

***A Brief  
Review  
of the  
Planning  
Process***

*The greatest  
thing in this  
world is not so  
much where we  
are but in  
what direction  
we are moving.*

*—Oliver Wendell Holmes*



**W**ould you start out on a journey without having a destination in mind? Would you be comfortable with getting “close enough” to your intended destination but still uncertain if this is where you really wanted or needed to end up? Community strategic planning is a journey to create a future that is better than the present. It asks and answers the questions:

- ◆ Where are we now?
- ◆ Where do we want to be?
- ◆ How do we get there?
- ◆ How do we track our progress and measure our success?

Like any other trip, there will be pleasant surprises, barriers to success, unpredictable events, possible dangers, and opportunities. However, when you arrive at your destination, you will know and feel you’ve accomplished good things.

## Successful Strategic Planning

Throughout this resource guide, you will learn about different characteristics of successful community strategic planning, as well as strategies to assist your team in being one of those successes. However, in this chapter, we will focus on several key concepts that are central to any well-executed community planning initiative: vision, mission, goals, outcomes, outcome indicators, objectives, and strategies/action steps. This type of planning, often called outcome-based planning, is useful because it not only gives your team a roadmap to get to your desired destination, but it also helps your team make progress toward your goal, demonstrate successes, and determine if your efforts are really making a difference in the lives of the people in your community. Focusing on outcomes is essential to engaging support and sustaining your team’s work.

## Some Terminology

Vision statements. Mission statements. Goals. Objectives. Strategies. Action Steps. Outcomes Indicators. Outcomes. These terms form the basis of outcome-based planning. However, if you look at different organizations’ strategic action plans, many of these terms are used interchangeably or “incorrectly” based on any given definition. Even dictionaries have different definitions for each word. What’s a planning team to do?

To begin with, think about strategic planning as a way to help you and your team get from Point A to Point B. To do that, you need two different types of processes, each related to and working with the other:

- ◆ **A way to visualize where you want to be and what you must do to get there.** This is where your vision statement, mission statement, outcomes, goals, objectives, and strategies/action steps come in.

# Why Plan Well?

*You’ve got to  
be careful if  
you don’t know  
where you are  
going, because  
you might not  
get there.*

—Yogi Berra

- ◆ **A way to ensure that you are steadily making progress** toward your dreams and measure your success. This is where your team will use outcome indicators and outcomes.

The basic components of outcome-based strategic planning will help your team achieve both of the processes above. Try to focus more on the concepts behind each term rather than the actual name. Encourage your team to do the same.

Discussing and completing the basic concepts and requirements behind each component *is* very important for a successful community planning process. Understanding and agreeing upon definitions for components at the beginning of your teams' work will help your team communicate in a unified, consistent manner and avoid frustration and wasted time. Here are *working* definitions of the different components associated with strategic planning for common use throughout this resource. Your team may decide you like the definitions below exactly as is, or it may want to create its own terminology. Either way is fine as long as your team has the key concepts necessary to complete the two processes discussed above.

## Visualizing Where You Want to Be and How to Get There

**Your vision statement** is a short statement—sometimes only a sentence or two long—describing what your community would look like in the future in an ideal world. A vision statement

- ◆ defines your dream and is a mental image of what you strive to obtain
- ◆ exists to push toward future achievement
- ◆ sets forth a desirable future that would be better than the past or present
- ◆ contains broad goal areas and directs the outcomes
- ◆ energizes stakeholders around shared desires and intentions.

Your team's vision statement should be developed early and agreed upon by the entire team. Your vision statement should be short enough for everyone—and we mean everyone—on your team to be able to memorize and share with others in the community.

**Your mission statement** is slightly more specific and usually a little longer than your vision statement. Basically, it explains your team's reason for being. In addition, it can help your team create unity, move from ideas to action, and establish the culture of your group. Really good mission statements help elicit emotional or motivational responses in team members and/or in the overall community. Traditionally, mission statements

- ◆ spell out the team's purpose
- ◆ say what the team does, for whom, and where

- ◆ clarify why the vision statement matters
- ◆ answer why your chosen outcomes are necessary.

Many mission statements are only one paragraph long, though some are a little longer. No matter how long your mission statement is, your team must believe in each word and know that they will strive to uphold the statement.

**Goals** are broad, general, long-range statements of what your team wants to accomplish. However, even though goals are broad statements, they are still more specific than your vision and mission statements. Meeting goals is the way to accomplish your vision and mission statements. Each goal that your team sets must

- ◆ be consistent with the vision and mission statements
- ◆ be realistic, yet challenging
- ◆ set no specific milestones, timelines, or tasks to accomplish the goal
- ◆ not conflict with other goals.

An example of a general goal is: “To improve the mental health of older adults and disabled adults in Rowan County.”

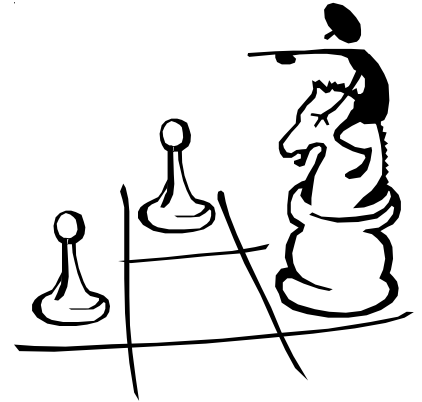
**Objectives** are the steps that will help your team accomplish their goals and intended outcomes. Each goal should have at least one—and usually more—objective associated with it. A term that is often used with objectives is the acronym “SMART.” SMART stands for: **s**pecific (Who is involved? What will be accomplished? Where will it happen?), **m**easurable, **a**ttainable, **r**ealistic, and **t**ime-limited. An example of a SMART objective is: “By March 2006, 1,500 older adults, younger adults with disabilities, and their caregivers in Rowan County will be able to identify the symptoms of depression.”

**Action steps** or **strategies** are very specific, concrete tasks necessary to complete to accomplish your objectives. There are usually several action steps or strategies per objective. This is where the “rubber meets the road,” because action steps say exactly what will be done, by whom, and when. Here are some examples of action steps.

- ◆ The county department of aging will arrange for and conduct educational presentations on depression at all congregate nutrition sites during FY 2006.
- ◆ The Mental Health Association of Rowan County and the Senior Center will co-author articles on the warning signs of depression, places to seek evaluation and treatment, and personal strategies to avoid becoming depressed and submit them to the *Rowan County Daily News* to be published during December 2005.

## Making Progress and Measuring Success

**Outcomes** describe what changes as a result of an intervention, event, or program. See the chapter on evaluation for a more detailed description of both outcomes and outcome indicators,



but here's a brief description. Written outcomes contain "change" words such as *reduces*, *expands*, *develops*, *increases*, *eliminates*, *forms*, *creates*. Outcomes

- ♦ target the desired effects or impact of the service or intervention on the individual (e.g., finds a home), family (e.g., decreases caregivers' stress), community (e.g., increases shared housing), or system of services (e.g., integrates services into a one-stop referral system)
- ♦ describe what will change as a result of the services and action steps and have accompanying indicators to measure success
- ♦ can and should indicate what will happen in the short, middle, and long term.

Here is an example of an outcome: Older adults, adults with disabilities, and caregivers in Rowan County will know the symptoms and risks of depression, where to seek treatment, and refer themselves appropriately.

As you may notice, however, this outcome itself is not directly measurable in any kind of practical way. One could administer depression inventories on a regular basis to all older or disabled adults and their caregivers and check to see whether the ones who scored in the "depressed" range sought treatment, but this is too intrusive and not very practical. Very often you will have to develop outcome indicators to evaluate your progress.

**Outcome indicators** are related to the outcome in some logical way. For example, to determine whether your educational strategy is having the desired effect, you might measure one or more of these things.

The change in the number of suicides or suicide attempts among your target groups, reported by the police, hospitals, and mental health care providers.

The change in percent of older adults, adults with disabilities, and their caregivers seeking treatment for depression at the Mental Health Association, the Rowan County Hospital, Rowan County DSS, and the Rowan County Medical Clinic. You would probably gather data in December of this year and in December next year, after you've held your educational programs.

Self-assessments of mental well-being among participants at congregate meal sites before the educational program and six months and a year later. You may be able to identify which participants elected to take the educational program and which did not and compare their results.

The outcome indicators often address the "why?" of the outcome—in this case, reducing the risk of suicide in these vulnerable populations, or more positively, increasing personal perceptions of well-being, knowledge about where and how to get help when it's needed, and getting that help.

When you write outcomes and outcome indicators, you might try the following steps:

- ♦ Agree as a team on what success consistent with the vision and mission will look like.
- ♦ Develop a set of outcomes and indicators that describe the benefits or differences you want to see as a result of your planning efforts. (The question to answer is: “How will we know we have achieved our vision?”)
- ♦ Write outcome indicators for which it is feasible to collect data that link vision and strategies.
- ♦ Identify at least one indicator per outcome.
- ♦ Plan how to collect and analyze data that will inform your strategic plan and help you create/refine achievable indicators, and then collect and analyze it.
- ♦ Develop an evaluation plan to track the status and success of the change effort.

## The Bottom Line

At the end of the day, focus on the structure of planning and not on the terminology. Someone once characterized hell as an endless discussion of the difference between goals and objectives. Don't stifle your creativity—or procrastinate—by debating definitions. Get your ideas down first, and, if you really must, worry about the definitions later.

## Resources

Nevada Department of Human Resources. 2002. *Strategic Plan for Senior Services*. <http://www.nvaging.net/FinalSeniorPlan.pdf> (This document outlines Nevada's targeted areas for results, strategies, and target indicators in their Senior Plan.)

O'Halloran, Richard, and David O'Halloran. 2000. *The Mission Primer: Four Steps to an Effective Mission Statement*. Richmond, Va.: Mission Inc.

Resources for Seniors (Wake County, NC). 2004. *Wake County Aging Plan*. <http://www.resourcesforseniors.com/agingplan.pdf>

Seattle Human Services Department, King County Department of Community and Human Services, and United Way. 2003. *2004–2007 Area Plan on Aging*. <http://www.ci.seattle.wa.us/humanservices/aging/AreaPlan/AreaPlan2004-07.pdf> (This website includes Seattle's Strategic Plan for elders and adults with disabilities with examples of goals, outcomes, and action steps.)

Scott, Cynthia, D., Dennis T. Jaffe, and Glen Tobe. 1993. *Organizational Vision, Values and Mission*. Menlo Park, Calif: Crisp Learning.

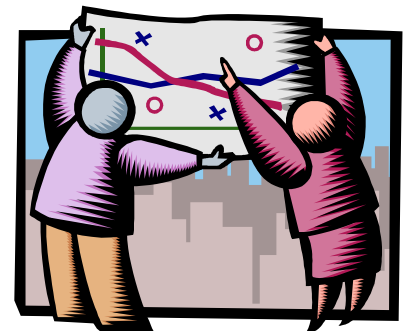
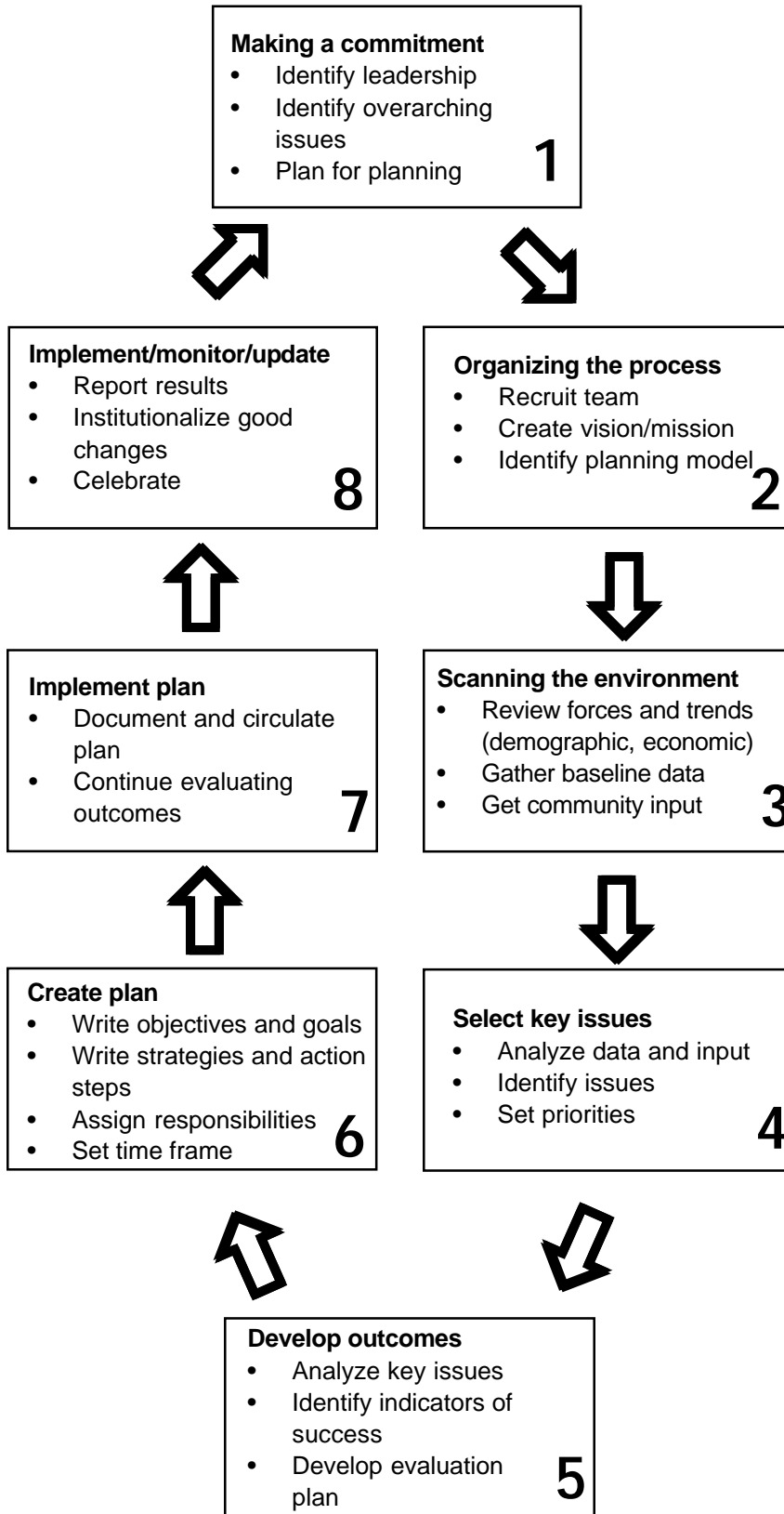
Senge, Peter. 1994. *The Fifth Discipline Fieldbook*. New York: Doubleday.

United Way. <http://national.unitedway.org/outcomes/> (This well-known outcome management resource site defines outcome measurement terms, explains the Logic Model for outcome-based planning and evaluation, offers downloadable documents, and other relevant resources.)

W. K. Kellogg Foundation. 2001. *Logic Model Development Guide*. <http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf> (This guide outlines the principles and steps in applying the “Logic Model” in planning, outcome development, implementation, and evaluation.)



# Steps in Strategic Planning



## Resources

- Allison, Michael, and Jude Kaye. 1997. *Strategic Planning for Nonprofit Organizations: A Practical Guide and Workbook*. New York: John Wiley.
- Barry, Bryan W. 1986. *Strategic Planning Workbook for Nonprofit Organizations*. St. Paul, Minn.: Amherst H. Wilder Foundation. *Community Toolbox*. Chapter 8, Developing a strategic plan. [http://ctb.ku.edu/tools/en/chapter\\_1007.htm](http://ctb.ku.edu/tools/en/chapter_1007.htm)
- Jenne, Kurt. 1986. Strategic planning: Taking charge of the future. *Popular Government*, Spring, pp. 36–43.
- . 1988. From vision to reality: Effective planning by the governing board. *Popular Government*, Summer, pp. 33–38.
- Pfeiffer, J. William, Leonard D. Goodstein, and Timothy M. Nolan. 1989. *Shaping Strategic Planning: Frogs, Dragons, Bees, and Turkey Tails*. San Diego, Calif.: University Associates.

In *Close Encounters of the Third Kind*, the people who saw the visiting extraterrestrials' craft were affected by a strange compulsion. They painted pictures and sculptures of the landmark where the visitors proposed to land, trying to get the details right. Caught in the grip of this vision, some made their way to Wyoming, to the Devils Tower, to be present at the landing, even at the cost of home and marriage and despite the army's warning that they would die of a purported release of nerve gas in the area. When the army commander was preparing to ship out the last of them, the lead scientist protested, "You don't understand. They were invited."

That vision thing is what invites the people in your community to join in the planning effort. Although the level of obsession in *Close Encounters* is uncomfortable, you want your neighbors to be able to say, as does the principle character when he is shown a drawing of Devils Tower and asked if he's seen anything like it, "Yeah, I've got one in my living room." His offhand statement doesn't reveal that his is three dimensional and covers a ping-pong table. Later in the film he identifies a way to the top that the others, who made drawings, weren't aware of. Just as you want your planning initiative in every living room, you also want your many stakeholders imagining the outcomes of the process in great detail, the better to help you find your way through difficult terrain.

### What is a vision?

The *Community Toolbox*, an invaluable resource that will be frequently cited in these pages, says this about it:

Your vision is your dream. It's . . . how things would look if the issue important to you were completely, perfectly addressed. . . . It may be well articulated by one or more vision statements. Vision statements are short phrases or sentences that convey your community's hopes for the future.

There are certain characteristics that most vision statements have in common. In general, vision statements should be:

- ♦ understood and shared by members of the community
- ♦ broad enough to include a diverse variety of local perspectives
- ♦ inspiring and uplifting to everyone involved in your effort
- ♦ easy to communicate—for example, they are generally short enough to fit on a T-shirt.

### How do you get one?

Short of inviting extraterrestrials, the *Community Toolbox* suggests several things. First, it is important for the planning group to practice drafting a vision. What consensus can you reach together? Where are the disputed areas? Axner and Berkowitz

## That Vision Thing



*Vision without  
action is a  
dream. Action  
without vision is  
simply passing  
the time. Action  
with vision is  
making a  
positive  
difference.*

—Joel Barker

suggest a visioning exercise to get you going, reprinted at the end of this chapter.

Once you have done that, it's time to get feedback on the vision statement from the community. You can do this through community forums, listening sessions, focus groups, or surveys, to name a few methods that will be examined later in this book. Your goal is to listen uncritically but to steer community members toward describing what they wish to see, rather than what is wrong currently or how they would fix it. Both deficits and solutions can be useful things to learn, but focusing on them initially, rather than on vision, tends to curtail creativity and may lead to old, failed, or limited strategies, rather than inspiring new ones that will succeed.

## **Bricks or Clouds?**

Sometimes you have to sneak up on a vision. It is often easier to identify things that aren't working than things that are. As will be discussed in the chapter on public relations, people's learning styles affect how they come to terms with the world—do they work from the global to the specific or from the specific to the global? "Visionaries," those big-picture people, often lose patience with people who focus on specifics. People who start from specifics (see, there isn't even a word for them), either can't get a grip on the vision or think it's impractical or academic. Half the battle in planning and executing the plan is getting people in the two groups to speak a common language and respect one another's contributions. For the moment, let's assume that one group builds castles in the sky, while the other makes bricks for castle construction.

### **A Word to Brick People**

Don't lose patience with this vision thing. When you're climbing a mountain, it is usually better to look at the trail just ahead of you, rather than focusing on the top. However, it's important to look at the top from time to time to make sure you're going the right direction and to encourage yourself with your progress. Cloud people are often most valuable at the beginning of a planning process, when they act as cheerleaders, and they can get downright annoying later on with their lack of attention to detail. Brick people come into their own later in the process, when their attention to sequence and detail promote steady progress.

### **A Word to Cloud People**

One premise of counseling is that many people who are struggling with an issue are already working toward a solution. They may not be able to articulate a vision, but they are acting it out daily. It is worth examining what people are currently doing about a problem to understand more about what they

want to see changed. And, like pictures composed of a mosaic of small photographs, sometimes the grander vision becomes clearer if you step back a little. Often it is more productive to ask the question, “How would things be if they were a little better?” and then ask it again, rather than asking people to imagine a perfect world.

### **Resources**

Axner, Marya, and Bill Berkowitz. Developing and communicating a vision. *Community Toolbox*, [http://ctb.ku.edu/tools/en/sub\\_section\\_main\\_1130.htm](http://ctb.ku.edu/tools/en/sub_section_main_1130.htm)

Nagy, Jenette, and Stephen Fawcett. Proclaiming your dream: Developing vision and mission statements. *Community Toolbox*, [http://ctb.ku.edu/tools/en/sub\\_section\\_main\\_1086.htm](http://ctb.ku.edu/tools/en/sub_section_main_1086.htm)

Hampton, Chris, and Catie Heaven. Understanding and describing the community. *Community Toolbox*, [http://ctb.ku.edu/tools/en/sub\\_section\\_main\\_1020.htm](http://ctb.ku.edu/tools/en/sub_section_main_1020.htm)

## **A Visioning Exercise Adapted from the *Community Toolbox***

Imagine your community the way you would like it to be. Write out your ideas. Don't worry about how they sound. This is sort of like a personal brainstorming session—get everything in your head out on paper without judging it. You can clarify and focus later. Use some of the questions below to help you think or make up your own questions.

*Sometimes it's hard to do this exercise in writing. Can your team or community members draw your answers? Act them out? Tell stories that illustrate what you want to see? Any of these may give a different perspective on the community.*

- ♦ What does your community look like physically? What kind of buildings are there? What kind of public spaces? How do people usually get where they need to go? Is it safe to walk around it during the day and at night? How easily can you get around if you have difficulty walking?
- ♦ What kind of work do people do? Who has what kind of jobs? How far must they travel to go to work? Do people like their work? To what extent do the principle employers accommodate family caregiving?
- ♦ How well do people get along with each other? How diverse is the community? Who lives here? Do people from different groups communicate and get along? Do younger and older people have contact and good relationships with each other?
- ♦ How are decisions made? Are things fair among different groups? Does every group have a fair say? Are many people involved in sharing their ideas and solving problems? How are people involved in decision making?
- ♦ What do families look like? Do people within families get along? Are there places where women and men can get help if they need it? Is there child care available? Is there elder care? Is there respite for caregivers? Do neighbors help each other? Do single people feel there is a place for them in the community?
- ♦ Where do people play? Do people in the community go to recreational events together? What possibilities are there for young people, old people, and everybody in between?

Adapted from Marya Axner and Bill Berkowitz, *Developing and Communicating a Vision, Community Toolbox*, [http://ctb.ku.edu/tools/en/sub\\_section\\_main\\_1130.htm](http://ctb.ku.edu/tools/en/sub_section_main_1130.htm)

## A Readiness Assessment

Yes or No?

- \_\_\_\_\_ 1. Can you state the need for developing a strategic plan in one sentence?
- \_\_\_\_\_ 2. Is there evidence the need is real?
- \_\_\_\_\_ 3. Has something changed to support the success of this strategic plan? What is critical in the environment that makes planning important now?
- \_\_\_\_\_ 4. Is there a core group of respected individuals who are committed to seeing the process through?
- \_\_\_\_\_ 5. Is a common vision obtainable?
- \_\_\_\_\_ 6. Is there legitimate authority to proceed?
- \_\_\_\_\_ 7. Are you willing to work with a diverse group of people during the process, including those most affected by the plan?
- \_\_\_\_\_ 8. Do you believe conflict is normal and expectable?
- \_\_\_\_\_ 9. Have you assessed the skills your core group can contribute?
- \_\_\_\_\_ 10. Have you begun to find people with strengths and skills not represented in your core group?
- \_\_\_\_\_ 11. Are you willing to deal with internal and external resistance?
- \_\_\_\_\_ 12. Does the core group understand the process of strategic planning?
- \_\_\_\_\_ 13. Are you willing to take risks?
- \_\_\_\_\_ 14. Does your core planning group have a mission based upon a shared vision?
- \_\_\_\_\_ 15. Is your core group open to creativity and innovation?
- \_\_\_\_\_ 16. Have you identified the key stakeholders and their interests?
- \_\_\_\_\_ 17. Have you selected a planning model to use?
- \_\_\_\_\_ 18. Have you defined the terms used within your selected planning process (i.e., vision, mission, goal, objective, outcome, etc.)?
- \_\_\_\_\_ 19. Have you identified resources that will support the planning process?
- \_\_\_\_\_ 20. Have you established a time frame for the planning process that takes into consideration other planning cycles, rapid change in the environment, and the attention span of those involved?

***Are You  
Ready to  
Plan?***

*Luck is a  
matter of  
preparation  
meeting  
opportunity.*

continue on the next page

- \_\_\_\_\_ 21. Have you identified barriers to the planning process and discussed ways to overcome them?
- \_\_\_\_\_ 22. Does the core leadership team represent diverse skills, strengths, knowledge, experience, and interests?
- \_\_\_\_\_ 23. Do participants have time and energy to devote to the success of the planning effort?
- \_\_\_\_\_ 24. Is there real commitment to using the resulting plan as a guide and framework for action that can be measured?
- \_\_\_\_\_ 25. Do you need an internal or external facilitator for any part of the process?
- \_\_\_\_\_ 26. Have you discussed how to support regular communication among the core leadership team?
- \_\_\_\_\_ 27. Are the people who are expected to carry out the plan involved with the planning process?
- \_\_\_\_\_ 28. Have you determined who will document the planning process and write the plan?
- \_\_\_\_\_ 29. Do you have a plan for evaluating your success?
- \_\_\_\_\_ 30. Is the time of the core group members sanctioned by any needed authority?
- \_\_\_\_\_ 31. Are data and other necessary information available for the assessment phase of the planning process?
- \_\_\_\_\_ 32. Are there opportunities to sustain and expand the implementation of the plan?

In North Carolina in June 2004, there were several ongoing planning processes related to service for older or disabled adults. You should strongly consider including representatives from any other established planning groups on your planning team, to help reduce duplication of efforts and increase collaboration. Although some planning processes are mandated by state and federal laws and are governed by strict regulations, others may be able to be incorporated into your community's overall long-term care planning process. Here are some of the most common local planning processes for aging and disabled adult services in NC.

## ***Established Planning Initiatives for Services for Older or Disabled Adults in NC***

### **Healthy Carolinians Task Forces**

**Division of Public Health/Office of the State Health Director**  
Healthy Carolinians Task Forces are coalitions of diverse partners who work together to identify and address their communities' major health issues. There are over 70 Healthy Carolinians Task Forces across the state, 64 of which are "certified." To become certified, task forces must conduct various planning activities, including establishing a steering committee and a community partnership group; performing a community health assessment using established data and community surveys, focus groups, or forums; and developing an action plan. While many task forces focus on broad health concerns that affect the general population (such as smoking cessation and seatbelt use), several have already worked to improve the health of older and disabled adults in their communities. For example, older adults are a priority group in Ashe County, and the task force is working on improving end-of-life care and diabetes management programs. Bladen County's task force has established a Parish Nursing Program for older adults, Cabarrus County's task force is developing a mobile dental service for residents of long-term care facilities, and several task forces across the state are working to address prescription drug issues and develop training on diabetes, cardiovascular disease, and other chronic illnesses. For more information about Healthy Carolinians, and for a summary of county-specific activities, please visit the Healthy Carolinians website ( [www.healthycarolinians.org](http://www.healthycarolinians.org)) or call the Office of Healthy Carolinians at (919) 715-4173.



### **Planning for Aging**

#### **Division of Aging and Adult Services**

Extensive planning for services for older adults happens at the regional and county levels. Area Agencies on Aging (AAAs) were established under the 1973 amendments to the Older Americans Act to respond to the needs of Americans age 60 and over in every community. In North Carolina, 17 AAAs are located within regional Councils of Government

(COGs). The Older Americans Act mandates five major areas of AAA responsibility: planning, advocacy, program and resource development, information brokerage, and funds administration and quality assurance.

Related to their planning functions, AAAs are responsible for developing four-year plans to establish and maintain networks of local service providers to ensure a continuum of home and community-based services. AAAs also develop, support, and sometimes facilitate extensive county-based planning processes to allocate Home and Community Care Block Grant (HCCBG) funds. Planning processes for HCCBG funds are different from AAA to AAA, and often from county to county within an AAA's service region. However, the planning entity in every county submits recommendations to the county commissioners, who make the final decisions regarding allocation of HCCBG funding for home and community-based services. County commissioners also determine the lead agency for their county. Ten AAAs serve as lead agency, for a total of 32 counties across the state. Other lead agencies include county departments of social services, local service providers, and county managers' offices.

Some local planning groups have expanded beyond the HCCBG and are also involved in aging policy for the county, monitoring quality and improving services of providers, and advocacy on behalf of older adults. Other planning groups, with support from the AAA, have expanded further and begun planning processes for the younger disabled population. You can find contact information for your county's AAA at <http://www.dhhs.state.nc.us/aging/aaa.htm> or by calling Julie Bell at the NC Division of Aging, (919) 733-0440.

## **Community Alternatives Program for Disabled Adults (CAP-DA) Committees**

### **Division of Medical Assistance**

Medicaid waiver rules require CAP-DA lead agencies to have an advisory committee. Committees vary from county to county, and the CAP-DA lead agency determines membership, meeting frequency, and committee roles. Membership often includes local officials, service providers, and consumers. In general, committees offer guidance and support to the program and the lead agency. The committees do not have funding or oversight authority; however, they are used as a way to keep community members involved in the CAP-DA program and to bring new ideas and suggestions to the lead agency. Some lead agencies use their committees to help solve various problems and to educate the public about the program. For more information, please contact Mary-Jo Littlewood at the NC Division of Medical Assistance, (919) 733-6608.

## **County Boards of Social Services**

### **Division of Social Services**

NC General Statute 108A-9 defines the duties and responsibilities of county boards of social services. One provision in the statute is that they are to advise county and municipal authorities in developing policies and plans to improve the social conditions of the community. County boards also establish policies for public assistance and social services programs consistent with federal and state laws, regulations, and policies. County boards have either three or five members who are appointed for a three-year term by the county's commissioners, the state Social Services Commission, and other members of the board. State law requires county boards of social services to meet at least once a month. To learn more about your county's board, contact your county department of social services. Contact information and a listing of the board members for each county can be found at [http://www.dhhs.state.nc.us/dss/cty\\_cnr/dir.htm](http://www.dhhs.state.nc.us/dss/cty_cnr/dir.htm) or by calling the NC Division of Social Services at (919) 733-3055.

## **Local Management Entities and Local Consumer and Family Advisory Committees**

### **Division of Mental Health/Developmental Disabilities/ Substance Abuse Services (MH/DD/SAS)**

The *State Plan 2001: Blueprint for Change*, a five-year plan to transform the present MH/DD/SAS system, calls for the development of two major entities related to local planning for services.

1. *Local Management Entities (LMEs)*. The *State Plan* requires each county's commissioners to appoint an agency as Local Management Entity to develop and manage the local MH/DD/SAS system. Each county decides whether to appoint an LME that serves only itself or to join others to form a multicounty LME. LMEs do not provide direct services. Instead, they collaborate with community partners to develop a business plan for services, which must be approved by the county commissioners. In addition, they must continuously assess local needs for services, address unmet needs, evaluate statistical data about service usage, troubleshoot issues of access and treatment, and establish a Consumer and Family Advisory Committee (explained below). Other separate agencies, which actually provide MH/DD/SAS services, will make up the community's provider MH/DD/SAS network. The purpose of this separation of work is to make sure the agencies that are being

paid for services are not the same agencies that are coordinating decisions about funding and services.

2. *Local Consumer and Family Advisory Committees.* Each LME is required to develop and staff a local consumer and family advisory committee to provide input into activities and policies. Committee membership must be made entirely of consumers and family members representing all disability groups. According to the *State Plan 2001: Blueprint for Change*, local committees will advise the LME on its planning process, provide recommendations about service gaps and service development, educate elected officials on issues, and monitor activities to improve quality.

For more information about LMEs and local consumer and family advisory committees, please visit the MH/DD/SAS State Plan Reform Implementation website at <http://www.dhhs.state.nc.us/mhddsas/stateplanimplementation/index.html> or call the Division of MH/DD/SAS's Community Policy Management Department at (919) 733-4670. You can also find direct links to your county's area MH/DD/SAS program at <http://www.dhhs.state.nc.us/mhddsas/dirbox.htm>.

## **Mayors' and Local Committees for People with Disabilities**

### **Division of Vocational Rehabilitation**

Mayors' and Local Committees for People with Disabilities are associated with a national committee called the President's Committee on Employment of People with Disabilities. North Carolina has one of the largest networks of Mayors' and Local Committees in the United States, with 25 committees across the state. Often the groups are formed by someone in a community with a disability or who knows someone with a disability, and membership includes people with disabilities, human service professionals, local employers, and other interested individuals. These committees work to improve the quality of life and participation of persons with disabilities in the workforce and in society, mostly through advocacy and educational efforts. The committees also work to address needs in their community, ranging from promoting policy changes related to persons with disabilities to organizing job fairs. A listing of committees can be obtained at <http://dvr.dhhs.state.nc.us/DVR/committees.htm> or by calling Ed Bristol at the NC Division of Vocational Rehabilitation Services at (919) 855-3569.

**W**hen you or your organization agreed to become a lead agent of a planning process, whether you knew it or not, you immediately undertook a huge responsibility! Group members usually look to the lead agent as their primary leader, in charge of guiding them through the planning process. They expect their lead agent to be organized, energetic, fair and unbiased, honest, and an excellent facilitator. Often, it feels like a thankless job, but by assisting your community in identifying issues and working toward change, you are providing a significant public service—making your community a much better place for its citizens. Without you, the planning process likely would not occur.

Communities can decide to have one or multiple lead agents for their planning process. Most choose to have one, but a community may decide that sharing responsibilities would be more collaborative, politically acceptable, or quicker. During tight budget times, sharing responsibilities among agencies and organizations can also reduce the fiscal impact of devoting staff time and material to the process.

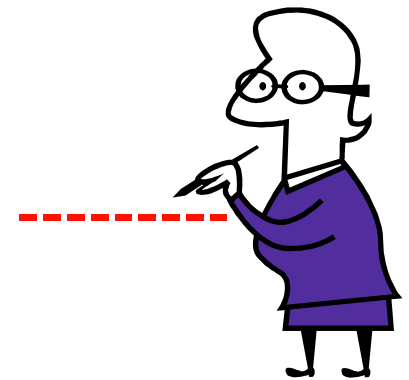
### **Responsibilities of Lead Agents in the NC Communications and Coordination Initiative**

Here is the text of the agreement lead agents make who participate in the North Carolina DHHS Communications and Coordination Initiative. As planning progresses, your responsibilities will evolve and new ones be added to this list.

Lead agents are responsible for

- ♦ Providing adequate staff time to lead the local planning efforts;
- ♦ Convening the planning team at regular intervals;
- ♦ Managing the administrative tasks involved in the local planning process, which may include documenting the steps taken/best practices/barriers/etc. in developing the community initiative, researching issues, taking minutes, mailing meeting announcements, etc.;
- ♦ Helping keep the planning team energized and working towards established outcomes and goals;
- ♦ Working with local organizations, leaders, and government officials to ensure that all groups required by IOM Recommendation #16, as well as any other groups that should be involved in evaluating LTC services and developing a comprehensive community LTC system, are included in the planning team;
- ♦ Mediating any conflicts that arise during the planning process;

## ***Roles and Responsibilities of the Lead Agent***



*Leaders don't  
force people to  
follow—they  
invite them on  
a journey.*

*—Charles S. Lauer*

- ◆ Attending meetings and teleconferences related to the project. Participating on any listservs, websites, etc. that are created to help communities interact with each other and with State professionals;
- ◆ If needed, researching local, state, and national funders for possible grants to help fund any local initiatives that result from the planning process and sometimes assuming a major role in applying for potential funds;
- ◆ Providing or arranging for needed training for the planning team on special population issues, the IOM recommendations, planning processes, data utilization, etc.;
- ◆ Assisting with evaluating the usefulness of LTC data available under the Network;
- ◆ If determined necessary, ensuring that local data collection is completed according to guidelines;
- ◆ Sharing information with the State Team and the LTC Community Interests Group (meetings of all participating communities, State Team members, and others interested in local planning for LTC) regarding the planning process;
- ◆ Ensuring that the interests of all affected populations are adequately represented in the planning team; and
- ◆ Assisting with evaluating the usefulness of the Network.