.998	26.979	.327

Professional Values and Ethics Domain in Consumer Control, Choice, and Direction

This domain consisted of five items regarding professional values and ethics. The scale ranged from 0 = no skill at all to 4 = expert skill. At pre-test, the mean score for this domain was 2.66, and at post-test, the mean score was 3.03, an average increase of 14.3% from pre- to post-test. All items in the values domain showed statistically significant change ($p < .000$) as measured by paired t-tests for comparing pre- and post-course assessments. Chart 11 below highlights the three largest competency increases from pre-test to post-test within this domain to illustrate the areas where the most change occurred.

Chart 11. Three Highest Increases in Values Competencies



To further explore these competency gains, an independent samples t-test was conducted for each item based on assessments taken before the course and then again on assessments taken after course completion. The following means table shows the item scores of ILCs and AAAs at pre and post training in the values domain (Table 12).

Table 12: Means Table for Values Domain

Group Statistics for Values Domain					
	Agency Setting	N	Mean	Std. Deviation	Std. Error Mean
Pre: Understand the consumer's right to consumer control, consumer choice, consumer direction, dignity of risk, and self-determination	AAA	68	2.63	.731	.089
	ILC	17	3.06	.827	.201
Post: Understand the consumer's right to consumer control, consumer choice, consumer direction, dignity of risk, and self-determination	AAA	67	3.12	.591	.072
	ILC	16	3.31	.602	.151
Pre: Recognize the importance of respecting the strengths, values and preferences of consumers	AAA	68	2.74	.745	.090
	ILC	17	3.18	.728	.176
Post: Recognize the importance of respecting the strengths, values and preferences of consumers	AAA	68	3.16	.614	.074
	ILC	16	3.25	.577	.144
Pre: Recognize the impact of one's own values and biases on one's ability to provide quality options counseling related to aging and disabilities	AAA	68	2.54	.742	.090
	ILC	17	2.88	.781	.189

Post: Recognize the impact of one's own values and biases on one's ability to provide quality options counseling related to aging and disabilities	AAA	68	3.06	.667	.081
	ILC	17	3.06	.748	.181
Pre: Understand the value of cultural inclusion and cultural humility when working with consumers	AAA	67	2.39	.673	.082
	ILC	17	2.88	.781	.189
Post: Understand the value of cultural inclusion and cultural humility when working with consumers	AAA	68	2.78	.789	.096
	ILC	17	3.00	.866	.210
Pre: Understand professional sense of self, the importance of self-care, and the boundaries and limits of Options Counseling	AAA	68	2.57	.779	.094
	ILC	17	2.88	.781	.189
Post: Understand professional sense of self, the importance of self-care, and the boundaries and limits of Options Counseling	AAA	67	2.91	.690	.084
	ILC	17	3.12	.600	.146

The following table shows the items in this domain that did not reveal statistically differences between groups (see Table 13). These items are related to recognizing biases and understanding boundaries and limits of Options Counseling. These items are not as centrally related to the logic of consumer control and direction, so the lack of differences between to the two groups is not that surprising.

Table 13. Independent Samples Test for Non-Significant Value Items

Values Items		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
Pre: Recognize the impact of one's own values and biases on one's ability to provide quality options counseling related to aging and disabilities	Equal variances assumed	.764	.384	-1.664	83	.100
	Equal variances not assumed			-1.613	23.738	.120
Post: Recognize the impact of one's own values and biases on one's ability to provide quality options counseling related to aging and disabilities	Equal variances assumed	.043	.837	0.000	83	1.000
	Equal variances not assumed			0.000	22.777	1.000
Pre: Understand professional sense of self, the importance of self-care, and the boundaries and limits of Options Counseling	Equal variances assumed	1.410	.238	-1.462	83	.148
	Equal variances not assumed			-1.459	24.575	.157
Post: Understand professional sense of self, the importance of self-care, and the boundaries and limits of Options Counseling	Equal variances assumed	.154	.696	-1.132	82	.261
	Equal variances not assumed			-1.231	27.787	.228

The areas where the differences between groups changed from pre- to post-training were in the three above-mentioned items in Chart 11 with the highest increases.

As shown in Table 14 below, there were statistically significant differences between groups at pre-training on these items as measured by an independent samples t-test

($p=.039$; $p=.031$; $p=.011$). These differences were not statistically significant after training; therefore, the intervention of the training may have had an impact on these competencies related to consumer control and direction between groups (see Table 14).

This is a noteworthy finding to support the goal that providing training may impact Options Counselors' understanding of guiding logics especially in the key concept areas of consumer control and dignity of risk. The fact that there were differences in the groups before training and that those differences were no longer significant after training is important when considering how to successfully bring two different organizations with distinct institutional logics together to form a hybrid organization, and training could be an important component in successfully merging the aging and disability organizations together.

Table 14. Independent Samples Test for the Three Highest Values Competencies

Values Items		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
<i>Pre</i> : Understand the consumer's right to consumer control, consumer choice, consumer direction, dignity of risk, and self-determination	Equal variances assumed	.418	.519	-2.096	83	.039
	Equal variances not assumed			-1.945	22.657	.064
<i>Post</i> : Understand the consumer's right to consumer control, consumer choice, consumer direction, dignity of risk, and self-determination	Equal variances assumed	.764	.385	-1.170	81	.245
	Equal variances not assumed			-1.157	22.425	.260

<i>Pre:</i> Recognize the importance of respecting the strengths, values and preferences of consumers	Equal variances assumed	1.024	.315	-2.192	83	.031
	Equal variances not assumed			-2.225	25.087	.035
<i>Post:</i> Recognize the importance of respecting the strengths, values and preferences of consumers	Equal variances assumed	.000	.998	-.523	82	.602
	Equal variances not assumed			-.543	23.657	.592
<i>Pre:</i> Understand the value of cultural inclusion and cultural humility when working with consumers	Equal variances assumed	.229	.634	-2.617	82	.011
	Equal variances not assumed			-2.393	22.404	.026
<i>Post:</i> Understand the value of cultural inclusion and cultural humility when working with consumers	Equal variances assumed	.141	.708	-1.011	83	.315
	Equal variances not assumed			-.956	23.089	.349

Course Evaluation

Course participants completed an evaluation containing eleven questions measuring satisfaction using a five-point scale and two qualitative questions. Participants rated their satisfaction level on these questions using a rating of strongly disagree; disagree; neutral; agree; or strongly agree. Fifty-six participants who completed the course (55.4%) took the evaluation. For the five questions containing the course's learning objectives, at least 89.3% of those who took the evaluation agreed or strongly agreed that these objectives were met. When asked if the training expanded their knowledge and understanding of the topic area, 85.7% of respondents either agreed or

strongly agreed. When asked if they believed that the training would help them apply practice skills within the topic area, 80.4% either agreed or strongly agreed. When asked if they believed that the training would help them in their work with older adults or people with disabilities, 85.7% either agreed or strongly agreed. These responses can be seen in Charts 12-14 below, and they relate to the project outcomes of increasing staff knowledge and skills in consumer control and direction in order to deliver options counseling in more unified way across the two distinct agencies.

Chart 12. Training Expanded Knowledge and Understanding

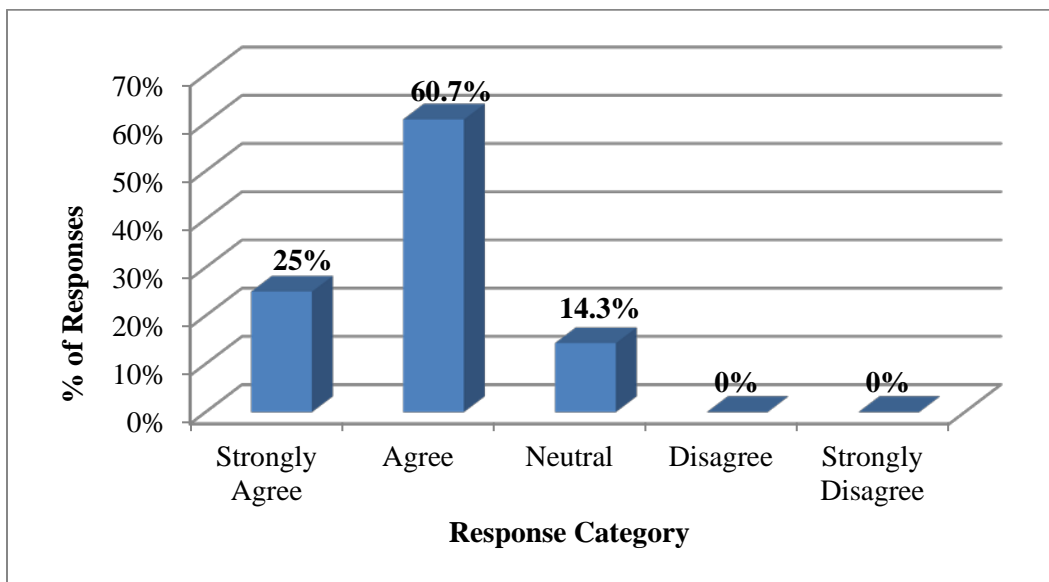


Chart 13. Help Me in My Work with Older Adults and/or People with Disabilities

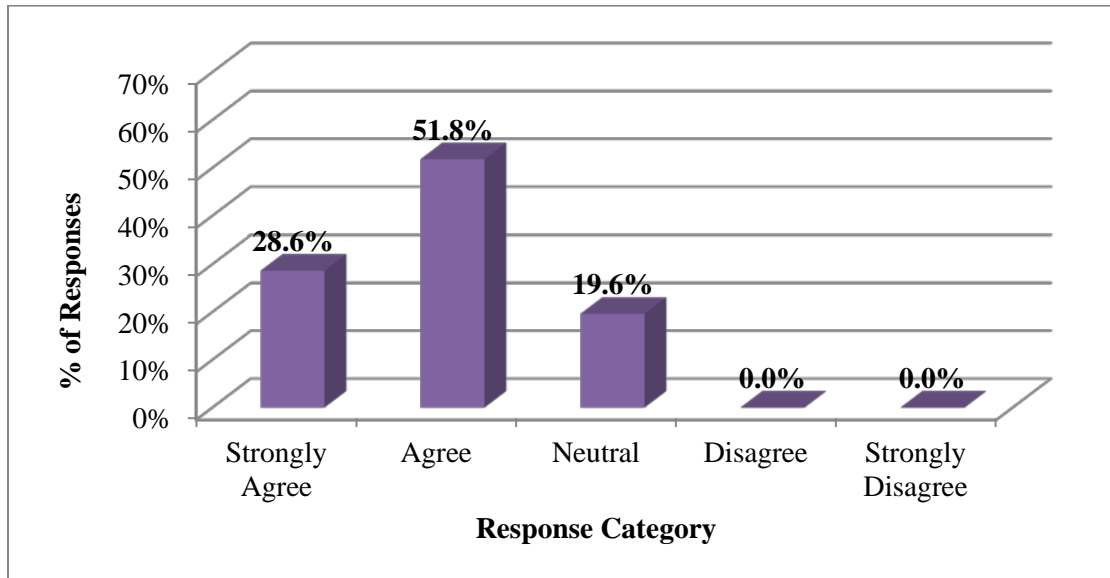
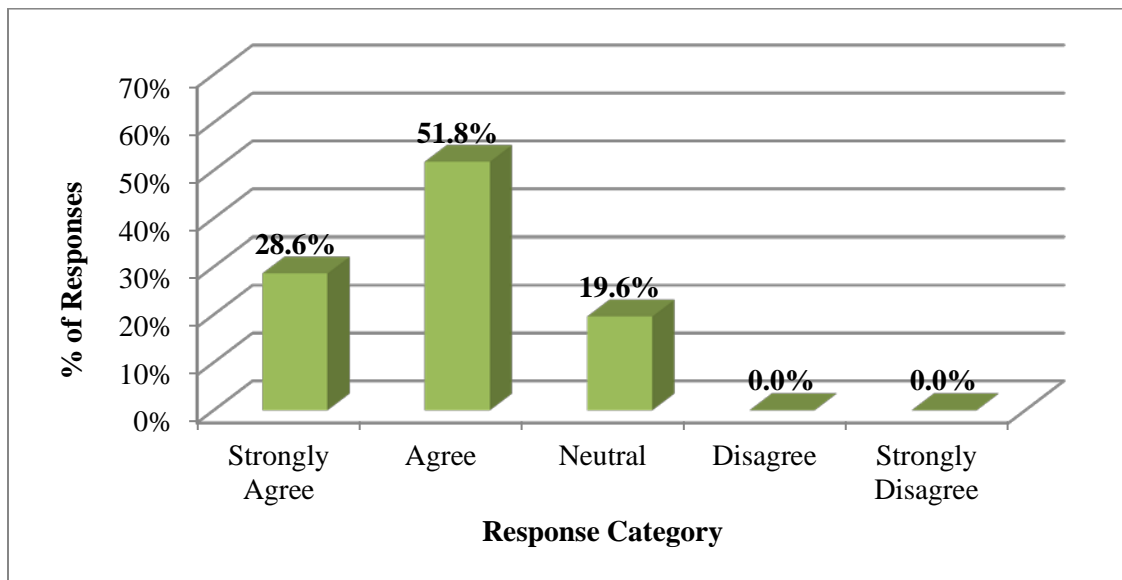


Chart 14. Training Will Help Me Apply Practice Skills



The following quotes are from Options Counselors, as documented in their comments from the course evaluations. All of the statements below are from Options Counselors in AAAs. These comments relate to their satisfaction in gaining a better

understanding of the ILC philosophy and the important concepts of consumer control. These data support the utility of this type of training in helping to bring a deeper understanding in differing service philosophies and in finding common ground to work together in order to serve the needs of older adults and people with disabilities. Some of the following comments were made:

Historical perspective was helpful in understanding present day mission and practice. – **AAA Options Counselor**

I really enjoyed the history of the ILC movement. – **AAA Options Counselor**

While I already had knowledge of the Independent Living Movement, I learned some new things and it reinforced my previous knowledge. – **AAA Options Counselor**

I liked the review of consumer directed care and control and how it related to Options Counseling. – **AAA Options Counselor**

The only comment that came from an Options Counselor at an ILC was a suggestion for improvement, and it is directly related to the overarching logic of consumer control, as stated below:

To understand more of how the disabled consumer is in control of daily living. – **ILC Options Counselor**

This statement reaffirms previous findings presented in earlier chapters about how central the concept of consumer control is to the work of ILC Options Counselors and while AAA Options Counselors reported substantial learning gains in this area, the ILC worker feels that there could have been more depth in this topic area.

Summary

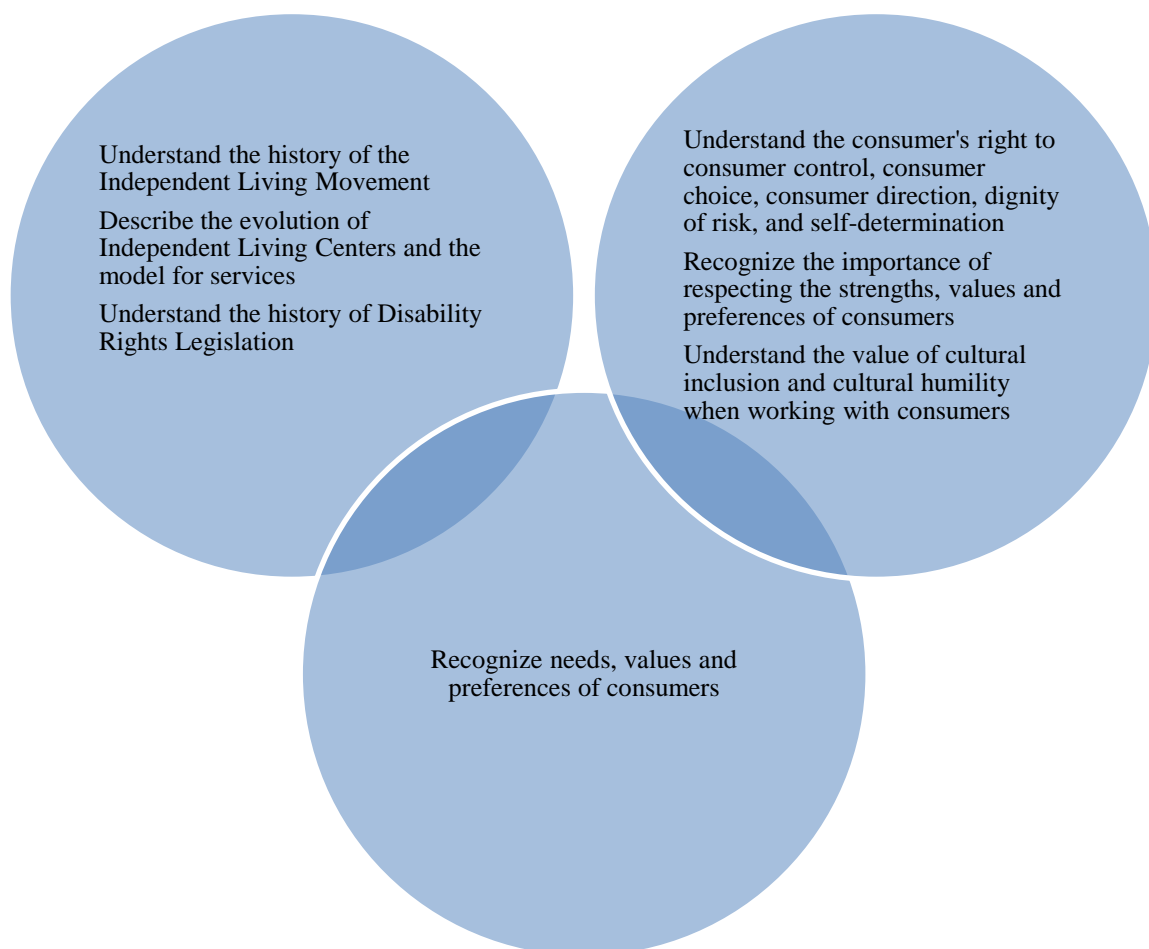
By analyzing results from the Options Counselors who completed the online course entitled: “*An Options Counselor’s Guide to Consumer Control, Consumer Choice, and Consumer Direction*,” I was able to assess whether the training had an impact on Options Counselors’ perceptions and engagement with the professional logic of consumer control. Some of the short-term outcomes from this training were evident in increased knowledge, skills, and value competencies for the Options Counselors in the professional logic of consumer control. One of the more distal outcomes that these findings suggest is that the delivery of options counseling may be more consumer-driven and uniform across agencies.

Pre- and post-course competency assessments and online course evaluations were used to measure study outcomes. Mean scores for knowledge, skills, and values competencies had significant increases in all areas from pre-to-post-test based on paired t-test. Many of the competency items between the two groups that were significantly different before training were no longer significant after training based on independent t-tests. These findings suggest that this training program helped to minimize the differences between Options Counselors located at an ILC or an AAA. Further, online course evaluations were also extremely positive for this course, with the majority of respondents (85.7%) agreeing or strongly agreeing that training expanded their knowledge and understanding of the topic area; 80.4% stating the training would help them apply practice skills within the topic area; and 85.7% stating that the training would help them in their work with older adults or people with disabilities. Together, these

results suggest that the online course may be an effective tool in creating a better understanding of the independent living model logic and may, in particular, enhance the meaning and practice of consumer control for Options Counselors at AAAs by bringing more unification in the understanding of this logic across agencies.

The following figure shows the interconnectedness of the competencies related to the logic of consumer control and direction, and, specifically, those that were impacted by the training program (see Figure 1 below). There were group differences between these items at the pre assessment in that ILCs scored higher levels of understanding in these concepts than workers at AAAs. After training, these differences were no longer statistically significant, which supports the idea that training can help to bring deeper understanding to an institutional logic and bridge the differences between two different groups of workers who have varying logics guiding their work.

Figure 1. Knowledge, Skills, and Values in Consumer Control and Direction



In this course, the Advisory Group members defined consumer control as the overarching philosophy that individuals with and without disabilities have control over their own lives and services. The key elements of consumer control are:

- Choice
- Significant participation in society
- Authoritative influence and a role in decision-making

- The right to take risks
- Having personal control over life choices, services, and activities
- And the exercise of that power

(Massachusetts Options Counseling Curriculum Grant Advisory Group members;
Independent Living Center of the North Shore and Cape Ann, Inc.)

Based on the findings and the definition of consumer control, the above figure suggests that the key concepts related to consumer control were influenced by the training program. Specifically, those that dealt with understanding the consumer's right to consumer control, dignity of risk, and self-determination and the importance of respecting and recognizing the strengths, values, and preferences of consumers. These findings suggest that the training program had an impact on increasing the understanding of the professional logic of consumer control as these workers came to understand the meaning and implementation of these concepts in a deeper way along with gaining a better understanding of how to deal with the complex issues surrounding safety and risk. Further, the results of the training program seemed to help minimize the differences between Options Counselors located at an ILC or an AAA, which may lead to better unification across the workforce.

CHAPTER 8: DISCUSSION AND IMPLICATIONS

The purpose of this dissertation was to examine the experiences of Massachusetts in using ADRCs to combine aging and disability services. The focus of analysis for this dissertation was on the organizational members, the micro level, rather than the meso-level of the organization itself. Specifically, the main research goal was to analyze and compare the institutional logics of directors and Options Counselors at Area Agencies on Aging (AAA) and Independent Living Centers (ILC) to determine whether distinctive institutional logics can be identified for each group, and to assess similarities and differences between them. Another research aim was to analyze how Options Counselors understand the service philosophy of consumer direction and the challenges or barriers in implementing this practice and to determine whether intense engagement with this institutional logic through an online training course would alter Options Counselors' perceptions with this logic and their level of readiness to adopt the new logic.

Through this research, I found that there was a distinct and clear institutional logic/service delivery philosophy for Independent Living Centers. This was also the case for Area Agencies on Aging; although, their institutional logic of medical professionalism that follows a care management service philosophy was being challenged as they merge under the umbrella of ADRCs. I found that there is not a unified institutional logic or service delivery philosophy for ADRCs, a hybrid organization, as understood by Options Counselors. A secondary objective of this dissertation was to assess the effects of methods to orient or socialize the new workforce tasked to work in these hybrid organizations. I found that the training program that was designed to orient

all Options Counselors – whether located in an AAA or ILC – contributed to an increased understanding in workers at AAAs in the institutional logic of consumer control, which is the logic that guides the work of ILCs.

The professional logic of consumer control comes from the social movement known as the Independent Living Movement and the core group of people who were instrumental in this movement were younger people with disabilities, older adults were not active participants (DeJong, 1979). This movement began in the 1970s, more than 40 years ago, and it is likely that the advocates leading this effort are now approaching their older adult years. This country is faced with a new group of consumers – the baby boom generation of older adults and people with disabilities who grew up during the Independent Living Movement. By nature, this will likely change how consumers direct their care and the relationship they have with their providers.

In 1979, Gerben DeJong published a seminal article on moving from a medical model (or as referred to in this dissertation, a professional logic) 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 that the individual (referred to as the “patient”) needs to be “fixed” by medical or professional interventions where 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 does not believe 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). This guiding philosophy was ever present in this study – both ILC workers and directors spent a lot of time educating the AAA workers and directors about this paradigm.

Managing Competing Institutional Logics and Efforts Towards Hybridity

One positive finding from this dissertation related to the issue of merging competing logics is that when these groups collaborated they were able to see that they have many similarities and that a training program could help orient AAA workers to this new paradigm. 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. Through this research, it was apparent that these steps were important factors in managing these competing logics. But, because the funding came from the Executive Office of Elder Affairs, along with the ultimate decision-making since they controlled the money, there was always a feeling of power imbalance between the two groups as the Independent Living Centers were resource dependent on Elder Affairs. The power was not shared fully as Elder Affairs was controlling the money and therefore the ultimate direction of the project. This was very apparent in my focus groups as many of the ILC directors, in particular, did not believe that Elder Affairs made the right choice in selecting BU as a training partner and did not like the idea that the course would be written from professional aging experts. Immediately, it was clear we needed to change this process and make the course development a more shared decision-making process

that included representatives from both organizations vetting content and decisions all along the way. Although, this was successful, the power residing in the aging organizations because they controlled the resources never really left the consciousness of stakeholders.

Reay and Hinings (2009) also state that the first step towards a “pragmatic collaboration” that could lead to a unified organizational logic is including both stakeholders at the table, which is then followed by giving these stakeholders from each group a role in decision making. As stated below from one ILC director, it is clear that they feel that they are not involved in critical conversations early on and are brought to the table after a decision has been made. This perfunctory role is transparent and only angers the disability stakeholders, as noted below.

You get that feeling when you have multiple partners within the ADRC. And in the beginning, I didn't feel it and the more we get into our meetings and into our partnership, it's clear that when we go to a meeting, there have been so many conversations among the other four that decisions have really actually already been made, but they're just going to be polite and try and wrap us around it and it's causing more and more friction now. So it's a horrible position to be in. When you're trying to be an equal partner. – ILC director

I think where some frustration is coming, too, is, at least on my side where I'm seeing frustration, is it seems like many, many times even a focus group like today, the decision's already been made at elder affairs. And we're expected to rubber stamp it. That's not how we work. I'm going to be honest with you about it. The fact that that's the way it's working right now is really frustrating the hell out of me. And I have to ask why would I want to continue this type of relationship at times. – ILC director

I agree that a pragmatic collaboration is important, but I would also add to this that the collaboration must be driven by common values and shared resources with equal power among the two groups. The collaboration needs to expand beyond pragmatics and be firmly grounded in shared values and professional orientations. Further, I believe that there needs to be fifth step added to Reay and Hinings' work: the need for shared resources and power in order for hybridity to be fully realized in Aging and Disability Resource Centers. The lack of this dimension was critical in hampering the full development of the collaboration between the aging and disability organizations as resources are so intricately tied to power domination, and this kept breaking down the ability to fully collaborate.

Ultimately, Aging and Disability Resource Centers (ADRCs) are combining two different service delivery organizations, but these organizations – AAAs and ILCs – have differing guiding institutional logics. An important move towards hybridity for ADRCs would be to work together towards creating a new unifying 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 form a unified stance in order to adopt a new logic that will ultimately be translated to workers 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 on each field as new logics, language, guiding principles, and structures emerge.

Importance of Discourse in Institutional Logics

Inherent in the professional logic of consumer control is the use and understanding of language. The theme of language was critical in all of the focus groups with workers and directors across organizations. What words to use and the appropriate definitions for each whether consumer control, consumer choice, or consumer direction were an important part of the work needed to come to a deeper understanding of this logic. In fact, before the training course on consumer control, choice, and direction was launched, the Advisory Group came together to review each time these words were used in the course to determine whether the words were being used correctly throughout. In this study, it was important for aging and disability stakeholders to find common ground in the discourse in order to focus their efforts in a creating a unified training program for Options Counselors in these hybrid organizations.

There is a window for change when there is an analysis of alternate discourses and this can be used to identify why change might not be occurring (Grant and Marshak, 2011). If the discourses remain contradictory and, for instance, if the prevailing discourse at a disability organization is to focus on consumer control and the discourse at an aging organization is still focused on care management models based on assessment and treatment then there will be variations in practice among workers who need to assist both populations. Additionally, if state level officials mandate that all workers take a training program on consumer control and embody this new practice philosophy in their work, it will be challenging to implement at a field level if the directors of the local agencies are not trained or aware of the new narratives. It was apparent through this

research that in order for there to be a unification of institutional logics and a movement towards hybridity, it will be necessary to reconcile the different discourses between the aging and disability workforce at all levels.

It is in the discourse where the change in institutional logics is occurring for aging and disability organizations. In this study, key actors met regularly about how to define populations, create service models, and train workers in a unified aging and disability language. The challenge with discourse analysis comes in factoring out what might be coercive or constrained discourse that is influenced by the institutional environment, such as dialogue that happens in the presence of those who hold power or funding at the state level. There is a distinction between public discourse and hidden dialogue, which often does not occur in the eyes of those who hold power (Leca, Battilana, and Boxenbaum, 2009). Specifically, who has power and who is attaching meaning to various issues has an impact on organizational discourse and institutional logics. Power structures are critical in reconciling competing institutional logics in hybrid organizations and this was apparent throughout this research.

Power Structures and Actors in Institutional Logics

The competing logics and different service philosophies in the aging and disability fields complicate the power structure. The power source in an Aging and Disability Resource Center depends on if the organization is located in an AAA or ILC. This is complicated for Options Counselors as the decision-making authority and social construction of symbols will be different if their supervisor is an aging director or independent living director. This might suggest that the impetus for change needs to

come from a unified voice at a higher level in order to create a new overarching template. The fragmentation that exists currently could ultimately impact the effectiveness of the work being carried out by the Options Counselor, which could also affect patient outcomes.

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 and Santos, 2010). Oliver (1991) describes five strategies to deal with institutional demands, they are: (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 medical professional 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 towards hybridity and the ability to operate with multiple institutional logics.

What is interesting is that while Independent Living Centers are resource dependent to Elder Affairs and have smaller representation, their defiance to adhering to the overarching medical logic that comes from aging organizations is very strong and present. 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 (Pache and Santos, 2010;

Greenwood, & Hinings, 1996; Kim, Shin, Oh, & Jeong, 2007). 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 more powerful and united. They are organized and are accustomed to fighting difficult battles and have the strength in their convictions to do this.

Historically, disability advocates have been successful in leading social movements to fight for changes in society – this will be another moment in time when disability advocates could play a crucial role in changing the way services are delivered to older adults and people with disabilities. The potential for change is significant and wide sweeping. The ideal solution would be for aging consumers to join forces with disability advocates to articulate the need for change and offer solutions as to how this could occur in a joint service delivery system. Unfortunately, in joint discussions throughout this research, the aging and disability voices are not in concert – they appear to talk at cross purposes and from their own perspective, and aging consumers – unlike their counterparts with disabilities – are often not even present for the conversation.

Study Implications

The implications for practice and policy derived from the study's key findings and contributions are the: 1) application of institutional logics in the examination of combining aging and disability networks; 2) examination of a hybrid organization and the impact on the workforce; and 3) utilization of a training program to combine institutional logics. In this dissertation, I found that there were competing logics between directors

located at aging organizations when compared to directors at Independent Living Centers. These competing logics were also present among their staff in these organizations. As a mechanism to manage the co-existing logics and move towards hybridity, I found that the joint activity of collaborating in creating a training course to describe overarching philosophies and ideals of practice helped to unify the directors at the two organizations. Additionally, I found that the workers located at aging organizations who took the newly created course had increases in their understanding of the professional logic of consumer control, which is dominant in the disability organizations; therefore, this suggests that this training helped in managing the co-existence of logics.

Implications on Institutional Logics

Applying institutional logics theory to my dissertation topic, the logic of aging organizations and disability organizations are at odds in that the aging organizations follow the logic of medical professionalism and the disability organizations logics come from a social movement focused on a philosophy of consumer control. In this view, the conflict in logics between these two types of service organizations can almost be characterized as a conflict between professional and anti-professional logics. The two professions hold differing beliefs and values; therefore, the creation of a new position in these hybrid organizations might be beneficial in creating new professional standards and guiding philosophies (Lounsbury, 2007).

The application of institutional logics theory revealed many important findings in the focus group analysis of aging and disability directors and Options Counselors. This dissertation contributes to the literature on institutional logics theory by adding an

additional mechanism to previous research on methods to manage competing logics (Reay & Hinings, 2009). This research showed that issues surrounding resources and financing are critical to creating a shared power model to reinforce the “pragmatic collaboration”. In fact, it was clear that the reasons in this study to manage co-existing logics and bring these different professions together were indeed very pragmatic, but without shared power and equal voices at the table, the relationship is flawed and competing logics are difficult to manage. One of the successful mechanisms in this research that continued to evolve through the project was in giving more credence to the voice of the workers and directors in the Independent Living Centers through creating a course based on one of the main tenets that guides their work – consumer control.

Future avenues for this collaboration must begin to deal with the funding inequities. In order for Independent Living Centers and AAAs to work as a hybrid organizations under the umbrella of ADRCs, policy makers should be cognizant of how the money flows down to each organization. If the money is directed to AAAs and their representatives are involved in policy initiatives without proper representation from ILCs, it will continue to challenge 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 hybridity among these organizations.

Implications on the Workforce Located in the Hybrid Organization

The impact of competing logics and the struggle towards hybridity on the workforce of Options Counselors, as analyzed through the focus groups, revealed that the workers were lacking cohesiveness as a group. The participants 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 certainly helped the Options Counselors from AAAs and ILCs feel more connected and they realized how much they learned from each other during that time. This was an important step towards managing the multiple institutional logics and helping the two organizations move towards hybridity.

One of the more significant impacts on the ILC workforce was in this feeling of being “outnumbered” by Options Counselors from the AAAs. ILC workers spent a majority of their time defending their professional logic of consumer control and expressed fear that this would be “watered down” by the professional logics of safety and care management. This struggle to reconcile the power differential seemed to hamper the ability to come together with a unified institutional logic.

The findings about staff professionalization are also noteworthy because it only emerged with ILC directors and no other group. Institutional logic research shows that staff creation bodes well in the creation of new institutional logics (Lounsbury, 2001), but the very nature of creating new staff and credentialing standards does not comply with the social movement logics that built the ILC model. Therefore, this becomes a more complex issue where staff training created and vetted by both aging and disability leaders should become the precedence, as shown through this dissertation.

Implications for Training

Through this research with directors and Options Counselors, it became clear that members from Independent Living Centers were very vocal in their articulation and defense of their overarching logic of consumer control, while AAA workers struggled to understand this. The training program seemed to help AAA organizational members understand this logic better and future studies could examine whether this had a long lasting impact on their practice.

This research assessed the differences in training impact based on whether the worker is located at an AAA compared to an ILC, which is an important contribution to the growth of ADRCs nationwide. Information gathered on the usefulness of this training program dependent upon agency location could have national implications for the implementation of services based in the logic of consumer control at ADRCs across the country. This research will provide insight into the challenges of implementing consumer control in AAAs compared to ILCs and could provide a model for national implementation.

The ongoing process of gaining input in the training curriculum throughout the project was a key feedback loop, and as a result, both aging and disability organizations felt greater ownership and pride over the content. It was also clear that this training course did not have the goal to overrule lived experiences in this workforce or to create certification, and once that fear was put to rest, the collaboration was able to unfold between these two parties.

The creation of the online training course in consumer control, direction, and choice began with very vocal internal tensions. In fact, sitting in the room for a meeting was often charged and coming to a consensus was a challenge. As we moved through the focus groups, outline and competency development, and, ultimately, the creation of the online course, the group began to understand each other better. The shared decision-making and working meetings to discuss these overarching logics helped forge new relationships based on mutual understanding and trust. During our final meeting together as a group, one ILC director stated that she wanted me to write in my final report to our federal funder that this the journey together was the most rewarding part and that this was an important step towards breaking down the silos between the aging and disability worlds and an important step towards hybridity for these organizations operating under the ADRC umbrella. This ILC director was the most confrontational at the beginning of the project and she had no hesitations in stating her disdain at my role as I was coming from an academic institution and a Center that focused on social work and aging issues. Earning her support and respect through this project was one of the more validating aspects of this work because what seemed insurmountable at the beginning had been overcome through shared decision-making, formal roles, and collaboration. This highlights the importance of developing structures and processes to work together toward common goals.

The results from this dissertation suggest that the training program was successful in orienting Options Counselors located at AAAs to a different institutional logic, namely consumer direction and control. It is hoped that through this training there will be a

systemic impact throughout the organization. Training is an ongoing challenge in the geriatric field as a result of shortages of trained professionals, retirements of older workers who have experience in working with older adults, and a lack of emphasis in aging in schools (Institute of Medicine, 2008; Whitaker, Weismiller & Clark, 2006). This is further intensified by the need to understand issues for both older adults and people with disabilities; therefore, the implication for social work practice is located in the need for well-trained professionals in aging coupled with the need for training in the issues faced by people with disabilities. Social workers – by virtue of their training, history, and position in the long-term care workforce – are in a unique position to play a significant and vital contribution, both to meet immediate needs and to establish a higher standard of care for older adults and people with disabilities.

The implications to social work and the field of aging as a whole are far reaching. If the merging of services for older adults and people with disabilities continues to move forward, as policy funding and initiatives are foreshadowing, then practice and professional logics must also continue to evolve. Social workers often declare a population that they specialize in or work with most frequently, i.e. child welfare workers or care managers at AAAs. This merger of populations will inevitably demand that the workforce know more about issues that impact people across the lifespan. It will require additional cross training and continue to force the breakdown of silos surrounding specialties. The findings revealed in this dissertation about differing professional logics for the aging and disability fields will need to be addressed in professional social work education programs as there will be limited time left to be in opposing or different camps

of specialties. Workers will now be tasked with working with clients who are young and have a disability and those who are older and in need of services. Determining professional logics to guide this new umbrella of workers and organizations is occurring at the macro systems level in federal agencies, but it is critical to have both aging and disability voices at the table who have shared funding and decision-making power to work on continuing to create unified programs to ensure that this newly combined field meets the shared goals of this emerging profession.

Study Limitations

One of the main study limitations was that this was an applied study based on a federally-funded project; therefore, some of the data collection methods were pre-determined, 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 from AAA directors was 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.

There are temporal limitations to this study in that there has been limited additional follow-up with the directors or the Options Counselors in a formalized method. It would be interesting to hold additional focus groups to see if there is more alignment in professional logics at the director level as new funding opportunities have occurred since this project began. It would also be worthwhile to see if the impact of the training

sustained with the Options Counselors at 6 or 12 months follow-up. A longitudinal study examining logics over time would be a natural next step for future work in this area. It is also important to be cautious about overstating the impact of the training program on altering participant's engagement in a new institutional logic as there could be a training effect. Additionally, the competency measures were a self-reported assessment, not a measurement of demonstrated skill; therefore it would be interesting for future work to see if these gains were evident if assessed by a supervisor or consumer, rather than the worker. This supports the importance of continued evaluation activities to assess the impact and sustainability of the training program on moving organizations and their members towards hybridity.

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 very vocal group of disability advocates that are prominent in Washington, D.C. and who were active during the disability rights social movement. Had this research taken place in another state with less vocal disability advocates, an unanswered question is: would there have been such pronounced differences in professional logics? Future research should look at cross national differences to see how other states are dealing with combining aging and disability services under one umbrella.

Conclusion and Suggestions for Future Research

This research provided important information on a new group of workers – Options Counselors – who are tasked with working between two target populations

consisting of older adults and people with disabilities. Originally developed by the Administration on Aging and Centers for Medicare and Medicaid Services, this new hybrid organization and occupational category was created in an effort to support independence and choice to living in the community longer and diverting placements into long-term care facilities (Aging and Disability Resource Center 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 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 people that will likely utilize the services being offered. While it was important for workers 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 needs to be considered as there are concerns about how a fully embraced logic of consumer control might work for frail older adults.

Future research is needed to assess whether training in professional logics can have a lasting impact on practice. This analysis suggests that the training had an immediate impact, but whether it made a systemic change in the organizational culture would be of interest for future work. Additionally, resource allocation is an important

mechanism to managing competing logics. Power and money need to be shared in order for a true collaboration and hybridity 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. Further funding should also continue to focus on training 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.

*“After watching the horses trot farther and farther from the aging and disability consortium stable, federal infrastructure money will likely do nothing more than create more competition, and less cooperation. And likely, those who have the power now will hold tight to it, and the funding, as they maneuver to favor the programs and philosophies and rules that they already hold dear.” – ILC
Options Counselor*

APPENDIX A: FOCUS GROUP QUESTIONS/PROTOCOL

1. What does the term consumer direction mean to you?
2. How does consumer direction affect your work and what you do? (Can you give examples?)
3. How do you work with consumers to support them in the process of consumer control, autonomy, self-determination and dignity?
4. What resources about consumer direction do Options Counselors need to know in order to better serve their consumers?
5. What information and knowledge do Options Counselors need to work effectively with consumers in applying consumer direction?
 - a. What are the skills and abilities that Options Counselors need to work effectively with consumers in consumer directed care?
 - b. What are the attitudes Options Counselors need to have to work effectively with consumers in consumer directed care?
6. What are the most important topics that should be covered in the new course on consumer direction? What would best meet your learning needs around these topics? (Probe: face-to-face, learning in groups, visual, auditory, written?)
7. What is your level of professional or personal experience with consumer directed programs and services within your agency or community?
8. What are some of the barriers or challenges you face when providing consumer directed services to consumers?

9. How do you support consumer directed options 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?)
10. Did you have a burning question about consumer directed services or resources you hoped would be answered today? Was it answered or been covered?
11. What are your suggestions to us as we move forward with this curriculum?
12. Have we missed anything?

APPENDIX B: QUESTIONNAIRE FOR AAA DIRECTORS

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 does the term consumer control mean to you?
4. Does the philosophy of consumer control guide your work? Please explain the ways in which this impacts your work within your agency.
5. If this 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 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.

APPENDIX C: PRE AND POST COMPETENCIES EVALUATION FOR OPTIONS COUNSELORS

Knowledge

- Understand the history of the Independent Living Movement
- Describe the evolution of Independent Living Centers and the model for services
- Define consumer control, consumer choice, and consumer direction in providing community based long-term living supports and services
- Explain the right of choice and risk to consumers
- Understand the core roles and functions of Options Counseling
- Understand the difference between a case manager and an Options Counselor
- Understand the history of Disability Rights Legislation
- Identify legal and ethical considerations that are involved when working with consumers and families

Skills

- Describe how to recognize personal bias and judgments in an Options Counseling session
- Recognize needs, values and preferences of consumers
- Demonstrate the difference between case management and Options counseling
- Develop strong interpersonal communication skills to support the consumer in the decision-making process, including decision making support, effective

ways to ask questions while providing resources, active listening, and paraphrasing

- Demonstrate creative ways to research services and supports as an Options Counselor
- Determine how to effectively support family members' interest in participation and assist with the problem-solving and resources

Values

- Understand the consumer's right to consumer control, consumer choice, consumer direction, dignity of risk, and self-determination
- Recognize the importance of respecting strengths, values and preferences of consumers
- Recognize the impact of one's own values and biases on one's ability to provide quality options counseling related to aging and disabilities
- Understand the value of cultural inclusion and cultural humility when working with consumers
- Understand professional sense of self, the importance of self-care, and the boundaries and limits of Options Counseling

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