ABSTRACT

TEIXEIRA-POIT, STEPHANIE MARIE. Developing Systems of Care among Organizations that Provide Services to Older Adults: Collaboration, Communication, and Adaptation amidst Environmental Uncertainties. (Under the direction of Dr. Michael Schulman).

Older adults overwhelmingly wish to maintain their independence in their own homes and communities. Organizations develop to meet the needs of older adults in communities, but are often not equally equipped to provide all types of services. Specialized organizations frequently provide services to older adults without coordinating services with other organizations. As a result, older adults often do not receive the services that they want or need. An alternative care approach involves developing collaborative networks of organizations, which have been described in the scholarly literature as systems of care and age-friendly communities. Although collaborative networks of organizations are more effective and efficient in providing services, structural factors may present barriers to collaboration and communication among organizations. Collaboration can be conceptualized as a function of the structural features of organizations, perceptions of environmental pressures, and attitudes of organizational leaders towards collaboration and competition. Drawing on in-depth interviews with representatives of organizations that provide services to older adults, this dissertation investigates (1) structural differences among organizations, (2) the environmental uncertainties that contribute to adaptations among these organizations, and (3) the ways in which organizations collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs for older adults. In addition, this dissertation examines how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations.

Developing Systems of Care among Organizations that Provide Services to Older Adults: Collaboration, Communication, and Adaptation amidst Environmental Uncertainties

by
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APPROVED BY:

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DEDICATION

For the loves of my life, Benjamin and Christian Teixeira-Poit.

Mommy loves you to the moon and back. May you always have inquisitive minds and never cease asking “Why?”

And for my partner and best friend who gave me the two greatest gifts,

Bryan Teixeira-Poit.

BIOGRAPHY

Stephanie Teixeira-Poit grew up in Enfield, Connecticut and attended Suffield High School in Suffield, Connecticut. She graduated *summa cum laude* from Stonehill College in Easton, Massachusetts, with a Bachelor of Arts Degree in Communication and Sociology and a minor in Criminology. Deciding to continue her educational journey, she moved to Raleigh, North Carolina to attend graduate school at North Carolina State University (NCSU). She graduated with her Master of Science Degree in Sociology from NCSU and pursued her PhD in Sociology from NCSU with a minor in Women's and Gender Studies. Her doctoral specializations included: (1) Class, Race, and Gender Inequality; and (2) Global Social Change and Development.

Ms. Teixeira-Poit is a Research Public Health Analyst at RTI International in Research Triangle Park, North Carolina. Ms. Teixeira-Poit conducts quantitative and qualitative research and evaluation examining how organizations in the health care system affect patients with noncommunicable diseases, including cancer, stroke, multiple sclerosis, and other chronic diseases. Her substantive interests include exploring systems and processes that can improve access to care, delivery and quality of care, and health disparities based on rural/urban location, gender, race, ethnicity, socioeconomic status, and age. She is deeply interested in turning research into actionable insights that can inform national policy for health care. Before joining RTI International in 2011, Ms. Teixeira-Poit was a Research Associate for five years at the Center for Urban Affairs and Community Services in Raleigh, North Carolina.

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This dissertation would not have been possible without support from RTI International. Before I was employed at RTI International, researchers from RTI designed a study of organizations that provide resources and interventions for individuals 65 years or over in Sarasota County. Researchers collaborated with the Institute for the Ages in Sarasota County, which officially endorsed this study. They developed the semi-structured interview protocol and supplemental materials (e.g., personalized lead and endorsement letters). They also designed the sampling approach and secured institutional review board approval from RTI's Committee for the Protection of Human Subjects. I would like to thank Project Director, Paul Pulliam, who allowed me to become one of the core researchers on the project team and provided permission to use these data for this dissertation research. I would also like to thank the core team of researchers who participated in the data collection and preliminary coding including: Christine Carr, Ariana Napier, and Jessica Williams. Finally, I would like to thank RTI International for awarding me a Professional Development Award (PDA), which provided the financial support needed to receive methodological training and draft this dissertation. Thank you to Pam Spain and Deborah Porterfield for encouraging me

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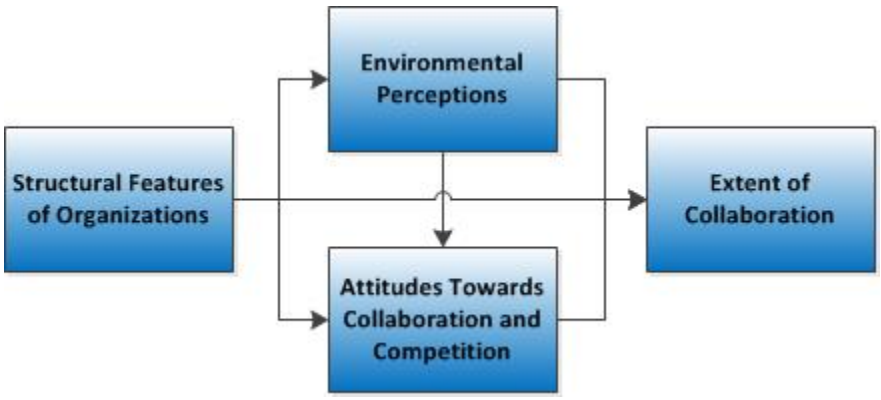
CHAPTER 1. INTRODUCTION

STATEMENT OF THE PROBLEM

Older adults overwhelmingly wish to maintain their independence in their own homes and communities (Wiles, Leibing, Guberman, Reeve, and Allen 2012). Nearly 90% of older adults desire to age in place by remaining in their residence as long as possible (Keenan 2010). Organizations develop to meet the needs of older adults in communities, but are often not equally equipped to provide all types of services. Specialized organizations frequently provide services to older adults without coordinating services with other organizations. As a result, older adults often do not receive the services that they want or need. An alternative care approach involves developing collaborative networks of organizations, which have been described as systems of care and age-friendly communities in the scholarly literature. Although collaborative networks of organizations are more effective and efficient in providing services (Gittell and Weiss 2004; Sinha and Van de Ven 2005; Provan and Milward 1995; Grandori and Soda 1995), structural factors may present barriers to collaboration and communication among organizations. Collaboration can be conceptualized as a function of the structural features of organizations, perceptions of environmental pressures, and attitudes of organizational leaders towards collaboration and competition (see ***Figure 1.1;*** Foster and Meinhard 2002). Drawing on this conceptual framework, this dissertation investigates (1) structural differences among organizations that provide services to older adults in a study community, (2) the environmental uncertainties that contribute to adaptations among these organizations, and (3) the ways in which organizations collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs for older adults in the community under investigation.



Source: Modified from Foster and Meinhard (2002)

Figure 1.1. Conceptual Framework for the Extent of Collaboration

RESEARCH QUESTIONS

This study of collaboration and communication among organizations that provide services to older adults is particularly timely. On February 24, 2015, the study community in this dissertation formally acknowledged its commitment to being an age friendly community by enrolling in AARP's Network of Age-Friendly Communities (AARP 2015). Moreover, the 2015 White House Conference on Aging (WHCoA) recently acknowledged the importance of age-friendly communities:

> "Creating and supporting communities that are age-friendly can allow older adults to age in place in the community as well as assist in supporting their health and vitality. Bringing together enhanced partnerships among health care services, aging services, and housing can help support older Americans thriving in their communities as they age." (U.S. Department of Health and Human Services, n.d.)

Furthermore, *The Gerontologist's* special issue on the 2015 WHCoA featured an article that called researchers to explore how to engage organizations traditionally outside the field of aging to collaborate on age-related issues (Greenfield et al. 2015). The present study addresses this research question by exploring structures and processes that facilitate and

hinder collaboration and communication among different types of organizations that can help older adults age in place by remaining in their residence as long as possible.

In this dissertation, Chapter 2 offers a brief review of relevant literature and theoretical perspectives, including key concepts from the sociological, gerontological, and public health literatures. Chapter 3 provides an overview of the research methods used to collect, manage, and analyze the data. Chapter 4 explores the size and structure of organizations in the sample to develop an organizational typology or analytic device for organizing and presenting the data in Chapters 5 and 6. Chapter 5 explores patterns and identifies emerging themes concerning environmental uncertainties (e.g., funding sources, staffing, local disparities in access to and quality of care) that contribute to adaptations among these organizations. Chapter 6 explores the ways in which organizations collaborate and communicate to provide services to older adults. In these analyses, I use the organizational typology developed in Chapter 4 and the perceptions of environmental uncertainties identified in Chapter 5 to understand the extent to which organizations collaboration or cooperate with other organizations. By doing so, Chapter 6 explores whether different structural features or organizations and perceptions of environmental uncertainties facilitate or hinder collaboration and communication among organizations. In essence, Chapters 4 and 5 provide the background on organizational structures and perceptions necessary to conduct analyses in Chapter 6 to determine what structures and perceptions facilitate and hinder collaboration and communication among organizations.

The research questions for this dissertation directly correspond to Chapters 4, 5, and 6:

1. How do organizations serving older adults vary in terms of their size and structure in the study community?
2. What are environmental uncertainties in the study community that contribute to adaptations among organizations serving older adults?
3. What are the ways in which organizations serving older adults collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs? How do structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations?

My first research question examines the structural differences among organizations serving older adults in the study community. I investigate the number of paid and unpaid employees, the longevity of the organization, perceptions of to whom the organization is accountable, funding sources for the organization, demographic characteristics of populations served, residential status of the populations served, and types of services provided. Examining the structural differences among organizations in the sample from the study community yield an organizational typology that identifies groups of organizations that are specialized to deal with specific parts of the environment and likely have values and orientations that diverge from those of other groups of organizations (Lawrence and Lorsch 1967). The organizational typology is used as an analytic device for organizing and presenting the data in subsequent chapters.

My second research question investigates environmental uncertainties that contribute to adaptations among organizations in the sample from the study community. This

dissertation focuses on three types of environmental uncertainties: (1) funding sources, (2) staffing, and (3) local disparities in access to and quality of care that are identified by organizations. Perceptions of environmental uncertainties are examined across the organizational typology identified in the data analyses related to the first research question to explore three hypotheses:

H1: Government and non-profit organizations have different perceptions of funding uncertainties than for-profit organizations.

H2: Small formal organizations (i.e., those with fewer paid employees) and organizations specialized in fewer types of programs and services have different perceptions of staffing uncertainties than large formal organizations (i.e., those with more paid employees) and specialized in more types of programs and services.

H3: Government organizations, nonprofit organizations, and organizations that target services to women, racial and ethnic minorities, or low-income populations have different perceptions of local disparities in access to and quality of care than for-profit organizations and organizations that provide services to the general population.

My third research question examines the ways in which organizations in the sample from the study community are collaborating and communicating (or failing to collaborate and communicate) to enhance programs for older adults in the study community. In addition, this research question explores how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations in the community under investigation. Integration involves communication and coordination between specialized groups of organizations (Lawrence and

Lorsch 1967). Integrated networks of organizations may be more efficient and effective when providing programs (Gittell and Weiss 2004; Sinha and Van de Ven 2005; Provan and Milward 1995; Grandori and Soda 1995). After describing collaboration among organizations in the sample from the study community, variations in the ways in which organizations collaborate and communicate (or fail to collaborate and communicate) are examined across the organizational typology and perceptions of environmental uncertainties examined in the data analyses related to the first two research questions to explore the following hypothesis:

> H4: Older organizations; large organizations; organizations with diversified programs and services; organizations dependent on government funding; and organizations that target service provision on women, racial or ethnic minorities, or low-income populations have collaboration and cooperation with other organizations.[1]

Identifying characteristics of organizations and environments that have successfully or unsuccessfully collaborated and communicated with other organizations may help provide guidance for communities that seek to develop collaborative networks of organizations for older adults.[2] The scholarly literature suggests that specialized organizations frequently

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[1] In this hypothesis, collaboration and cooperation are operationalized using definitions provided by Himmelman (2002).

[2] To understand fully how organizations successfully or unsuccessfully collaborate and communicate with other organizations, it may be important to know why and how the organization initially developed. A limitation of the study is that the interview protocol did not specifically include questions on why and how the organization initially developed. However, the interview protocol did ask questions about the goals of the organization for the present and future and the extent to which organizations have or seek to develop collaborative relationships with other organizations. The interview protocol also provided information on the historical development of organizations in the sample by asking the following questions:

- How has your agency evolved (changed) over time?
- Where do you see your organization in 5 years?
    - What will you need to get there?
    - What are the challenges in carrying that out?
- Does your organization have a formal development plan?

provide services to older adults without coordinating services with other organizations and, as a result, older adults often do not receive the services that they want or need. An alternative care approach involves developing collaborative networks of organizations, which have been described as systems of care and age-friendly communities in the scholarly literature.

CONTEXT OF THE STUDY COMMUNITY

The study community in this research is Sarasota County, Florida. Sarasota County has 37 miles of shoreline on the western coast of Florida (see ***Figure 1.2*** for a map illustrating the location of Sarasota County within Florida). Sarasota County is adjacent to Manatee County to the north, Desoto County to the east, and Charlotte County to the south. Sarasota County consists of four incorporated places including the Cities of Sarasota, Venice, and North Port and the Town of Longboat Key (Sarasota County Government 2013).

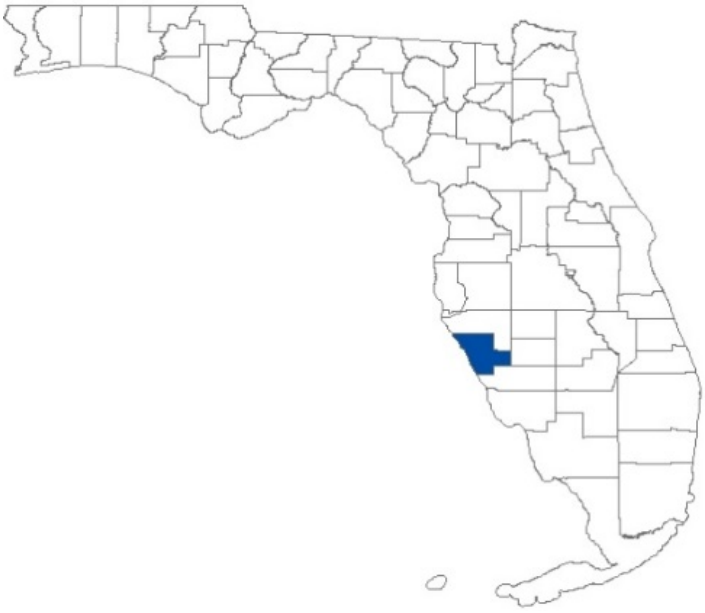


Figure 1.2. Location of Sarasota County within Florida

- What are the parts of that?

History of the Study Community

Sarasota County has a history of colonization and experienced extensive in-migration of white settlers. Early after white settlement, Sarasota County became a seasonal destination for tourists. This legacy continues as Sarasota County is now renowned for its snowbird population (i.e., temporary migration of older adults to the county during the winter months). Regardless of season, Sarasota County has a high percentage of the population 65 years and over and, consequently, has numerous organizations that provide services for older adults in the community. The following historical overview provides a context that helps situate the research questions within the unique circumstances and realities of the community and population.

Context of exploration and colonization in Florida. Florida has a history of colonization under Spanish, British, and U.S. control. In the 1500s, Spanish conquistadors Ponce de León and Hernando de Soto explored Florida. In 1565, Pedro Menendez de Aviles established the first permanent European settlement in Florida. Spain claimed control of Florida and retained this control until the late 1660s, despite British and French attempts to overcome them. In 1763, Britain gained control of Florida in exchange for Havana, Cuba, and the Spanish-evacuated Florida because of the exchange. In 1781, Spain regained control of Florida after the American Revolution as part of the Treaty of Paris. After the British evacuation of Florida, Spanish colonists, settlers from the newly formed United States, and escaped slaves from the United States began settling in Florida. In 1821, the Spanish ceded control of Florida to the United States under the Adams-Onís Treaty. At this time, Andrew Jackson traveled to Florida to establish a territorial government for the United States (Florida Department of State 2013a, 2013b).

Early records of the study community. Legend connects the name Sarasota with "Sara," the daughter of conquistador Hernando de Soto who was chartered in 1537 by King Charles I of Spain to explore for gold and silver in the present-day Sarasota area (City of Sarasota 2013; Florida Department of State 2013a; Hernando De Soto Historical Society 2013). In the 1700s, maps labeled the area as Port Sarasote and Sarazota and an indigenous trading post in the area was labeled Saraxota. In 1839, the government's first complete printed maps of Florida labeled the area as Sarasota (City of Sarasota 2013).

Indigenous heritage of the study community. Indigenous peoples resided in the Sarasota area at least 12,000 years ago and developed complex cultures, forms of social organization, cultivated agriculture, and trade relations with other groups in the present-day southeastern region of the United States. Some indigenous peoples residing in the area were of Creek descent and were called the Seminoles by European colonists. Under President Andrew Jackson, the United States sought to forcibly remove the Seminoles from their land because white settlers desired this land. In the 1800s, three Seminole wars resulted in the "voluntary" migration of indigenous peoples, their capture and forcible relocation to Indian Territory in present-day Oklahoma, or their escape into the Everglades (City of Sarasota 2013; Florida Department of State 2013a).

White settlement in the study community: 1850s to 1890s. William Whitaker became the first permanent white settler in present-day Sarasota in the 1850s, Richard Roberts in present-day Venice in the 1870s, and Thomas Mann in present-day Longboat Key in 1891 (City of Sarasota 2013; City of Venice 2013; Town of Longboat Key 2013). The period between 1868 and 1883 marked the first large-scale arrival of white settlers in the area. During this

period, John Webb settled in the area and opened the area's first manufacturing plant, a sugar refinery. John Webb also built the area's first winter resort with individual guest cottages, which was advertised in northern newspapers. In the early 1870s, the first post office was established in the area under the name Sara Sota and the first school was established by Caroline Abbe. In the late 1870s, the citrus industry was established in the area, and Charles Reeves became the first homesteading settler in 1876 (City of Sarasota 2013).

By 1883, nearly 700,000 acres of land were sold to settlers arriving in the Sarasota area. Around this time, migration of settlers into the area drastically decreased. In response, the Florida Mortgage and Investment Company of Edinburgh purchased 60,000 acres of land and its owner, John Gillespie, began developing the area by building the DeSoto Hotel and what is presumed to be the first golf course in the United States. In the late 1800s, the fishing industry flourished in the area, and channels were dredged to promote water commerce and shipping. In 1899, the area established its first newspaper and telephone service from the Gulf Coast Telephone Company. During this time, the Seaboard Railroad was extended to connect Tampa to Sarasota (City of Sarasota 2013).

Expansion and tourism in the study community: 1900s to present. Sarasota was incorporated as a town in 1902 and as a city in 1913. In 1910, Potter Palmer visited the Sarasota area and purchased 80,000 acres to establish a cattle ranch. Two years later, John and Charles Ringling, who founded the Ringling Brothers Circus, invested in Sarasota and Longboat Key. The investments of Palmer and the Ringling brothers sparked interest in the area marked by an influx of tourists (City of Sarasota 2013; Town of Longboat Key 2013).

Sarasota County was established in 1921, and the City of Sarasota was designated as the county seat in 1924 (City of Sarasota 2013). In 1926, the BLE Realty Corporation was organized to develop the City of Venice. Later that year, the first paved streets and school in the city opened and the construction of hotels and residences began. The following year, the town council, police department, and fire department formed (City of Venice 2013). By the end of the Florida boom in the 1920s, Sarasota County had modern hotels; business districts; apartment homes; single family homes; paved streets; public amenities such as a golf course, school system, and hospital; bridges from keys to the mainland; and improved railroad and boat transportation systems (City of Sarasota 2013).

The Great Depression marked a bleak time for Sarasota County. The City of Venice could not afford its electronic street lights nor pay its city employees (City of Venice 2013). The end of the Great Depression and World War II was marked with expansion and increase in the tourist industry in Sarasota County (City of Sarasota 2013). The Town of Longboat Key was incorporated in 1955 and the City of North Port was incorporated in 1959 (Town of Longboat Key 2013; City of North Port 2013). As with the Great Depression, many businesses in Sarasota County closed with the recessions of the 1970s and 2000s and prospered with economic shifts in the 1980s and 1990s (City of Sarasota 2013).

In 1971, Sarasota County adopted a Home Rule Charter that established a commissioner-county administrator form of government with five county commissions across the county elected to 4-year terms. Typical of other charter counties, Sarasota County is considered a full-service county because it provides fire protection and emergency medical services; utility services including water and sewer, storm water, and solid waste; public

transportation with interconnecting routes in a neighboring county; community services such as parks, recreation, planning, zoning, and environmental resource management; and primary support services such as financial planning, information technology, and communications (Sarasota County Government 2013).

The economic recession that began in 2007 dramatically impacted Sarasota County. According to U.S. Census and Bureau of Labor data, Sarasota County and neighboring Manatee County lost 46,000 jobs between 2007 and 2010 (McQuaid 2011). It is important to note that the data collection for this study occurred in 2011. During this period, Sarasota County was recovering from the aftermath of the 2008 economic recession.

Current Population of the Study Community

In Sarasota County, 31 percent of the population is 65 years and over and 5 percent of the population is 85 years and over (see ***Table 1.1*** for a comparison of population characteristics of the study community versus the United States). These percentages are significantly higher than the national averages of 14 percent and 2 percent, respectively. The high percentage of the population 65 years and over in Sarasota County reflects a growing in-migration of retirees (U.S. Census Bureau 2010b). The percentage of individuals 65 years and over whose usual residence is Sarasota County is projected to increase from its current 31 percent to nearly 40 percent of residents by 2030. The median age is not uniform within Sarasota County. The northern part of Sarasota County and a large portion of the City of North Port have a younger population with a median age of fewer than 45 years (Sarasota County Government 2012a).

Table 1.1. Population Characteristics of the Study Community vs. the United States

Population Characteristic	Sarasota County		United States	
	Number	Percent	Number	Percent
Total Population	379,448	100.0	308,745,538	100.0
Age [a]				
19 years and under	66,703	17.6	83,267,556	26.9
20 to 24 years	15,253	4.0	21,585,999	7.0
25 to 29 years	15,816	4.2	21,101,849	6.8
30 to 34 years	15,366	4.0	19,962,099	6.5
35 to 39 years	17,649	4.7	20,179,642	6.5
40 to 44 years	20,467	5.4	20,890,964	6.8
45 to 49 years	24,875	6.6	22,708,591	7.4
50 to 54 years	26,757	7.1	22,298,125	7.2
55 to 59 years	27,384	7.2	19,664,805	6.4
60 to 64 years	30,951	8.2	16,817,924	5.4
65 to 69 years	31,362	8.3	12,435,263	4.0
70 to 74 years	26,961	7.1	9,278,166	3.0
75 to 79 years	22,833	6.0	7,317,795	2.4
80 to 84 years	19,045	5.0	5,743,327	1.9
85 years and over	18,026	4.8	5,493,433	1.8
Gender [a]				
Male	181,041	47.7	151,781,326	49.2
Female	198,407	52.3	156,964,212	50.8
Race [a]				
White (one race alone)	342,090	90.2	223,553,265	72.4
Black or African American (one race alone)	17,815	4.7	38,929,319	12.6
American Indian and Alaska Native (one race alone)	945	0.2	2,932,248	0.9
Asian (one race alone)	4,903	1.3	14,674,252	4.8
Native Hawaiian and Other Pacific Islander (one race alone)	134	0.0	540,013	0.2
Some Other Race (one race alone)	7,556	2.0	19,107,368	6.2
Two or More Races	6,005	1.6	9,009,073	2.9
Ethnicity [a]				
Hispanic or Latino (of any race)	30,033	7.9	50,477,594	16.3
Not Hispanic or Latino	349,415	92.1	258,267,944	83.7
Median Household Income (dollars) [b]	49,212	—	52,762	—
Total Households [b]	169,256	—	114,761,359	—
With Earnings	103,625	61.2	90,888,685	79.2
Mean Earnings (dollars)	65,598	—	73,702	—
With Social Security	81,734	48.3	32,005,143	27.9
Mean Social Security Income (dollars)	18,524	—	16,213	—
With Retirement Income	48,485	28.6	20,126,376	17.5
Mean Retirement Income (dollars)	28,546	—	22,490	—
With Supplemental Security Income	4,874	2.9	4,948,413	4.3
Mean Supplemental Security Income	10,340	—	8,629	—
With Cash Public Assistance Income	1,814	1.1	2,948,651	2.6
Mean Cash Public Assistance Income	3,512	—	3,729	—
With Food Stamps/SNAP Benefits in the Past 12 Months	9,315	5.5	11,759,700	10.2

(continued)

Table 1.1 (continued)

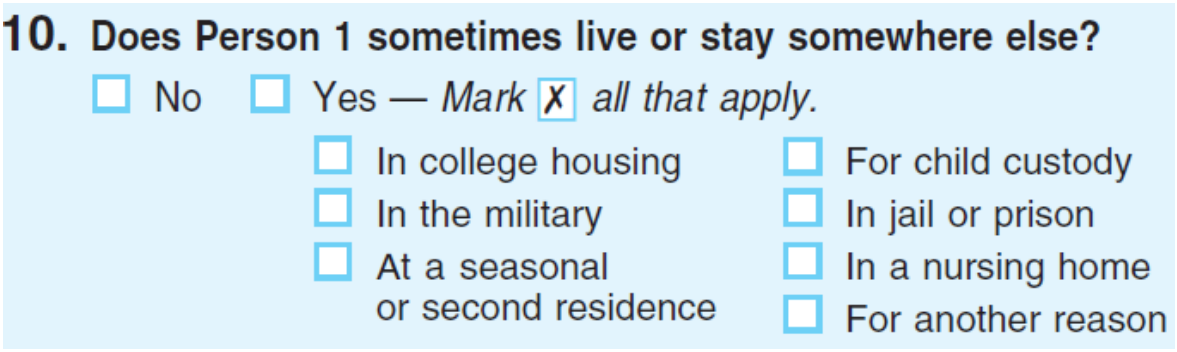
Population Characteristic	Sarasota County		United States	
	Number	Percent	Number	Percent
Percent in Poverty [b]				
All people	—	11.0	—	14.3
Under 18 years	—	17.2	—	20.0
18 years and over	—	9.8	—	12.5
18 to 64 years	—	11.8	—	13.1
65 years and over	—	6.3	—	9.4

[a] 2010 U.S. Census (U.S. Census Bureau 2010c)
[b] 2007–2011 American Community Survey 5-Year Estimates (U.S. Census Bureau 2007–2011)

As mentioned earlier, the seasonal migration of tourists to Sarasota County began in the 1800s when John Webb built the area's first winter resort and advertised it in northern newspapers. Nearly 2 centuries later, many individuals 65 years and over reside in northern states and migrate to Sarasota County during the winter months. These individuals, termed snowbirds, significantly increase the percent of population 65 years and over residing in Sarasota County during the winter months. Sarasota County Government (2013) suggests that snowbirds increase the population of the county by nearly 20 percent during the winter months rendering the population about 51 percent 65 years and over in that season.

The data presented in ***Table 1.1*** are compiled from the 2010 U.S. Census and 2007–2011 American Community Survey 5-Year Estimates (U.S. Census Bureau 2007–2011, 2010c). The U.S. Census Bureau (2010a:N.p.) counts people who live at two or more residences—including snowbirds who travel seasonally between residences—at their usual residence "where they live and sleep most of the time." If people spend equal time at multiple residences, they are counted in the location where they are staying on Census Day, which is April 1st. The U.S. Census Bureau determined that the 2000 U.S. Census may have over-counted the U.S. population; certain populations, such as snowbirds, may have been

counted more than once (Pew Research Center 2011). The U.S. Census Bureau made a concerted effort to count accurately the snowbird population during the 2010 U.S. Census by adding a survey question on whether people sometimes live or stay somewhere else, such as at a seasonal or second residence (see ***Figure 1.3***). Thus, the data presented in ***Table 1.1*** likely do not include the snowbird population because many snowbirds do not live and sleep most of the time in the study community and many snowbirds travel back north before April 1st. Snowbirds likely increase the population of the county from approximately 380,000 permanent residents to more than 450,000 residents during the winter months (Sarasota County Government 2013).



Source: U.S. Census Bureau (2010d)

Figure 1.3. Additional Survey Question on 2010 U.S. Census

The median household income in Sarasota County is slightly lower than that of the median household income in the United States ($49,212 versus $52,762), which is not surprising given that Sarasota County has a higher percentage of retirees than the nation. Because of its large population 65 years and over, Sarasota has a significantly higher percentage of those with Social Security Income (48% versus 28%) and retirement income

(29% versus 18%) compared to the national population. Yet, Sarasota County's population is less likely to be stricken with poverty than the national population. Sarasota County has a significantly lower percentage in poverty for the population overall and by each age category than the nation. Taken together, these data suggest that, overall, the population of individuals 65 years and over in Sarasota County may fare better with regards to income than that of the nation.

Median household income varies across municipalities in Sarasota County. The Town of Longboat Key has the highest median household income with $102,600, followed by the City of North Port with $47,655, City of Venice with $44,975, and City of Sarasota with $40,183. The City of Sarasota has not only the lowest median household income, but also the highest percentage of households in poverty with 17 percent of households below the federal poverty line. The Cities of North Port and Venice follow with 8 percent of household in poverty. The Town of Longboat has the highest median household income and the lowest percentage in poverty—5 percent (Sarasota County Government 2012b).

CHAPTER 2. LITERATURE REVIEW AND THEORETICAL PERSPECTIVES

This dissertation integrates scholarly literature from multiple disciplines including sociology, gerontology, and public health. The purpose of this chapter is not to provide a comprehensive review of these scholarly literatures, but rather to introduce concepts that I explore in the dissertation. The sociological literature on organizational theory contributes several concepts that are applicable to this study including: differentiation, integration, isomorphism, resource dependence, and intersectionality. The gerontological and public health literatures also provide concepts that are applicable to this study including: age-friendly communities, conceptual frameworks on service use among older adults, public policy and legislation, and the public health model on systems of care. Concepts from the sociological, gerontological, and public health literatures are briefly described below.

KEY CONCEPTS FROM THE SOCIOLOGICAL LITERATURE

The sociological literature provides theoretical frameworks for understanding the structural differences among organizations, perceptions of environmental uncertainties among organizations, and variation in collaboration and communication among organizations.

Differentiation, Integration, and Isomorphism

Organizations adapt to conditions in their environment. Adaptations are limited so it is possible for groups of organizations to develop structures that are similar to one another. One adaptation is for organizations to differentiate functions, yet groups of organizations may differentiate in similar fashions and end up with similar structures (e.g., leadership structure with chief executive officer). The sociological concept of differentiation directly relates to the first research question on how organizations servicing older adults develop

structural differences. The sociological concepts of integration and isomorphism directly relate to the third research question on the ways in which organizations serving older adults collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs. The concepts of integration and isomorphism help explain how organizations may develop structural similarities to other organizations and why developing collaborative networks across organizations may be beneficial. Each of these sociological concepts is briefly described below.

As organizations adapt to conditions in their environment, they may attempt to differentiate functions (i.e., specialize). Organizational contingency theory asserts that organizations are most effective when their differentiation corresponds to the differentiation of their environment (Lawrence and Lorsch 1967). Organizations whose structure does not reflect the structure of the environment are likely to perform poorly (Parsons 1951; Thompson 1967). Societies require more coordination as organizations become more specialized and members develop different values and tastes (Durkheim [1893] 1997). Extending this argument to formal organizations and groups of organizations, as organizations specialize within their environment, their values and tastes diverge from other organizations and integration between specialized organizations becomes challenging (Lawrence and Lorsch 1967).

In the sociological literature, integration involves communication and coordination between specialized organizations (Lawrence and Lorsch 1967). Integrated organizations may be more efficient and effective (Gittell and Weiss 2004; Sinha and Van de Ven 2005; Provan and Milward 1995; Grandori and Soda 1995). Integration of organizations facilitates

learning, represents a mechanism for status attainment, provides economic benefits, facilitates the management of resource dependence, and provides autonomy for employees (Bradach and Eccles 1989). In the broader scholarly literature, integration refers to organizations that are "completely merging operations, administrative structures, and budgets" (Mashek 2005: N.p.). Before organizations are completely merged, they can engage in interorganizational activities that lie on a continuum (see ***Figure 2.1***):

(1) networking is "exchanging information for mutual benefit";

(2) coordinating is "exchanging information and altering activities for mutual benefit and to achieve a common purpose"; and

(3) cooperating is "exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose"; and

(4) collaborating is "exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose" (Himmelman 2002:2-3).

These strategies build upon one another, and organizations determine which strategies are most appropriate and relevant given what they desire to accomplish and the context in which they need to accomplish the work (Himmelman 2002).

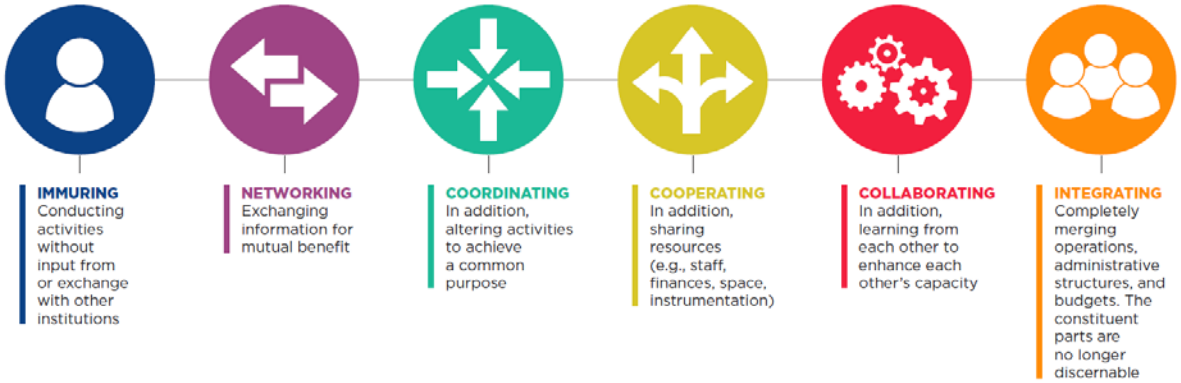


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Figure 2.1. Collaboration Continuum

Adaptations are limited so it is possible for groups of organizations to develop structures that are similar to one another. This concept of isomorphism was introduced into the scholarly literature by Hawley (1968:334) who argues that "units subjected to the same environmental conditions […] acquire a similar form of organization." Ecologists theorize a survival-of-the-fittest competitive process of adaptation where organizations assume the form best adapted to survive in a given environment (Hannan and Freeman 1989; see below for a critique of this conceptual framework). Unlike ecologists, neoinstittuionalists theorize a social-fitness adaptation process where organizations assume forms considered as legitimate in a particular environment. Neoinstitutionalists contend that, although organizations may become more similar over time, this similar form may not be the most efficient form (DiMaggio and Powell 9183). Isomorphism elucidates two features of contemporary organizations. First, the structural features of organizations tend to be similar within a particular organizational field (e.g., hospitals resemble one another). Structural features make

organizations recognizable and help them conform with normative and regulative requirements. Second, organizations have formal structures or ways of conducting business that may or may not reflect informal structures or actual patterns of behavior and work routines. Thus, isomorphism helps understand how environmental regulations, norms, and culture create tension between formal and informal structures (Scott 2008).

Resource Dependency

The resource-dependence model directly relates to the second research question on perceptions of environmental uncertainties and the third research question on how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations. Thematic analyses of data show that some organizations may collaborate with other organizations because they lack resources; other organizations may avoid collaborating with organizations because they are resource rich and do not want to share their resources. On this basis, resource dependency may help explain why organizations serving older adults collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs.

Several conceptual frameworks address the relationship between organizations and their environment. The natural-selection model contends that environmental factors differentially select organizational characteristics that best fit the environment (Hannan and Freeman 1974). The natural-selection model has been critiqued for assuming that organizations do not change and adapt; inadequately operationalizing basic concepts; failing to recognize historical processes; and failing to provide evidence of competitive adaptation processes (Young 1988). The natural-selection model also has been critiqued for ignoring how decisions are made in organizations. According to critics, organizations engage in

political decision-making processes that enable them to strategically adapt to their environment (Aldrich and Pfeffer 1976). These models include the political-economy model (Benson 1975; Wamsley and Zald 1973), the dependence-exchange model (Jacobs 1974; Hasenfeld 1972), and the resource-dependence model (Pfeffer 1972). These three models are hereafter collectively referred to as the resource-dependence model.

The resource-dependence model contends that organizations lack the resources or capabilities to function completely autonomously and, consequently, enter relationships with organizations in the environment that can supply resources and capabilities. Organizational interdependencies can be based on differentiation and the division of labor (Aldrich and Pfeffer 1976). Organizational interdependencies also can be specifically sought or avoided on the basis of power or control issues inherently related to dependence (Blau 1964). Unlike the natural-selection model articulated by population ecologists (Hannan and Freeman 1974), the resource-dependence model identifies that the organization can actively adapt to and affect the environment and the environment can provide a range of possible social structures capable of survival (Aldrich and Pfeffer 1976).

In an extension of the resource-dependence model, Oliver (1991) identifies five ways that organizations can respond to institutional pressures, which may or may not help explain adaptations to perceived environmental uncertainties in the present study. The first strategy, acquiescence, involves conforming to institutional demands or imitating other organizations that are considered models. The second strategy, compromise, occurs in situations where organizations strategically maneuver to placate or negotiate institutional demands. The third strategy, avoidance, involves buffering some parts of the organization from having to

conform to requirements. One example is decoupling, where organizations adopt required structures but avoid carrying out technical activities in practice (Meyer and Rowan 1977). Organizations, especially reluctant adopters, may select this smoke-and-mirror approach when they perceive symbolic gains for adoption and high costs for implementation (Westphal and Zajac 1994). The fourth strategy, defiance, occurs when organizations avoid conforming to institutional demands in a highly public manner. The final strategy, manipulation, occurs when organizations strategically attempt to control the environment (Oliver 1991).

While isomorphism helps understand why groups of organizations may develop similar structures and practices, the resource-dependence model reminds us that organizations may respond to environmental uncertainties in divergent ways. Strategic adaptations to environmental uncertainties may result in divergent outcomes across organizations.

Intersectionality

Scholars refer to the relationship between race, class, and gender using various terminologies such as matrix of domination (Collins 1990), complex inequality (McCall 2001), intersectionality (Crenshaw 1991), integrative (Glenn 1999), or race-class-gender approach (Pascale 2007). As suggested by the multiple terminologies used to refer to the relationship between race, class, and gender, scholars vary in their conceptual understandings of intersectionality and in their theoretical and methodological approaches to studying intersectionality. Three approaches to studying intersectionality include the group-centered, process-centered, and system-centered approaches. The group-centered approach conceptualizes intersectionality as “giving voice to the oppressed” by including multiple-marginalized groups; this approach calls attention to the non-additive effects of multiple

social inequalities. The process-centered approach conceptualizes intersectionality as an analytic interaction or non-additive, multiplicative process that transforms main effects into interaction effects. Scholars who employ the process-centered approach consider main effects to be important, but sometimes emphasize interaction effects. The process-centered approach calls attention to examining context and comparing intersections to highlight processes organizing power. Finally, the system-centered approach focuses on how institutions overlap and co-determine interactions from the beginning, thus advocating for an intersection-only approach (Choo and Feree 2010).

The system-centered approach is an "intersection-only" model that identifies multiple institutions as overlapping and co-determining social inequalities to create intersections from the beginning rather than adding on interaction effects to the main effects (Choo and Feree 2010; Weldon 2008). Walby (2009) identifies this intersectional model of institutions that produces social inequalities as a complex system. However, the complex system interpretation of intersectionality places gender and race as embedded in and working through capitalism. By prioritizing capitalism and defining it in terms of class, the complex system interpretation of intersectionality actually prioritizes the main effect of capitalism over the intersectional processes. Acker (2006) considers it misleading to think about race, class, and gender as separate but intersecting systems of oppression because class is constituted by race and gender. Capitalism was founded by a small group of white men who used gender and race to organize production and sort people into paid and unpaid jobs. Capitalists assumed women's unpaid household labor and exploited gender and racial divisions in the paid workforce (Acker 2006).

On the basis of her understanding of inequalities, Acker (2006) developed a conceptualization of class that is based on inequality regimes or interlocked organizational mechanisms that produce and reproduce inequalities within particular organizations. Inequality regimes are based on six main criteria: (1) bases of inequality, (2) organizing processes that maintain inequality, (3) visibility of inequality, (4) legitimacy of inequality, (5) control and compliance, and (6) competing interests. Organizations draw bases of inequality and difference. Organizing processes maintain inequality. Organizations reproduce inequality as they construct and deconstruct hierarchies. For example, until recently, African Americans were only allowed to participate in the lower levels of these bureaucracies. Organizations also reproduce inequality through their recruitment and hiring practices. Management decides who to hire on the basis of stereotypes about which categories of people can best perform certain jobs and on the basis of social networks—thus reproducing gendered and racialized inequality. Moreover, organizations also reproduce inequality through both bureaucratized wage-setting practices (e.g., where employees' job classifications determine their wages) and individualized wage-setting practices (e.g., where an employee bargains for his/her wage). Many wage-setting practices, like trade union bargaining and seniority-based pay, influence gender wage inequality. Furthermore, organizations reproduce inequality through jobs that are not gender-neutral. Jobs are gendered; maleness is the normative standard for jobs. Other elements of inequality regimes follow. Organizational members have differing awareness of inequality and members who are aware often view inequality as legitimate or justified. In addition, organizations implement direct and indirect measures of control on workers. Finally, organizations have

competing interests in the reproduction of inequality. Managers may attempt to reduce inequality, empower workers, and preserve a committed and productive workforce. Alternatively, managers may use inequalities to further their own agenda through exploitation.

One limitation of the system-centered approach is that scholars employing intersectional lenses alone may fail to examine how processes that produce different inequalities may differ in significant ways; for example, the causal mechanisms reproducing gender inequality may differ from those reproducing other forms of oppression (Risman 2004). Scholars using the system-centered approach have to identify the contingent and path-dependent configurations of inequalities (Choo and Feree 2010). This dissertation draws on Acker's (2006) contribution to the system-centered approach to help explain how the structural features of organizations influence adaptations to environmental uncertainties (i.e., processes) that produce and reproduce gender, race, and class inequalities.

KEY CONCEPTS FROM GERONTOLOGICAL AND PUBLIC HEALTH LITERATURES

The gerontological and public health literatures use a problem-oriented and practice-focused approach to illustrate how the structural differences among organizations, perceptions of environmental uncertainties among organizations, and variation in collaboration and communication among organizations influence the lived experience of older adults.

Age-Friendly Communities

The gerontological concept of age-friendly communities directly relates to the third research question on the ways in which organizations are collaborating and communicating (or failing to collaborate and communicate) to enhance programs for older adults. Age-

friendly communities provide a rationale for why organizations may collaborate and communicate in order to develop environments that support healthy aging among older adults.

Age-friendly environments have been proposed as a core component to meeting the needs of older adults. Age-friendly environments consider the importance of physical infrastructure, social environment, and governance structure. Examples of physical infrastructure include outdoor spaces, buildings, housing, and transportation, while examples of the social environment include social participation, respect and social inclusion, and civic participation and employment. Scholars recognize that older adults desire to socialize and integrate with other age groups and conceptualize age-friendly environments as places that promote social inclusion for people of all ages (World Health Organization 2007).

Numerous terminologies have been used to describe age-friendly environments (Lui et al. 2009). World Health Organization (2007) coined the terminology age-friendly cities with the development of its *Global Age-Friendly Cities Project*. The Canadian Government adopted this framework and used the terminology age-friendly community in policy documents (Federal/Provincial/Territorial Ministers Responsible for Seniors 2007). Other terminology used to describe this concept include livable community (Kihl et al. 2005; Kochera, Straight, and Guterbock 2005; Kochera and Bright 2006; National Association of Area Agencies on Aging 2007; Oberlink 2008), lifetime neighborhood (Harding 2007; Kohler 2007), elder-friendly community (Alley, Liebig, and Pynoos 2007; Austin et al. 2005), senior-friendly community (North Carolina Department of Health and Human Services 2007), and age-friendly community initiative (Greenfield et al. 2015).

These terminologies reflect conceptual approaches that focus on different positions along the continuum of physical versus social environments and the continuum of top-down versus bottom-up governance structures (Lui et al. 2009). For instance, the concept livable communities places greater emphasis on physical infrastructure including housing and transportation (National Association of Area Agencies on Aging 2007). In contrast, the concept lifetime neighborhoods places greater emphasis on the social environment including social inclusion, participation, and personal development (Harding 2007; Kohler 2007). Nevertheless, scholars generally consider physical infrastructure and social environment as mutually reinforcing.

Regardless of conceptual orientation, scholars tend to acknowledge "the need to construct an environment where all social and physical facilities and services are integrated and mutually enhancing to support people to age well" (Lui et al. 2009: 118). Scholars tend to identify broad-based collaboration among multiple community stakeholders, such as nonprofit organizations, for-profit organizations, and citizen advocacy groups, as a crucial component to integrating services for older adults and promoting age-friendly environments (Greenfield et al. 2015; Lui et al. 2009).

Conceptual Frameworks on Service Use Among Older Adults

Conceptual frameworks on service use provide necessary background to examine the second research question on perceptions of environmental uncertainties and the third research question on how perceptions of environmental uncertainties facilitate or hinder collaboration and communication among organizations. In theory, conceptual frameworks of service use should help explain how organizations can facilitate *or* hinder service use among older adults. Understanding the influence of organizations on service use is a pre-requisite for

exploring the more complex question of how organizations can adapt to better meet the needs of older adults.

Two major conceptual frameworks have been used to explain service use among older adults. The basic conceptual framework was developed by Anderson (1968) and modified and adopted by other researchers (e.g., Starrett et al. 1989). This framework outlines a causal model with three groups of factors that explain service use: predisposing, enabling, and perceived-need factors. Predisposing factors include psychological, sociological, and demographic characteristics that make individuals susceptible to service use (e.g., race, gender, beliefs, attitudes). Enabling factors help individuals obtain existing services (e.g., transportation, availability and affordability of services, community and family supports). If individuals have predisposing and enabling factors, they also must perceive that they need a service for service use to occur. Although this framework identifies potential factors affecting service use, researchers have found mixed evidence regarding the significance of these factors in predicting service use (Mindel and Wright 1982; Krout 1983). In addition, this framework does not address the role of organizations in facilitating service use among older adults.

The practice-oriented conceptual framework identifies conditions that must be present for a potential client to use a service: knowledge of the service, access to it, and intent to use the service. Knowledge includes the perceived need for a service, awareness of existing services, and knowledge needed to use a service. Access involves the affordability of services, availability of services, and ability to travel to services. Intent refers to potential clients' willingness and interest in obtaining services. Examples of intent barriers include

cultural differences between potential and active clients or between service providers and potential clients, negative attitudes toward help, and negative perceptions of services.

This framework indicates that potential clients with one or more of these conditions experience barriers to service use, and service providers can implement strategies to prevent knowledge, access, or intent barriers from impeding service use (Yeatts, Crow, and Folts 1992). Unlike the basic conceptual framework, the practice-oriented conceptual framework addresses the role of organizations in facilitating service use among older adults. This framework identifies strategies that service providers can implement to overcome potential barriers toward service use. However, this framework oversimplifies the role of the organization in service provision and the complexities involved in the process. Service use among older adults is not only influenced by individual-level barriers but also by barriers at the organizational level. In this sense, organizations can either facilitate *or* impede service use among older adults—depending on multiple factors including organizational responses to uncertainties in the sociophysical environment.

Public Policy and Legislation

Since the United States provides publicly funded age entitlement services, public policy and legislation significantly informs the development of service models for older adults in the United States. As such, public policy and legislation provide the necessary background to understand all of the research questions including possible structural features of organizations, perceptions of environmental uncertainties, and collaboration and communication among organizations.

Examples of important public policy and legislation include the establishment of the White House Conference on Aging (WHCoA), the Older Americans Act (OAA), the Senate

Special Committee on Aging, and advocacy and interest groups such as the National Association of Area Agencies on Aging (n4a) and National Association of States United for Aging and Disabilities (NASUAD). Each of these topics is briefly described in turn.

In 1958, Congress introduced legislation for a WHCoA to discuss challenges experienced by older adults and develop federal policy recommendations to overcome these challenges. Congress convened WHCoAs in Washington, DC in 1961, 1971, 1981, and 1995. The first WHCoA laid the groundwork for the 1965 enactment of the OAA, which has developed the service and funding models that have provided home- and community-based services to older adults over the past 50 years.

The scope of Title I of the OAA is broad and includes ensuring adequate retirement income; physical and mental health; housing; community-based care so older adults can maintain independence in their homes; employment without discrimination; ability to retire; opportunities for participation in cultural, educational, and recreational programs; community services such as affordable transportation; benefits from research; and free will to manage and plan one's own life. The OAA's other titles address specific policy initiatives (Niles-Yokum and Wagner 2011).

In 1965, Title II of the OAA established the Administration on Aging (AoA), an agency of the Department of Health and Human Services, that is responsible for overseeing services funded by the OAA. The AoA established a local aging network consisting of the State Units on Aging (in 1965), the Area Agencies on Aging (AAAs; in 1973), and individuals who provide services to older adults. In addition, Title II developed the National

Elder Locator Service that disseminates information about services to older adults (Niles-Yokum and Wagner 2011).

Title III of the OAA established funding streams for community services for older adults including supportive, nutrition, family caregiver, disease prevention, and health promotion services. Broadly, supportive services included information and referral assistance, care management, transportation, chore services, personal care services, and adult day services. Title IV of the OAA supported research and development on the aging network. Title V authorized grants to local organizations to establish senior centers and a Community Service Employment grant program administered through the Department of Labor. The latter program helped low-income people 55 years and over secure employment. Title VI provided grants for indigenous populations to develop nutritional and supportive services for older adults. Finally, Title VII authorized vulnerable elder rights programs and a national nutritional program for older adults (Niles-Yokum and Wagner 2011).

Congress annually funds the OAA and, in Fiscal Year 2009, appropriated $2.063 billion to the OAA. To support the local aging network, Congress allocates funds on a per capita basis to the State Units on Aging. In turn, the State Units on Aging redistributes funds through AAAs. Thus, the OAA has largely developed the structure and provided funds for community-based services in the United States (Niles-Yokum and Wagner 2011).

The Senate Special Committee on Aging was established as a temporary committee in 1965 and became a permanent committee in 1977. The purpose of this committee was to review issues related to older adults, conduct oversight of programs for older adults, and provide recommendations for legislation to the Senate. The Senate Special Committee on

Aging provided oversight to the OAA (U.S. Senate Special Committee on Aging 2014). For example, before the OAA's reauthorization in 1991, the Senate Special Committee on Aging convened workshops of government officials, service providers, caregivers, academia, and older adults. The purpose of these workshops was to review the effectiveness of the OAA and develop policy recommendations for its reauthorization. Overall, the findings of the workshops indicated that the OAA was largely successful in providing services to older adults, which undoubtedly influenced the recommendations for continued funding and possible expansion of existing programs—despite a federal budget deficit (U.S. Senate Special Committee on Aging 1991). Thus, the Senate Special Committee has historically played an important role in the continued funding of the aging network.

In addition to the public policy and legislation mentioned above, advocacy and interest groups have played an important role in shaping the aging network. For example, NASUAD was founded as the National Association of States United on Aging (NASUA) in 1964. NASUA changed its name to NASUAD in 2010 to reflect how common elements of care affect older adults and younger individuals with disabilities. This transition resulted from legislation and a system change at the federal level related to the Association for Community Living and the AoA and its disability section. NAUSAD represents 56 agencies on aging and disabilities that implement the OAA. As a result, NAUSAD advocates for public policy and legislation supporting the OAA, especially with regard to provision of long-term services and supports (National Association of States United for Aging and Disabilities 2014a, 2014b).

Also, for example, the n4a is the major advocate for AAAs under Title II of the OAA and nutritional and supportive services for indigenous populations under Title VI of the OAA. In addition to serving as a policy advocate, the n4a provides training and technical assistance to 618 AAAs and 246 Title VI programs (National Association of Area Agencies on Aging 2014).

Public Health Model: Systems of Care

As mentioned above, the gerontological concept of age-friendly communities provides a rationale for why organizations may collaborate and communicate to develop environments that support healthy aging among older adults. The public health community has a related concept to age-friendly communities called the "system of care." Thus, systems of care directly relate to the third research question on the ways in which organizations are collaborating and communicating (or failing to collaborate and communicate) to enhance programs for older adults and how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations.

According to Pires (2002), "a system of care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels" (p. 3). The system of care philosophy promotes core values that the system of care should be: (1) person-centered care with patient needs determining the services provided; (2) community-based with the locus and management of services grounded in the community and supported by collaboration across multiple organizations; and (3) culturally competent and responsive

to the cultural, racial, and ethnic differences of populations served. The system of care framework suggests that service providers should coordinate service delivery across all life domains including: (1) mental health services, (2) social services, (3) educational services, (4) health services, (5) substance abuse services, (6) vocational services, (7) recreational services, and (8) operational services (Stroul and Friedman 1986).

The systems-of-care approach represents a conceptual framework and value base rather than a discrete model for replication. Researchers cannot definitively identify the presence or absence of a system of care within a community. Instead, it is more productive to consider the system of care as a process of development and to define the level of development of the system of care within a community. The system of care is not static; it can evolve and adapt over time to meet the changing needs of patients and the environmental uncertainties in a community (Stroul 2002).

In 2001, the Institute of Medicine produced a report encouraging the medical community to consider the benefits of a system of care approach. According to this report, the U.S. health care delivery system has become increasingly complex, and the public's health care needs have changed. Americans have longer life expectancies partially because of rapid advances in medical science and technology. This aging population has higher prevalence and incidence of chronic conditions, such as heart disease, diabetes, and asthma. These chronic conditions require a wide range of complementary services, but the health care delivery system is poorly organized and lacks the multidisciplinary infrastructure required to coordinate services for those with chronic conditions. Health care professionals, organizations, and hospitals tend to work in silos and provide care on the basis of incomplete

patient medical history. The U.S. health care delivery system needs to be redesigned in order to meet the complex needs of patients. One example of system redesign is the sharing of knowledge and medical information among health care professionals. Health care delivery system redesign requires changing the structures and processes of the environment in which health care professionals function. For example, the transition to electronic medical records, the use of email communication between patients and health care professionals, and the use of automated systems for ordering prescriptions are examples of innovations that could improve the environment in which health care professionals function (Institute of Medicine 2001).

Although the medical community is now beginning to embrace the tenet of the system of care approach, system of care scholars would argue that reform within a particular system—such as the primary health care system—is inadequate. The system of care approach should cross organizational boundaries. A non-categorical approach to reform involves developing a holistic system of care to improve outcomes for targeted populations. This non-categorical reform needs to be owned at the local level and needs to embrace community strengths and realities. System redesign requires collaboration across organizations at the community level and partnership with stakeholders at other levels, such as the state and national levels, to promote sustainability over time (Pires 2002).

As mentioned above, systems of care is a broad term that theoretically and empirically includes various organizations. System of care relates to the concepts of transitions of care and continuum of care that are used throughout scholarly literature on the primary health care system. Transitions of care are defined as “a set of actions designed to

ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location" (Coleman 2003: 30). Similar to transitions of care, continuum of care refers to guiding patients through comprehensive health services across different levels of care (Evashwick 1989). Although some scholars describe these concepts as involving a system of care (Evashwick 1989), systems of care scholars argue that process redesign of the primary health care system does not adequately reflect the system of care approach, which includes organizations outside the primary health care system (Pires 2002).

It is important to distinguish the difference between addressing the needs of the community versus the needs of individuals. Some types of organizations are likely required in all communities. The system of care approach has the potential to benefit individuals and the community as a whole. For example, Daleiden et al. (2006) found that developing a system of care to promote collaboration across child and adolescent mental health services in Hawaii resulted in significant improvements in status ratings across a 10-year period and significant acceleration in the rate of improvement over time. Status ratings were indicators comprising emotional and behavioral well-being, academic learning progress, personal responsibility, safety and personal well-being, community living, caregiver functioning, and child and family satisfaction. A case study of a system of care providing emotional and behavioral health services to Vermont children yielded similar results. After a year of receiving wraparound services, children experienced a significant reduction in incidence of negative behaviors placing them at risk of removal from the community, an increase in compliance behaviors, a reduction in their total problem behaviors, and an increase in the

likelihood of maintaining in the community (Bruns, Burchard, and Yoe 1995). Taken together, these results suggest that systems of care have the potential for improving health outcomes and the well-being of individuals.

RELATION BETWEEN THE SCHOLARLY LITERATURES

This dissertation bridges the sociological, gerontological, and public health literatures. Scholars in these fields tend to work in intellectual silos. For example, the gerontology concept of age-friendly communities outlines a similar conceptual framework as the public health concept of systems of care. In the past 10 years, the medical community has embraced the notion of systems of care without acknowledging the long-standing contribution of gerontologists, and vice versa. Taken together, insights across sociology, gerontology, and public health can provide a more robust understanding of the structural differences among organizations, perceptions of environmental uncertainties among organizations, and variation in collaboration and communication among organizations.

The sociological literature provides theoretical frameworks to understand how and why organizations adapt to conditions in their environment. Adaptations are limited so it is possible for organizations to develop structures that are similar to one another. Organizations may differentiate functions or respond to environmental uncertainties in divergent ways, yet groups of organizations may differentiate in similar fashions and develop similar structures and practices. Alternatively, differentiated organizations may develop collaborative networks with other organizations to create efficiencies.

The gerontological concept of age-friendly communities and the public health concept of systems of care provide a practice-oriented rationale for why organizations may collaborate and communicate in order to develop environments that support healthy aging

among older adults. Collaboration and communication is not just for the sake of creating efficiencies, but also can ensure that older adults receive services that meet their holistic needs, provide seamless transitions of care, and facilitate a continuum of care. From an applied perspective, care coordination is about facilitating service use among older adults, enhancing quality of care, and improving quality of life among older adults.

Another rationale for bridging the scholarly literatures is to keep the study grounded within the social context that the study organizations are providing services to the older adult population. These organizations may have different responses to environmental uncertainties and different approaches to service provision in general because of the unique needs and realities of their target population, older adults. Without considering this social context, the study's findings are unlikely to offer meaningful theoretical contributions or practical insights for organizations providing services to older adults.

The scholarly literature was used to inform topics to explore in this dissertation including the structural differences among organizations, perceptions of environmental uncertainties among organizations, and variation in collaboration and communication among organizations. Gaps in the scholarly literature included inadequate exploration of: (1) the composition of organizations and how that composition may influence collaboration and communication with other organizations and (2) how community environments may contribute uncertainties and challenges to collaboration and communication among organizations.

Sociological studies of community structure have given little attention to the composition of organizations in communities (Freeman and Audia 2006). Moreover, the

differentiation and integration literature in organizational sociology tends to concentrate on organizations with a particular composition: private, for-profit organizations (Buck et al. 2011). These gaps in the scholarly literature encourage us to explore how organizations in the community vary in terms of their composition and how that composition (e.g., for-profit versus non-profit, private versus public) may influence their collaboration and communication with other organizations.

Past studies of networks of organizations have been critiqued for ignoring the challenges that underlie the formation of networks and their maintenance of boundaries (Podolny and Page 1998). In addition, most of the research on age-friendly communities has been conducted in large cities. Older adults residing in small cities or in rural areas may have different aging pathways and experiences than the general population (Lui et al. 2009). Consequently, the scholarly literature leads us to question how community environments may introduce uncertainties and how local organizations respond to these challenges when collaborating and communicating in order to develop age-friendly communities.

CHAPTER 3. RESEARCH METHODS

MEASUREMENT

To address my research questions, I worked with a research team at RTI International to conduct qualitative interviews with representatives of organizations that provide services to people 65 years or over in Sarasota County, Florida. My first research question examines the concept of **differentiation** including how organizations in the sample vary in terms of their size and structure. The size of the organization was measured by asking respondents questions about **the number of employees** at the organization:

- How many full-time employees work at this organization?
- How many part-time employees work at this organization?
- How many contractors provide services for the organization?
- How many volunteers do you have?

The structure of the organization was measured by asking respondents questions about the **longevity of the organization** and the **mission and mandate of the organization**:

- How long has this agency been in existence?
- To whom is your organization accountable?

The structure of the organization also was measured by asking respondents questions about the **funding sources for the organization** to organizations that provide services to older adults (e.g., resource distribution, lobbying to the federal government):

- What are your top five sources of revenue?
- Do your program users pay your organization for services they receive?
- Does your organization seek government funding?
- Do you write grants?

The structure of the organization also was measured by asking respondents questions about the **demographic characteristics of populations served** and **the residential status of the populations served**:

- Can you describe the populations you serve and how they differ?
    - How would you describe the populations you serve in terms of socio-economic status, race, ethnicity, or other characteristics?
- Do you provide services to so-called snowbirds?

- Where do your program users live?
  - Do your program users live in single family homes, multiunit housing, assisted living, or residential care?
  - In which neighborhoods do your program users live?

Finally, the structure of the organization also was measured by asking respondents questions about the **types of services** provided to older adults:

- What programs and services do you provide to people over age 65 in Sarasota County?
- What are the most important products and services your organization targets at older adults?

The second research question explores environmental uncertainties that contribute to adaptations among organizations in the sample. This dissertation focuses on three types of environmental uncertainties: (1) funding sources, (2) staffing, and (3) local disparities in access to and quality of care. **Perceptions of environmental uncertainties** were measured by asking respondents questions about the challenges experienced by the organization and other organizations in the county, how the organization can overcome challenges, how the organization has evolved over time, and how the organization expects to evolve in the next 5 years:

- What are the biggest challenges in terms of improving your programming?
- What challenges do you have starting new programs (other than funding)?
- Other than your organization, what do you think are the broader challenges for organizations like yours in Sarasota?

- What are things you'd like to do for your clients that you aren't able to do?
- What are your thoughts about local disparities and individuals' access to programs?
    - What are the challenges in addressing local disparities?
    - What ways are organizations in the county working or not working to address local disparities?
    - Does your organization do work to specifically address local disparities?
    - How involved are you with [addressing local disparities]?
- How long has this agency been in existence?
- How has your agency evolved (changed) over time?
- Where do you see your organization in 5 years?
    - What will you need to get there?
    - What are the challenges in carrying that out?
- Does your organization have a formal development plan?
    - What are the parts of that?

The third research question examines the ways in which organizations in the sample are collaborating and communicating (or failing to collaborate and communicate) to enhance programs and how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations. The collaboration and communication of the organization were measured by asking respondents questions about **formal and informal collaborations with other organizations**:

- Do you have formal agreements for wraparound services? Tell me about those. (A wraparound service is an integrated set of community services typically involving interagency collaboration and a defined planning process that is individualized for the client and focused on achieving a positive set of outcomes.)
- How do you coordinate with other organizations outside the county (e.g., providers in other states)? For example, how do you hand off or receive health records from providers elsewhere?
- What are the top three organizations or agencies that you collaborate with?
- Does your organization experience barriers to collaboration? What are those?
- What organizations would you like to collaborate with that you are not now? What's preventing this?
- Are there non-institutional partners your organization interacts with? How does your organization engage with these non-institutional partners?

DATA

As one component of a larger research effort, I worked with a research team at RTI to conduct qualitative interviews with representatives of organizations that provide services to people 65 years or over in Sarasota County, Florida. To develop the interview guide, the research team compiled topics relevant to understanding the available services for older adults in Sarasota County. The research team convened subject-matter experts to review and recommend topics. Using the revised list of topics, the research team adapted existing questions and crafted new questions to draft an interview guide.

The draft guide included questions on services provided to older adults; organization's background, characteristics, and business outlook; funding sources; collaboration with organizations; and outreach to older adults (see ***Appendix A*** for the interview protocol). To ensure comprehensiveness and usability of the interview guide, a team of subject-matter experts reviewed and commented on the guide, which was revised on the basis of their feedback. The research team conducted pretest interviews that resulted in final revisions to the guide. RTI received an exemption from its institutional review board for this portion of the study.

The research team used convenience and snowball sampling to identify 191 organizations that provide services to older adults in Sarasota County. We operationally defined organizations as formal businesses officially registered to provide services in Sarasota County. We excluded informal businesses, self-employed individuals, formal businesses that did not provide services in Sarasota County, and—because of their unique attributes—formal businesses that provided long-term institutionalization of older adults. We operationally defined services as resources and interventions that affect the lives of older adults. We operationally defined older adults as individuals 65 years or over. To be included in the study, organizations targeted some or all of their services specifically toward individuals 65 years or over. We included organizations that targeted some services specifically toward individuals 65 years or over and other services specifically toward other age groups. We excluded organizations that did not target any services specifically toward individuals 65 years or over. During our interview process, we learned that some organizations in our sample defined older adults as individuals 55 years and over. In contrast,

some organizations in our sample considered individuals 65 or 70 years of age as young and defined older adults as individuals in their 80s, 90s, or 100s.

The research team conducted internet searches and reviewed web-based publications to generate a list of organizations. We also asked respondents to recommend organizations that should be interviewed. Twenty-one organizations were removed from the sample because they were suggested but did not meet the study criteria: they either did not provide services to older adults or did not provide services in Sarasota County.

Personalized lead and endorsement letters were mailed to an executive (e.g., executive director, president, CEO) of the remaining 170 organizations in August 2011 with telephone follow-up about 5 days later. Organizations were contacted and invited to participate in a telephone interview. Fifty-one organizations agreed to participate in 1-hour semi-structured interviews from August through October 2011. Interviews were recorded, and these recordings were used to produce verbatim transcriptions. Two completed interviews were removed from the final sample because the interviews revealed that the organizations did not provide services to the target population. In addition, one completed interview was removed from the final sample because the audio recording failed during the interview and therefore the transcript of the audio recording was incomplete (see ***Chapter 4*** for more information).

Forty-eight organizations were included in the final analysis, representing different types of organizations including: health systems; skilled nursing facilities; adult education classes; spiritual, social, and wellness programs; library services; transportation services; home care services; companionship services; meals services; moving services; home

accessibility services; geriatric care management; advocacy organizations; guardianship and legal service organizations; government organizations; and advisory councils.

Throughout data collection, we monitored sample saturation by reviewing the completed interviews by organization type. Once we no longer received new information from interviews with a particular organization type, we stopped recruiting that organization type. Similarly, when we had few completed interviews for a particular organization type, we aggressively recruited to complete additional interviews with that organization type.

RTI provided permission to use these data for this dissertation research (see ***Appendix B*** for the data usage permission letter). North Carolina State University provided institutional review board approval for this dissertation research (see ***Appendix C*** for the institutional review board approval letter). In addition to the materials presented in ***Appendixes A-C***, the lead and endorsement letters are available upon request.

CODING

Interview transcripts were entered into the qualitative analysis software ATLAS.ti for coding (ATLAS.ti 2011). Drawing on grounded theory (Charmaz 2008), we did not have a predetermined "problem" or set of codes; instead, we initially engaged in open-coding where we broadly reviewed the data and coded for everything to identify emerging themes (Esterberg 2002). Open coding identified 26 key emerging themes, which were used to develop thematic codes. In addition, we reviewed the scholarly literature to develop theoretical codes (Burla et al. 2008; Kurasaki 2000; MacQueen 1998). On the basis of the thematic and theoretical codes, we drafted a codebook that included one code for each key emerging theme and included the code name, definition, an example, inclusion criteria, and exclusion criteria (Burla et al. 2008; MacQueen 1998).

Next, we conducted focused coding of key themes identified during open coding (Esterberg 2002). Focused coding began with at least two team members coding each interview to establish interrater reliability. After we achieved acceptable interrater reliability, one team member coded each remaining interview. Throughout the coding process, the coding team constantly met to review coding decisions; discuss and reach consensus in terms of variations in assigning codes; and refine the codebook by clarifying definitions, adding examples, and modifying inclusion and exclusion criteria. The coding team used the refined codebook to revisit coding decisions and, as necessary, recode interviews (Hruschka et al. 2004; MacQueen et al. 1998). The revised codebook is available upon request.

We implemented interrater reliability procedures to ensure quality control of the coding process, improve agreement when assigning codes, and reduce bias in interpretation (Hruschka et al. 2004; MacQueen et al. 1998). We used a random number generator to select 20 percent of the interviews for the assessment of interrater reliability (Burla et al. 2008; Carey, Morgan, and Oxtoby 1996; Haynes and Krippendorff 2007; Hruschka et al. 2004). Each coding round involved coding independent subsets of the interviews (Hruschka et al. 2004) and creating a summary matrix of these interviews (Kurasaki 2000; MacQueen et al. 1998). We entered summary matrices into the online utility *ReCal* to generate statistics to calculate interrater reliability. We selected the statistic Cohen's kappa to calculate interrater reliability, which ranges from negative one to positive one with positive one indicating perfect agreement, zero indicating agreement no better than chance, and negative coefficients indicating disagreement greater than chance (Burla et al. 2008; Hruschka et al. 2004). Based on statistical convention and following Hruschka et al. (2004), we determined that a

coefficient of greater than 0.80 was acceptable. We generated an average Cohen's kappa coefficient of 0.81 in the first round, 0.84 in the second round, and 0.85 in the third round. Overall, we achieved average Cohen's kappa coefficients of greater than 0.80 across all variables for all cases. Drawing on the pre-defined criteria, we interpreted this coefficient as acceptable.

ANALYSES

Researchers employ various approaches for developing qualitative analyses. Following Esterberg (2002), this dissertation develops qualitative analyses by: (1) exploring patterns, (2) constructing typologies, (3) comparing cases, and (4) engaging in grounded analyses.

Exploring Patterns

The first step to developing qualitative analyses is to explore patterns and identify emerging themes in the data (Esterberg 2002). During preliminary coding, the research team explored patterns in the data and identified emerging themes related to the following broad topics, each of which had numerous sub-codes:

- Program Feedback or Client Satisfaction
- Technology
- Healthy Aging
- Collaboration
- Local Disparities
- Facilitators
- Barriers

- Organizational Characteristics or Direction
- Client Population
- Funding
- Empowerment

In combination with the scholarly literature, I used these emerging themes to develop the research questions for this study. I conducted a second round of focused coding to explore patterns of emerging themes specific to this study. For example, Chapter 5 in this dissertation explores patterns concerning perceptions of environmental uncertainties. I identified emerging themes by examining environmental uncertainties identified by the organization including challenges concerning funding sources, staffing, and local disparities in access to and quality of care.

Constructing Typologies

Another step to developing qualitative analyses is constructing typologies or "a system for categorizing types of things" (Esterberg 2002: 169). In this dissertation, Chapter 4 explores the structure of organizations in the sample to develop an organizational typology or analytic device for organizing and presenting the data in Chapters 5 and 6. To build the typology, I explore similarities and differences between organizations in terms of their size and structure. The typology accounts for the size and structure of the organization by analyzing patterns in the number of paid and unpaid employees at the organization, the longevity of the organization, perceptions of to whom the organization is accountable, the funding sources of the organization, the demographic characteristics of the populations

served by the organization, the residential status of the populations served by the organization, and the types of services that the organization provides to older adults.

Comparing Cases

Another step to developing qualitative analyses is systematically comparing cases, the definition of which varies across research studies (Esterberg 2002). This dissertation operationally defines cases according to typologies of organizations identified in Chapter 4.

As mentioned above, Chapter 4 explores the size and structure of organizations in the sample to develop an organizational typology or analytic device for organizing and presenting the data in Chapters 5 and 6. Chapter 5 explores patterns and identifies emerging themes concerning perceptions of environmental uncertainties. Chapter 6 explores collaboration among organizations. This chapter involves *systematically comparing cases* to understand the ways in which organizations collaborate with other organizations and structures and environmental uncertainties that facilitate and hinder collaboration. I expect that organizations with particular structural features (i.e., different organizational typologies) and environmental uncertainties may have different adaptations that facilitate or hinder collaboration. For example, small organizations may lack staff and may adapt by pooling staffing, which requires extensive collaboration with other organizations.

To compare cases, I examine collaboration by the organizational typology developed in Chapter 4 and the perceptions of environmental uncertainties identified in Chapter 5. By doing so, I explore whether organizations with different structural features and perceptions of environmental uncertainties may have different adaptations that facilitate or hinder collaboration. In essence, Chapters 4 and 5 provide the background needed in Chapter 6 to determine what structures and perceptions facilitate and hinder collaboration.

Engaging in Grounded Analyses

Another step in developing qualitative analyses is grounding the analyses to "verify that your interpretation of the data is actually a good one" (Esterberg 2002: 173). Two methods of verifying the accuracy of your argument include exploring negative cases and examining the null hypothesis. Oftentimes, qualitative researchers draw on positive examples that support their interpretation. When qualitative researchers explore negative cases, they search for evidence that disconfirms their argument (Esterberg 2002). Another strategy for avoiding inaccurate interpretations is to assume initially that no patterns exist in the data. Similar to quantitative researchers, qualitative researchers can initially support the null hypothesis that no patterns exist in the data. By doing so, qualitative researchers have to compile sufficient evidence to support patterns in the data in order to reject the null hypothesis (Becker 1998).

INVOLVEMENT IN DATA COLLECTION AND ANALYSES

This study proposes to conduct a secondary analysis of data collected by researchers at RTI. Before I was employed at RTI, researchers from RTI designed a study of organizations that provide resources and interventions for individuals 65 years or over in Sarasota County. Researchers collaborated with the Institute for the Ages in Sarasota County, which officially endorsed this study. They developed the semi-structured interview protocol and supplemental materials (e.g., personalized lead and endorsement letters). They also designed the sampling approach and secured institutional review board approval from RTI's Committee for the Protection of Human Subjects. After joining RTI, I became one of the core researchers on the project team. In 2011 and 2012, I helped identify and recruit organizations to participate in this study, conducted one-third of the interviews, served as the

team lead for the data coding and assessment of interrater reliability, and coded one-third of the interviews.

CHAPTER 4. STRUCTURAL DIFFERENCES AMONG ORGANIZATIONS

This chapter explores my first research question on the structural differences among organizations in Sarasota County: "How do organizations serving older adults vary in terms of their size and structure in the study community?" To answer this research question, I present data on the number of paid and unpaid employees the organization has, the longevity of the organization, perceptions of to whom the organization is accountable, funding sources for the organization, demographic characteristics of populations served, residential status of the populations served, and types of services provided. After presenting data on the size and structure of organizations in the sample, I recommend variables that can be used as an organizational typology or analytic device for organizing and stratifying data in subsequent chapters.

ANALYTIC APPROACH

This chapter presents descriptive statistics on the structural differences among organizations that were compiled from qualitative interviews with representatives of organizations that provide services to people 65 years or over in Sarasota County. During the analysis process, I determined that several representatives of organizations were missing data on interview questions. Missing data are prevalent in qualitative data collection because: (1) interviewers may not ask the same questions in the first place, (2) interviewers may not probe for detailed answers on questions, (3) interviewers may not adequately record the answers to responses, and (4) respondents may be unwilling or unable to answer questions (Bernard and Ryan 2010).

In the present study, the qualitative data collection involved a semi-structured protocol in which different interviewers asked the same core questions of respondents.

However, different interviewers did not probe all respondents in the same manner. Moreover, some respondents did not remember the answer to specific questions (e.g., the number of full-time employees) or felt that they were not the best person in the organization to provide accurate answers to some questions. Furthermore, I discovered that ID 43 was systematically missing data across the interview. After further investigation, I removed this completed interview from the final sample because the audio recording failed during the interview and therefore the transcript of the audio recording was incomplete.

Appendix D includes a table identifying missing data along with recoding decisions for missing data by the IDs of organizations in the final sample. After carefully compiling missing data, I conducted an exhaustive secondary data abstraction of online sources, such as the organization's official website, to fill in or impute missing data.

RESULTS

Number of Paid and Unpaid Employees for Organizations in Sample

Table 4.1 displays the number of paid and unpaid employees for organizations in the sample, including full-time employees (categorized in quartiles), part-time employees (categorized in quartiles), contractors (dichotomous categories), and volunteers (categorized in terciles).

Organizations reported having relatively few paid employees compared to unpaid employees. Across the organizations, the median number of full-time employees was nine, part-time employees was two, contractors was zero, and volunteers was 21.

Table 4.1. Number of Paid and Unpaid Employees for Organizations in Sample

Characteristic	Number	Percent
# Full-Time Employees [a]	39	100.0
0 to 2	10	25.6
3 to 9	10	25.6
10 to 30	9	23.1
More than 30	10	25.6
Median	9	—
# Part-Time Employees [a, b]	39	100.0
0	11	28.2
1 to 2	9	23.1
3 to 14	9	23.1
More than 14	10	25.6
Median	2	—
# Contractors [a]	36	100.0
0	23	63.9
1 or more	13	36.1
Median	0	—
# Volunteers	39	100.0
0	13	33.3
1 to 50	13	33.3
More than 50	13	33.3
Median	21	—

[a] Because of the nature of the organization, *# Full-Time Employees, # Part-Time Employees, and # Contractors* are "not applicable" for one organization. This organization is treated as missing for these variables.
[b] One respondent from an organization did not specify whether employees were full-time or part-time. Because of the nature of the organization, it is likely that the employees are part-time.

Longevity, Mission and Mandate, and Funding Sources for Organizations in Sample

Table 4.2 displays the longevity, mission and mandate, and funding sources for organizations in the sample. Longevity of the organization was operationally defined as years in existence (categorized in quartiles). Mission and mandate of the organization was operationally defined using respondents' perceptions of to whom the organization was accountable (eight categories). Funding sources for the organization were operationally

defined as receiving top revenue sources (eight categories), seeking out-of-pocket payments (categorized as yes or no), seeking government funding (categorized as yes or no), and writing grants (categorized as yes or no).

Most organizations had been established in the community for numerous years. Nearly half of organizations had existed for 20 or more years; and nearly three-quarters had existed for 9 or more years (see Table 4.2).

Organizations generally reported that they were accountable to multiple entities (see ***Table 4.2***). Forty-three percent of organizations considered themselves accountable to an internal board of directors or other internal leadership, such as a chief executive officer. Over one-third of organizations considered themselves accountable to government entities, such as the Board of Commission, State Unit on Aging, Department of Elder Affairs, or the Administration on Aging. One-quarter of organizations reported that they were accountable to a corporate office, franchise, or national board of directors. About 23 percent of organizations considered themselves accountable to regulatory, licensing, bonding, or accrediting agencies such as the Area for Healthcare Administration under the Department of Health. A similar percentage of organizations reported that they were broadly accountable to the community, citizens, or taxpayers. One-fifth of organizations more specifically reported being accountable to their members or clients served. About 16 percent of organizations considered themselves accountable to professional associations. Finally, one-quarter of organizations reported that they were accountable to other entities, such as donors or partner organizations.

Table 4.2. Longevity, Mission and Mandate, and Funding Sources for Organizations in Sample

Categories	Number	Percent
Longevity of the Organization		
Years in Existence	47	100.0
Less than 9 years	12	25.5
9 to 19 years	12	25.5
20 to 32 years	11	23.4
More than 32 years	12	25.5
Median	19	—
Mission and Mandate of the Organization		
Perceptions of to Whom Accountable [a]	44	N/A
Internal board of directors or other internal leadership	19	43.2
Government	15	34.1
Corporate office, franchise, or national board of directors	11	25.0
Regulatory, licensing, bonding, or accrediting agencies	10	22.7
Community, citizens, or taxpayers	10	22.7
Members or clients served	9	20.5
Professional associations	7	15.9
Other	11	25.0
Funding Sources for the Organization		
Top Revenue Sources [b, c]	48	N/A
Private pay	22	45.8
Other grant funding	16	33.3
Government funding	14	29.2
Private health insurance	11	22.9
Medicaid	8	16.7
Medicare	5	10.4
Veterans Benefits Administration	4	8.3
Other	24	50.0

(continued)

Table 4.2 (continued)

Categories	Number	Percent
Seeks Out-of-Pocket Payments	48	100.0
Yes	31	64.6
No	17	35.4
Seeks Government Funding	48	100.0
Yes	25	52.1
No	23	47.9
Writes Grants	48	100.0
Yes	26	54.2
No	22	45.8

[a] Organizations identified multiple entities to whom they are accountable and, therefore, the column percentage adds up to greater than 100 percent.
[b] The top five sources of revenue identified by an organization may not reflect all of its funding sources.
[c] Organizations identified multiple sources of revenue and, therefore, the column percentage adds up to greater than 100 percent.

Organizations were asked about their top five sources of revenue (see ***Table 4.2***). Forty-six percent of organizations considered private payments to be one of their top five funding sources. One-third of organizations reported that other grant funding was one of their top five funding sources, and over one-quarter of organizations reported government funding was one of their top five funding sources. Among types of health insurance, private health insurance was most commonly reported as a top funding source (23%) followed by Medicaid (17%), Medicare (10%), and Veterans Benefits Administration (8%). More than half of organizations reported other top five funding sources, such as donations from private sources, in-kind support, and royalty fees.

The top five sources of revenue may or may not reflect all of the funding sources accepted by organizations. For example, some organizations may accept private payment, but not consider private payment to be one of their top five funding sources. To explore funding

sources further, organizations were asked whether program users pay for services received. Sixty-five percent of organizations reported that they seek out-of-pocket payments from program users for services received (see ***Table 4.2***). Recall that 46 percent of organizations reported private payments as one of their top five funding sources. The discrepancy in these percentages suggests that about 20 percent of organizations accept private payments, but do not consider private payments as one of their top funding sources. It is possible that these organizations serve populations with limited financial resources that cannot afford to pay out-of-pocket for services.

Organizations were also asked whether they seek government funding and grant funding (see ***Table 4.2***). Fifty-two percent of organizations reported that they seek government funding, and 54 percent of organizations reported that they seek grant funding. These percentages were higher than those reported when organizations were asked about their top five funding sources. This suggests that some organizations seek funding from the government and grants on a limited basis and do not consider these funding sources as primary contributors to their revenue.

Populations Served by Organizations in Sample

Table 4.3 displays the demographic characteristics of populations served and the residential status of the populations served. Demographic characteristics of populations served were operationally defined as women (categorized as yes or no), racial or ethnic minorities (categorized as yes or no), low-income populations regardless of ability to pay (categorized as yes or no), and snowbirds (categorized as yes or no). Residential status of populations served was operationally defined in nine categories.

Nineteen percent of organizations reported that they primarily provide services to women. Fifteen percent indicated that they target services to racial and ethnic minorities, and more than one-third target services to low-income populations. All organizations reported that they provide services to the snowbird population that temporarily migrates to the county during the winter months. Populations served most commonly resided in single-family homes (76%); assisted living facilities (70%); multiunit housing such as condominiums or apartments (50%); skilled nursing facilities or nursing homes (37%); or residential care facilities, independent living facilities, or retirement communities (35%).

Table 4.3. Demographic Characteristics of Populations Served and Residential Status of Populations Served by Organizations in Sample

Categories	Number	Percent
Demographic Characteristics of Populations Served [a]	48	N/A
Women	9	18.8
Racial/Ethnic Minorities	7	14.6
Low-Income Populations (Regardless of Ability to Pay)	17	35.4
Snowbirds	48	100.0
Residential Status of Populations Served [b, c]	46–48	N/A
Single-family homes	35	76.1
Assisted living facilities	32	69.6
Multiunit housing, condominiums, or apartments	23	50.0
Skilled nursing facilities or nursing homes	17	37.0
Residential care facilities, independent living facilities, or retirement communities	16	34.8
Manufactured home communities	5	10.9
Hospitals or mental health facilities	4	8.7
Other [d]	4	8.7
Unspecified, multiple	2	4.2

[a] Organizations identified multiple populations served and, therefore, the columns percentage adds up to greater than 100 percent.
[b] Organizations identified multiple places where program users live and, therefore, the column percentage adds up to greater than 100 percent.
[c] N=48 for *Unspecified, multiple*; otherwise, N=46.
[d] Other places where program users live included residences of family members (N=2) and no residence (i.e., homeless; N=2).

Types of Programs and Services Provided by Organizations in Sample

Table 4.4 presents the programs and services that organizations provided to people over age 65 in Sarasota County. The most common programs or services provided by organizations in the sample were adult education classes (52%), caregiver support or respite care (48%), transportation (42%), and resource and referrals (40%). About one-third of organizations also provided programs or services related to safety and security, geriatric care management, or disaster preparedness. In addition, about one-third of organizations reported that they provided free or low-cost programs or services. Fewer than 30 percent of organizations provided the remaining types of programs or services.

Organizations were also asked to report the most important products and services that they target at older adults (see ***Table 4.4***). Although organizations reported they provided multiple types of programs and services, organizations generally identified one type of program and service as most important. Eight percent of organizations identified adult education classes as most important, and 6 percent of organizations identified resource and referrals or legal services as most important. Fewer than 5 percent of organizations identified the remaining types of programs and services as most important.

Table 4.4. Types of Programs and Services Provided to Older Adults by Organizations in Sample

Categories	Number	Percent
Types of Programs and Services Provided to Older Adults [a]	48	N/A
Adult Education Classes	25	52.1
Caregiver Support or Respite Care	23	47.9
Transportation	20	41.7
Resource and Referrals	19	39.6
Safety and Security	17	35.4
Geriatric Care Management	17	35.4
Disaster Preparedness	16	33.3
Free or Low-Cost Services	16	33.3
Independence Related	14	29.2
Fraud Prevention	13	27.1
Counseling	13	27.1
Companionship Services	12	25.0
Meal Preparation	11	22.9
Elder Abuse Prevention	11	22.9
Government Entitlements and Insurance Assistance	11	22.9
Health Screenings	10	20.8
Nutritional Services	10	20.8
Spiritual Services	10	20.8
Social Activities	10	20.8
Employment Services	8	16.7
Fall Prevention	8	16.7
Home Health/Skilled Nursing Services in the Home	8	16.7
Vision/Hearing	8	16.7
Domestic Services (Cleaning, Grocery Shopping)	8	16.7
Property Issues Relating to Hurricane Threats	7	14.6
Legal Services	7	14.6
Exercise and Movement Programs	7	14.6
General Support Group	7	14.6
Home Repair/Maintenance	6	12.5
Wellness Checks	6	12.5
Mental Health Services	6	12.5
Alzheimer's and/or Dementia Programs	6	12.5
Advocacy	5	10.4
Crisis Intervention Resources/Services	5	10.4
Personal Care (Bathing, Toileting, Transferring Weight)	5	10.4

(continued)

Table 4.4 (continued)

Categories	Number	Percent
Types of Programs and Services Provided to Older Adults [a] (continued)	48	N/A
Housing	4	8.3
Adult Day Care	4	8.3
Substance Abuse Services	4	8.3
Senior Center Services	3	6.3
Low-Income Energy Assistance	3	6.3
Short-Term Financial Assistance	2	4.2
Financial Planning	2	4.2
Health Care	2	4.2
Skilled Nursing Services Outside the Home	2	4.2
Dental Care	1	2.1
Moving Services	1	2.1
Other Programs and Services	29	60.4
Most Important Products and Services Targeted at Older Adults	48	100.0
Adult Education Classes	4	8.3
Resource and Referrals	3	6.3
Legal Services	3	6.3
Personal Care (Bathing, Toileting, Transferring Weight)	2	4.2
Transportation	2	4.2
Meal Preparation	2	4.2
Geriatric Care Management	2	4.2
Mental Health Services	2	4.2
Home Health/Skilled Nursing Services in the Home	1	2.1
Health Care	1	2.1
Nutritional Services	1	2.1
Counseling	1	2.1
Social Activities	1	2.1
Skilled Nursing Services Outside the Home	1	2.1
General Support Group	1	2.1
Caregiver Support	1	2.1
Adult Day Care	1	2.1
Senior Center Services	1	2.1
Exercise and Movement Programs	1	2.1
Spiritual Services	1	2.1
Disaster Preparedness	1	2.1
Independence Related	1	2.1
Employment Services	1	2.1
Crisis Intervention Resources/Services	1	2.1
Government Entitlements and Insurance Assistance	1	2.1
Other Programs and Services	15	31.3

[a] Organizations identified multiple types of programs and services provided to older adults and, therefore, the columns percentage adds up to greater than 100 percent.

Organizational Typology for Organizations in Sample

In Chapter 1, structural differences among organizations were hypothesized to be associated with perceptions of environmental uncertainties related to funding, staffing, accessibility of care, quality of care, and the likelihood of collaboration and communication with other organizations. Characteristics of organizations that were identified for further exploration included: (1) longevity of the organization defined in terms of years in existence; (2) formal organization size defined in terms of number of paid employees; (3) dependency on volunteer labor; (4) specialization defined in terms of the number of types of programs and services provided; (5) government, nonprofit, or for-profit status of organizations; and (6) population focus of service provision (whether or not organizations target service provision to women, racial or ethnic minorities, or low-income populations). ***Table 4.5*** presents recoded versions of variables from previous tables to provide an overview of these characteristics of organizations in the sample.

As mentioned above, longevity of the organization was operationally defined as years in existence (categorized in quartiles; see ***Table 4.5***). Most organizations had been established in the community for numerous years. Nearly half of organizations had existed for 20 or more years; and nearly three-quarters had existed for 9 or more years.

Formal organization size was operationally defined using the median number of full-time and part-time employees that work at the organization (see ***Table 4.5***). Half of organizations were characterized as small for having equal to or less than the median number of employees, and half were characterized as large for having greater than the median number of employees. In addition, one-quarter of organizations were considered dependent

on volunteer labor for being small organizations with greater than the median number of volunteer workers.

Table 4.5. Organizational Typology for Organizations in Sample

Categories	Number	Percent
Years in Existence	47	100.0
Less than 9 years	12	25.5
9 to 19 years	12	25.5
20 to 32 years	11	23.4
More than 32 years	12	25.5
Formal Organization Size [a]	40	100.0
Small	20	50.0
Large	20	50.0
Dependent on Volunteer Labor [b]	48	100.0
Yes	12	25.0
No	36	75.0
Specialized [c]	48	100.0
Yes, 1 to 3 types of programs or services	15	31.3
Yes, 4 to 7 types of program or services	11	22.9
No, 8 to 12 types of program or services	10	20.8
No, 13 or more types of program or services	12	25.0
Median	7	—
Government, Non-Profit, or For-Profit Status	48	100.0
Government	11	22.9
Nongovernment, nonprofit	21	43.8
Nongovernment, for-profit	16	33.3
Population Focus of Service Provision	48	100.0
Targets Services to Women, Racial/Ethnic Minorities, or Low-Income Populations	23	47.9
Provides Services to the General Population	25	52.1

[a] Size of organization was operationally defined using the median number of full-time and part-time employees that work at the organization (Median=18.5). Small organizations were defined as having equal to or less than the median number of employees, while large organizations were defined as having greater than the median number of employees.
[b] Dependent on volunteer labor was operationally defined as small organizations (see size of organization) with greater than the median number of volunteer workers (Median=21.0).
[c] Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County.

Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County (see ***Table 4.5***). Nearly one-third of organizations specialized in one to three types of programs and services, and more than one-fifth of organizations specialized in four to seven types of programs and services. The

remaining organizations were diversified and offered eight or more types of programs and services.

Formal organization size was significantly associated with the number of programs and services provided by the organization (data not shown). Generally speaking, small organizations specialized in fewer types of programs and services than large organizations, which were more diversified (M = 5.5 compared to M = 12.9, t-test statistic, $t(38) = -3.30$, p = 0.0021). In addition, formal organization size was significantly associated with dependency on volunteer labor (data not shown). Small organizations were more dependent on volunteer labor than large organizations (Mdn = 30 volunteers compared to Mdn = 11 volunteers, Fisher's exact, $p < 0.0001$).

One-fifth of organizations were government organizations such as government departments, public libraries, and public hospital districts or authorities (see ***Table 4.5***). About 44 percent of organizations were nongovernment, nonprofit organizations. The remaining one-third of organizations were nongovernment, for-profit organizations.

During the interviews, only five government, four nonprofit, and two for-profit organizations ever mentioned public policy and legislation that has significantly informed the development of service models for older adults in the United States (data not shown). Of the nonprofit organizations, one reported being established by the Older Americans Act, which developed the service and funding models that have provided home- and community-based services to older adults over the past 50 years. Since this nonprofit organization was mandated by public policy and legislation, this organization was recoded into the government category for analysis purposes.

Population focus of service provision was operationally defined into dichotomous categories: (1) targeting services to women, racial or ethnic minorities, or low-income populations or (2) providing services to the general population. Organizations were almost evenly split between targeted versus general service provision (48% compared to 52%).

CONCLUSION

After reviewing the size and structure of organizations that provide services to older adults in the study community, I propose to use five variables as an organizational typology or analytic device for organizing and stratifying data in subsequent chapters: (1) longevity of the organization; (2) formal organization size; (3) specialization; (4) government, nonprofit, or for-profit status of organizations; and (5) population focus of service provision. As mentioned earlier, formal organization size was statistically associated with specialization and dependency on volunteer labor. In developing the organizational typology, I prioritized formal organization size and specialization as stratifying variables. Although I excluded dependency on volunteer labor from the organizational typology, dependency on volunteer labor may be useful to help explain trends in data.

CHAPTER 5. PERCEPTIONS OF ENVIRONMENTAL UNCERTAINTIES

This chapter examines my second research question on the perceptions of environmental uncertainties among organizations that provide services to older adults (see ***Figure 5.1***). In this chapter, I focus on three types of environmental uncertainties: (1) funding sources, (2) staffing, and (3) local disparities in access to and quality of care that are identified by organizations. To examine these environmental uncertainties, I first draw on thematic analyses to describe the perceptions of environmental uncertainties among organizations in the sample. Then I conduct bivariate statistical analyses to examine the relationship between structural features of organizations and perceptions of environmental uncertainties.

Research Question

2. What are environmental uncertainties in the study community that contribute to adaptations among organizations serving older adults?

Hypotheses

H1: Government and non-profit organizations have different perceptions of funding uncertainties than for-profit organizations.

H2: Small formal organizations (i.e., those with fewer paid employees) and organizations specialized in fewer types of programs and services have different perceptions of staffing uncertainties than large formal organizations (i.e., those with more paid employees) and specialized in more types of programs and services.

H3: Government organizations, nonprofit organizations, and organizations that target services to women, racial and ethnic minorities, or low-income populations have different perceptions of local disparities in access to and quality of care than for-profit organizations and organizations that provide services to the general population.

Figure 5.1. Research Question and Hypotheses Explored in Chapter 5

ANALYTIC APPROACH

Thematic Analyses

I conducted thematic analyses of semi-structured interview data. As mentioned in ***Chapter 3***, preliminary coding involved a two-stage coding process of data. The first stage involved open coding to broadly examine the data and to identify emerging themes, and the second stage involved focused coding of key emerging themes identified during open coding (Esterberg 2002). Funding uncertainties, staffing uncertainties, and local disparities in access to and quality of care were three codes identified during open coding. ***Table 5.1*** presents the description, example, inclusion criteria, and exclusion criteria for these codes. After completing the coding process, I conducted a detailed review of all coded data to explore patterns.

Table 5.1. Coding Schema for Funding Uncertainties, Staffing Uncertainties, and Local Disparities in Access to and Quality of Care

Code	Description	Examples	Inclusion and Exclusion Criteria
Funding Uncertainties	Description of how and why money or funding issues are barriers for organizations or clients	➢ Organization cannot afford to purchase initial or additional minivans needed to transport program users to and from their facility.	➢ Code includes past, present, and future (i.e., potential) barriers. ➢ Code does **not** include discussions of resources in general. ➢ Code includes discussions of the economy.
Staffing Uncertainties	Description of how and why staffing issues with paid full- or part-time staff and volunteers providing program services are barriers	➢ Organization lacks the qualified or available staff needed to perform the duties to improve existing programs or start new programs.	➢ Code includes past, present, and future (i.e., potential) barriers. ➢ Code includes discussions of staff being over-worked, stressed, or stretched thin
Local Disparities in Access to and Quality of Care	Description of who, how, and why some seniors suffer from disparities; includes all mentions of local disparities	➢ Home care organization identifies isolated populations as those who lack access to services.	➢ Code includes discussions of disparities across specified populations. ➢ Code includes the absence.

Bivariate Analyses

Drawing on the thematic analyses above, I constructed an Excel database consisting of variables for the structural features of organizations and perceptions of environmental uncertainties. After importing the Excel database into Stata 14.0, I computed Pearson chi-square tests or, as necessary because of small expected frequencies, Fisher's exact tests to assess associations of structural features of organizations with their perceptions of environmental uncertainties.

RESULTS: FUNDING UNCERTAINTIES

Thematic Analyses

The majority of organizations (83%) reported one or more funding uncertainties (see ***Table 5.2***). The most common funding uncertainty reported was that organizations wanted to provide additional services, but could not because they lacked available funding (46%) followed by:

- Relying heavily on fundraising / having problems with sustainability of fundraising over time (33%);
- Relying heavily on government funding / having problems with uncertainty of government funding over time (31%);
- Denying access to clients who could not afford services (25%);
- Reporting funding was impacted by recession (13%);
- Reporting competition with other organizations for scarce funding resources (8%);
- Reporting other funding uncertainties (8%).

Other funding uncertainties reported included needing to lend money to stay afloat (N=3), reporting that the government refused to fund a particular type of services (N=1), and lacking demand for services (N=1).

Table 5.2. Funding Uncertainties

Funding Uncertainties	Number	Percent
Wanted to provide additional services, but could not because they lacked available funding		
Yes	22	45.8
No	26	54.2
Relied heavily on fundraising / had problems with sustainability of fundraising over time		
Yes	16	33.3
No	32	66.7
Relied heavily on government funding / had problems with uncertainty of government funding over time		
Yes	15	31.3
No	33	68.8
Denied access to clients who could not afford services		
Yes	12	25.0
No	36	75.0
Reported funding was impacted by recession		
Yes	6	12.5
No	42	87.5
Reported competition with other organizations for scarce funding resources		
Yes	4	8.3
No	44	91.7
Reports other funding uncertainties		
Yes	4	8.3
No	44	91.7

Twenty-two organizations reported that they wanted to provide additional services, but could not because they lacked available funding (see ***Figure 5.2***). Many organizations described that they wanted to add various types of new services, such as home health, meal services, and respite services for caregivers. For example, one organization described how, to remain competitive in the future, they would need to invest funding to expand their services and provide multiple services under one umbrella:

> "In other words, what people want, what, not only do the doctors and case managers want, but the clients and their families would like to have, is one agency. Because of the issues, and we've run into this, too, is dealing with more than one agency, there's confusion, miscommunication issues, a lot of things. So the way to solve that is to have all of the services under one umbrella. And so we've got, they realize that the only way to be competitive and the only way to provide the completely needed services that are needed this day and time with more and more medical needs is to provide skilled services along with this. So, we have to figure out a way that we can either merge with a private skilled agency or find the funding to get accreditation and licensing and staffing for a skilled agency, which is a huge financial undertaking." (ID 17)

In contrast, some organizations wanted funding to spread their current services rather than add new services. For instance, one organization described how it wanted to invest funding to expand its program using a "train-the-trainer" approach:

> "We could see where this program would be so much more successful if we could afford to pay for the training to get the train the trainer type training and then train volunteers to do that program for us." (ID 34)

In this approach, the organization envisioned having a few "master trainers" from the program train a larger number of volunteers who could then facilitate the program independently. Another organization also expressed a need for funding to spread information about its programs and services, but wanted to do so by developing a website. In addition, three organizations hoped to make investments in technology used by older adults, such as computer labs and barcode wristbands. A couple of organizations also wanted funding to support infrastructure investments to make buildings more accessible for older adults.

Example Quotations for Funding Uncertainties

Wanted to provide additional services, but could not because they lacked available funding

"Our long-term plans are to develop some computer labs and have them available at each of our locations. And we'll just, you know, going to need to do some fundraising to, to, in order to be able to afford that." (ID 10)

"I wish that we had a way to provide some nominal home health companion type care rather than refer out so that we can, you know, consolidate what we do. I wish, I wish that we could do, I wish that we could do that. I wish that we had programs here five days a week, that we had the capacity of the funding to do that." (ID 14)

"One thing we wanted to do with the special needs thing, was provide a barcode type wristband, that when they entered the bus it automatically registers that they're on the bus, and when they get to the shelter it registers that they're at the shelter, and sort of like a tracking. But now we, we can't afford to do that because of the technology and the cost of the equipment." (ID 21)

"I think that if we had more funding we could do more stuff but we have zero funds so we don't get any funding from anywhere so, and all, everybody who's part of it works a full-time job somewhere else so we're all just trying to do the best that we can. If we, you know, got a $10,000 grant or something like that, then I could see that we would disseminate more literature for the population and we, you know, or have a website but we have nothing." (ID 40)

Figure 5.2. Example Quotations for Funding Uncertainties: Wanted to Provide Additional Services, But Could Not Because They Lacked Available Funding

Sixteen organizations reported that they relied heavily on fundraising and, as a result, programs and services that relied on funding support from fundraising efforts had problems with sustainability over time (see ***Figure 5.3***). Of these sixteen organizations, most organizations reported that that they relied on funding obtained through private donations and fundraising. Organizations varied in the extent of their reliance on private donations and

fundraising, with some organizations reporting being fully funded by these sources and other organizations reporting being partially funded (e.g., 50%; 70%):

> "Ours are totally on private donations and grants. If the economy dips, our private donors will not be as willing to donate. That would be an issue for us and that will, in fact, limit how we want to expand and increase our programs since we are only private donation and grants." (ID 38)

In addition to or in lieu of private donations and fundraising, several organizations relied on grant funding. Two of these organizations indicated that they had trouble obtaining grants, because they lacked non-profit status.

> "We're kind of up against the, [laughter] between a rock and a hard place on grant writing because we are not, we're, we're part of a school, we're not part of a, a 501, what is it, 503(C) or [laughter] 503, whatever, whatever that is, we're not one because we're part of the, you know, we're part of the school district. So we have run up against that challenge because you look at most grant applications for things that we, every once in a while we'll think, "Oh, we could," you know, "Go for a grant for this kind of thing."... We get knocked out of eligibility right away because of not having that status." (ID 18)

Since these organizations could not obtain grants directly, they sometimes partnered with other organizations with nonprofit status that could apply for grants:

> "The financial aspect of it, being able to obtain, as we discussed earlier, grants, the, the contracts, and the individuals that we work with. Even though we're not able to obtain the, the grants directly, the availability of grants for the non-profit organizations is, is huge. The financing for people, the financial capability for people to maintain their organizations because without them we certainly suffer." (ID 44)

Regardless of whether the organizations relied on private donations, fundraising, or grant funding, organizations generally agreed that these funding sources were critical to keeping them afloat.

Example Quotations for Funding Uncertainties

Relied heavily on fundraising / had problems with sustainability of fundraising over time

> "It just, you know, we can sustain what we're doing right now with what we're doing as far as fundraising. How much more we may or may not be able to fundraise to continue to constantly elevate it, because every time you add a volunteer driver your costs go up because you have to add a million dollars in insurance over and above what insurance they carry, you have to pay for all of the testing that they go through, so it's, you know, there's not, there's no way you're ever going to change that statistic, that 30% is covered by fees and 70% has to be fundraised, because it's not going to ever come from the rides. You can't make the rides so expensive that they'd actually pay for this type of individualized caring service. You just have to raise the funds." (ID 2)

> "Funding. As I said, we're self-funded through the sale of donated goods, but again, there's, you never have all the funds you want so I would say that that's, it's a funding issue." (ID 10)

> "Private donations is another, one of our largest sources of funding. We get some county money and then we do get, our next biggest pot of money is probably just local private foundations, and that changes every year on, you know, what our focus is." (ID 25)

> "The source of funding are just the, the few members who we have that are, been loyal all the years. And we have a little, we have six people on a board of directors who help out... I haven't taken a salary really since we started." (ID 37)

> "More than half of our programs, to support our programs we have to raise through our own fundraising." (ID 51)

Figure 5.3. Example Quotations for Funding Uncertainties: Relied Heavily on Fundraising / Had Problems with Sustainability of Fundraising Over Time

Fifteen organizations reported that they relied heavily on government funding and noted a substantial problem with uncertainty about the availability of government funding over time (see ***Figure 5.4***). For example, one organization expressed this uncertainty bluntly:

> "There's not going to be any federal funding, there's not going to be any state funding, there will be zero funding for anybody." (ID 45)

Organizations expressed that cuts to government funding impacted the programs and services that they provided, because they were essentially expected to do the same work using fewer resources:

> "Well, they'll only give you a certain amount, they just cut us back 11%. So for, for Medicaid dollars it's an all-inclusive rate. And they cut us back 11% so I have less money to do the same amount of work and pay the same amount of people. And I've still got to provide food and, and everything else. I mean, the electric bill doesn't go down, the water bill doesn't go down, you know, those kinds of things. So you just find yourself very stretched." (ID 19)

For some organizations, this decrease in resources occurred partially because the county decreased property taxes, and many programs and services relied on funding derived from tax revenue:

> "Well, we're, you know, we're a government agency so basically our revenue comes from taxes, property taxes. And our general revenue, we're not, we don't have our own taxing district, we're not like the fire department, we don't get any ad valorem or anything, it's strictly general fund… *How does the government funding shape your program development?* It's very critical and very important that, you know, depending on the amount of funding that we receive we can provide, you know, additional services or information to the public." (ID 29)

Some organizations changed the way that they provided services in an attempt to overcome this lack of funding. For example, one organization turned to technology to create efficiencies in staffing in response to staffing being reduced because of a lack of government funding.

Out of the fifteen organizations that relied heavily on government funding, several organizations expressed the need to justify the existence of their programs and services to continue to obtain government funding. One organization explained that one major barrier is

overcoming cultural expectations about what should or should not be funded by the government:

> "Money, funding is the main. We all know that the society's belief now is that the government shouldn't fund these programs. But where I come from, if society and government isn't going to, and the family isn't going to, how do we take care of people? It goes to, who is responsible? If a person is unable to care for themselves, and do have a lack of funds, who is responsible to take care of them? That's a philosophical question." (ID 23)

Several organizations expressed similar concerns about who should care for low-income, disabled, and older populations who may have difficulty taking care of themselves. Organizations that relied on Medicaid or Medicare funding expanded this notion to the government's funding of safety net programs:

> "You know, the legislature last year passed a pretty significant Medicaid reform piece of legislation, which is going to consolidate all of the Medicaid programs... The economy obviously is going to play a really large role in terms of the ability to expand the services to elders in the State of Florida… I'm not sure where we will fit in the future Medicaid world." (ID 22)

These organizations indicated a general lack of appropriate Medicaid and Medicare funding. They reported that making the justification for the government's role in providing a safety net would continue to be critical as the legislature proposes reductions to Medicaid and Medicare coverage.

Example Quotations for Funding Uncertainties

Relied heavily on government funding / had problems with uncertainty of government funding over time

"Well, the <de-identified> was started by a state grant, which is right now, and changes every year, but it's in the, in the budget as a recurring funds. Before this year we were fighting for it every year but, and because the legislature can either put it in or take it out of the budget and the governor has the same ability every year, so we are always trying to maintain the funds that we have. And that is an annual contract with the State of Florida that has several requirements that we have to meet and reports that we have to write in order to justify the use of the funds." (ID 7)

"Well, the two biggest driving factors as far as libraries are concerned are technology and lack of funding, so we have to use technology in order to make up for the fact that we basically can't afford to have as many staff as we used to. That's continually being reduced. Technology's continually being introduced to try and help cope with the situation." (ID 20)

"The county is laid off, I mean, Sarasota, the tax basis has been cut in half. There's no, there's no money to be had by anybody. Everybody's had huge funding cuts with everything." (ID 40)

"I mean, it, it, when you have a Medicare patient you can see patients and you will be paid. The payment structure for all cognitive areas is deficient. You know, just, the winners in the Medicare game are the people that do procedures and the losers are those who sit at the bedside and talk, and we're not the later." (ID 47)

Figure 5.4. Example Quotations for Funding Uncertainties: Relied Heavily on Government Funding / Had Problems with Uncertainty of Government Funding Over Time

Twelve organization indicated that they denied access to clients who could not afford services (see ***Figure 5.5***). Organizations indicated that this denial of services based on the inability to pay disproportionately affected black, Hispanic, and uninsured populations:

> "Race-wise we have more, you know, I, I guess this isn't very nice to say but we have more Whites that, or Caucasian, that can afford us than Blacks or Hispanics." (ID 1)
>
> "*What is the main barrier to participation for people in your programs?* Funding, obviously. As far as getting our services, people that can't take advantage of it is because they can't afford it and they have no other means, they have no insurance, long term care insurance, that will pay for it. They don't qualify for the VA, and here again the Medicaid program that pretty much is non-existent to a point, or is very limited." (ID 17)

Organizations indicated that many older adults lacked long-term insurance that would cover needed programs and services. A couple of organizations contended that this was problematic from a financial toxicity perspective, because the organization could not refer the client to programs and services that would be more cost-efficient in the long-run.

Example Quotations for Funding Uncertainties

Denied access to clients who could not afford services

> "But our service is a pay service so, you know, it's only, you know, unfortunately only those who are able to afford it use our service." (ID 2)
>
> "They're going to have to pay and they have to be able to afford it. Now they don't have to be wealthy because I think care management saves people money in the long run, but they have to be able to pay their bill." (ID 4)
>
> "Well, I think primarily the people that I come in contact with are on an average to higher socioeconomic [inaudible] because this is a service for which there is no insurance, they have, they would have to pay for it." (ID 5)

Figure 5.5. Example Quotations for Funding Uncertainties: Denied Access to Clients Who Could Not Afford Services

Six organizations reported that their funding was substantially impacted by the economic recession (see ***Figure 5.6***). Several organizations indicated that they weathered

previous economic recessions, but were particularly impacted by the economic recession of 2008:

> "Yeah, understand that, well, when we first started out funding was not an issue. We funded ourselves and there were, there was quite a bit there. And then after 2008 we literally got kind of wiped out, just like many seniors with their retirement funds as well as our other funds. And so, and then our business cost is three times the projected amount so, and then we started pursuing other funding, bank funding, but at that time the banks needed bailouts, too, so they were of no help. So, we basically went to someone that helped with the cash flow, a short-term lending based on invoices." (ID 17)

This organization continued to explain that it is required to pay for all services up-front and then seek reimbursement from the government. Given the economic recession and the slow reimbursement process from the government, the organization entered a new business relationship with a short-term lender that could provide a cash flow to keep the organization afloat while it waited for government reimbursement.

Among the six organizations that explicitly discussed the economic recession as a funding barrier, most discussed how the economic recession created a dollar shortage that exacerbated difficulties paying for basic operating costs, such as the electric bill. Most organizations described addressing the economic recession after it occurred, but one organization prepared for it in advance:

> "Well, I think some of the challenges is, you know, as we've watched the economy really struggle over the last four years I think a lot of the, the middle management that was able to kind of move in and around programs and look out for disparities, that, those, those management positions were eliminated. We've reduced our staff by more than 25% in 2005 and '06 when actually the economy was riding high. I have a boss who is very clairvoyant and he saw it coming and he said, "We've got to get ready, we've got to reduce staffing," so we, we just naturally attritioned positions out and combined programs." (ID 15)

This organization foresaw the economic recession and reduced staff in anticipation.

Example Quotations for Funding Uncertainties

Reported funding was impacted by recession

"I've got a real crisis, my insurance is up to $8,000, I can, I've got a little cash flow, I'll be okay in three months, tied me," I can't do that, I've got, so all of us are scrambling to pay the light bill, we're all figuring out how to make payroll. So that I'm not, I don't think it's a maliciousness or we're callous or we're territorial. This economy has hit us so bad it's, you know, I'm the, I know I'm the, part of my job is to the vision for this organization, to do the planning, and, and I, though I try to keep doing that, amid the, the real dollar shortage that we have been facing." (ID 8)

"Well, you know, we've been hard hit by, by the recession. I mean, Florida, you know, really got hard hit earlier because of the housing challenges. So, in terms of our revenue coming in it's been just budget cuts consistently. So, a lot of the, I'd say a lot of the federal county and state grants that we've gotten, they've just, they've got, they've got less money and so the allocations are being cut. You know, it's always, you know, 10%, 5%, 3%, 7% cuts so you're, you're dealing with less money." (ID 14)

"Just like the funding for many nonprofit organizations is way down. And even the same with churches and things like that because of the economic situation, it has impacted us like no other recession. And I've been through recessions and we didn't have any issues then, basically speaking, that it was just a typical cycle. But this time it has just really made such a huge difference in what's going on with what people are receiving for care and, because of the families out there working any kind of job they can sometimes, and sometimes picking up odd jobs just to try to make ends meet because there's salary cuts, or having to take any job they can get when they're laid off and, and so it's, it's changed the whole family structure. Now we see a lot of kids moving in with their parents down here now, and these kids had good paying jobs and now they're living with mom who's living on social security, and so it's, it's changed a lot." (ID 17)

Figure 5.6. Example Quotations for Funding Uncertainties: Reporting Funding Was Impacted by Recession

Four organizations reported competing with other organizations for scarce funding resources (see ***Figure 5.7***). These organizations explained that, because of the large number of organizations in Sarasota County, they competed against other organizations for finite resources:

> "Well, I think funding. I mean, it's very, very competitive. Sarasota County alone has over 1,600 non-profits. And a lot of people are interested in entering the aging field or somehow introducing aging into what they're doing. So, we're competing locally for funds, for volunteers, for media coverage, so that's always a, a challenge. In a three-county area, Manatee, Sarasota, and Charlotte County, there are more than 2,700 non-profits. Now I don't know if that means anything to you but when I tell people about that from around the country they just are shocked. So, what does that mean? There's a lot of people with our hand out." (ID 15)

As a result, organizations found it critical to distinguish themselves from other organizations so that they could set themselves apart in the eyes of private funders and grant agencies.

Example Quotations for Funding Uncertainties

Reported competition with other organizations for scarce funding resources

> "Yeah, we're, as far as the county funding is concerned, we're just part of the county budget. We compete with all the other government agencies or local entities for funding. We just got another 5% budget cut." (ID 20)
>
> "I do see a, again, there's competition for, for funding money and that has become more acute as, as government funding has dried up and as things have become tighter all around. I think there is competition and I think some of these smaller programs should probably be folded into bigger programs so then we'd get more efficiency to scale and don't have all this duplication necessarily." (ID 46)
>
> "Well, it, no, it's not, not unfavorably, well, for example, the oncologists don't get along with hospice well because they're, they're kind of in direct competition for patients. If you go to hospice, you don't get oncology and if you go to oncology, you don't get hospice. So they have bad feelings to some degree that, you know, made them slow and reluctant to use that service. On the other hand, with, with Tidewell pulling out there's no real problem anymore. If they have patients that need further, you know, general education support of the type that we provide in the palliative care service there's no reason not to call us and let us be involved. Not looking to convince them to go to hospice." (ID 47)

Figure 5.7. Example Quotations for Funding Uncertainties: Reported Competition with Other Organizations for Scarce Funding Resources

Bivariate Analyses

Bivariate analyses examined the relationship between structural features of organizations and funding uncertainties. Three measures of the structural features of organizations were significantly associated with funding uncertainties: (1) years in existence; (2) government, nonprofit, for-profit status; and (3) population focus of program (see ***Table 5.3***). Younger organizations (i.e., less than 9 years) were more likely to report that they denied access to clients who could not afford services than older organizations (i.e., 9 years

or more; Fisher's exact, p = 0.044). In addition, organizations 20 to 32 years old were more likely to report that they relied heavily on fundraising compared to organizations in other year categories (Fisher's exact, p = 0.037).

Government, nonprofit, and for-profit status was significantly associated with several measures of funding uncertainties. Bivariate analyses provided support to my first hypothesis:

> H1: Government and nonprofit organizations have different perceptions of funding uncertainties than for-profit organizations.

Generally speaking, government and nonprofit organizations were more likely to report funding uncertainties compared to for-profit organizations, including:

- Reporting one or more funding uncertainties (Fisher's exact, p = 0.024);
- Wanting to provide additional services, but could not because lacked available funding (Fisher's exact, p = 0.016);
- Relying heavily on fundraising / having problems with sustainability of fundraising over time (Fisher's exact, p = 0.003); and
- Relying heavily on government funding / having problems with uncertainty of government funding over time (Fisher's exact, p < 0.001).

However, for-profit organizations were more likely to deny access to clients who could not afford services compared to government and nonprofit organizations (Fisher's exact, p < 0.001).

Population focus of service provision was significantly associated with several measures of funding uncertainties. Organizations that targeted services to women,

racial/ethnic minorities, or low-income populations were more likely to report funding uncertainties compared to organizations that provided services to the general population, including:

- Wanting to provide additional services, but could not because they lacked available funding (X^2 (1, N = 48) = 6.68, p = 0.010);
- Relying heavily on government funding / having problems with uncertainty of government funding over time (Fisher's exact, p = 0.029); and
- Reporting competition with other organizations for scarce funding resources (Fisher's exact, p = 0.046).

In contrast, organizations that provided services to the general population were more likely to report that they denied access to clients who could not afford services compared to organizations that targeted services to women, racial/ethnic minorities, or low-income populations (40% vs. 9%, respectively; Fisher's exact, p = 0.019).

Formal organization size and specialization were not significantly associated with any funding uncertainties.

Table 5.3. Funding Uncertainties by Organizational Typology

Categories	Number	Funding Uncertainties: Percent "Yes" [c]						
		A	B	C	D	E	F	G
Years in Existence				*		*		
Less than 9 years	12	75	25	8	17	58	8	8
9 to 19 years	12	75	33	25	42	17	8	0
20 to 32 years	11	100	64	64	18	9	18	9
More than 32 years	12	83	67	42	42	17	17	17
Formal Organization Size [a]								
Small	20	80	45	40	30	10	10	10
Large	20	85	60	35	30	30	20	10
Specialized [b]								
Yes, 1 to 3 types of programs or services	15	73	40	40	27	33	0	7
Yes, 4 to 7 types of program or services	11	100	55	36	55	9	9	9
No, 8 to 12 types of program or services	10	70	40	30	30	10	30	0
No, 13 or more types of program or services	12	92	50	25	17	42	17	17
Government, Nonprofit, or For-Profit Status		*	*	*	*	*		
Government	11	100	73	27	91	0	9	18
Nongovernment, nonprofit	21	91	52	57	19	10	14	10
Nongovernment, for-profit	16	63	19	6	6	63	13	0
Population Focus of Service Provision			*		*	*		*
Targets Services to Women, Racial/Ethnic Minorities, or Low-Income Populations	23	87	65	39	48	9	13	17
Provides Services to the General Population	25	80	28	28	16	40	12	0

* $p < 0.05$ ("Yes" vs. "No") † $p < 0.10$ ("Yes" vs. "No")

[a] Size of organization was operationally defined using the median number of full-time and part-time employees that work at the organization (Median=18.5). Small organizations were defined as having equal to or less than the median number of employees, while large organizations were defined as having greater than the median number of employees.

[b] Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County.

[c] A = Reported one or more funding uncertainties
B = Wanted to provide additional services, but could not because lacked available funding
C = Relied heavily on fundraising / had problems with sustainability of fundraising over time
D = Relied heavily on government funding / had problems with uncertainty of government funding over time
E = Denied access to clients who could not afford services
F = Reported funding was impacted by recession
G = Reported competition with other organizations for scarce funding resources

RESULTS: STAFFING UNCERTAINTIES

Thematic Analyses

The majority of organizations (75%) reported one or more staffing uncertainties (see ***Table 5.4***). The most common staffing uncertainty reported was that organizations reported a substantial need for volunteers (33%) followed by:

- Lacking staff capacity / having overworked staff (29%);
- Having difficulty recruiting and retaining quality staff (19%);
- Needing money to support staff or could not add programs (15%);
- Lacking staff who supported ideas for new programs / having staff who were resistant to change (8%); and
- Reporting other staffing uncertainties (10%).

Other staffing uncertainties reported included reporting staffing needs fluctuated and were unpredictable (N=1), wanting to provide more jobs to older adults but needed additional skills training (e.g., digital literacy; N=1), needing to reduce staff in response to the economic recession (N=1), reducing staff because of they lacked grant funding (N=1), and reducing staff because they lacked government funding (N=1).

Table 5.4. Staffing Uncertainties

Staffing Uncertainties	Number	Percent
Reported any staffing uncertainties		
Yes	36	75.0
No	12	25.0
Reported substantial need for volunteers		
Yes	16	33.3
No	32	66.7
Lacked staff capacity / had overworked staff		
Yes	14	29.2
No	34	70.8
Had difficulty recruiting and retaining quality staff		
Yes	9	18.8
No	39	81.3
Needed money to support staff or could not add programs		
Yes	7	14.6
No	41	85.4
Lacked staff who supported ideas for new programs / had staff who were resistant to change		
Yes	4	8.3
No	44	91.7
Reported other staffing uncertainties		
Yes	5	10.4
No	43	89.6

Sixteen organizations reported a substantial need for volunteers (see ***Figure 5.8***). Organizations varied in their dependence on volunteers. Some organizations had no paid employees and were completely reliant on volunteers. Other organizations indicated that they had paid employees but could not maintain their programs and services without volunteers. Many organizations reported volunteers numbering in the hundreds or thousands (e.g., 340; 440; 1,100).

Despite the need for volunteers, the supply of volunteers did not keep pace with the demand for them:

> "And, you know, there's a finite number of attorneys in our community that hasn't grown to meet the need. And so, you know, we have so many volunteers, and even though we try to bring in new volunteers all the time, they're maxed out a lot quicker." (ID 25)

Organizations reported challenges in obtaining volunteers. One challenge was that the substantial influx and outflux of the snowbird population greatly affected the supply of volunteers:

> "It's more a, just not having enough people, especially in the Summer. In the Winter we're, we're blessed and then in the Summer it's a dry season and it's really hard to, we can't maintain all of our programs and we end up with just a couple of people who are kind of overstretched as they're trying to keep things going, and it's hard, so." (ID 24)

This meant that organizations had more volunteers and better support for programs and services in the winter months, but lacked volunteers in the summer months when the snowbirds returned home.

In addition to seasonal variations in the supply of volunteers, organizations reported three other challenges to obtaining volunteers. First, volunteers had many competing demands on their time and, therefore, time limited their ability to volunteer. Second, volunteering sometimes came with substantial costs (e.g., transportation costs), which may be difficult to overcome. Finally, organizations sometimes reported difficulty finding volunteers who had a particular skillset needed to be successful volunteers, such as computer skills, communication skills, or governess skills:

> "I think governess is a challenge. I think it's harder and harder to find quality volunteers who understand that, that being a part of a governess board takes time, talent, treasure, and it's a real commitment. I think there's a lot of people who think they want to be on boards of directors. I think there's, the, that there are few really good people who understand what's involved. I think that's a big challenge." (ID 8)

Organizations reported overcoming these barriers by aggressively advertising for volunteers using multiple modalities, including television, radio, newspaper, Craigslist, and booths at fairs.

Example Quotations for Staffing Uncertainties

Reported substantial need for volunteers

"But we do advertising for volunteer drivers on TV, on the radio, and in the newspaper. You know, not, it's not a continually running thing but, like about a month ago we had a great article in the Sarasota Herald Tribune, front page of the Local section, and it talked about our volunteer drives and our member riders and it's things like that that get people to know about it. It is hard, you know, especially in a tough economy, to get people to, who are able to do things, who would like to do it free of charge. And with our program, you know, you may even end up spending money volunteering for us, which I find unbelievable that people do it and they, and they enjoy doing it. You know, I mean, we do reimburse you for your mileage but you never know, you know, like are you getting exactly what you spent on the gas? You know, I mean, we do it by the mile and everything's computerized and they get a printout of their mileage and everything, but do you ever really know how much you spent, what you drove that day as opposed to what you're being reimbursed?" (ID 2)

"Yes. Yeah, we have a lot of people who are here between four to six months, seven to eight months a year, so depending on when they're here. I mean, you know, usually there's a flow and so probably, oh, at the end of October, first of November we have more people coming, coming down who might be calling. Also, that's, we have more volunteers coming that time of year so that's the other, that's the other challenge that we have, we have programs that need volunteer staffing. Sometimes we're a little short in the Summer and we have an overabundance, you know, for a six-month period. So that's a challenge when we, when we're using volunteers to staff programs." (ID 14)

"And years ago, I relied on churches for Meals-on-Wheels program, we had hundreds and hundreds of volunteers. But the situation is now that people need to work more than ever and oftentimes they don't have the time or the money to do the things that they used to be able to do. And so, the volunteer program is, is suffering in a lot of ways." (ID 17)

"And so, when we, we have a situation like that we try to recruit volunteers who have good communication and computer skills and try and provide some one on one time for those that really need the extended help." (ID 21)

Figure 5.8. Example Quotations for Staffing Uncertainties: Reported Substantial Need for Volunteers

Fourteen organizations reported that they lacked staff capacity and/or had overworked staff (see ***Figure 5.9***). All fourteen organizations reported that they lacked staff to manage their current programs and services. Many organizations reported that staff were overworked and described their work habits as stressful, unhealthy, and unsustainable:

> "And we have very, very limited employees so, you know, myself and one other person are the only two full-time employees, so literally everybody's wearing every hat. *That must be a challenge.* It is a challenge. To be perfectly blunt, it's actually not healthy. [laughter] But I do have such a commitment to the mission and I can probably maintain this level of six to seven days a week until 7-7:30 at night, I get up at 5:00, for about another six months and then we'll have to try and, hopefully have raised enough that we can do a little more balanced work." (ID 2)

Several organizations reported that they were not simply having trouble keeping up on their current workload, but were also getting more and more behind each passing day. For example, one organization described how their work backlog was now 100 clients long:

> "Well, you cannot file that petition unless you have a guardian that is willing and able to serve. So the 100 people that are on my waiting list that we've assessed and said, "Uh-huh [yes], they definitely need a guardian," [laughter] there's no other resources, no other alternative and they are at immediate risk but we cannot take them." (ID 26)

These long backlogs meant that older adults who needed urgent services were not receiving them.

Example Quotations for Staffing Uncertainties

Lacked staff capacity / had overworked staff

> "And it's, we're always seeming like we're short staffed, to try to find that because the demand's growing and other agencies hiring people and hiring our staff, too, so that sometimes we do lose staff to other cases." (ID 17)
>
> "Probably the big, our biggest challenge is, is staff, you know, having, and, you know, the, you know, being fully funded in order to have the staff to be able to manage the programs to, you know, to do the work. Without the staff, you know, you, it's difficult." (ID 28)
>
> "We are very stressed with the amount of work each of the <de-identified> people are doing. It is a tremendous job. We are doing it because it's a wonderful, wonderful mission that this organization has but there isn't a person here who's very bored." (ID 38)

Figure 5.9. Example Quotations for Staffing Uncertainties: Lacked Staff Capacity / Had Overworked Staff

Nine organizations reported that they had difficulty recruiting and retaining quality staff (see ***Figure 5.10***). Organizations reported that they had difficulty recruiting staff with the necessary skills and qualifications to provide services:

> "Well, with any business that you're growing you're always going to see challenges finding the right quality of people for employees and drivers, those type of things. We want, because we do have a very high standard on employees it's sometimes difficult to find exactly the right employee. That's probably going to be our biggest challenge, is, is making sure that the employees fit our company profile that we want to maintain." (ID 48)

Organizations mentioned that examples of needed skills included soft skills, such as compassion. Although most organizations described the challenge as finding the "right" applicant within a large workforce, one organization considered the workforce to be limited. This organization sought younger employees, which were not as readily available in Sarasota County.

In addition to skills and qualifications, organizations reported difficulties recruiting staff who were motivated to perform particular work assignments. For instance, one organization found it challenging to find staff who would be interested in working with disabled populations. Organizations not only found it difficult to recruit motivated staff, but also to retain staff by motivating them with a competitive salary and benefits:

> "I think you, you constantly face the challenge of a workforce, of getting, of a multi-generational workforce that you have to recruit, retain, and motivate. I can't, and when you don't have the dollars that a corporation has, and so you are competing. I mean, I pay, I give them health insurance, I pay 75% of it, 75% of it, the employee pays 25%. Down the street a not-for-profit is paying 100%. If health insurance is important to somebody, could be equal, they're not going to come work for the <de-identified>. So that's a major, major challenge." (ID 8)

This organization found it challenging to complete with other organizations that were providing health insurance at no cost to staff.

Organizations also reported challenges with retaining staff because of the nature of their workflow. One organization described how their work ebbed and flowed and, therefore, the work hours made available to staff also ebbed and flowed:

> "I think there's a lot of challenges in getting people, good people, to work for you. It's constant. Even though the unemployment rate may be huge it's just making it a harder job to find the right person in the masses.... But the problem is maintaining and keeping them because of the way we do business. So, I may gain five hundred hours in twenty minutes and I may lose five hundred hours in twenty minutes. So that means all the people that are associated with that timeframe lose their case or gain the case, and you may not have enough people to ramp up that quickly and then you may lose so many people very quickly. So, they can only hold on so much, so a lot of people work for multiple, well, we don't allow our caregivers to work for multiple companies, we ask that they only work for ours. Our home health aides and CNAs, we had to allow that because of the nature of that beast, so we had to make some concessions there… The CNAs and home health aides are allowed to work for other agencies because normally they work for three or four or five of them, unfortunately, it's a different kind of animal. But our caregivers, you know, a lot of them, it originally started out with people that were doing volunteer work, and they just wanted to get paid a little bit to be able to do the job, but then when the economy

> changed so much it was like a third job or a second job for somebody versus the way we did it where we could pull from before. So, things have changed radically over the last probably three or four years with the type and the person that we can retain and get. And, you know, if you need to pay your bills, you may have two jobs and this is one of them and you don't have the hours you need to move on, and that's what's difficult. Even though they want to stay with you they just, they can't do it anymore." (ID 36)

For some staff, this unpredictability of work hours meant that they did not have security in their income. To overcome this barrier, staff either had to complement their work hours with additional work hours elsewhere or, if the organization did not allow "moonlighting", secure a completely new job opportunity. Finding staff who were willing to take on this lack of security was increasingly challenging for this organization.

Example Quotations for Staffing Uncertainties

Had difficulty recruiting and retaining quality staff

"What I mostly need is, is I guess awareness that we're here and filling the, the jobs with qualified, skilled people. *What challenges do you think you'll have with that?* The challenges that, that we have is finding the skilled and compassionate people… We, we get, we get a large number of applicants but being qualified is a different story." (ID 9)

"Well, obviously finding additional qualified staff. And it's, we're always seeming like we're short staffed, to try to find that because the demand's growing and other agencies hiring people and hiring our staff, too, so that sometimes we do lose staff to other cases. And they still want to work for us but when they have another case they can't work for us sometimes. So that's been a challenge, that when we have new agencies that come to town, especially some that are, do the skilled as well, they tend to grab a lot of the business and our caregivers because they can provide more for them as far as maybe benefits and larger shifts, things like that. So that's been, that's been a challenge, is getting the qualified staff in." (ID 17)

"Yeah, right now there's a, you know, huge market out there as far as people going into home health because that's where the jobs are. But it isn't necessarily the highest quality of people that are, you know, going into that and, and don't have a lot of training, so obviously keeping the quality at a level that you're comfortable with and certainly training the number of people, you know, keeping them up to date and trained as they come into the job market because this isn't something that they've done before." (ID 41)

"I would say one challenge is workforce, finding individuals who want to provide this type of work and are motivated to provide this type of work." (ID 44)

"But in Sarasota County it's 30%, 30.-something percent are over 65. So that doesn't leave much of a workforce, you know, and looking for staff that would be probably younger. It's a limited workforce compared to other, other cities if that makes sense to you." (ID 50)

Figure 5.10. Example Quotations for Staffing Uncertainties: Had Difficulty Recruiting and Retaining Quality Staff

Seven organizations reported that they needed additional money to support staff or could not add programs (see ***Figure 5.11***). Organizations described how they were doing the most that they could do with available staff. They could not even consider improving current services or adding additional services without first securing additional staff because existing staff were at capacity.

> "Oh, let's see, I think the much, a bit more comprehensive rather than provide the class, provide the service, sort of empower them, get them on their way. I think if we could follow-up, reach out to, to even those that we serve so that we're, we're giving them not just one rope to hang onto but two. [laughter] I would make those services much more, more comprehensive. But I'd need some more staff and whatnot to do that… And I think a lot of our grantors and our, would love us to be more case managers, I mean, follow these women for a lot longer to do the kind of measurements that might really be helpful. I don't have the money or the staff for that. That's expensive. I can only hope in that finite period of time I can get them on their feet and they'll be more productive members of society." (ID 8)

This organization described how it wanted to provide more comprehensive care, but lacked the staff to provide this enhanced level of services; providing enhanced services would have been extremely costly to the organization.

Example Quotations for Staffing Uncertainties

Needed money to support staff or could not add programs

> "So, I think, you know, if we had more money we could have more staff, we could do more things, but we're doing what we can with what we have right now, so writing a lot of grants." (ID 15)

> "You know, certainly with having additional programming that often warrants having additional staff, so, you know, I think working in a community healthcare setting, you know, we all feel that we're doing, you know, the best and the most that we can possibly do, and are grateful to be able to do that but, you know, at, at times feel like there's plenty more that we could be doing." (ID 30)

Figure 5.11. Example Quotations for Staffing Uncertainties: Needed Money to Support Staff or Could Not Add Programs

Four organizations reported that, when starting new programs and services, they lacked staff who supported new ideas and/or had staff who were resistant to change (see ***Figure 5.11***). Organizations identified needing to obtain multiple levels of buy-in, from the corporate office, management, and front-line workers:

> "We have restrictions - I can't start a program unless I'm told from [the corporate headquarters] to start it. I'm restricted from what government allows me to do. I can't just start a program." (ID 23)

Organizations not only needed to obtain buy-in for the idea, but also identify a champion with the interest and availability to implement the idea.

Example Quotations for Staffing Uncertainties

Lacked staff who supported ideas for new programs / had staff who were resistant to change

> *"What challenges do you have starting any new programs?* Well, I guess just getting support, [laughter] you know, from colleagues." (ID 3)

> "Yes, if we're implementing a new way to fill out the care notes, for an example, it may take thirty days for us to get all eighty of those people on board even though they've been educated over and over and over, so it could be a resistance to change. *And that's from the caregiver?* Yes." (ID 11)

> "*What challenges do you have starting new programs other than funding?* Finding staff who are willing to take on the responsibility, finding resources within the community that I can use in order to provide the programming, because generally speaking we don't put on programs." (ID 20)

Figure 5.12. Example Quotations for Staffing Uncertainties: Lacked Staff Who Supported Ideas for New Programs / Had Staff Who Were Resistant to Change

Bivariate Analyses

Bivariate analyses examined the relationship between structural features of organizations and staffing uncertainties. Three measures of the structural features of organizations were significantly associated with staffing uncertainties: (1) formal organization size; (2) government, nonprofit, for-profit status; and (3) population focus of program (see ***Table 5.5***). Small organizations were more likely to report that they had a substantial need for volunteers than large organizations (55% vs. 20%, respectively; Fisher's exact, $p = 0.048$). In addition, small organizations were more likely to report that they lacked staff capacity or had overworked staff compared to large organizations (moderately significant, Fisher's exact, $p = 0.092$).

Government, nonprofit, and for-profit status was significantly associated with several measures of staffing uncertainties. Government organizations were more likely to report one or more staffing uncertainties compared to for-profit and non-profit organizations (Fisher's exact, $p = 0.047$). All government organizations reported one or more staffing uncertainties compared to 75% of for-profit organizations and 62% of non-profit organizations. Nonprofit organizations were more likely to report a substantial need for volunteers compared to government and for-profit organizations (Fisher's exact, $p = 0.011$). About half of nonprofit organizations reported a substantial need for volunteers compared to 36% of government organizations and 6% of for-profit organizations. Finally, for-profit organizations were more likely to report that they had difficult recruiting and retaining quality staff (Fisher's exact = 0.008). Forty-four percent of for-profit organizations reported that they had difficulty recruiting and retaining quality staff compared to 10% of non-profit organizations and no government organizations in the sample.

Population focus of service provision was associated with two measures of staffing uncertainties. Organizations that targeted services to women, racial/ethnic minorities, or low-income populations were more likely to report one or more staffing uncertainties compared to organizations that provided services to the general population (moderately significant, Fisher's exact, $p = 0.098$). In addition, organizations that targeted services to women, racial/ethnic minorities, or low-income populations were more likely to report that they needed money to support staff or they could not add programs compared to organizations that provided services to the general population (26% vs. 4%, respectively, Fisher's exact, $p = 0.044$).

Taken together, these results provide mixed support for the second hypothesis:

> H2: Small formal organizations (i.e., those with fewer paid employees) and organizations specialized in fewer types of programs and services have different perceptions of staffing uncertainties than large formal organizations (i.e., those with more paid employees) and specialized in more types of programs and services.

The findings support the notion that small organizations had different perceptions of staffing uncertainties than large organizations. Bivariate analyses showed that small organizations reported a greater need for volunteers and had overworked staff. However, bivariate analyses did not find any relationship between specialization and staffing uncertainties. Specialization and years in existence were not significantly associated with any staffing uncertainties.

Table 5.5. Staffing Uncertainties by Organizational Typology

Categories	Number	Staffing Uncertainties: Percent "Yes" [c]					
		A	B	C	D	E	F
Years in Existence							
Less than 9 years	12	91.7	16.7	41.7	33.3	10.0	16.7
9 to 19 years	12	75.0	25.0	33.3	16.7	20.0	8.3
20 to 32 years	11	81.8	54.5	27.3	9.1	10.0	9.1
More than 32 years	12	58.3	41.7	16.7	16.7	20.0	0.0
Formal Organization Size [a]			*	†			
Small	20	85.0	55.0	45.0	10.0	10.0	10.0
Large	20	75.0	20.0	20.0	35.0	20.0	5.0
Specialized [b]							
Yes, 1 to 3 types of programs or services	15	73.3	26.7	40.0	26.7	0.0	0.0
Yes, 4 to 7 types of program or services	11	63.6	45.5	27.3	0.0	18.2	9.1
No, 8 to 12 types of program or services	10	80.0	40.0	0.0	20.0	20.0	20.0
No, 13 or more types of program or services	12	83.3	25.0	41.7	25.0	25.0	8.3
Government, Nonprofit, or For-Profit Status		*	*		*		
Government	11	100.0	36.4	54.5	0.0	36.4	18.2
Nongovernment, nonprofit	21	61.9	52.4	19.0	9.5	9.5	0.0
Nongovernment, for-profit	16	75.0	6.3	25.0	43.8	6.3	12.5
Population Focus of Service Provision		†				*	
Targets Services to Women, Racial/Ethnic Minorities, or Low-Income Populations	23	87.0	39.1	34.8	21.7	26.1	4.3
Provides Services to the General Population	25	64.0	28.0	24.0	16.0	4.0	12.0

* $p < 0.05$ ("Yes" vs. "No") † $p < 0.10$ ("Yes" vs. "No")

[a] Size of organization was operationally defined using the median number of full-time and part-time employees that work at the organization (Median=18.5). Small organizations were defined as having equal to or less than the median number of employees, while large organizations were defined as having greater than the median number of employees.

[b] Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County.

[c] A = Reported one or more staffing uncertainties
B = Reported substantial need for volunteers
C = Lacked staff capacity / had overworked staff
D = Had difficulty recruiting and retaining quality staff
E = Needed money to support staff or could not add programs
F = Lacked staff who supported ideas for new programs / had staff who were resistant to change

RESULTS: LOCAL DISPARITIES IN ACCESS TO AND QUALITY OF CARE

Thematic Analyses

The majority of organizations (96%) reported one or more local disparities in access to and quality of care (see ***Table 5.6***). The most common local disparity reported was that organizations did not provide services to older adults with physical disabilities or mental health issues (65%) followed by:

- Reporting clients experienced barriers to accessing transportation (46%);
- Reporting broader issues in community for low-income populations (35%);
- Reporting issues with socially isolated and/or homebound clients who had trouble accessing services (29%);
- Having to turn away clients who could not afford services (23%);
- Reporting difficulty accessing services because of lack of organizations in geographic area (19%);
- Reporting barrier for low-income populations because insurance coverage did not support services (15%);
- Not providing services to the homeless (15%);
- Reporting physical health as a barrier to accessing services (13%);
- Reporting middle income clients were falling through the cracks because their priority for services was not high enough (8%); and
- Reporting other local disparities to access or quality of care (33%).

Other local disparities reported included: (1) challenges faced by racial/ethnic minorities because of their income and limited resources in the geographic area where racial/ethnic

minorities reside; (2) English as a second language as a barrier; (3) lack of education as a barrier; (4) lack of programs and services for various audiences of older adults, such as non-US citizens, those with substance abuse issues, and those in crisis; (5) lack of programs and services provided in particular geographic areas (e.g., across the county border); (6) older adults being financially damaged by recession / older adults needing to return to work post-retirement; (7) older adults having digital literacy issues that were barriers to applying for services.

Nearly two-thirds of organizations reported that they could not provide services to older adults with physical disabilities or mental health issues (see ***Figure 5.13***). Several organizations reported that they were unable to provide services to older adults in wheelchairs, because their buildings were not wheelchair accessible or their vehicles used to transport older adults to programs and services did not have wheelchair lifts. One organization was unable to provide services to older adults on ventilators, citing that they lacked the appropriate resources. Some organizations also reported that they would provide services to older adults with mild or moderate mental health issues if they were controlled by medications, but would not provide services to older adults with mental health issues that were perceived to be more serious, such as schizophrenia. In addition to mental health issues, some organizations reported that they would not provide services to older adults who had injuries or disorders that affected the brain, such as dementia, Alzheimer's, and traumatic brain injuries; these organizations perceived older adults with these injuries and disorders to be "unpredictable".

Table 5.6. Local Disparities in Access to and Quality of Care

Local Disparities	Number	Percent
Reported any local disparities to access or quality of care		
Yes	46	95.8
No	2	4.2
Could not provide services to older adults with physical disabilities or mental health issues		
Yes	31	64.6
No	17	35.4
Reported clients experienced barriers to accessing transportation		
Yes	22	45.8
No	26	54.2
Reported broader issues in community for low-income populations		
Yes	17	35.4
No	31	64.6
Reported issues with socially isolated and/or homebound clients who had trouble accessing services		
Yes	14	29.2
No	34	70.8
Had to turn away clients who could not afford services*		
Yes	11	22.9
No	37	77.1
Reported difficulty accessing services because of lack of organizations in geographic area		
Yes	9	18.8
No	39	81.3
Reported barrier for low-income populations because insurance coverage did not support services		
Yes	7	14.6
No	41	85.4
Did not provide services to the homeless		
Yes	7	14.6
No	41	84.4
Reported physical health as a barrier to accessing services		
Yes	6	12.5
No	42	87.5
Reported middle income clients were falling through the cracks because their priority for services was not high enough		
Yes	4	8.3
No	44	91.7
Reported other local disparities to access or quality of care		
Yes	15	31.3
No	33	68.8

* Note that 12 organizations indicated that they denied access to clients who could not afford services in ***Table 5.2***, but only 11 of these organizations self-reported that this reflected a local disparity in access to or quality of care in ***Table 5.6***.

Example Quotations for Local Disparities in Access to and Quality of Care

Could not provide services to older adults with physical disabilities or mental health issues

"The only people we can't serve are those confined to a wheelchair, because our program, that we don't have vehicles with wheelchair lifts on them. And that, the only reason we don't serve them is because we don't have the equipment to do so." (ID 2)

"*Are there any populations that you do not serve?* I would say severely disabled people. Our emphasis is on work, and so if it's a person that is unable to work in a competitive setting that's not going to be a population that we'll do our best work with." (ID 10)

"We don't serve people who are handicap beyond the point of doing things, like [laughter] they're very, if they're very incapacitated they would not be able, they can get into the building, it's handicap, you know, available, but those people would probably have difficulty getting to our facility." (ID 13)

"We don't take trachs, we don't take vents… We're not equipped for that. We try to stay away from anybody with traumatic brain injury to the frontal lobe because their behavior's unpredictable. They can't, there's not inhibitions and you don't know when they're going to strike out because it, it doesn't take something to provoke them. So, we, we're choosy about some of the diagnosis. And if somebody has a major psyche history and diagnosis, I will take them if they're say depression because they, they're bipolar, because you can treat them with medications and as long as they're on their meds, they're stable. But not an acute schizophrenic state or anything like that because, again, you're, we're not a psyche hospital." (ID 19)

"Our facility is not, you know, it needs improvement in accessibility, it's a quite, it's an older building so only parts of the building are accessible." (ID 28)

Figure 5.13. Example Quotations for Local Disparities in Access to and Quality of Care: Could Not Provide Services to Older Adults with Physical Disabilities or Mental Health Issues

About 46% of organizations reported that older adults experienced barriers to accessing transportation (see ***Figure 5.14***). Organizations reported that many older adults no longer drive and, thus, older adults need to access transportation to get to programs and services. Organizations differed in their perceptions of whether Sarasota County offered quality transportation services. Although some organizations thought that the county offered comprehensive transportation services, several organizations reported that transportation remained an issue in the county. Some organizations noted that, although transportation services were available, they were not available across all locations in the county and were limited across the county-line.

When transportation services were available, organizations noted three challenges to older adults accessing them. First, many transportation services were cost-prohibitive to older adults, especially those considered low-income. Second, some older adults were not comfortable accessing public transportation services:

> "There's a perception about public transportation for that generation. They often are not comfortable getting on a bus. Taxi service is really expensive, and if you're on a fixed income that's a challenge." (ID 15)

If older adults could afford transportation and felt comfortable using it, organizations reported that older adults still may not be able to access services because of physical, mobility, or vision issues:

> "Transportation in Sarasota is a challenge. We don't have great public transportation. I think our public transportation really tries hard, I just think it's not real accessible when the closest bus stop is two blocks away and you're disabled." (ID 15)

Organizations noted that, although the county offers services to these populations, there was sometimes restrictions that prevented older adults from using these services.

Example Quotations for Local Disparities in Access to and Quality of Care

Reported clients experienced barriers to accessing transportation

"And transportation also is a problem that needs to be addressed in some of these, even these assisted living centers. Because we run into problems where, what I mentioned before, is like a husband goes into the hospital and the wife is there and she wants to go visit, she doesn't drive anymore and they don't take her. So, we offer to do that and they say they can't do it because of insurance purposes so the person is stuck there feeling just left out and lonely because they don't, they can't even go see their spouse. And that's, that's a major heartache for them." (ID 37)

"The greatest difficulty that I see oldest people have, and seniors, is transportation to get to appointments for medical appointments, as well as everything else." (ID 38)

"The issues are clients oftentimes can't get to the service. The client doesn't have access as far as transportation, maybe they don't have a caregiver to get there and help them stay there or to create the opportunity for them to be aware of the program. So, the programs are there but there's an obstacle with getting the person to the program. I think that's a huge obstacle in this area because of a need for quality transportation. And then there's a cost to the transportation so I think that although the programs are there, they could become prohibitive even if the program is a, is a free program because it's a cost, the cost for the person wanting to participate in the program to get to the program." (ID 41)

"We have, because people are visually impaired they can't drive and even though we have SCAT Plus there are some restrictions as far as who can ride SCAT Plus, depending on where they live. So, it still is a big barrier… And now the cost of transportation is higher, even for SCAT Plus, which is the paratransit. That went up from $2.00 to $2.50 each way. I mean, it's a great service but I don't, it's limited." (ID 51)

Figure 5.14. Example Quotations for Local Disparities in Access to and Quality of Care: Reported Clients Experienced Barriers to Accessing Transportation

More than one-third of organizations reported broader issues in community for low-income populations (see ***Figure 5.15***). Several organizations indicated that older adults who were low-income were often overlooked and underserved in the county:

> "You know, we have quite a bit here but I don't know how much there really is for people that can't afford services. You know, I don't know how much there is for those people. I mean, I know if you're in a, in an assisted living facility or a nursing home they usually have plenty to do and of course they provide transportation, too, sometimes, sometimes at a cost. But, you know, Sarasota, Sarasota's just not, sometimes my husband and I [laughter] say it's just not real life here. There's lots of money in Sarasota and lots of people with lots of money so I think sometimes the people, low-income people, get a little bit overlooked." (ID 12)

Knowing this, one organization explained that the question becomes:

> "How do you reach the very, the very isolated and poor and, and how do they find you and how do you have enough resources since they can't find you to go find them?" (ID 46)

Organizations described a wide array of issues for low-income populations in the community, such as being homeless, being unemployed, being hungry and/or food insecure, and experiencing barriers to self-sufficiency. These organizations recounted how older adults who were low-income often were forced to make tough decisions and prioritize their needs. For example, should they purchase medication or food this week?

Figure 5.15. Example Quotations for Local Disparities in Access to and Quality of Care: Reported Broader Issues in Community for Low-Income Populations

Example Quotations for Local Disparities in Access to and Quality of Care

Reported broader issues in community for low-income populations

"Well, I'm thinking of, you know, specific, specifically the sort of lower income, you know, people that live in, in the Newtown area for example. Sometimes people that live in mobile home communities, I think they're underserved." (ID 3)

"Well, I think that the reality of Sarasota County is a great sort of divide between, and it saddens me to say this, kind of between haves and have-nots. You have many people who retire and move here, and if you make a choice to come here that's a pretty, that's a pretty expensive choice… And that group takes, takes advantage of the arts, takes advantage of the theater or takes advantage of the opera and the ballet and all the sporting and the water sports, the boating, the whatnot. When you say social service, their social services are typically the healthcare needs of, because of their age... But overwhelmingly those people can either afford it or have some kind of health insurance and whatnot. I think you then overwhelmingly have the other group in Sarasota and, and I don't mean this to be flippant or sound cruel or insensitive but it's a visual way you may know what I'm talking about. I mean, these are the folks who clean our pools, clean our houses, you know, make the golf course really nice, probably serve us in restaurants, they're maids in the hotels, work in the banks, they do the umpty-ump things in the infrastructure of any city that makes it go. And they're at all levels, I'm not suggesting they're all at minimum wage here. [laughter] Nevertheless, excuse me, these are not the folks who are going to the opera, who are, you know, taking advantage of a boat ride that's a boat of a friend or that they own. Maybe they'll go fishing but that's about it. And now their access to services is very different because here's where I think life becomes rather difficult." (ID 8)

"Well, I have all of that data. We work with people who have barriers to self-sufficiency. And when we talk about barriers to self-sufficiency that is people with disabilities and people with disadvantaging conditions. So that is going to include unemployed and dislocated workers, older workers, working poor, high school dropouts, ex-offenders, non-English speakers, welfare recipients, illiterate folks, at risk youth. Those are the types of people that we service, so anyone that has a barrier to self-sufficiency. I think that what they all have in common is low economic range, that they're all poor, very poor." (ID 10)

Example Quotations for Local Disparities in Access to and Quality of Care

Reported broader issues in community for low-income populations (continued)

"I also think some of the healthcare issues are problematic for our older folks. They are still having to make decisions between purchasing medication or purchasing food." (ID 10)

"The homeless population is probably the most difficult because they're so transient and a lot of them do not want interaction with especially government agencies so they tend to kind of fend for themselves and, and seek their own services or they know where to go to, but it's, it's hard to reach out to them. It's one of the biggest challenges." (ID 29)

Twenty-nine percent of organizations reported issues with socially isolated and/or homebound clients who had trouble accessing services (see ***Figure 5.16***):

> "Those that are homebound or those that are still living in their own home but are elderly or mildly disabled, that do not have the family members or friends available to take them where they need to go. You know, when a person loses their driving abilities or they are, they basically become prisoners in their own homes at times. They can no longer get to where they need to go, they can no longer get to social events, and they, it leads to depression, it leads to confinement, and being out of touch with family and friends. And we're hoping to provide that service for them." (ID 48)

Organizations reported substantial difficulties reaching socially isolated populations.

Example Quotations for Local Disparities in Access to and Quality of Care

Reported issues with socially isolated and/or homebound clients who had trouble accessing services

"I think there's a great deal of social isolation that comes as people get older. They're no able to get out as much and they may find that their social circle begins to shrink, and I believe that healthy aging is part of that, is going to be having, having some social opportunities available to you. I think those are, and so, and then, you know, making sure that that senior has good healthcare, access to good nutritious food, a social, social opportunities and that they can stay in their own home if that's what they want to do." (ID 10)

"But we are trying to reach the people who aren't being reached many times, the people isolated in their homes, people that aren't aware of programs that are out there, and we try, we do a newsletter as well to try to let them know programs that are out there for them, to educate them and to provide other services to them. So, there's still a need to reach the people that are isolated in their homes, that's the biggest issue that I saw 35 years ago and I see today." (ID 17)

"I suppose reaching, reaching the folks to begin with. Many, you know, as you probably know, most, many people on a lower socioeconomic status tend to be a little more isolated and, you know, difficult to get to them and they, they are more challenged at trusting something coming from the outside and, and so forth. You know, so I would say that's one of the biggest challenges." (ID 18)

"Some of them, of course, are, are home base, they're home-ridden, they can't leave, they're in bed or they're in a nursing home or something like that." (ID 37)

Figure 5.16. Example Quotations for Local Disparities in Access to and Quality of Care: Reported Issues with Social Isolated and/or Homebound Clients Who Had Trouble Accessing Services

The remaining themes about local disparities in access to and quality of care were reported by less than 25% of the organizations sampled. Example quotations for these remaining themes are provided in ***Figure 5.17***.

Figure 5.17. Other Example Quotations for Local Disparities in Access to and Quality of Care

Other Example Quotations for Local Disparities in Access to and Quality of Care

Had to turn away clients who could not afford services

> "Well, having come from a background where I, I worked with the Meals-on-Wheels and adult daycare where we had a sliding scale, where no one was excluded because of lack of funding, it's kind of frustrating for me being a private business owner that has no federal funds to deal with and limit, very limited funds as far as Medicaid and VA, that the, a lot of people that don't qualify for either one of those or they, they don't have the money right now for a lot of the Medicaid diversion, they need the care and they can't get it. It's a very frustrating situation for me, to not be able to provide services when I get calls or I go to see people and we look at the cost for the care and it's something where they cannot afford it and do without or they find other ways that they end up being cared for, which is kind of, sometimes very difficult for families who try to take care of the older adults." (ID 17)

Reported difficulty accessing services because of lack of organizations in geographic area

> "That there's just not enough programs that are close enough for people to avail themselves. We just need more programs. You know, if someone's only able to travel a certain distance, be it by car or by bus or, you know, they're only going to travel so far to a program. So, we just need more in the community to make it easier for people to come." (ID 31)

> "It's not, it's not easy to find appropriate mental health services. You know, that, that is, from my perspective, one of the weaker components of our community systems, you know. *And why would you say that, just because it's not offered?* Yeah, it's not offered. Well, I think there's still an awful lot of disparity between physical and mental illness and availability of services and specifically dealing with the dementia population. There are many times where it's just absolutely true that there are patients with needs that no one, that everyone is running away from and will, you know, continue to run away from for the foreseeable future. And I would specifically mention behavioral problems in patients with dementia as a good example of that." (ID 47)

Other Example Quotations for Local Disparities in Access to and Quality of Care

Reported barrier for low-income populations because insurance coverage did not support services

"*Does your organization ever experience any barriers that inhibit people over 65 participating in your services?* For us, yes, because we are, we're a private-pay, private-duty so we don't accept Medicare or Medicaid, which is a problem for a large portion of the population." (ID 9)

"Health insurance does not cover geriatric care management." (ID 27)

"But also in healthcare right now we know there are significant challenges and that, you know, people who, you know, once were insured had no challenges whatsoever accessing healthcare and we now know, you know, with the restrictions on, you know, health insurance and how, you know, limited some of the resources are that makes it, you know, maybe harder for people to know what their eligibility is for benefits and, and to know what they are able to access in the way of care. So, I think that's the greatest challenge because when people are confronted with the health crisis, certainly learning about, you know, what they have in the way of healthcare benefits is kind of disillusioning sometimes and overwhelming to them." (ID 30)

Did not provide services to the homeless

"We don't usually take the homeless. I have done that in the past and it's, it's a horror because they're used to living on the streets and having independence. When they come in and, and you want to institutionalize them it, it, they don't like it. They're going to try to escape, and they have. So, no, we don't take the homeless." (ID 19)

Reported physical health as a barrier to accessing services

"Again, some of it is just, you know, their ability to sit through a class for a couple hours, that might also be a barrier. You know, depends on the health of the individual of course." (ID 18)

Other Example Quotations for Local Disparities in Access to and Quality of Care

Reported middle income clients were falling through the cracks because their priority for services was not high enough

"The biggest lack would be, you know, for those individuals who either don't qualify because their priority for services isn't high enough, or they do qualify but funding isn't available for those services in their area. That would be the, you know, area that we, that we have the least ability to address." (ID 22)

"I think, well, with what we do, anyone that actually has resources and has funding can get almost any service they need. The lower income clients or those, actually middle class, middle class to lower income clients, it's harder actually for the middle class to find access to services, I think, than it is for the lower income because there are programs specifically geared for the lower, lower income clients. When you hit above a certain income level or have a minimal amount of assets but you're not at that poverty level with assets, then it's almost impossible." (ID 26)

"There's a whole group of individuals who are falling through the cracks because they don't qualify for our programs but they can't afford to pay for it for themselves. You know, is there some solution that we could do for that." (ID 34)

"So many of them don't qualify for the income level. You know, they're not, they're not destitute yet but they're, but they are because they need something else, but they can't qualify so they get knocked out already. And that's a really serious situation, I think, for the elderly because they really do need it and they don't have enough money but they're not destitute yet to where they can qualify. And there's that kind, you know, like it is with insurance where people can't qualify for certain insurances and things like that, where they kind of fall in that little hole there." (ID 36)

Ninety-two percent of organizations reported that they implemented strategies to overcome local disparities to access to and quality of care. Reported strategies for overcoming local disparities included:

- Provided free / pro bono services (N=37);
- Implemented services that helped clients overcome access barriers to care (e.g., provided transportation; provided translation services; N=21);
- Brought services to clients' homes (N=7);
- Provided resources for visually impaired (e.g., talking books; N=5);
- Charged based on what clients could afford (N=4);
- Enhanced services to racial and ethnic minorities (N=4);
- Enhanced services for homeless populations (N=3);
- Worked to get services paid for (e.g., Medicaid diversion; N=2);
- Enhanced services for veterans (N=2);
- Lobbied to government (N=2);
- Made buildings accessible (N=2);
- Enhanced services for substance abusers (N=1);
- Enhanced services in a geographic area (N=1); and
- Asked staff to volunteer to "pitch in" off hours (N=1).

Bivariate Analyses

Bivariate analyses examined the relationship between structural features of organizations and local disparities in access to and quality of care. Three measures of the structural features of organizations were significantly associated with at least one local

disparity reported: (1) specialization; (2) government, nonprofit, for-profit status; and (3) population focus of program (see ***Table 5.7***). Years in existence was moderately associated with reporting broader issues in community for low-income populations (Fisher's exact, p = 0.064). Also, formal organization size was moderately associated with having to turn away clients who could not afford services (Fisher's exact, p = 0.091). Nearly one-third of large organizations reported turning away clients who could not afford services compared to 5% of small organizations.

Specialization was statistically associated with two local disparities reported: (1) organizations could not provide services to older adults with physical disabilities or mental health issues; and (2) middle income clients were falling through the cracks because their priority for services was not high enough. Specialized organizations were more likely to report that they could not provide services to older adults with physical disabilities or mental health issues compared to diversified organizations (Fisher's exact, p = 0.015). In contrast, diversified organizations with 13 or more types of programs or services provided were more likely to report that middle income clients were falling through the cracks compared to organizations with less than 13 types of programs or services provided (Fisher's exact, p = 0.005).

Government, nonprofit, and for-profit status was significantly associated with several measures of local disparities. For-profit organizations were more likely to report the following compared to government and non-profit organizations: (1) they turned away clients that could not afford services (Fisher's exact, p = 0.005); (2) low-income populations experienced barriers to accessing programs and services, because they were not covered by

insurance (Fisher's exact, $p = 0.015$); and (3) physical health was a barrier for older adults to access programs and services (Fisher's exact, $p = 0.047$).

Population focus of service provision was associated with two measures of local disparities. Organizations that provided services to the general population were more likely to report that they turned away clients that could not afford services compared to organizations that targeted services to women, racial/ethnic minorities, or low-income populations (Fisher's exact, $p = 0.039$). Nearly one-third of organizations that provided general services reported turning away clients for ability to pay compared to less than nine percent of organizations that provided targeted services. In addition, organizations that targeted services to women, racial/ethnic minorities, or low-income populations were more likely to report that middle income clients were falling through the cracks compared to organizations that provided services to the general population (17% vs. 0%, respectively, Fisher's exact, $p = 0.046$).

Taken together, these results provide support for the third hypothesis:

> H3: Government organizations, nonprofit organizations, and organizations that target services to women, racial or ethnic minorities, or low-income populations have different perceptions of local disparities in access to and quality of care than for-profit organizations and organizations that provide services to the general population.

Bivariate analyses showed that government, non-profit, and for-profit status was associated with three local disparities: (1) turning away clients that could afford services; (2) low-income populations experiencing barriers to accessing programs and services, because they were not covered by insurance; and (3) physical health being a barrier for older adults to

access programs and services. Furthermore, population focus of service provision was related to turning away clients for ability to pay and reporting middle income clients were falling through the cracks.

Table 5.7. Local Disparities in Access to and Quality of Care by Organizational Typology

Categories	Number	Local Disparities in Access to and Quality of Care: Percent "Yes" [c]					
		A	B	C	D	E	F
Years in Existence					†		
Less than 9 years	12	100.0	66.7	41.7	16.7	33.3	50.0
9 to 19 years	12	100.0	66.7	50.0	66.7	8.3	16.7
20 to 32 years	11	90.9	45.5	45.5	36.4	45.5	9.1
More than 32 years	12	100.0	75.0	50.0	25.0	33.3	16.7
Formal Organization Size [a]							†
Small	20	100.0	80.0	55.0	45.0	25.0	5.0
Large	20	100.0	55.0	55.0	30.0	45.0	30.0
Specialized [b]			*				
Yes, 1 to 3 types of programs or services	15	100.0	86.7	33.3	40.0	13.3	20.0
Yes, 4 to 7 types of program or services	11	90.9	81.8	63.6	36.4	18.2	18.2
No, 8 to 12 types of program or services	10	100.0	50.0	40.0	20.0	50.0	10.0
No, 13 or more types of program or services	12	91.7	33.3	50.0	41.7	41.7	41.7
Government, Nonprofit, or For-Profit Status							*
Government	11	100.0	72.7	54.5	36.4	9.1	0.0
Nongovernment, nonprofit	21	95.2	71.4	47.6	33.3	42.9	14.3
Nongovernment, for-profit	16	93.8	50.0	37.5	37.5	25.0	50.0
Population Focus of Service Provision							*
Targets Services to Women, Racial/Ethnic Minorities, or Low-Income Populations	23	100.0	56.5	47.8	39.1	30.4	8.7
Provides Services to the General Population	25	92.0	72.0	44.0	32.0	28.0	36.0

(continued)

* $p < 0.05$ ("Yes" vs. "No") † $p < 0.10$ ("Yes" vs. "No")

[a] Size of organization was operationally defined using the median number of full-time and part-time employees that work at the organization (Median=18.5). Small organizations were defined as having equal to or less than the median number of employees, while large organizations were defined as having greater than the median number of employees.

[b] Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County.

[c] A = Reported any local disparities to access or quality of care
B = Could not provide services to older adults with physical disabilities or mental health issues
C = Reported clients experienced barriers to accessing transportation
D = Reported broader issues in community for low-income populations
E = Reported issues with socially isolated and/or homebound clients who had trouble accessing services
F = Had to turn away clients who could not afford services

Table 5.7 (continued)

Categories	Number	Local Disparities in Access to and Quality of Care: Percent "Yes" [c]				
		G	H	I	J	K
Years in Existence						
Less than 9 years	12	33.3	25.0	16.7	8.3	0.0
9 to 19 years	12	16.7	25.0	8.3	16.7	8.3
20 to 32 years	11	18.2	0.0	9.1	18.2	18.2
More than 32 years	12	8.3	8.3	25.0	8.3	8.3
Formal Organization Size [a]						
Small	20	20.0	10.0	10.0	10.0	5.0
Large	20	20.0	20.0	15.0	20.0	15.0
Specialized [b]						*
Yes, 1 to 3 types of programs or services	15	13.3	20.0	13.3	6.7	0.0
Yes, 4 to 7 types of program or services	11	18.2	18.2	0.0	9.1	0.0
No, 8 to 12 types of program or services	10	20.0	10.0	10.0	30.0	0.0
No, 13 or more types of program or services	12	25.0	8.3	33.3	8.3	33.3
Government, Nonprofit, or For-Profit Status			*		*	
Government	11	36.4	18.2	9.1	18.2	18.2
Nongovernment, nonprofit	21	9.5	0.0	9.5	0.0	4.8
Nongovernment, for-profit	16	18.8	31.3	25.0	25.0	6.3
Population Focus of Service Provision						*
Targets Services to Women, Racial/Ethnic Minorities, or Low-Income Populations	23	26.1	13.0	8.7	17.4	17.4
Provides Services to the General Population	25	12.0	16.0	20.0	8.0	0.0

* $p < 0.05$ ("Yes" vs. "No") † $p < 0.10$ ("Yes" vs. "No")

[a] Size of organization was operationally defined using the median number of full-time and part-time employees that work at the organization (Median=18.5). Small organizations were defined as having equal to or less than the median number of employees, while large organizations were defined as having greater than the median number of employees.

[b] Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County.

[c] G = Reported difficulty accessing services because of lack of organizations in geographic area
H = Reported barrier for low-income populations because insurance coverage did not support services
I = Did not provide services to the homeless
J = Reported physical health as a barrier to accessing services
K = Reported middle income clients were falling through the cracks because their priority for services was not high enough

CONCLUSION

My second research question investigates the perceptions that organizations have about environmental uncertainties that affect service provision to older adults: "What are environmental uncertainties in the study community that contribute to adaptations among organizations serving older adults?" Thematic analyses identified that organizations were concerned with environmental uncertainties related to (1) funding sources, (2) staffing, and (3) local disparities in access to and quality of care.

For funding sources, the top three uncertainties reported by organizations were that they: (1) wanted to provide additional services, but could not because they lacked available funding; (2) relied heavily on fundraising and had problems with sustainability of fundraising over time; and (3) relied heavily on government funding and had problems with uncertainty of government funding over time. Bivariate analyses showed that government, nonprofit, and for-profit status was significantly associated with measures of funding uncertainties. This finding supports the first hypothesis:

> H1: Government and nonprofit organizations have different perceptions of funding uncertainties than for-profit organizations.

Generally speaking, government and nonprofit organizations were more likely to report funding uncertainties compared to for-profit organizations.

For staffing, the top three uncertainties reported by organizations were that they: (1) had a substantial need for volunteers; (2) lacked staff capacity and had overworked staff; and (3) had difficulty recruiting and retaining quality staff. Bivariate analyses examining the relationship between structural features of organizations and staffing uncertainties provide mixed support for the second hypothesis:

> H2: Small formal organizations (i.e., those with fewer paid employees) and organizations specialized in fewer types of programs and services have different perceptions of staffing uncertainties than large formal organizations (i.e., those with more paid employees) and specialized in more types of programs and services.

Bivariate analyses support the notion that small organizations had different perceptions of staffing uncertainties than large organizations. Small organizations reported a greater need for volunteers and had overworked staff. However, bivariate analyses did not find any relationship between specialization and staffing uncertainties.

The top three local disparities to access to and quality of care reported by organizations were that: (1) they could not provide services to older adults with physical disabilities or mental health issues; (2) older adults experienced barriers to accessing transportation; and (3) broader issues existed in the community for low-income populations. Bivariate analyses examining the relationship between structural features of organizations and local disparities provide support for the third hypothesis:

> H3: Government organizations, nonprofit organizations, and organizations that target services to women, racial or ethnic minorities, or low-income populations have different perceptions of local disparities in access to and quality of care than for-profit organizations and organizations that provide services to the general population.

Bivariate analyses showed that government, non-profit, and for-profit status was associated with three local disparities: (1) turning away clients that could not afford services; (2) low-income populations experiencing barriers to accessing programs and services, because they

were not covered by insurance; and (3) physical health being a barrier for older adults to access programs and services. Furthermore, population focus of service provision was related to turning away clients for ability to pay and reporting middle income clients were falling through the cracks.

CHAPTER 6. COLLABORATION AMONG ORGANIZATIONS

This chapter draws on three research methods: (1) thematic analyses; (2) bivariate statistical analyses; and (3) qualitative comparative analyses. First, I draw on thematic analyses to examine my third research question about the extent to which organizations in the sample are collaborating and communicating (or failing to collaborate and communicate) to enhance programs for older adults in the study community (see ***Figure 6.1***). Second, I perform bivariate statistical analyses to explore the relationship between structural features of organizations (identified in ***Chapter 4***) and collaboration and communication with other organizations. Finally, I perform a qualitative comparative analysis examining the structural features of organizations and perceptions of environmental uncertainties – alone or in combination – that are necessary or sufficient to produce collaboration and cooperation with other organizations. Each of these methods and their results are described below.

Research Question and Hypothesis Explored in Chapter 6

Research Question

3. What are the ways in which organizations serving older adults collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs? How do structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations?

Hypothesis

H4: Older organizations; large organizations; organizations with diversified programs and services; organizations dependent on government funding; and organizations that target service provision on women, racial or ethnic minorities, or low-income populations have collaboration and cooperation with other organizations.

Figure 6.1. Research Question and Hypothesis Explored in Chapter 6

THEMATIC ANALYSES

Analytic Approach

I conducted thematic analyses of semi-structured interview data. As mentioned in ***Chapter 3***, preliminary coding involved a two-stage coding process of data. The first stage involved open coding to broadly examine the data and to identify emerging themes, and the second stage involved focused coding of key emerging themes identified during open coding (Esterberg 2002). Collaboration with organizations was a code identified during open coding. ***Table 6.1*** presents the description, example, inclusion criteria, and exclusion criteria for this code.

Table 6.1. Coding Schema for Collaboration with Organizations

Code	Description	Examples	Inclusion and Exclusion Criteria
Collaboration with Organizations	Description of how, why, and what organization does to coordinate with other organizations (e.g., collaborations with foundations or nonprofit organizations)	➢ Organization collaborates with foundation on fundraising efforts.	➢ Code includes discussions of formal agreements for wrap-around services. ➢ Code includes discussions of referrals. ➢ Code includes discussions of top three collaborating organizations and organizations hoping to establish future collaborations. ➢ Code includes the absence. ➢ Code includes discussions of independent contractors. ➢ Code may or may not include discussions of encouraging participation in programs at other organizations. ➢ Code includes discussions that do not specify whether the organization is collaborating with an independent organization or a program within the same organization.

After open coding for the concept of collaboration, I engaged in focused coding to identify where organizations lie on the continuum of collaboration. Following Himmelman (2002), I coded organizations in the sample along the continuum of collaboration using four categories:

(1) networking is “exchanging information for mutual benefit”;

(2) coordinating is “exchanging information and altering activities for mutual benefit and to achieve a common purpose”; and

(3) cooperating is “exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose”; and

(4) collaborating is “exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose” (2-3).

Table 6.2 provides an overview of the characteristics of networking, coordinating, cooperating, and collaborating, including the formality of the relationship, sharing of resources, time commitment, level of trust, access to turf, and primary purpose. I used these characteristics to identify where each organization lay along the collaboration continuum.

Table 6.2. Characteristics of Categories in Collaboration Continuum

Characteristics	Collaboration Continuum			
	Networking	Coordinating	Cooperating	Collaborating
Formality of Relationship	Informal	Formal	Formal	Formal
Sharing of Resources	No Mutual Sharing of Resources	No or Minimal Mutual Sharing of Resources	Moderate to Extensive Mutual Sharing of Resources; Some Sharing of Risks, Responsibilities, and Rewards	Full Mutual Sharing of Resources; Full Sharing of Risks, Responsibilities, and Rewards
Time Commitment	Minimal	Moderate	Substantial	Extensive
Level of Trust	Limited	Moderate	High	Very High
Access to Turf	No	No	Significant	Extensive
Primary Purpose	Exchange Information	Improve Access	Share Resources to Achieve a Common Purpose	Enhance Each Other's Capacity to Achieve a Common Purpose

Source: Himmelman (2002)

Results

As mentioned in ***Chapter 2***, organizations can engage in collaboration using different strategies that lie on a continuum that includes: networking, coordinating, cooperating, and collaborating. These strategies build upon one another, and organizations determine which strategies are most appropriate and relevant given what they desire to accomplish and the context in which they need to accomplish the work (Himmelman 2002). **Figure 6.2** provides an overview of where organizations in the sample lay along the collaboration continuum.

Twenty-five percent of organizations engaged in networking, 27% percent in coordinating, 27% in cooperating, and 21% in collaborating.

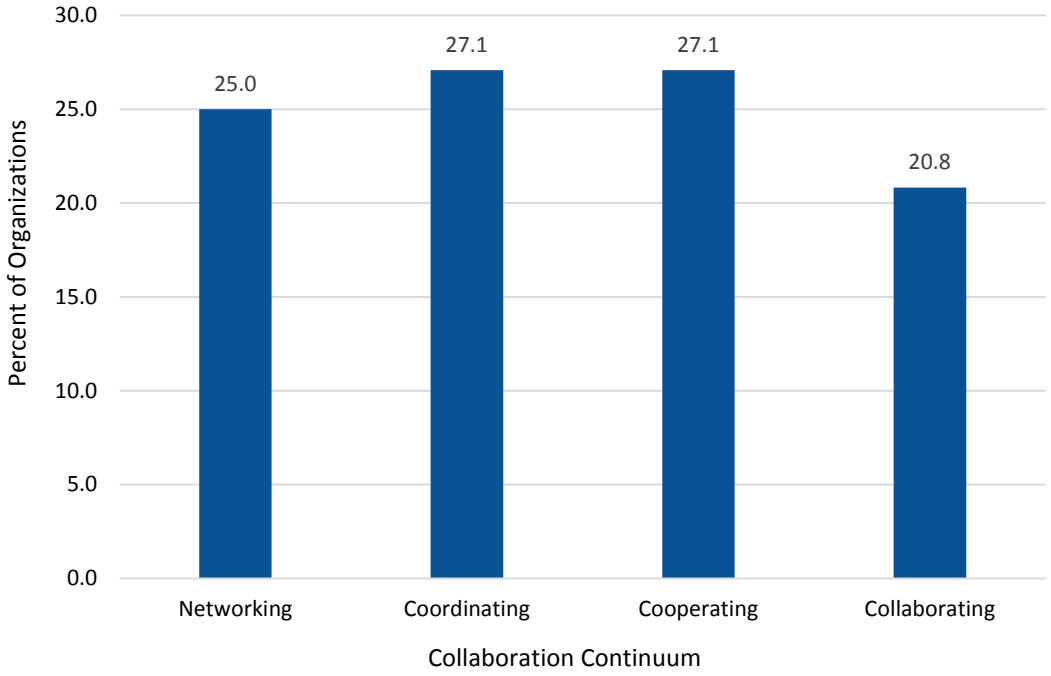


Figure 6.2. Sample Organizations' Location Along Collaboration Continuum

Networking. Twelve organizations in the sample were coded as engaging in networking (see ***Figure 6.3***). The purpose of networking is exchanging information (Himmelman 2002). Nine out of the twelve organizations described how they provided referrals to and shared information with other organizations:

> "We also get referrals from lots of local non-profits… any local agencies that, when they know there's a <de-identified> need, hopefully, you know, they'll pick up the phone and call us or they'll say, you know, "Why don't you call <de-identified>, they may be able to help." (ID 25)

Three organizations reported that they did not interact with other organizations and were not interested in collaboration. These organizations can theoretically be described as "immuring" or "conducting activities without input or exchange from other institutions" (Mashek 2005, N.p.). Since so few organizations were considered immuring, I coded these organizations as networking, which was the simplest form of interorganizational activity along the collaboration continuum.

Example Quotations for Networking

Referrals

"Do you ever collaborate with other agencies? Occasionally I get a referral from another agency or I may make a referral if it's, if it's a job that I can't do I will make a referral to an agency, but I don't know if that's what you mean." (ID 12)

Lack of Collaboration

"Yeah, we haven't really collaborated with anybody. You know, we're, we're a pretty big company and this is a <de-identified> program. You know, a lot of companies with very little money will collaborate to get funding and so forth but we don't even have that option here, you know. So, yeah, right, that might not apply to us." (ID 50)

Figure 6.3. Example Quotations for Networking

Coordinating. Thirteen organizations in the sample were coded as coordinating, which involves exchanging information and altering activities to make services more user-friendly

and reduce barriers to accessing services (see ***Figure 6.4***; Himmelman 2002). Coordinating does not involve sharing resources or accessing turf.

Five out of the thirteen organizations engaged in care coordination, which can be defined as:

> "…deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient." (Agency for Healthcare Research and Quality 2016: N.p.).

Several organizations reported that they purposefully did not seek out formal agreements with other organizations when they engaged in care coordination:

> "Well, what I, what I want to point out is that a care manager is a professional who is independent of outside influence. So it's not a government that controls the care manager and says, "You can't take that client, you have to take this one," or whatever, and it's, it's not another agency. And so being independent is really important for ethical reasons, that you don't get more services in there than the client actually needs. And so I, I do not contract with any other agencies in any way, don't have any kickbacks or don't accept any fees for referring somebody. Like if I referred a number of people to the same assisted living it would only be because I thought that was the right one for them and the price was right and the services were good. I wouldn't do it because I had some arrangement with them. And it, and it can really change. I've seen it happen. You might have a very good nursing home or assisted living place and next week they're sold and the new owner comes in and there's a new administrator and a new nurse manager and everything changes. So I, I don't do contracts with other entities." (ID 4)

These organizations described how they maintained ethical principles by remaining independent from other organizations; they considered it problematic to engage in formal agreements that would obligate them to coordinate care with any particular organizations.

Four organizations were coded as coordinating because they participated in informal committees or radio shows that sought to make services more user-friendly or reduce barriers

to accessing services. Another six organizations coordinated their program content with other organizations or coordinated the timing of their services with other organizations. For example, an arts organization was concerned that older adults were having difficulty accessing the theatre because they could not drive at night when performances were scheduled. The arts organization worked with a transportation organization to coordinate their service schedules so that the transportation organization could drive older adults to the theatre:

> "Same thing with all the arts, they put us in all the playbills for the volunteers again with a big picture saying that, you know, 'Giving is an art.' It's very clever, beautiful ads with big pictures showing people enjoying getting to the arts. The main reason that people stop going to the arts that have money and would like to go to the arts is they will not drive at night. Most, very senior seniors have tried other forms of transportation, they're not comfortable with it because it doesn't have that, "A friend is picking me up, a nice person that I can trust." Trust is an issue for seniors. And though taxis may be wonderful, you may never have a problem, I've never had a problem, I've, [laughter] I've been scared but I've never, [laughter] but they actually feel intimidated. They don't understand, they often can't hear, the person will say, "No, that's the wrong amount of money," they have to carry cash. All of that is a stressor." (ID 2)

The arts organization also advertised for the transportation organization in the theatre playbills. By implementing these strategies, these organizations reduced barriers to accessing the theatre for older adults.

Example Quotations for Coordinating

Care Coordination

"Because I guess some people see this service as a consulting type service where the problem situation is evaluated and then some sort of a plan is offered and then they can follow that plan or they can have a care manager put the plan in place. So that would begin then with an assessment, which is a very comprehensive evaluation of the individual's health and social wellbeing and long-term care needs and, depends on how they're functioning, and then would be setting up some sort of a care plan based on that information. So that would be a very tailor-made type plan and individualized. And this is, this is usually done in the elderly person's home so you see that person in their own environment. Their home might be in assisted living or a nursing home but it's where they reside. So, it's a service that comes to the client, they don't come to some office to do all this. And then probably the next description would be if, you know, the family member or the client wants the care manager to put this plan in place would be to set up the services and coordinate the care and follow it to make sure things happen the way they need to happen, or if circumstances change that you can respond to those changes." (ID 4)

"There's nothing that we don't do for our clients. If they, we're managing their personal and their financial affairs so if they own a veterinary clinic by the time we become their guardian, we have to run that until [laughter] we find somebody that can. If they, whatever service they need, it's our responsibility to make arrangements or provide. So, we literally, anything you would do for your own self we're having to do for our clients." (ID 26)

Committee to Improve Access to Services

"I'm part of a committee to form a resource book that's written in several languages to reach all populations so that they know the resources available. I'm part of a cancer care coalition. We previously did a tri-fold so it's an easy handout so that all providers have in one hand a place where people can link and get services. As soon as they link to either cancer support community or leukemia, lymphoma, we all work together to make sure that the people receive the correct services." (ID 38)

Figure 6.4. Example Quotations for Coordinating

Cooperating. Thirteen organizations in the sample were coded as cooperating, which involves exchanging information, altering activities, and sharing resources (see ***Figure 6.5***). Cooperating requires a more substantial time commitment than coordinating or networking and, as a result, may involve formal, written agreements. Three out of the thirteen organizations participated in formal partnerships with collaboratives. Another three organizations maintained formal agreements with other organizations for referrals and care coordination. Yet another two organizations maintained formal agreements to take responsibility of service provision for another organization in the event of natural disaster, such as a hurricane.

Cooperating may involve moderate to extensive sharing of resources and significant access to turf. One out of the thirteen organizations coordinated schedules of staff who worked at multiple organizations and was working with these organizations to develop a pooled staffing model:

> "Here again is, the biggest challenge is, is finding enough qualified staff. I work with a couple of the agencies now, that we kind of work with each other as far as staffing and knowing that we have kind of the same staff members here and we've all discussed it. We're going to have to probably eventually get to a pool of staffing that we can combine the resources so that we can organize schedules so that we can cover this, because we can see that in three to five years the growth of the older population in this area versus the population that can care for it is going to be, the gap is going to be wider than it is now and be a real challenge to be able to have enough staff to meet the needs. *That's a good observation. So you said you're going to combine the resources.* Well, we're looking at a way that we can coordinate our resources, schedule-wise and know what's available, and looking at the ways that we can do it within HIPAA guidelines and all the other regulations that, that go along with it. As long as our, our competitors who are our friends that have the same high standards that we have as far as the type of caregivers that they want and the training they have, that the things that they focus on, the similarities." (ID 17)

Among the thirteen organizations that were coded as cooperating, six organizations allowed another organization to use their facility space for programs and services, or vice versa. For two organizations, this involved allowing other organizations to set-up mobile units in their parking lots. For a third organization, this involved allowing another organization to permanently install a kiosk in their facility space. For a fourth organization, this involved providing programs and services in the facility space provided by another organization.

Figure 6.5. Example Quotations for Cooperating

Example Quotations for Cooperating

Formal Agreements

"We have, we've kind of teamed up with another agency that if we can't handle a patient, if we have such an overload we call them and say, "Hey, can you staff this one?" Or they call us and say, "Hey," you know, "We've got a 24-hour that came on," or "We've got three that came on at once, we're out of staff. Can you help us staff it?" We do those kind of things. We have contracts between us that says if my organization is knocked down in a hurricane that, you know, that she will take over, you know, because she's in another part of the county, I'm in another part of the county. You know, I will send workers from my part of the county to go help her in her part of the county, those kind of things." (ID 1)

"So, we do have a few formal agreements and we have some just memorandums of understandings with numerous other agencies to help us with the cross-referral system." (ID 10)

"We provide a large amount of evacuation agreements for facilities. *Are those generally assisted living facilities?* Generally, the evacuation agreements are through assisted living facilities, institutions, long term care, short term care institutions. We actually have a couple of agreements with different entities for individuals, a couple of the home health entities that we have, we've got agreements for picking up their, their clients at their residence in the event of a, of an emergency. So, you know, we have that agreement with them and should something come up, say, you know, with Florida hurricanes they pop up like, you know, most people change the channel on a TV. So, we're forever, "Can you go get this one? Can you take that one here?" So, we'll help out with evacuation and relocation to higher ground for some of the, some of the residents that we have." (ID 44)

"We do have contractual agreements with rehabilitation centers, same-day surgery centers, and health agencies, senior agencies, <de-identified>, radiation and oncology centers, [inaudible] centers." (ID 48)

Example Quotations for Cooperating (continued)

Resource Sharing and Turf Access

"We have partnerships with the <de-identified> and they bring their mobile units to our locations and we can help people get that service for free right at our location with the, with assistance from the <de-identified>." (ID 10)

"We're also a community health and improvement partnership information center. This was developed by the Community Health Improvement Partnership, which is a coalition of agencies in the county, and so we, we think health and wellness is one of those perennials that we really want to help our, our customers, give them the, the wherewithal and the resources to get the information for them to make informed decisions about their health... The Community Health Improvement Partnership has a kiosk here… *It's a health kiosk?* It is a touch screen-driven series of menus that links with the CHIP website and provides information about local resources like where the Sarasota County health clinics are located and how to find out information about insurance options. And you go to get a health assessment online in places like <de-identified> and, so there's four quadrants there and it's all driven by touch screen. And so, people who maybe are uncomfortable approaching a staff member with a health question, they can get, get that on their own through the kiosk." (ID 21)

"We have a blood mobile that comes a couple of times a month and that's very effective, they get several things. And then we have a doctor who is, is, presently he's trying to work with another group with getting the, the health issues for these people." (ID 33)

"Right now, we're going to a place called <de-identified>, it's an assisted living center, and we hold worship services there every Sunday and Bible study we do on Wednesdays, Wednesdays and also Saturday mornings. One of my associates helps out with that and that's what we do, we provide services for the seniors and we try to make it like it's their home church. Even though they're away from home they can feel like this is their church and we look after them when they're not feeling well and that type of thing." (ID 37)

Collaborating. Ten organizations in the sample were coded as collaborating, which involves exchanging information, altering activities, sharing resources, and enhancing the capacity of another organization so that they can provide the best possible services (see ***Figure 6.6***). Two out of the ten organizations provided training to build capacity of staff or improve development plans at other organizations. Another two organizations used staff that were paid for by other organizations in order to increase their capacity. Yet another two organizations were mandated to serve as conveners and capacity builders for numerous organizations in the community:

> "Well, our agency receives state and federal dollars to provide services, and what we do is we actually contract out for those services so we don't, there's only a limited amount of services that we provide directly in-house. But what we contract for include many in-home services like chore, companionship, homemaking, housing improvement, personal care, pest control, respite, shopping assistance, medical supplies, case management, transportation, financial assistance, adult day care, home delivered meals, skilled nursing, emergency alert response units. We also have some community services that's provided. There are training and support services for caregivers. Relatives, caregiver training which would be for like our grandparents raising grandchildren, education counseling, health and wellness, things like Tai Chi, chronic disease health management, elder abuse prevention education. We also contract for electric assistance when people are in crisis, as well as provide assistance for individuals who are looking at Medicare and what options are available and if they have any issues with billing or if they suspect fraud we also provide assistance with that." (ID 34)

These organizations disseminated funding streams to other organizations that were used to provide a wide array of services for older adults.

Collaborating involves sharing risks, responsibilities, and rewards with other organizations. Two out of the ten organizations reported that they served as formal sponsors for other start-up organizations. Another two organizations indicated that they assumed the risks and responsibilities of other organizations that were struggling. In these instance, the

organizations either helped the organizations build capacity to stay afloat independently or eventually subsumed the organizations to ensure continuity of care for older adults.

Example Quotations for Collaborating

Capacity Building

"They're going to sit in on our twice a month peer training professional development. That's a pretty major tie-in." (ID 8)

"The one that comes to mind is <de-identified>. On occasion, they will supply us with individuals that they're paying to supplement staffing." (ID 20)

"We work directly with assisted living facilities and nursing homes and independent living facilities for, for persons over, you know, over 65, and we review their emergency plans and provide them guidance and support and, you know, to prepare their plans to take care of their own populations in the event of an emergency." (ID 29)

Sharing Risks, Responsibilities, and Rewards

"That program has been running on its own but the, that program had funding difficulties when it was separate from <de-identified>. And then it came to <de-identified> and said, "Hey, would you guys help us and take this over? We think we have something here where it would give your, your members something worthwhile to do… And plus, you'd be able to afford to keep it going because we're," they were just living from funding request to funding request. So <de-identified> took it over and there was a formal process involved thereof, because it's part of the foundation and the foundation board had to vote on it and so on and so forth." (ID 46)

"They directed the <de-identified> services up until May and then they quit because the money, couldn't afford it, and now we can't afford it… <de-identified> announced that they were quitting and it was either have no service or have <de-identified> develop something. <de-identified> felt the need to see the program continue so we took what was available…, and we're attempting to continue the service." (ID 47)

Figure 6.6. Example Quotations for Collaborating

BIVARIATE ANALYSES

Analytic Approach

Drawing on the thematic analyses above, I constructed an Excel database consisting of variables for the structural features of organizations, perceptions of environmental uncertainties, and collaboration and communication with other organizations. After importing the Excel database into Stata 14.0, I computed Pearson chi-square tests or, as necessary because of small expected frequencies, Fisher's exact tests to assess associations of structural features of organizations with collaboration and communication with other organizations.

Results

Organizations' location on the collaboration continuum significantly varied by (1) government, nonprofit, or for-profit status of organizations; and (2) population focus of service provision (see ***Table 6.3***). Government and nonprofit organizations were more likely to engage in collaboration compared to for-profit organizations (Fisher's exact, $p = 0.010$). About 55% of government organizations engaged in collaboration compared to 19% of nonprofit organizations and 0% of for-profit organizations. In terms of population focus of service provision, organizations that targeted services to women, racial/ethnic minorities, or low-income populations were more likely to engage in collaboration compared to organizations that provided services to the general population (Fisher's exact, $p = 0.008$). About 39% of organizations that targeted services to women, racial/ethnic minorities, or low-income populations engaged in collaboration compared to 4% of organizations that provided services to the general population. In bivariate analyses, longevity of the organization, formal

organization size, and specialization were not significantly associated with location on the collaboration continuum.

Table 6.3. Collaboration Continuum by Organizational Typology

Categories	Number	Collaboration Continuum: Row Percent (%) Networking	Coordinating	Cooperating	Collaborating	p-value
Years in Existence						0.513
Less than 9 years	12	41.7	16.7	33.3	8.3	
9 to 19 years	12	8.3	50.0	25.0	16.7	
20 to 32 years	11	18.2	27.3	18.2	36.4	
More than 32 years	12	25.0	16.7	33.3	25.0	
Formal Organization Size [a]						0.463
Small	20	25.0	30.0	20.0	25.0	
Large	20	30.0	10.0	35.0	25.0	
Specialized [b]						0.731
Yes, 1 to 3 types of programs or services	15	33.3	33.3	20.0	13.3	
Yes, 4 to 7 types of program or services	11	36.4	18.2	36.4	9.1	
No, 8 to 12 types of program or services	10	20.0	20.0	30.0	30.0	
No, 13 or more types of program or services	12	8.3	33.3	25.0	33.3	
Government, Nonprofit, or For-Profit Status						0.010*
Government	11	9.1	0.0	36.4	54.5	
Nongovernment, nonprofit	21	28.6	33.3	19.0	19.0	
Nongovernment, for-profit	16	31.3	37.5	31.3	0.0	
Population Focus of Service Provision						0.008*
Targets Services to Women, Racial/Ethnic Minorities, or Low-Income Populations	23	17.4	13.0	30.4	39.1	
Provides Services to the General Population	25	32.0	40.0	24.0	4.0	

* $p < 0.05$ † $p < 0.10$

[a] Size of organization was operationally defined using the median number of full-time and part-time employees that work at the organization (Median=18.5). Small organizations were defined as having equal to or less than the median number of employees, while large organizations were defined as having greater than the median number of employees.

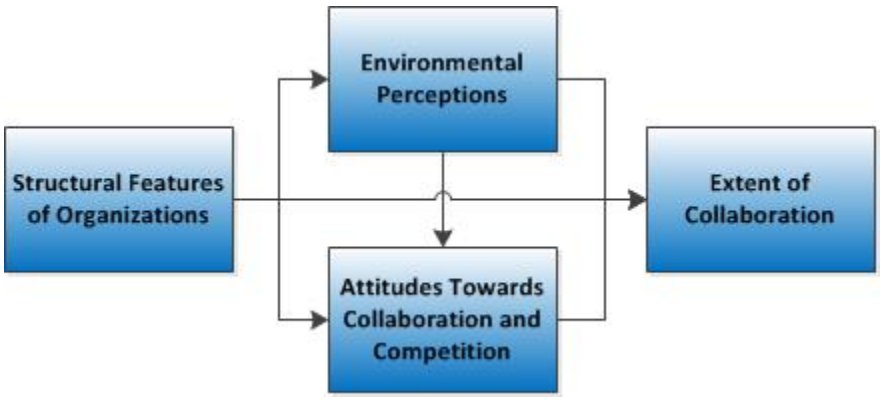
[b] Specialization was operationally defined as the number of programs and services provided to people over age 65 in Sarasota County.

QUALITATIVE COMPARATIVE ANALYSES

My third research question explores how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations in the study community. Qualitative comparative analysis (QCA) is an appropriate methodology for exploring this research question. QCA is a relatively new analytic technique developed by Charles C. Ragin that uses Boolean algebra to understand combinations of conditions that are sufficient or necessary to produce an outcome (Ragin 2008; Vaisey 2015). Using QCA, I identify structural features of organizations and their perceptions of environmental uncertainties – alone or in combination – that are sufficient or necessary to produce collaboration and communication with other organizations. QCA uses set theory, a branch of mathematical logic that studies the properties of sets (known as "conditions"), to examine relationships between combinations of conditions (i.e., features, characteristics) present among cases and an outcome (Ragin, 1999; Schneider and Wagemann 2010; Rihoux and Ragin 2009). In ***Appendix E***, I provide a detailed overview of key assumptions and concepts in QCA.

Methods

Selection of QCA conditions. Drawing on a conceptual framework of collaboration as well as the thematic and bivariate statistical analyses above, I identified conditions to use in the QCA model. As mentioned earlier, Foster and Meinhard (2002) developed a conceptual framework where the extent of formal collaboration was a function of organizational characteristics, perceptions of environmental pressures, and attitudes of organizational leaders towards collaboration and competition (see ***Figure 6.7***).



Source: Modified from Foster and Meinhard (2002)

Figure 6.7. Conceptual Framework for the Extent of Collaboration

Foster and Meinhard (2002) used organization size as an organizational characteristic in their model. Although some previous research found that organization size was associated with the extent of formal collaboration (Foster and Meinhard 2002; Guo and Acar 2005), bivariate analyses in the present study found that longevity of the organization, formal organization size, and specialization were not significantly associated with location on the collaboration continuum. In this study, I selected organizational characteristics for the QCA by drawing on the structural features of organizations that were significantly ($p < 0.05$) associated with collaboration and communication in the bivariate analyses, including (1) government, non-profit, and for-profit status and (2) population focus of service provision. Since the QCA uses a crisp-set (i.e., dichotomous conditions), I recoded government, non-profit, and for-profit status to examine whether the organization had reliable private-pay funding. This conceptualization is consistent with previous research that found that having

larger budget sizes and relying on fewer government funding streams was associated with the extent of formal collaboration (Guo and Acar 2005).

I drew on the scholarly literature and results from the thematic analyses to select QCA conditions related to the perceptions of environmental pressures and attitudes toward collaboration and competition. For the perceptions of environmental pressures, I selected staffing uncertainties as a QCA condition. The resource-dependence model contends that organizations lack the resources or capabilities to function completely autonomously and, consequently, enter relationships with organizations in the environment that can supply resources and capabilities (Aldrich and Pfeffer 1976). Therefore, understanding the perceptions of staffing resources and capacities of organizations may help understand the extent to which organizations collaboration and communication with other organizations in the study community.

For the attitudes toward collaboration and competition, Foster and Meinhard (2002) theorized that organizations that perceive more benefits to the collaboration are more likely to engage in collaboration. They conceptualized attitudes toward collaboration and competition, in part, by using a measure of motivation for collaboration where organizations rated reasons for collaboration on a scale from *not at all important* to *very important.* Previous research found that the industry of operation (e.g., not operating in education and research or social services industries) was associated with the extent of formal collaboration, but authors were unclear why organizations in these industries were less likely to engage in formal collaboration (Guo and Acar 2005). Although studies have examined the industry of the services, they have not – to my knowledge – examined the setting of the services. I

selected setting of the service (e.g. home-based service vs. non-home-based, community-based service) as a QCA condition. The setting may impact whether organizations perceive collaboration to be worthwhile and, therefore, may affect their motivation to collaborate.

Through this process, I selected four conditions for the QCA model, including:

(1) has a reliable stream of private-pay funding (hereafter, "reliable private-pay funding");

(2) targets services to women, racial/ethnic minorities, or low-income populations (hereafter, "targeted services");

(3) reports one or more staffing uncertainties (hereafter, "staffing uncertainties"); and

(4) provides services within older adults' homes that focused on home care, companionship, meals, moving, and home accessibility (hereafter, "home-based services").

Calibration of conditions. Calibration refers to using expert or substantive knowledge to establish thresholds and decision rules for membership in a condition (Schneider and Wagemann 2010). In this analysis, I use a crisp set calibration that established 1 as fully in the set and 0 as fully out of the set (see ***Table 6.4*** for calibrations).

Table 6.4. Conditions Used in Qualitative Comparative Analysis Examining Collaboration and Cooperation

Calibration	Calibration Decision
Reliable Private-Pay Funding	
1.00	The organization is fully in the set if the organization met three criteria: (1) the organization reported that older adults were required to privately pay for some or all the services provided; (2) the organization reported that private pay was a primary revenue source; and (3) the organization reported that a substantial portion of the older adults that they served were considered "upper income".
0.00	The organization is fully out of the set if the organization met any one of the following criteria: (1) the organization did not report that older adults were required to privately pay for some or all the services provided; (2) the organization did not report that private pay was a primary revenue source; and (3) the organization did not report that a substantial portion of the older adults that they served were considered "upper income".
Targeted Services	
1.00	The organization is fully in the set if the organization targets services to women, racial/ethnic minorities, or low-income populations.
0.00	The organization is fully out of the set if the organization provides services to the general population.
Staffing Uncertainties	
1.00	The organization is fully in the set if the organization reported one or more staffing uncertainties (see ***Table 5.4*** for examples of staffing uncertainties).
0.00	The organization is fully out of the set if the organization did not report staffing uncertainties.
Home-Based Services	
1.00	The organization is fully in the set if the organization provided services within older adults' homes that focused on home care, companionship, meals, moving, and home accessibility.
0.00	The organization is fully out of the set if the organization provided services outside of older adults' homes in the community. The organization either: (1) provided clinical services (e.g., health systems; skilled nursing facilities); (2) provided non-clinical services (e.g., adult education; spiritual, social, and wellness programs; library services; transportation); or (3) disseminated information about and provided referrals to other types of organizations (e.g., resource/referral organizations; geriatric care management; advocacy organizations).

Calibration of Collaboration and Communication. Drawing on Himmelman's (2002) collaboration continuum, I selected "achieving collaboration or cooperation" as the outcome where fully in the set was defined as "collaborating" or "cooperating" and fully out of the set was defined as "coordinating" or "networking". In the thematic analysis above, I calibrated 23 out of 48 organizations in this analysis as achieving collaboration or cooperation; the remaining 25 organizations were calibrated as not achieving collaboration or cooperation.

Analytic Approach

I used Stata and fs/QCA software to conduct analysis according to standards of good practice defined by Schneider and Wagemann (2010). First, I evaluated each condition for individual necessity and sufficiency relationships with the outcome. Then I created a truth table from the data and used the software to logically minimize sufficient solutions in the truth table (see ***Table 6.5*** for a truth table). I used the intermediate solution and set directional expectations based on empirical or theoretical knowledge about how the condition is likely to influence outcomes; I set the directional expectations so that the absence of reliable private-pay funding, the presence of targeted services, the presence of staffing uncertainties, and the absence of home-based services contributed to the outcome. I calculated parameters of fit—including consistency, raw coverage, and unique coverage—for each solution and calculated overall consistency and coverage for the solution as a whole. *Consistency* assesses whether the combination produces the outcome regularly ("the degree to which the empirical data are in line with a postulated subset relation") (Ragin, 1999, p. 324); *coverage* determines the empirical relevance of a solution and quantifies the variation in combinations of conditions that produce an outcome. I used a conventional consistency threshold of 80%, but also tested at 75% and 90%.

Table 6.5. Truth Table

Reliable Private-Pay Funding	Targeted Services	Staffing Uncertainties	Home-Based Services	N	Outcome	Consistency	Case IDs
0	1	1	0	15	1	0.9	7, 8, 10, 15, 20, 21, 22, 25, 26, 29, 30, 32, 34, 44, 47
0	0	1	0	8	0	0.5	14, 23, 24, 28, 33, 35, 37, 38
0	0	0	0	6	0	0.2	13, 27, 40, 42, 45, 51
1	0	1	1	5	0	0.4	1, 9, 11, 17, 41
1	1	1	0	3	0	0.7	18, 48, 50
1	0	0	1	2	0	0.0	5, 12
1	0	1	0	2	0	0.0	2, 3
0	1	0	0	2	0	0.0	19, 31
1	1	1	1	1	0	0.0	36
1	1	0	0	1	1	1.0	46
1	0	0	0	1	0	0.0	4
0	1	1	1	1	0	0.0	6
0	0	1	1	1	0	0.0	49
1	1	0	1	0	?*	-	
0	1	0	1	0	?*	-	
0	0	0	1	0	?*	-	

*Since no cases had this combination of conditions, I set directional expectations based on empirical or theoretical knowledge about how the condition is likely to influence outcomes; I set the directional expectations so that the absence of reliable private-pay funding, the presence of targeted services, the presence of staffing uncertainties, and the absence of home-based services contributed to the outcome.

Results

In the QCA, I analyzed whether four conditions were sufficient or necessary to produce collaboration and cooperation: (1) reliable private-pay funding; (2) targeted services; (3) staffing uncertainties; and (4) home-based services. None of these conditions were individually necessary or sufficient for achieving collaboration or cooperation; no necessary combinations occurred.

In this section, I discuss combinations of conditions that represent 16 out of 23 organizations that achieved collaboration or cooperation. An additional 25 organizations did not collaborate or cooperate and, therefore, have no combinations of conditions that produced this outcome. Overall, two combinations of conditions were sufficient to achieve collaboration or cooperation (see ***Table 6.6***):

- Not having reliable private-pay funding in combination with having targeted services, having staffing uncertainties, and not having home-based services.
- Having reliable private-pay funding in combination with having targeted services, not having staffing uncertainties, and not having home-based services.

Table 6.6. Sufficient Combinations of Conditions that Led to Collaboration or Cooperation

Solution	Combinations of Conditions	Description of Combination
1	not reliable private-pay funding and TARGETED SERVICES and STAFFING UNCERTAINTIES and not home-based services	Not having reliable private-pay funding in combination with having targeted services, having staffing uncertainties, and not having home-based services.
2	RELIABLE PRIVATE-PAY FUNDING and TARGETED SERVICES and not staffing uncertainties and not home-based services	Having reliable private-pay funding in combination with having targeted services, not having staffing uncertainties, and not having home-based services.

In the column “Combinations of Conditions”, capitalization indicates the presence of the condition whereas non-capitalization indicates the absence of the condition.

Table 6.7 displays the consistency and coverage values for these combinations. Among the 15 organizations with the first combination (not having reliable private-pay

funding in combination with having targeted services, having staffing uncertainties, and not having home-based services), 13 organizations produced the outcome; thus, this combination of conditions worked 87% of the time. The second combination of conditions (having reliable private-pay funding in combination with having targeted services, not having staffing uncertainties, and not having home-based services), which included one organization, produced the outcome 100% of the time. The two combinations of conditions accounted for 61% of organizations in the sample (i.e., total coverage) that achieved collaboration or cooperation.

Table 6.7. Crisp Set Qualitative Comparative Analysis Exploring Conditions Related to Collaboration or Cooperation

Combinations of Conditions	Consistency	Raw Coverage	Unique Coverage	Case IDs
1. not reliable private-pay funding and TARGETED SERVICES and STAFFING UNCERTAINTIES and not home-based services	0.87	0.57	0.57	7, 8, 10, 15, 20, 21, 22, 29, 30, 32, 34, 44, 47*
2. RELIABLE PRIVATE-PAY FUNDING and TARGETED SERVICES and not staffing uncertainties and not home-based services	1.00	0.04	0.04	46
Total Solution Consistency:	0.88			
Total Solution Coverage:	0.61			

Note: Coverage indicates the empirical relevance of a combination. Raw coverage is the proportion of all cases represented by a combination; unique coverage indicates the proportion of cases that are covered by only a particular combination. Total coverage indicates the proportion of cases covered by all the combinations. Consistency quantifies the extent to which cases that share a combination exhibit the outcome.
*Case IDs 25 and 26 had this combination of conditions but did not produce the outcome.

CONCLUSION

This chapter drew on three research methods: (1) thematic analyses; (2) bivariate statistical analyses; and (3) qualitative comparative analyses. First, I drew on thematic analyses to examine my third research question about the extent to which organizations in the sample are collaborating and communicating (or failing to collaborate and communicate) to enhance programs for older adults in the study community. Thematic analyses demonstrated that 25% of organizations engaged in networking, 27% percent in coordinating, 27% in cooperating, and 21% in collaborating. Networking involved organizations providing referrals to and sharing information with other organizations. Coordinating involved organizations coordinating care, participating in informal committees, coordinating program content with other organizations, and coordinating timing of services with other organizations. Cooperating involved organizations participating in formal multi-organizational partnerships, maintaining formal agreements with other organizations, pooling staffing resources, and sharing facility space for programs and services. Collaborating involved organizations building capacity of staff at other organizations, improving development plans of other organizations, using staff paid for by other organization, serving as conveners and capacity builders for numerous organizations in the community, serving as formal sponsors for start-up organizations, and assuming risks and responsibilities of struggling organizations.

In this chapter, I also performed bivariate analyses to explore the relationship between structural features of organizations and collaboration and cooperation with other organizations. Taken together, bivariate analyses provide mixed support for the fourth hypothesis:

H4: Older organizations; large organizations; organizations with diversified programs and services; organizations dependent on government funding; and organizations that target service provision on women, racial or ethnic minorities, or low-income populations have collaboration and cooperation with other organizations.[3]

Findings provide support that organizations dependent on government funding and organizations that target service provision to women, racial or ethnic minorities, or low-income populations collaborate and cooperate with other organizations. Bivariate analyzes showed that government, nonprofit, and for-profit status and population focus of service provision variables were significantly associated with location on the collaboration continuum. However, longevity of the organization, formal organization size, and specialization variables were not associated with location on the collaboration continuum. These findings are consistent with previous research that found that longevity of the organization was not associated with the extent of formal collaboration (Foster and Meinhard 2002). However, these results differed from previous research that found organization size was associated with the extent of formal collaboration (Foster and Meinhard 2002; Guo and Acar 2005). Nevertheless, these findings were not surprising given that the scholarly literature generally reports mixed results on the impact of organization size. These mixed results are likely due to the different approaches used across previous studies to calculate organization size.

Finally, I performed a qualitative comparative analysis (QCA) examining the structural features of organizations and perceptions of environmental uncertainties – alone or

[3] In this hypothesis, collaboration and cooperation are operationalized using definitions provided by Himmelman (2002).

in combination – that were necessary or sufficient to produce collaboration and cooperation with other organizations. In the QCA, I analyzed whether four conditions were sufficient or necessary to produce collaboration and cooperation: (1) reliable private-pay funding; (2) targeted services; (3) staffing uncertainties; and (4) home-based services. None of these conditions were individually necessary or sufficient for achieving collaboration or cooperation, and no necessary combinations occurred.

Overall, the empirical results of the QCA showed that two combinations of conditions were sufficient to achieve collaboration or cooperation. The first combination of conditions that produced collaboration or cooperation was:

- Not having reliable private-pay funding in combination with having targeted services, having staffing uncertainties, and not having home-based services.

One interpretation of this finding is that government and nonprofit organizations that provided targeted services in the community may engage in collaboration or cooperation with other organizations in order to reduce substantial uncertainties in terms of funding and staffing. The qualitative data provide some support for this interpretation. For example, one organization indicated that it was challenged by uncertainty about government funding and needed additional funding to support staff in order to add programs. To address these uncertainties, the organization reported that it formally cooperated with other organizations, which included holding quarterly meetings to coordinate resources (ID 7).

Another interpretation of this finding is that – when faced by substantial funding and staffing uncertainties – government and nonprofit organizations with a mission or mandate to provide services to women, racial/ethnic minorities, and low-income populations seek alternative avenues, such as collaborating or cooperating with other organizations, to ensure

that they can provide programs and services. In this interpretation, the primary purpose of the collaboration or cooperation is not to reduce funding or staffing uncertainties, but rather to ensure that they provide continuity of care for underserved populations. The qualitative data provide some support for this interpretation. For example, one organization that had a mission and mandate to provide services to underserved populations described how it took on the responsibilities and risks of another organization:

> "They directed the <de-identified> services up until May and then they quit because the money, couldn't afford it, and now we can't afford it… <de-identified> announced that they were quitting and it was either have no service or have <de-identified> develop something. <de-identified> felt the need to see the program continue so we took what was available…, and we're attempting to continue the service." (ID 47)

This organization was plagued by funding and staffing uncertainties before collaborating with another organization and decided to take on the responsibilities and risks of another organization even though it would lead to additional funding uncertainties. This organization did not engage in collaboration in order to reduce uncertainties, but rather it engaged in collaboration because it considered continuity of care for underserved populations to be crucial – regardless of whether it created additional uncertainties.

The second combination of conditions that produced collaboration or cooperation was:

- Having reliable private-pay funding in combination with having targeted services, not having staffing uncertainties, and not having home-based services.

An interpretation of this finding is that organizations with reliable funding and staffing may engage in collaboration or cooperation with other organizations as part of a broader mission to improve access to services in the community for women, racial/ethnic minorities, or low-

income populations. As illustrated by the following quote from the one organization with this solution, the qualitative data support this interpretation:

> "Basically, you know, you have an issue and you think who else might be engaged in that issue and you call them up or they may call you up and say, "We have an issue and we think this may be of interest to <de-identified> so let's collaborate on this." That was certainly the case with healthcare reform and defending social security and so on and so forth. There's a number of groups that are, are engaged in those things so, you know, somebody calls somebody else up and says, "Are we together on this?"" (ID 46)

This organization collaborated with other organizations in order to further its mission and obtain support for issues for which it advocated.

CHAPTER 7. DISCUSSION AND CONCLUSION

DISCUSSION

Collaboration can be conceptualized as a function of the structural features of organizations, the perceptions of environmental pressures, and the attitudes of organizational leaders towards collaboration and competition (Foster and Meinhard 2002). This dissertation explored: (1) the structural differences among organizations that provide services to older adults, (2) the environmental uncertainties that contribute to adaptations among organizations, and (3) the ways in which organizations collaborate and communicate with each other (or fail to collaborate and communicate) to enhance programs for older adults. In addition, I investigated how structural features of organizations and their perceptions of environmental uncertainties facilitate or hinder their collaboration and communication with other organizations.

This dissertation draws on in-depth qualitative interviews with representatives from organizations that provided services to older adults in Sarasota County, Florida. Semi-structured, telephone interviews were conducted with representatives of organizations. Audio recordings of interviews were transcribed, and interview transcripts were entered into the qualitative analysis software ATLAS.ti for coding (ATLAS.ti 2011). Forty-eight organizations were included in the final analyses. Interrater reliability procedures were implemented on a random sample of 20% of the interviews to ensure quality of coding. Each coding round involved coding independent subsets of the interviews and creating a summary matrix of these interviews. I entered summary matrices into the utility *ReCal* to calculate Cohen's kappa for interrater reliability (Burla et al. 2008; Hruschka et al. 2004). Following Hruschka et al. (2004), the coding team determined that a coefficient of greater than 0.80 was acceptable for this study.

Overall, the coding team achieved average Cohen's kappa coefficients of greater than 0.80 across all variables for all cases. After completing the coding process, I conducted a detailed review of all coded data to explore patterns. In this chapter, I conceptually sort these patterns to identify how they relate to and inform existing theories.

This dissertation provides insights on concepts in the sociological, gerontological, and public health literatures that were outlined in ***Chapter 2***. Findings relate to the concept of intersectionality and the resource-dependence model in the sociological literature (Acker 2006; Aldrich and Pfeffer 1976). Findings also relate to the practice-oriented theoretical framework, the concept of age-friendly communities, and the public policy context in the United States described in the gerontological literature (Yeatts, Crow, and Folts 1992). In addition, findings contribute to understanding systems of care in the public health literature (Pires 2002). The following section describes how findings contribute to these concepts in the scholarly literature.

Thematic analyses identified environmental uncertainties related to (1) funding sources, (2) staffing, and (3) local disparities in access to and quality of care. For funding sources, the top three uncertainties reported by organizations were that they (1) wanted to provide additional services, but could not because they lacked available funding; (2) relied heavily on fundraising and had problems with sustainability of fundraising over time; and (3) relied heavily on government funding and had problems with uncertainty of government funding over time. For staffing, the top three uncertainties reported by organizations were that they: (1) had a substantial need for volunteers; (2) lacked staff capacity and had overworked staff; and (3) had difficulty recruiting and retaining quality staff.

The top three local disparities involving access to and quality of care reported by organizations were: (1) they could not provide services to older adults with physical disabilities or mental health issues; (2) older adults experienced barriers to accessing transportation; and (3) broader issues existed in the community for low-income populations. The local disparities reported by organizations are consistent with barriers to accessing services identified in the practice-oriented theoretical framework. According to Yeatts, Crow, and Folts (1992), barriers to accessing services include affordability of services, availability of services, and ability to travel to services.

When describing local disparities, many organizations indicated that they turned away older adults who could not afford services. Organizations acknowledged that local disparities for low-income individuals are linked to other axes of inequality, such as race and ethnicity. Organizations indicated that denial of services based on the inability to pay disproportionately affected black, Hispanic, and uninsured populations. Following the system-centered approach to intersectionality, this finding demonstrates how organizations can reproduce inequalities. This finding also demonstrates that it is misleading to think about race, class, and gender as separate but intersecting systems of oppression because class is constituted by race and gender (Acker 2006). From a practical perspective, this finding also suggests that more work needs to be done to meet the objectives of the system of care, which include providing culturally competent and responsive services that embrace the cultural, racial, and ethnic differences of populations served (Pires 2002).

This dissertation featured a qualitative comparative analyses (QCA) examining the structural features of organizations and perceptions of environmental uncertainties – alone or

in combination – that were necessary or sufficient to produce collaboration and cooperation with other organizations (Ragin 2008; Vaisey 2015). Overall, the QCA identified two combinations of conditions that were sufficient to achieve collaboration or cooperation:

- Not having reliable private-pay funding in combination with having targeted services, having staffing uncertainties, and not having home-based services.
- Having reliable private-pay funding in combination with having targeted services, not having staffing uncertainties, and not having home-based services.

One interpretation of the first solution is that government and nonprofit organizations that provided targeted services in the community may engage in collaboration or cooperation with other organizations in order to reduce substantial uncertainties in terms of funding and staffing. This interpretation is consistent with the resource-dependence model, which contends that organizations lack the resources or capabilities to function completely autonomously and, consequently, enter relationships with organizations in the environment that can supply resources and capabilities. This interpretation also highlights the adaptability of organizations as theorized in the resource-dependence model, which identifies that organizations can actively adapt to and affect the environment and the environment can provide a range of possible social structures capable of survival (Aldrich and Pfeffer 1976).

While the organizational isomorphism perspective contends that groups of organizations may develop similar structures and practices, the resource-dependence model reminds us that organizations may respond to environmental uncertainties in divergent ways. Strategic adaptations to environmental uncertainties may result in divergent outcomes across organizations. This brings us to an alternate interpretation of the first QCA solution. An alternate interpretation of the first QCA solution is that – when faced by substantial funding

and staffing uncertainties – government and nonprofit organizations with a mission or mandate to provide services to older adults who are women, racial/ethnic minorities, or low-income seek alternative avenues, such as collaborating or cooperating with other organizations, to ensure that they can provide programs and services. In this interpretation, the primary purpose of the collaboration or cooperation is not to reduce funding or staffing uncertainties, but rather to ensure that they provide continuity of care for underserved populations. Similarly, an interpretation of the second solution is that organizations with reliable funding and staffing may engage in collaboration or cooperation with other organizations as part of a broader mission to improve access to services for older adults in the community who are women, racial/ethnic minorities, or low-income. Both interpretations identify the mission and mandate of the organizations as a driver of collaboration and cooperation. This suggests that the public policy context in the United States, including the Older Americans Act, can both inform the missions and mandates of organizations and, as an extension, also foster collaboration and cooperation.

In this study, 15% of organizations reported a barrier for low-income populations because insurance coverage did not support services. In addition, 23% of organizations reported having to turn away clients who could not afford services. Taken together, these findings suggest that older adults want and need additional services that could benefit their quality of life. However, insurance coverage does not support all services that older adults are interested in receiving, and older adults do not have the financial means to pay for these services out-of-pocket. A policy implication is that insurance coverage should be expanded to support the comprehensive needs of older adults.

The gerontological concept of age-friendly communities and the public health concept of systems of care provide a practice-oriented rationale for why organizations may collaborate and communicate in order to promote a mission and mandate that supports healthy aging among older adults, even in the face of environmental uncertainties. Collaboration and communication is not just for the sake of creating efficiencies, but also can ensure that older adults receive services that meet their holistic needs, provide seamless transitions of care, and facilitate a continuum of care. From an applied perspective, care coordination is about facilitating service use among older adults, enhancing quality of care, and improving quality of life among older adults.

Although the medical community is now beginning to embrace the tenet of the system of care approach, scholars argue that reform within a particular system—such as the primary health care system—is inadequate (Pires 2002). The system of care framework suggests that service providers should coordinate service delivery across all life domains including: (1) mental health services, (2) social services, (3) educational services, (4) health services, (5) substance abuse services, (6) vocational services, (7) recreational services, and (8) operational services (Stroul and Friedman 1986). This study contributed to the scholarly literature on systems of care by examining collaboration and communications across multiple sectors of service delivery and across multiple types of organizations. Unlike many other studies of collaboration that focused on non-profit organizations (e.g., Foster and Meinhard 2002; Guo and Acar 2005), this study examined collaboration across government, nonprofit, and for-profit organizations.

FUTURE RESEARCH AVENUES

This dissertation identified characteristics of organizations and environments that have successfully or unsuccessfully collaborated and communicated with other organizations. A logical extension of this research is to develop a theoretical framework and practical guidance for communities that seek to develop complex yet efficient systems of care. As mentioned above, it is important to distinguish the difference between addressing the needs of the community and the needs of individuals. The system of care approach has the potential to benefit the community as a whole and individuals. One possible future research avenue is to conduct a case study of older adults who participate in collaborative and coordinated care to learn about their satisfaction with the accessibility and quality of care. Another potential future research avenue is conducting a study that more fully addresses the system of care approach by exploring collaboration across the entire continuum of care including different levels of care such as those provided by long-term care facilities.

Past studies of networks of organizations have been critiqued for ignoring the challenges that underlie the formation of networks and their maintenance of boundaries (Podolny and Page 1998). In addition, most of the research on age-friendly communities has been conducted in large cities. Older adults residing in small cities or in rural areas may have different aging pathways and experiences than the general population (Lui et al. 2009). Consequently, another potential future research avenue is further exploring how small city and rural environments may introduce uncertainties and how local organizations respond to these challenges when collaborating and communicating in order to develop age-friendly communities.

STRENGTHS AND LIMITATIONS

A major strength of this study is the interrater reliability procedures used. Interrater reliability procedures ensured quality control of the coding process, improved agreement when assigning codes, and reduced bias in interpretation (Hruschka et al. 2004; MacQueen et al. 1998). Another strength of this study is the case study approach that drew on in-depth data collection from organizations in a single community, Sarasota County, Florida. The case study method was well suited for this study because this study sought to (a) understand organizational behavior that could not be manipulated by the researcher and (b) uncover contextual conditions relevant to the phenomenon under study, collaboration or cooperation among organizations (Yin 2003).

Yet another strength is that this study used a mixed-methods approach when conducting data analyses. Using thematic analyses, bivariate statistical analyses, and qualitative comparative analysis enabled me to examine data patterns and trends in thorough detail. The qualitative comparative analysis optimized the analyses of combinations of conditions that achieved the outcome of interest, collaboration or cooperation among organizations. The qualitative comparative analysis method was designed to support studies with small sample sizes; this method obtained results when probabilistic methods may not have been able to do so (Kane et al. 2014).

Despite these strengths, this study has several limitations. First, organizations self-selected whether to participate in this study, which could bias the study sample. Although the number of respondents appears fairly small, it is not unusual for this type of study. Sample saturation was monitored to ensure that no new information or themes emerged from the data. Previous research found that saturation in non-probabilistic samples occurred within the

first 12 interviews and meta-themes were present within the first 6 interviews (Guest, Bunce, and Johnson 2006). Therefore, the number of completed interviews should be more than sufficient to obtain saturation.

Second, the quality of individual interviews was dependent on the individual skills of the interviewers. Missing data are prevalent in qualitative data collection because: (1) interviewers may not ask the same questions in the first place, (2) interviewers may not probe for detailed answers on questions, (3) interviewers may not adequately record the answers to responses, and (4) respondents may be unwilling or unable to answer questions (Bernard and Ryan 2010). In this study, the qualitative data collection involved a semi-structured protocol in which different interviewers asked the same core questions of respondents. However, different interviewers did not probe all respondents in the same manner. Moreover, some respondents did not remember the answer to specific questions (e.g., the number of full-time employees) or felt that they were not the best person in the organization to provide accurate answers to some questions. Furthermore, I discovered that one organization was systematically missing data across the interview. After further investigation, I removed this completed interview from the final sample because the audio recording failed during the interview and the transcript of the audio recording was incomplete.

Finally, as with any interview, the interview protocol was limited in the number of topics included and did not capture all factors related to systems of care, organizations, service provision, older adults, collaboration, communication, and environmental uncertainties. Since I was not involved in the study design or protocol development, I did not have the opportunity to provide feedback on the questions included in the interview protocol,

the question wording, the question order, or the inclusion and exclusion criteria for sample selection. The sample excluded informal businesses, self-employed individuals, formal businesses that did not provide services in Sarasota County, and—because of their unique attributes—formal businesses that provided long-term institutionalization of older adults. As a result, the sample does not adequately reflect the intention of the system of care approach, which would theoretically and empirically include entities such as long-term care facilities to account for transitions across different levels of care.

CONCLUSIONS

Bridging the gap in the sociological, gerontological, and public health literatures, this dissertation explored the notion that collaboration is a function of the structural features of organizations, perceptions of environmental pressures, and attitudes of organizational leaders towards collaboration and competition. This study demonstrated that organizations can engage in collaboration and cooperation across multiple sectors of service delivery and across multiple types of organizations. Drivers of collaboration and cooperation may be reducing environmental uncertainties as well as promoting continuity of care for underserved populations. This study identifies that the community of Sarasota County is in the process of developing systems of care. Moving forward, the system of care will likely evolve and adapt over time to meet the changing needs of patients and the environmental uncertainties in the community.

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APPENDICES

APPENDIX A. INTERVIEW PROTOCOL

V7.0

Institutions Affecting People
Over 65 in Sarasota County, FL
Qualitative Interview

Interviewer Name_____	Date of Interview _____

BEFORE YOU CALL, **BE PREPARED**:

- REVIEW THE ASSIGNMENT INFORMATION PROVIDED INCLUDING ORGANIZATION NAME, RESPONDENT NAME AND ORGANIZATIONAL ROLE, TELEPHONE NUMBER, AS WELL AS THE DATE OF THE INITIAL INTERVIEW.
- HAVE ALL INTERVIEWING MATERIALS AVAILABLE.

ANSWERING MACHINE MESSAGE IF NO ANSWER AT TIME OF APPOINTMENT

My name is [INTERVIEWER NAME] and I'm calling from Research Triangle Institute International, a nonprofit research firm that is conducting research about organizations that affect the lives of persons over age 65 in Sarasota County. I had on my calendar that we had an appointment scheduled for this date and time. Since now is not a good time I'd like to reschedule. Please call our project's toll-free line at 1-877-212-7228. I look forward to hearing from you. Have a wonderful day.

Interview Start Time: ___ ___ : ___ ___AM/PM

INTRODUCTION

Thank you for making time to talk with me by phone. As I mentioned, we are trying to create an understanding of resources and interventions for persons over age 65 in the area.

I will ask questions about the following topics: your tenure in this agency and in service delivery generally, your organization's characteristics, your programs for people over 65, program funding sources, your collaborators outside the organization, your outlook on the future, and perspectives on healthy aging.

None of my questions are meant to evaluate you personally or the work of your [agency/organization]. Rather they will help us learn about your organization and its role in the community. This will take about an hour. We will interview up to 50 other organizations to understand the range of services available to people age 65 and older in Sarasota County.

I also want you to know that your participation in this research is confidential. Your name and the name of your organization will never be reported with the information you provide. Your participation in this research is also voluntary. Refusal to participate will involve no penalty, and you may discontinue participation at any time.

With your agreement, I will audio record your interview. Is this okay with you? You can ask us to pause or stop the recording at any time. Only RTI research team members and a confidential transcription service will be able to listen to the recordings. The recordings will be destroyed after the end of the study. Comments from all interviews will be combined in a report that will not identify who made the comments.

[IF INTERVIEWEE INDICATES HE/SHE DOES NOT WANT TO BE AUDIO RECORDED LET HIM/HER KNOW THAT YOU WOULD LIKE TO RESCHEDULE IN ORDER TO HAVE ANOTHER PERSON FROM THE RESEARCH TEAM JOIN THE INTERVIEW TO TAKE NOTES]

Do you have questions for me before I begin?

BACKGROUND DATA

BD1. INTERVIEWER: IS RESPONDENT MALE OR FEMALE? CIRCLE RESPONSE TO RIGHT.
1 MALE
2 FEMALE

BD2. How long has this agency been in existence?
_____ years _____ months OR _____ year (YYYY)

BD3. How long have you been working at this particular agency?
_____ years _____ months OR _____ year (YYYY)

BD4. How long have you worked with the aging population, including time with other organizations or agencies?
_____ years _____ months OR _____ year (YYYY)

BD5: What is your title and role in the organization?
_____
_____

BD6: How many full-time employees work at this organization?_____

BD7: How many part-time employees work at this organization?_____

BD8: How many volunteers do you have? _____

BD9: How many contractors provide services for the organization?_____

Service Provision

SP0. What programs and services do you provide to people over age 65 in Sarasota County?

_____
_____
_____
_____
_____
_____

[CHECK THE ITEMS BELOW THAT ARE MENTIONED. AFTER RESPONSE GIVEN PROBE (AS APPROPRIATE) FOR ITEMS NOT MENTIONED]

Do you have programs that address:

SP1.	disaster preparedness	YES	NO
SP2.	safety and security	YES	NO
SP3.	property issues related to hurricane threats	YES	NO
SP4.	independence of older residents	YES	NO
SP5.	fraud and abuse	YES	NO
SP6.	transportation	YES	NO
SP7.	case management	YES	NO
SP8.	free or low-cost services	YES	NO
SP9.	Employment services	YES	NO
SP10.	Housing	YES	NO
SP11.	legal services	YES	NO
SP12.	falls prevention	YES	NO
SP13.	health screenings	YES	NO
SP14.	nutritional services	YES	NO
SP15.	meals	YES	NO
SP16.	spiritual needs	YES	NO
SP17.	learning opportunities	YES	NO
SP18.	Caregiver support and respite	YES	NO
SP19.	Home health	YES	NO
SP20.	Elder abuse	YES	NO
SP21.	Government entitlements and insurance Assistance (e.g., negotiating Medicaid/Medicare	YES	NO

	/Social Security/Health insurance)		
SP22.	Emergency assistance (short-term financial assistance)	YES	NO
SP23.	Vision/Hearing	YES	NO
	(Do you have programs that address)		
SP24.	Adult Day services	YES	NO
SP25.	Senior Center services	YES	NO
SP26.	Home improvement	YES	NO
SP27.	Low income energy assistance	YES	NO
SP28.	Wellness services/activities	YES	NO
SP29.	Wellness checks	YES	NO
SP30.	Counseling	YES	NO
SP31.	Mental health services	YES	NO
SP32.	Substance abuse services	YES	NO

[ADMINISTER A SHOWCARD THAT ENUMERATES PROGRAMS]

Programs for 65+

P1. Can you describe the populations you serve and how they differ? (PROBE: How would you describe the populations you serve in terms of socio-economic status, race, ethnicity, or other characteristics?)

P2. Are there any populations that you do not serve? (PROBE: What about seniors who have serious mental illness, are cognitively impaired, or are homeless?)

P3. Do you provide services to so-called "snow birds"?

P4. Where do your program users live? PROBE: SINGLE FAMILY HOMES, MULTI-UNIT HOUSING, ASSISTED LIVING OR RESIDENTIAL CARE, WHICH NEIGHBORHOODS, ETC.

P5. What are your thoughts about local disparities and individuals' access to programs?

P6. What ways are organizations in the county working or not working to address these disparities?

P7. [INTERVIEWER: IF THE ORGANIZATION DOES WORK TO ADDRESS DISPARITIES IT WILL LIKELY BE STATED IN PREVIOUS QUESTION. ONLY ASK THIS IF NEEDED] Does your organization do work to specifically address disparities? How involved are you with this?

P8. What are the challenges in addressing these disparaties?

P9. Does your organization offer support services for caregivers? What are they (e.g., respite care)?

P10. Does your organization offer programs for Alzheimer's and/or dementia? What are they?

P11. Does your organization work with home health agencies or adult day service centers to provide services for frail elders? If so, how has this been effective?

P12. How do you see/define healthy aging and how do your services support that?

P13. Do your clients use any programs with healthy aging components, either yours or another organization's? EXAMPLES: HEALTH PROMOTION, CHRONIC DISEASE MANAGEMENT, SOCIAL SUPPORT/NETWORKING.

P14. Do you have formal agreements for wraparound services? Tell me about those.

Wraparound service: An integrated set of community services, typically involving interagency collaboration and a definable planning process, that is individualized for the client and focused on achieving a positive set of outcomes.

P15. Do you screen for:
Substance abuse?
Mental health?
HIV?
Do you provide services for people with these health concerns?
Do you provide referrals to agencies that provide those services?

P16. What feedback do you get about your programs from the people you serve? PROBE: What do the people you serve like and dislike about your programs?

P17. How do you gather feedback from program users? What metrics do you use to measure performance and success? PROBE: FORMAL EVALUATIONS? SUGGESTION BOXES? FAMILIES OF CONSTITUENTS?

P18. Are programs with healthy aging components reaching the people who need them? If not, what are the barriers to outreach?

P19. What are the barriers to program participation for people over 65?

P20. What are things you'd like to do for your clients that you aren't able to do?

Institution Characteristics

IC 1. What are the most important **products and services** your organization targets at older adults?

IC 2. Are there any ways your organization supports job growth and entrepreneurship in Sarasota County? (THIS IS IN RELATION TO INDIVIDUALS 65+) If so, how?

IC 3. We are interested in learning how programs serving people over 65 may use technology. Do you use technologies to implement programming?

Do you use technologies to support staff?

PROBE: THESE COULD BE EMAIL, TWITTER, REMOTE HEALTH MONITORING, ELECTRONIC HEALTH RECORDS, DISTANCE LEARNING, SIMULATORS.

IC 4. How do the people who use your services feel about technology and innovation? PROBE: DO THEY REQUEST IT? DO YOU FACILITATE THEIR ADOPTION OF TECHNOLOGY?

IC 5. What services and programs does your institution provide that you are proud of?

IC 6. What are the biggest challenges in terms of improving your programming?

IC7. Other than your organization, what do you think are the broader challenges for organizations like yours in Sarasota?

IC8. How has your agency evolved (changed) over time?

Program Funding

PF1. What are your top 5 sources of revenue?

PF2. Do your program users pay your organization for services they receive? By this we mean out-of-pocket fees.

PF3. Do your program users pay for services through health insurance?

PF4. Do you do any pro-bono work? If so, why do you need to do it? How much do you do?

PF5. How does your organization quantify program usage? Do you track the numbers of different types of people using your services? PROBE: DO YOU TRACK AGE, RACE/ETHNICITY, SOCIOECONOMIC STATUS?

PF6. How does your organization identify the need for new programs? PROBE: FORMAL OR INFORMAL.

PF7. What challenges do you have starting new programs (other than funding)?

PF8. Does your organization seek government funding? If so, does that shape your program development? Do you write grants?

PF9. How proactive are you in seeking funding? How do you identify potential funders?

PF10. To whom is your organization accountable? PROBE: CONSTITUENTS, GOVERNMENT, OTHER FUNDERS?

PF11. In very general terms can you describe the reporting requirements for your programs?

Collaborators

C1. How do you coordinate with other organizations outside the county, e.g., providers in other states? For example, how do you hand off/receive health records from providers elsewhere?

C2. Do you have ways in which to involve clients' family members who may reside outside the Sarasota area? PROBE: HEALTH INFORMATION, PROGRAM NEEDS.

C3. What are the top 3 organizations or agencies that you collaborate with?

C4. Does your organization experience barriers to collaboration? What are those?

C5. What organizations would you like to collaborate with that you are not now? What's preventing this?

C6. Are there non-institutional partners your organization interacts with? PROBE: NEIGHBORS/ FRIENDS/ PEOPLE WHO HELP EACH OTHER OUT, FAITHGROUPS.

C7. How does your organization engage with these non-institutional partners?

Communication and outreach

CO1. How does your organization engage program users and disseminate information? [media, publicity, targeting]

CO2. Do you have a mailing list? How many are on your distribution list? How is it disseminated? PROBE: MAIL, E-MAIL, OTHER. How often is it distributed?

CO3. What are the most innovative organizations for older adults in Sarasota County?

Organizational Outlook

OO1. Where do you see your organization in 5 years?

OO2. What will you need to get there? What are the challenges in carrying that out?

OO3. Does your organization have a formal development plan? [BUSINESS DEVELOPMENT PLAN COUNTS] What are the parts of that?

OO4. Does your organization have specific technology plans or goals as you look to the future? What are they?

Closing the Interview

CL1. What other organizations or individuals do you think we should be speaking with about these topics?

CL2. Those are my questions but I may have missed a topic that is important to you. Can you tell me if there's anything that is important to understand about your organization, your program users, the environment for organizations like yours that we haven't touched on?

FINALIZE ANY INFORMATION EXCHANGE SUCH AS MATERIALS THEY MAY FAX OR MAIL (e.g., MISSION STATEMENT, TOOLKITS, BROCHURES).

THANK RESPONDENT.

APPENDIX B. DATA USAGE PERMISSION LETTER

RTI INTERNATIONAL

Chicago Office

230 West Monroe Street ▪ Suite 2100 ▪ Chicago, IL 60606-4901 ▪ USA
Telephone 312.456.5240 ▪ Fax 312.456.5250 ▪ www.rti.org

January 29, 2013

To Whom It May Concern:

I am the Principal Investigator for the *Institutions that Affect the Lives of Persons Over Age 65 in Sarasota County* study (RTI Project No. 0290001.001.084.002). I am the responsible person at RTI International for granting data usage requests for data collected for this study. I grant Stephanie Teixeira-Poit permission to use these data for her dissertation research and publications and presentations based on her dissertation research.

Sincerely,

Paul Pulliam

Director, Health Surveys and Registries Program

RTI International

APPENDIX C. INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

North Carolina State University is a land-grant university and a constituent institution of the University of North Carolina

Office of Research and Innovation
Division of Research Administration

NC STATE UNIVERSITY

Campus Box 7514
Raleigh, North Carolina 27695-7514

919.515.8754 (phone)
919.515.7721 (fax)

From: Jennifer Ofstein, IRB Coordinator
North Carolina State University
Institutional Review Board

Date: April 9, 2013

Title: Organizations, Socioeconomic Environment, and Service Provision for Older Adults

IRB#: 3214

Dear Stephanie,

The research proposal named above has received administrative review and has been approved as exempt from the policy as outlined in the Code of Federal Regulations (Exemption: 46.101. b.4). Provided that the only participation of the subjects is as described in the proposal narrative, this project is exempt from further review.

NOTE:

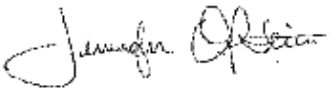
1. This committee complies with requirements found in Title 45 part 46 of The Code of Federal Regulations. For NCSU projects, the Assurance Number is: FWA00003429.

2. Any changes to the research must be submitted and approved by the IRB prior to implementation.

3. If any unanticipated problems occur, they must be reported to the IRB office within 5 business days.

Please forward a copy of this letter to your faculty sponsor, if applicable.
Thank you.

Sincerely,



Jennifer Ofstein
NC State IRB

APPENDIX D. RECODING DECISIONS FOR MISSING DATA ON THE BASIS OF SECONDARY DATA ABSTRACTION: BY IDS OF ORGANIZATIONS IN THE FINAL SAMPLE

Table D-1. Recoding Decisions for Missing Data on the Basis of Secondary Data Abstraction: By IDs of Organizations in the Final Sample

Variable (# of IDs Initially Missing Responses)	Recode Response for ID Based on Secondary Data	Treat Response for ID as Missing; Cannot Find Secondary Data
# Full-Time Employees (10 IDs)	ID 9 – Recode as "0."	IDs 1-5, 7, 36, 40 [a], 42
# Part-Time Employees (11 IDs)	ID 9 – Recode as "50." [b] ID 30 – Recode as "344."	IDs 1-5, 7, 22, 40 [a], 50
# Contractors (14 IDs)	ID 6 – Recode as "0." ID 26 – Recode as "0."	IDs 1-5, 7, 10, 22-23, 30, 33, 40 [a]
# Volunteers (11 IDs)	ID 24 – Recode as "40." ID 30 – Recode as "1,000."	IDs 1, 3-5, 7, 22, 33, 40, 51
Years in Existence [c] (3 IDs)	ID 23 – Recode as "3." ID 30 – Recode as "86."	ID 42
Perceptions on To Whom Accountable [d]		
Internal board of directors or other internal leadership (4 IDs)		IDs 1, 12, 13, 42
Government (4 IDs)		IDs 1, 12, 13, 42
Corporate office, franchise, or national board of directors (4 IDs)		IDs 1, 12, 13, 42
Regulatory, licensing, bonding, or accrediting agencies (4 IDs)		IDs 1, 12, 13, 42
Community, citizens, or taxpayers (4 IDs)		IDs 1, 12, 13, 42
Members or clients served (4 IDs)		IDs 1, 12, 13, 42
Professional associations (4 IDs)		IDs 1, 12, 13, 42
Other (4 IDs)		IDs 1, 12, 13, 42

(continued)

Table D-1 (continued)

Variable (# of IDs Initially Missing Responses)	Decision to Recode Response Based on Secondary Data Abstraction	Decision to Treat Response as Missing; Cannot Find Secondary Data
Top Revenue Sources		
Private Pay (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "Yes."	
Private Health Insurance (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "No."	
Medicare (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "No."	
Medicaid (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "No."	
Veterans Benefits Administration (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "No."	
Government/Taxes (1 ID)	ID 23 – Recode as "Yes."	
Other Grant (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "No."	
Other (2 IDs)	ID 23 – Recode as "No." ID 35 – Recode as "No."	
Seeks Out-of-Pocket Payments (2 IDs)	ID 35 – Recode as "Yes." ID 51 – Recode as "No."	
Seeks Government Funding (1 ID)	ID 23 – Recode as "Yes." ID 47 - Recode as "Yes." [e]	

(continued)

Table D-1 (continued)

Variable (# of IDs Initially Missing Responses)	Decision to Recode Response Based on Secondary Data Abstraction	Decision to Treat Response as Missing; Cannot Find Secondary Data
Where Users Live		
Single family homes (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Assisted living facilities (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Multi-unit housing, condominiums, or apartments (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Skilled nursing facilities or nursing homes (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Residential care facilities, independent living facilities, or retirement communities (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Manufactured home communities (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Hospitals or mental health facilities (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	
Other (2 IDs)	**Recode as "Unspecified, multiple":** IDs 25, 33	

(continued)

Table D-1 (continued)

Variable (# of IDs Initially Missing Responses)	Decision to Recode Response Based on Secondary Data Abstraction	Decision to Treat Response as Missing; Cannot Find Secondary Data
Formal Organization Size (9 IDs)	ID 9 – Recode as "Large."	IDs 1-5, 7, 40 [f], 42
Dependent on Volunteer Labor (9 IDs)	**Recode as "No":** IDs 1-5, 7 **Recode as "Yes":** IDs 24, 33, 40	
Government, Non-Profit, and For-Profit Status (29 IDs)	**Recode as "Non-Profit":** IDs 8, 10, 13, 19, 25, 26, 31, 33, 34, 40, 42, 46 **Recode as "For-Profit":** IDs 1, 3-5, 9, 11, 12, 17, 27, 35-36, 41, 44, 48-50	

[a] Because of the nature of the organization, *# Full-Time Employees, # Part-Time Employees, and # Contractors* are "not applicable" for ID 40. This organization is treated as missing for these variables.
[b] One respondent from an organization did not specify whether employees were full-time or part-time. Because of the nature of the organization, it is likely that the employees are part-time.
[c] The year was subtracted from 2011 to calculate *Years in Existence*.
[d] Perceptions are subjective and, thus, were not recoded based on secondary data.
[e] These data were not missing originally. This government organization originally answered "No" to this question.
[f] Because of the nature of the organization, *Formal Organization Size* is "not applicable" for ID 40. This organization is treated as missing for this variable.

APPENDIX E. OVERVIEW OF QUALITATIVE COMPARATIVE ANALYSIS

Qualitative Comparative Analysis (QCA) is a relatively new analytic technique developed by Charles C. Ragin that uses Boolean algebra to understand combinations of conditions that are sufficient or necessary to produce an outcome (Ragin 2008; Vaisey 2015). This appendix provides an overview of key assumptions and concepts in QCA.

Conceptual differences between QCA and the generalized linear regression model. QCA differs from the generalized linear regression model in four main ways. First, QCA researchers examine set relations instead of correlations. For example, QCA researchers would conceptualize perfect GRE scores as a subset of those admitted to graduate school (see ***Figure E-1***) instead of examining the correlation between perfect GRE scores and graduate school admission. QCA researchers would identify perfect GRE scores as sufficient, but not necessary for admission to graduate school; many individuals who are admitted to graduate school do not have perfect GRE scores (Ragin 2008; Vaisey 2015).

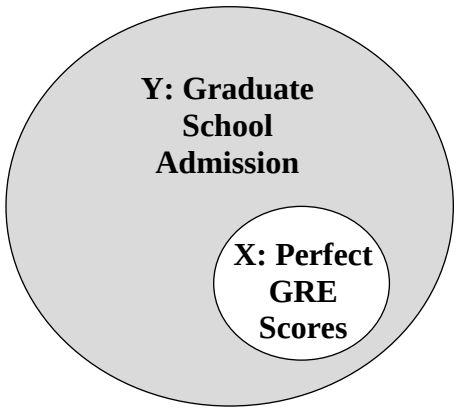


Figure E-1. Graphical Depiction of Set Relations (Adapted from Vaisey 2015)

Second, QCA researchers use calibrated sets instead of measured variables. For example, QCA researchers would study the concept “rich” instead of the measured variable “income in dollars.” In QCA, set membership varies from fully out of the set (value of 0) to fully in the set (value of 1). To calibrate or assign values to sets, QCA researchers rely on expert knowledge and empirical data (Ragin 2008; Vaisey 2015).

Third, QCA researchers examine combinations of conditions that produce an outcome instead of examining independent variables. QCA researchers acknowledge that some conditions may be substitutable in producing an outcome. For example, perhaps we seek to determine combinations of nickels, dimes, and quarters that could produce the outcome of 25 cents. We could identify multiple solutions that would be sufficient to produce the desired outcome:

Solution 1:	0 nickels	+	0 dimes	+	1 quarter	=	25 cents
Solution 2:	5 nickels	+	0 dimes	+	0 quarters	=	25 cents
Solution 3:	3 nickels	+	1 dime	+	0 quarters	=	25 cents
Solution 4:	1 nickel	+	2 dimes	+	0 quarters	=	25 cents

In Solution 1, we see that one quarter is sufficient to produce the outcome. Yet, in Solution 2, five nickels are also sufficient to produce the outcome. In other words, five nickels are substitutable for one quarter; five nickels can make up for having zero quarters. QCA researchers also acknowledge that some combinations of conditions are not substitutable. For example, dry wood and a spark can produce the outcome of fire. However, no amount of dry wood can produce fire in the absence of a spark (Ragin 2008; Vaisey 2015).

Fourth, QCA researchers conceptualize models using causal complexity instead of net effects. Instead of examining maximization (i.e., how to obtain the maximum value of the outcome), QCA researchers examine equifinality or multiple pathways to achieve the threshold of the outcome. QCA researchers address limited diversity or non-observed combinations of conditions by incorporating counterfactuals that draw on theoretical inference (Ragin 2008; Vaisey 2015).

Understanding key concepts of consistency and coverage. QCA researchers understand that set relations are usually not perfect because of coding and sampling errors. Therefore, QCA researchers examine consistency and coverage when interpreting results. QCA researchers consider two types of consistency: (1) consistency with sufficiency; and (2) consistency with necessity. Consistency with sufficiency asks: "If I have the condition X, do I have the outcome Y?" Consistency with necessity asks: "If I have the outcome Y, do I have the condition X?" Take, for example, attending class (X) and getting good grades (Y). Some professors structure their grading such that students have to attend class in order to get a good grade. In this example, if students got a good grade, then we know that they attended class; however, if students attended class, then they still may not have gotten a good grade. In other words, attending class would be necessary, but not sufficient to get a good grade (Ragin 2008; Vaisey 2015).

Coverage identifies the degree to which the condition X accounts for instances of the outcome Y. Take, for example, a failed parachute (X) and death (Y). Having a failed parachute is sufficient to produce the outcome death. However, having a failed parachute is a relatively rare cause of death; in the United States, the top three causes of death are heart

disease, cancer, and chronic lower respiratory diseases (Centers for Disease Control and Prevention, 2015). The concept of coverage would help us interpret having a failed parachute as a sufficient cause of death that is relatively unimportant from a policy perspective, since it accounts for few instances of death in comparison to heart disease, cancer, and other chronic health conditions (Ragin 2008; Vaisey 2015).

Research Steps for Performing QCA. After reviewing key assumptions and concepts used in QCA, we can begin to understand research steps for performing QCA, which include the following:

1. Identify and calibrate the conditions and outcome of interest.
2. Perform bivariate data visualization.
3. Develop a truth table that identifies all possible combinations of conditions (i.e., compound sets).
4. Incorporate counterfactuals to address limited diversity or non-observed compound sets.
5. Analyze the truth table to assess case membership in each row of the truth table, examine consistency for each row, set a decision rule to code true rows or solutions, and logically reduce solutions.
6. Compute additional statistics and conduct data visualization of solutions to further explore consistency and enhance confidence in results (Vaisey 2015).

To perform these research steps, Vaisey (2015) recommends alternating between two software packages:

1. fuzzy, a program that is available in Stata (Longest and Vaisey 2008; StataCorp 2013); and
2. fs/QCA (Ragin, Drass, and Davey 2006).

For this dissertation, I used the former software package to perform research steps one, two, and six and the latter software package to perform research steps three through five.

The first research step is to identify and calibrate the conditions and outcome of interest. As mentioned above, set membership varies from fully out of the set (value of 0) to fully in the set (value of 1). Set membership can be crisp or fuzzy. Crisp sets are operationalized using dichotomous values where fully out of the set is "0" and fully in the set is "1." Fuzzy sets are operationalized using either categorical or "continuous" values, which tend to have symmetry. For example, in a four-value fuzzy set, fully out is "0," more out than in is "0.33," more in than out is "0.67," and fully in is "1." In a six-value fuzzy set, fully out is "0," mostly but not fully out is "0.20," more or less out is "0.40," more or less in is "0.60," mostly but not fully in is "0.80," and fully in is "1." In a continuous fuzzy set, fully out is "0," a degree of membership more out than in assumes a value greater than 0 but less than 0.50, neither in nor out is "0.50," a degree of membership more in than out assumes a value greater than 0.50 but less than 1, and fully in is "1." To calibrate or assign values to sets, QCA researchers rely on expert knowledge and empirical data (Ragin 2008; Vaisey 2015).

The second research step is performing data visualization between each condition (X) and the outcome of interest (Y). QCA researchers can use bivariate data visualization to help prioritize or narrow conditions for inclusion in the analysis. Bivariate data visualization involves a preliminary exploration of consistency with sufficiency and consistency with

necessity to avoid including random noise in models. As mentioned above, consistency with sufficiency asks: “If I have the condition X, do I have the outcome Y?” Consistency with sufficiency has a floor effect where the level of the outcome Y cannot be below the level of the condition X. When consistency with sufficiency is graphically depicted, cases appear in the upper triangle of a scatterplot (see ***Figure E-2***). In contrast, consistency with necessity asks: “If I have the outcome Y, do I have the condition X?” Consistency with necessity has a ceiling effect where the level of the outcome Y cannot exceed the level of the condition X. When consistency with necessity is graphically depicted, cases appear in the lower triangle of a scatterplot (see ***Figure E-3***; Ragin 2008; Vaisey 2015).

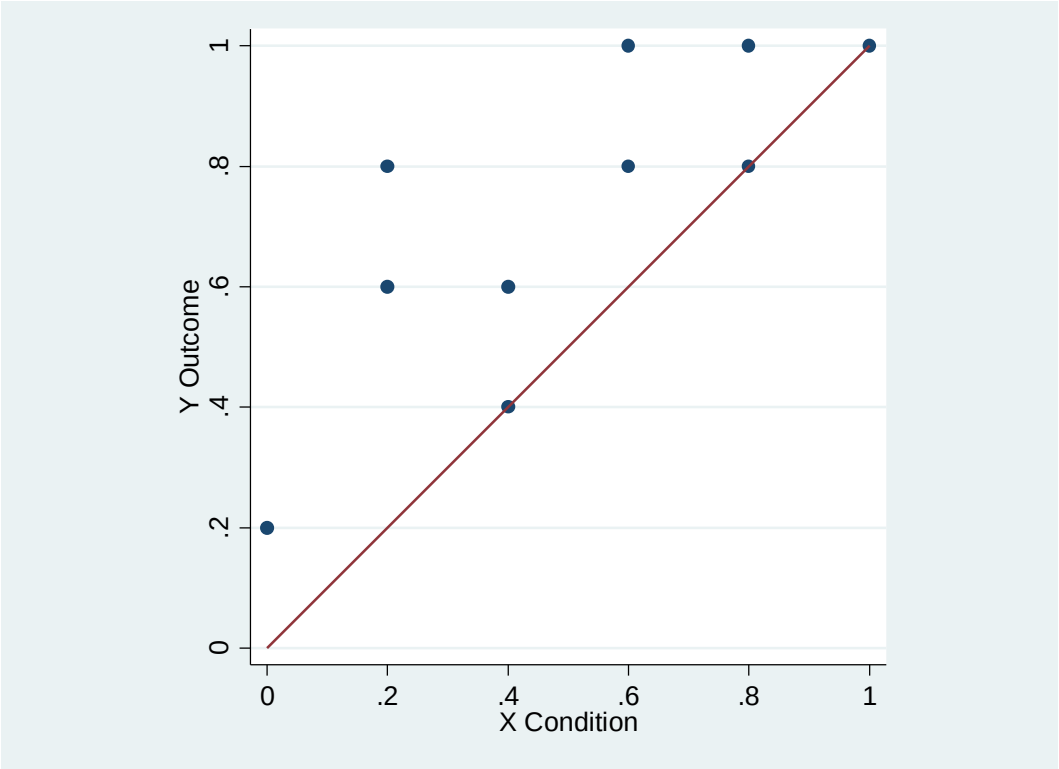


Figure E-2. Graphical Depiction of Consistency with Sufficiency

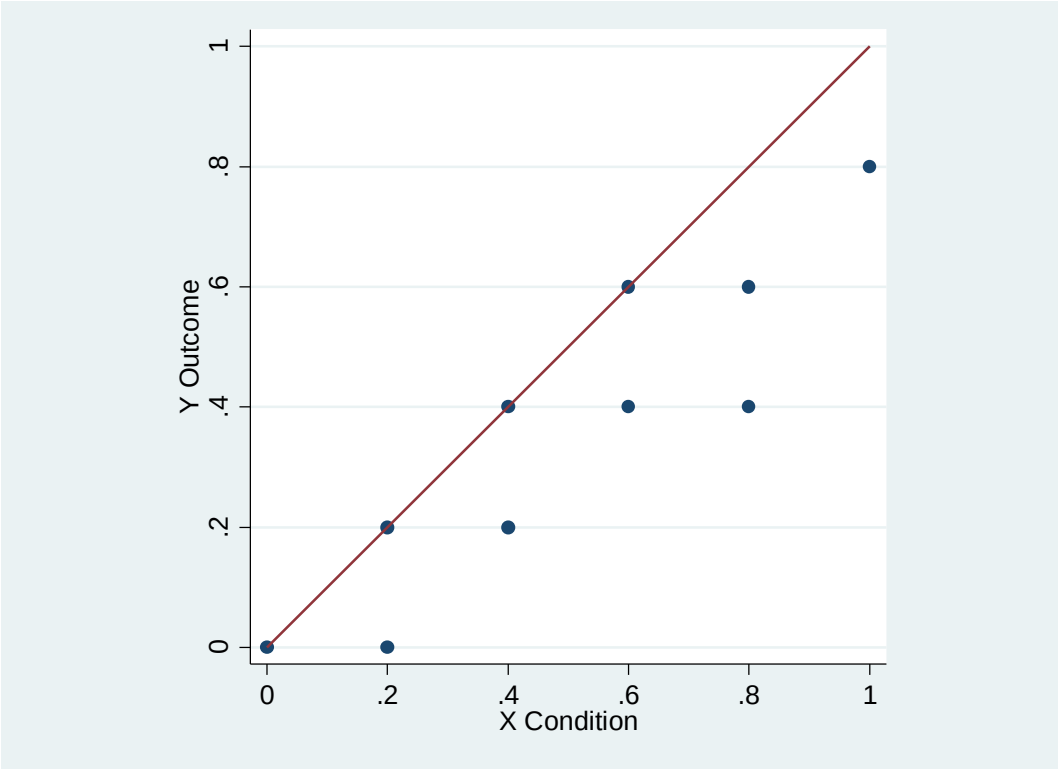


Figure E-3. Graphical Depiction of Consistency with Necessity

The third research step is developing a truth table that identifies all possible combinations of conditions or compound sets. QCA researchers express conditions using capital letters (e.g., A, B, C) to represent the presence of conditions and lower case letters (e.g., a, b, c) to represent the absence of conditions. When developing a truth table, QCA researchers identify all possible (2^k) compound sets. For example, three conditions would result in eight possible compound sets (see ***Table E-2***; Ragin 2008; Vaisey 2015).

Table E-2. Example of Truth Table for Three Conditions (Adapted from Vaisey 2015)

Compound Set	A	B	C	No. of Cases	If True, Is Y Also True?
A*B*C	1	1	1	2	?
A*B*c	1	1	0	3	?
A*b*C	1	0	1	4	?
A*b*c	1	0	0	1	?
a*B*C	0	1	1	2	?
a*B*c	0	1	0	0	?
a*b*C	0	0	1	0	?
a*b*c	0	0	0	0	?

The fourth research step is incorporating counterfactuals to address limited diversity or non-observed compound sets. Oftentimes, datasets have limited diversity where they do not contain observed cases of all compound sets (e.g., compound sets a*B*c, a*b*C, a*b*c in ***Table E-2***). When analyzing results, QCA researchers produce three solutions, each of which varies in its approaches to addressing limited diversity: (1) the complex solution; (2) the parsimonious solution; and (3) the intermediate solution. The complex solution assumes that non-observed compound sets do not produce the outcome of interest (i.e., are false). The parsimonious solution assumes that non-observed compound sets produce the outcome (i.e., are true) only if this would logically reduce the solution. Finally, the intermediate solution incorporates counterfactuals that draw on theoretical inference. To incorporate counterfactuals, QCA researchers identify whether prior studies suggest that the presence or absence of a condition would produce the outcome. For example, consider if A*B*c is observed in the dataset, but A*B*C is not observed. If A*B*c produces the outcome (i.e., is true) and prior studies suggest that the presence of C would likely help produce the outcome, then QCA researchers would assume that A*B*C would also produce the outcome if it were

observed in the dataset. Unlike the complex solution, the intermediate solution suggests that QCA researchers cannot assume that A*B*C would not produce the outcome just because it is not observed in the dataset (Ragin 2008; Vaisey 2015).

The fifth research step is analyzing the truth table to assess case membership in each row of the truth table, to examine consistency for each row, to set a decision rule to code true rows or solutions, and to reduce solutions logically. For fuzzy sets, QCA researchers examine consistency by computing inclusion coefficients for each row of the truth table. To examine consistency with sufficiency, the inclusion coefficient is mathematically expressed as:

$$\text{Consistency } (X_i \leq Y_i) = \frac{\sum [\min (X_i, Y_i)]}{\sum (X_i)}$$

To examine consistency with necessity, the inclusion coefficient is mathematically expressed as:

$$\text{Consistency } (Y_i \leq X_i) = \frac{\sum [\min (X_i, Y_i)]}{\sum (Y_i)}$$

The inclusion coefficient does not have an intuitive meaning, so QCA researchers cannot use a particular threshold to automatically code true rows or solutions. For example, an inclusion coefficient for sufficiency could be 0.70 or 0.80, but cases could be dispersed throughout the upper and lower triangle of a scatterplot (which would suggest inconsistency with sufficiency). This underscores the importance of pairing the inclusion coefficient with data visualization to enhance confidence in results. After examining consistency, QCA researchers set a decision rule to code “true” rows or solutions that consistently produce the outcome. In some instances, solutions can be logically reduced. For example, the solutions

A*B*C and A*B*c can be logically reduced to the solution A*B, because C and c would cancel one another out (Ragin 2008; Vaisey 2015).

The final research step is computing additional statistics and conducting data visualization of solutions to further explore consistency and enhance confidence in results. Only after establishing consistency, can QCA researchers explore coverage or the degree to which solutions account for instances of an outcome. Coverage when assessing sufficiency is mathematically expressed as:

$$\text{Coverage } (X_i \leq Y_i) = \frac{\sum [\min (X_i, Y_i)]}{\sum (X_i)}$$

Coverage when assessing necessity is mathematically expressed as:

$$\text{Coverage } (Y_i \leq X_i) = \frac{\sum [\min (X_i, Y_i)]}{\sum (Y_i)}$$

As mentioned previously, high coverage corresponds to empirically nontrivial sufficient or necessary solutions, while low coverage corresponds to empirically trivial sufficient or necessary solutions.

QCA researchers can also compute Wald tests (using an F distribution) between each compound set's y-consistency (inclusion in y) and its n-consistency (inclusion in not y). A significant p-value (≤ 0.05) indicates that the y-consistency and n-consistency of a compound set are statistically different. This provides confidence that solutions are not primarily a result of the distribution of X (e.g., imagine a distribution of X skewed near 0, which provides limited opportunity for cases to appear in the lower triangle of the scatterplot). To further enhance confidence in results, QCA researchers can also conduct data visualization of the relationship between the compound set and the outcome (Longest and Vaisey 2008).