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ABSTRACT

Florida's District 12 Veterans Administration (VA) wanted to deliver medical case-management services to veterans not receiving home-based services due to the geographic restrictions of the VA's Hospital-Based Home Care Program. The Florida Department of Health and Rehabilitative Services (HRS) desired to demonstrate the effectiveness of nurse case-managed home services in conjunction with caregiver training. This document describes a cooperative demonstration for medically dependent elderly and their caregivers under Medicaid waiver which was developed by Florida's VA and HRS. It presents the TEACH (Train the Elderly And their Caregivers at Home) project and the local service delivery model which was developed. The goals of the project are presented as the reduction of Medicaid nursing home expenditures by delaying or avoiding nursing home placement and the provision of improved support for informal care by the family and other caregivers. The planned evaluation of the TEACH project is discussed as a two-phase process: a service evaluation will assess service cost-effectiveness, impacts on the care receiver and caregiver, and impacts on health service utilization by the targeted Medicaid population over age 65; an interagency coordination evaluation will describe the coordination efforts in terms of domain consensus, goal congruence, and communication. A four-page reference list is included. (Author/NB)

# VA and HRS Local Coordination of Florida's Home-based Services to the Elderly

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FIGURES:



The slides used in this presentation are cited in the text and are available from the authors upon request.

## VA and HRS Local Coordination of Florida's Home-based Services to the Elderly


### ABSTRACT

The VA in Florida (District 12) and the Florida Department of Health and Rehabilitative Services (HRS) are planning a unique cooperative demonstration for medically dependent elderly and their caregivers under Medicaid waiver. The VA perceives a need to deliver medical case-management services to veterans who currently do not receive home-based services due to the geographic restrictions of the VA's Hospital-Based Home Care Program (HBHC). HRS desires to demonstrate the effectiveness of nurse case-managed home services in conjunction with caregiver training. Consequently, an opportunity exists to develop coordination agreements of cost sharing between the VA and HRS that result in local service delivery to the elderly. The demonstration includes an independent evaluation.

The evaluation project has two major phases: (1) service evaluation and (2) interagency coordination evaluation. The service evaluation will assess three outcomes: service cost-effectiveness, impacts on the care receiver and caregiver, and impacts on health service utilization by the targeted Medicaid population over 65. The inter-agency coordination evaluation will describe the coordination efforts in terms of: domain consensus, goal conruence, and communication. This paper discusses the service evaluation but focuses primarily on the inter-agency coordination issues.

## VA and HRS Local Coordination of Florida's Home-based Services to the Elderly

### Introduction

The theme of this APHA Conference is Local Health Services, the Crisis on the Front Line. At Dr. Steslicke's invitation Ms. Innette Chico and I are pleased to tell you about a very unique demonstration project for a new service to Florida's elderly and their caregivers.

This new service, like many before it, has been generated out of that crisis on the front line of health care - the crisis precipitated by a burgeoning elderly population and the push for health care cost containment in the public sector. Our discussion will focus on a local service delivery model that has been coordinated and planned at the state level, with the assistance of several state and national funding agencies. We will describe for you the service delivery model and a portion of the planned evaluation. The evaluation project will address both the cost-effectiveness of the new service and the process of inter-agency coordination between the two principal organizations - Florida's Adult and Aging Services Program within the Department of Health and Rehabilitative Services (HRS) and the District 12 Veterans Administration. Financial support has been received from the Robert Wood Johnson Foundation: a HCFA Waiver Approval has been granted; and additional funding has been appropriated from the Office of Human Development Services (OHDS) within the Department of Health and Human Services and the Florida Legislature.

The primary goals of the project are to reduce Medicaid nursing home expenditures by delaying or avoiding nursing home placement and to provide improved support for informal care by the family and other caregivers. The project has been called "T.E.A.C.H." because it will Train the Elderly And their Caregivers at Home. TEACH services can be described as home-based case management services to medically dependent elderly in conjunction with training and support of their informal caregivers. Services will be delivered in urban and rural areas by traveling nurse case managers.

### Florida's Current LTC Policy Environment

From 1974 to 1983, national long term care expenditures averaged an annual rate of increase approaching 20% (Doty, et al., p.73, 1985). This rate of increase is considerably above the 13.4% average for total personal health expenditures for the same period (Health U.S., 1984, p.138, 1984). These LTC expenses fall disproportionately on Medicaid amounting to an average of 45% of all federal and state Medicaid expenditures from 1974 to 1983 (Doty, et al., p.74, 1985). State and federal Medicaid policy makers have found they must seek alternatives for nursing home care.

Concurrent with this growth in expenditures is the explosive growth of the elderly population. "In the 20 years between 1960 and 1982 the number of Americans 65 or more years old increased ... from 9.2% to 16.7% of the U.S. population" (Lave, 1985, p.7). Florida's elderly population has grown at rates surpassing these national averages (Senate's Select Committee on Aging, 1985). Figures from 1980 indicated that 17.3% of Florida's population was over 65 years of age. These data ranked Florida first among the states in the proportion of population over 65. Estimates for 1985 suggest as much as 24% of Florida's population is now over 60 years of age. All forecasts indicate that continued growth of this age cohort should be expected. Total expenditures for public programs may therefore increase even with new cost-effective alternatives to nursing homes.

Both the VA and other public policy makers are concerned about these continuing financial and demographic trends (Vogel and Palmer, 1983; Feinstein, Gornick and Greenberg, 1984; VA, 1984). The VA's concern about LTC programs also stems from demographic and fiscal trends and the predicted interaction of these factors. The VA is concerned because it "...is about a decade ahead of the general population in facing the crunch of the older citizen..." and the associated health care expenses. The number of old old is doubling among the general population between 1980 and 2000, whereas it is increasing by nearly fivefold among the veteran population (Oriol, 1985, p.49). The demographic imperative will strike at the structure of the VA system very soon (Horgan, et al., 1983), especially in Florida.

The need for coordination between the VA and community agencies in the provision of LTC has been frequently reviewed in recent years. Discussing this "need for greater cooperation with the non-VA community, particularly in the provision of comprehensive chronic care services...", Donald L. Custis, then the VA's Chief Medical Director, stated, "This cooperation I believe will be an important component of the VA's ability to provide the needed long term and social services required by the elderly" (Custis, p. 35, 1983). That coordination should provide not only improved continuity of care for veterans, but also more cost-effective and efficient use of public resources.

Though such coordination has been mandated for the VA by administrative directives (VA MEDIPP Guidance, 1984) and discussed at national conferences, no evaluation of VA and state health service coordination has yet been initiated (VA HSR&D Current Projects Descriptions, 1985). The coordination evaluation phase of this project would represent the first in this critical area.

## Policy Options for Addressing the Issues

Concern over public cost containment and expected growth in long term care needs has lead to three major responses in the past. One response has been to design programs to insure the proper use of health care resources thereby limiting costs. Examples include nursing

home preadmission screening, certificates of need, and skilled-care reimbursement policy (Lave, 1985). These programs have concentrated on the nursing home where the majority of public funds for the elderly are spent.

A second approach has been to rethink the public/private nature of financing these services. **New mechanisms for financing long term care have been proposed**, including private LTC insurance (Meiners, 1983 & 1984; Ruchlin, Morris and Eggert, 1982); health trusts (Anlyan and Lipscomb, 1985); social health maintenance organizations (Greenberg and Leutz, 1984); congregate housing (Howell, 1984); block grants from the Federal government to communities (Hudson, 1981; Merrill and Smith, 1985); and home equity conversion (Jacobs and Weissert, 1984).

**New approaches to care delivery, most notably managed care by direct provision or brokerage of services**, have been explored in the hope that institutional care might be avoided or delayed. Many of these methods use community-based health services (Eggert, 1980; Quinn, et al. 1982; Yordi and Waldman, 1985).

Other tactics look to the family of the elderly for increased family-centered care (Cantor, 1984). This attempts to recognize the extent of informal care delivered by family members or friends. It has been documented that these **principal caregivers (PCGs) can play an important role in delaying or deferring nursing home placements** in Florida. A change in the status of the PCG (e.g., deteriorating health, job change, etc.) precipitated 29% of decisions to place someone into a nursing home in Florida (Bradham and Pendergast, 1984).

## Overview and Purpose of TEACH Services

The planned TEACH services combine these community-based and family-centered methods with nurse case management and PCG training for what is hoped will be more cost-effective community-based service to Florida's medically dependent, Medicaid eligible elderly. The two demonstration areas for TEACH services geographically include portions of HRS District 3 and District 11. Both HRS districts, one rural and one urban, are contained within the VA's District 12 (see Figure 1).

## Model of TEACH Service Intervention

The TEACH demonstration's service design is unique among alternatives to nursing home care for the frail elderly. Figure 2 illustrates the expected outcomes of TEACH services on the care receivers (CR) and their principal caregivers. Several environmental factors influence the condition of both the PCG and the CR. Low income and assets may reduce access to needed health services (Aday, Anderson & Fleming, 1980). When the PCG and the CR are the only members of a household, and when there are no back-up caregivers, the PCG and the elderly person may suffer additional stress. Dissatisfaction with help from other family members is a major reason for poor morale among caregivers (Gilhooly, 1984). These environmental factors tend to increase stress for both the PCG and the elderly care receiver.

Isolation, with its negative impact on social-emotional and cognitive functioning, is a major source of stress. The long hours and constant attention required of PCGs naturally cause mental and physical fatigue. Additional demands of work and family can "put a squeeze" on a PCG's time and energy. Declines in the health and physical functioning of either the CR or the PCG increase stress for both parties. These stressors negatively affect both the patient's condition and the PCG's ability to provide care (Rowe, 1985; Satariano et al., 1984). For elderly care receivers and their principal caregivers who are themselves elderly, as many are (Soldo, et al., 1983), age would tend to increase stress while lowering health status (Rowe, 1985).

The interpersonal relationship between the PCG and the CR is even more complex when the care receiver is medically dependent. TEACH will intervene in these medically dependent situations by working to counter the negative effects of stress, poor living arrangements, and age via training of PCGs and case management services. Thus improvement in the PCG's physical functioning and the quality of the PCG-CR relationship should occur, enabling PCGs to maintain their caring role longer. Any improvements in the condition of the PCG should in turn have a positive effect on the CR's condition. TEACH will, of course, also work to influence directly the patient's condition, both physical and mental, via case management and the provision of needed services.

In some cases, PCGs who are available to the medically dependent elderly feel unable to cope with the level of in-home medical support needed by their relative or friend. This often results in a nursing home placement which might be delayed or avoided if additional reassurance and/or training of the PCG were available. Streib (1983) has suggested that one significant role for the PCG is that of piloting the care receiver through the system of bureaucratic service programs and negotiating the merging of eligibility guidelines to affect the care needed and for which the care receiver is qualified. Nevertheless, recent research by Day (1985) warns that the family's capacity to carry this burden is tenuous and the burden can be too much.

**The TEACH service model is unique among case management demonstration projects** (such as CHANNELLING, ON-LOK, etc), because services will be directed to Medicaid eligible elderly who are medically dependent but remain at home because of the assistance of a principal caregiver (PCG) and because special training of the PCG will be targeted. Clients will be screened and designated as nursing home eligible[1] by Medicaid before referral to the service provider. Indigenous RNs will be trained in managing these cases using local health resources, providers, and the skills of PCGs. Following a thorough assessment, these **nurse case managers will tailor a program of services for the care receiver (CR) and training for the PCG** which fits both the patient's medical needs, and the age and abilities of the principal caregiver. The nurse case managers will also provide visible social support to the principal caregiver by monitoring the training and its impact.

The service goals of the demonstration fall into five major, multidimensional areas. When the experience of demonstration clients is compared to a similar group of elderly people with PCGs who are not receiving demonstration services, the following service outcomes are expected:

1. TEACH clients' long-run use of community services and institutional health services will be lower with the same health maintenance effect, thus providing a cost-effective alternative to nursing home care;

2. TEACH clients' use of health services of various types (e.g, ambulatory, hospital, and nursing home care) will be delayed longer;

3. TEACH clients' lengths of stay when hospitalized or placed in nursing homes wwill be shorter;

4. TEACH-trained PCGs will be retained longer; and

5. TEACH clients' rates of deterioration and mortality, within case-severity groups, will be slower and lower, respectively.

The implication is that the TEACH project should reduce overall expenses for the state Medicaid program for care rendered to these medically dependent clients either by delaying or avoiding nursing home care. **Confirming or rejecting expenditure reductions through evaluation of services is critical prior to any statewide replication.** This evaluation is especially important for state policy makers who

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TEACH Medicaid Waiver (Section 2176) Eligibility

TEACH clients must be 65 or older and have:

(a) Medicaid qualification for at least intermediate level care in nursing homes,

(b) a principal caregiver -- either family or other -- willing to be trained and to assist the client, and

(c) a condition for which the PCG can be trained to monitor and provide care.

are faced with rising expenditures for the elderly and dwindling or stagnant Federal resources (Merrill and Smith, 1985). Additionally, it is important to document the success of coordination by these two human service organizations as they seek to achieve cost-reductions (for HRS) and service extensions (for the VA) through this unique project.

## Interorganizational Coordination Research Objectives

In today's long term care (LTC) health policy environment, the development of cost-effective and innovative services is particularly important (Doty, Liu, and Wiener, 1985; Lave, 1985; Waldo and Lazenby, 1984). Equally significant is the development of inter-agency cooperation in serving the elderly (Wetle and Rowe, 1984), since growth of future public resources is constrained (Gramm-Rudman Act of 1985) If services are found to be cost-effective, it will be assumed that inter-agency coordination is partly responsible; and if not, then partly to blame. This is the impetus for the coordination evaluation between HRS and the VA. A comprehensive assessment of this demonstration requires analysis of the inter-agency cooperation, its process, and methods.

The purpose of this descriptive phase of the study is to evaluate in practical terms the interorganizational coordination taking place over the first eighteen months of the demonstration. As the VA and the Florida HRS agencies work together to achieve their mutual goals, coordination will be monitored through longitudinal survey responses of agency staff. Since the VA is mandated to coordinate its LTC programming (VA MEDIPP Guidance, 1984), these insights are critical for the VA but are no less important for statewide health service agencies in other states. To meet the management needs for future replication of this or other coordinated projects, factors that influence perceived levels of success in coordination will be explored. The study's major objectives include acquiring empirical answers to the following important program management questions:

1 Were the objectives of the project well understood by the members of each agency? How similar or divergent were the goals expressed by different individuals and different agencies?

2. Were the roles of the various agencies involved well understood? Did the service scope and responsibility for each agency overlap or were they distinct?

3. What communication patterns (frequency, reason, methods) existed among these agencies during the implementation period? Were they different from those used prior to the demonstration?

4. What issues became sources of conflict? Were these issues resolved in a timely manner? What was the quality of

conflict resolution? What actions contributed to their resolution?

5. What are the patterns of time allocation for those involved in inter-agency coordination activities? How expensive is the coordination in staff time and effort?

6. Are the initial factors of goal congruency, domain consensus, communication patterns, location, and respondent's background indicative of the individual's perception of the success of the inter-agency coordination?

## A Model of Coordination in LTC

Coordination in service delivery can take many forms. Figures 2A, and 2B demonstrate the complexity of the situation in a conceptual model of LTC service coordination. Using these figures the discussion below clarifies the different roles of inter-agency coordination and end-product coordination in the provision of LTC services to medically needy clientele.

Coordinating the acquisition of services and matching them to the needs and/or qualifications of clients is the role of case managers. Case management, whether by brokerage or direct service provision, represents end product coordination for each user's benefit from multiple service-provision programs and providers. Figure 3A depicts the hypothetical spectrum of LTC services that are available. These services range in level of independence from institutional dependency (ACUTE HOSPITAL) to independent living (SELF CARE) usually provided in the home. As one moves from the right side of the spectrum to the left, client's medical dependency is presumed to be less severe, and maintenance at their current level of functioning can be achieved with less formalized care.

When entitlement programs are available to subsidize the purchase of care, eligibility screens are often used to assure proper allocation of service benefits to the entitled income and/or disability groups. These screens are shown in the middle portion of Figure 3A and are located between users' demand prior to eligibility screens (bottom of the figure) and users' demand after these screens have been applied. The effect of the screens is to reduce the overall volume of services consumed and thereby reduce public expenditures. Therefore, the screen for the dual eligibility guidelines of income and disability (right side) is depicted as twice the size of that of income alone (left side). Based on perceived need, the aggregate of users' demand without screens would be larger than with the screens; (resulting in larger total public expenditures). The reduction is shown by twelve arrows pointing toward the screens and only four achieving the targeted LTC service spectrum.

Figure 3A also depicts the presumed value of case managers (e.g., the simplification of the complex system of end-products and eligibility guidelines). Navigating the system is a taxing role for the family or principal caregiver (Streib, 1983). Skilled case managers are adept at reducing frustrations and improving accessibility for their clients by selectively using available services (end-products) and eligibilities to meet their clients' perceived needs. This marketable service occurs without regard to inter-agency coordination. The case-manager is responsible for end-product coordination.

Inter-agency coordination is distinct from end-product coordination in that it reduces the level of duplicated services or end-products in the market and encourages joint production before products (services) are made available. Another indirect result may be the reduction of frustration in all end-product actors (e.g., clients and families, case-managers and providers) by reducing the diversity of choices. Coordination of service processes or inputs in LTC programs requires the insight and cooperation of program planners and administrators at higher organizational levels within the financing agencies than case managers and usually at earlier points in time. This form of coordination is inter-agency coordination and is depicted in the upper portion of Figure 3B.

The opportunity for inter-agency coordination is provided when similar clientele and goals are shared by two agencies. In periods of fiscal constraint, one might expect the incentive to cooperate to be enhanced. The literature reviewed below suggests otherwise (e.g. the competition for clientele and survival). The public agency's incentive is to provide or acquire the most cost-effective services. This is one rationale for cooperating with another agency, identifying the more efficient producer, and supporting that service over others.

## Planned Interorganizational Research Method

This section reviews appropriate literature first, then specifies the study's variables and their expected relationships using the conceptual model of case management in LTC service delivery presented above.

## Review of Selected Interorganizational Literature

All organizations have goals and objectives toward which their activities are directed. Achievement of these goals and objectives requires resources which are usually scarce. This scarcity may be particularly symptomatic of public human service agencies, especially in an austere policy era. One way organizations can deal with this problem is through coordination of their activities with those of other organizations. The concept of coordination as a measurable

construct has evolved as researchers have addressed this phenomenon from the early 1960s. Measurement techniques have changed as well.

Joseph Morrisey, Richard Hall, and Michael Lindsey refined the definition of the coordination concept which will guide this study. They stated that **coordination involves a process of concerted decision making and action in which two or more organizations participate with deliberate adjustment to one another to achieve a collective goal** (1982, pp.96-97). Successful coordination links the activities of individual organizations to effectively utilize the available resources. It may reduce duplication of services provided to the end-user (as depicted in Figure 3B). Or, through joint production, coordination may provide services to clients not served otherwise--which is the case under analysis.

Attempts at interorganizational coordination have varying levels of success. Studies of these relationships have revealed three major factors which have been associated with the success of these coordination efforts and therefore seem appropriate for a practical analysis of the VA and HRS coordination in this project. These are: **domain consensus, goal congruence, and communication.**

**Domain consensus** is defined as the degree to which an organization agrees with and accepts the activities that other organizations claim to be responsible for performing. The extent to which domain consensus exists between organizations has been found in a number of studies to influence the success of interorganizational coordination efforts. Levine and White (1961) found that exchange agreements between organizations depend on <u>prior</u> domain consensus. They stated that "within the health agency system, consensus regarding an organization's domain must exist to the extent that parts of the system will provide each agency with the elements necessary to attain its ends" (p.597). If coordination is to occur, there has to be a willingness to share resources. Levine and White's findings demonstrated a positive relationship between domain consensus and level of coordination.

In another study Levine, White, and Paul (1963) found that unless domain consensus exists, competition may occur between agencies offering the same services, especially when the agencies are operating at less than capacity. This finding demonstrates the relationship between domain consensus and coordination since in a competitive situation, organizations would not be likely to engage in efforts to coordinate their activities. Goldman, Burns, and Burke (1980), in their study of linkages between primary health care projects and community mental health centers, also found domain consensus to have an influence on coordination efforts They found that in the more easily implemented linkage projects there was a "clear understanding of common goals and an agreed-upon division of labor and responsibility" (p.537).

A second major factor associated with interorganizational coordination is **goal congruence.** Goal congruence is the extent to which organizations share the same perception of what the goals are

that they are working to achieve and what strategy should be used to achieve them. In their study of linkage projects Goldman, et al. (1980) found differences in perceived goals and strategies to be a source of conflict. These findings indicate that a lack of goal congruence would likely reduce the success of coordination efforts.

**Communication** is an exchange of information, with the purpose of achieving mutual understanding. Hall et al., (1977) found a positive correlation between frequency of interaction and coordination. They also found that person-to-person interaction was more strongly related to coordination than other modes of interaction.

The concept of **conflict resolution** will be included in the descriptive analysis. Conflict resolution is defined as the process of working out differences and deliberately adjusting attitudes, behaviors, and perceptions of goals between organizations. We believe, from the discussions of Morrisey, et al. (1982), that these factors will be significant covariates of the respondent's perception of the success of coordination. This concept has not been addressed in past studies of interorganizational coordination. It is explored here because this evaluation is focused on practical considerations which may be useful for the VA and other state level agencies in achieving effective coordination.

## Study Design, Objectives, and Approach

The research design is a one-group time-series study (Isaac and Michael, p.46-49, 1978). The independent factors--domain consensus, goal congruence, communication, and conflict resolution--will constitute the foci of our descriptive analysis. The likelihood of transition in these variables as time passes is high (Child and Kieser, 1981). Consequently, a longitudinal data collection approach is necessary to permit the measurement of changes in these influences on the dependent variable and its change over the same period. This trend analysis is important for practical results that can influence subsequent coordinated projects. The single group serves as its own control group with repeated measures being collected on the same subjects. This combination of pre/post and longitudinal approaches will control for the maturation effects of changes during the study period. This effect is an important phenomenon to be studied if the results are to be practically valuable.

## Methodological Limitations

Because of a non-randomized design, generalization beyond the LTC application area would be cautiously recommended. Generalization to the other forty-nine states and their VA districts for similar projects would be possible. The evaluation design suffers from no control of the selection biases of respondents. Clearly, these

individuals have been selected to participate in this project because they are considered to be effective in coordinated endeavors by their respective organizations. There is also an identified responsibility for coordination residing in the hands of the HRS Statewide Coordinator. Improving coordination is an assigned task and will be given significant energy. Thus, there is a risk that this observational data will simply confirm the impact of these efforts. However, the study results should be quite valuable to the VA and to HRS because major institutions would not leave such important coordination projects unattended. Interagency coordination is not spontaneous. Documentation of the results of associated efforts will assist in management of replications.

## Variable Definitions and Measures

The dependent variable, perceived success of coordination, will be tested for statistical association with measures of: (1) goal congruence; (2) domain consensus; (3) communication pattern (e.g., frequency, method, and reason); and (4) conflict resolution. The relationships of these concepts and others to be measured are displayed in Figure 4.

A six point scale for measuring perceived success of coordination was drawn from the work of Hall and associates (1977). A separate score will be obtained for the two other organizations from each respondent. That is, in the VA respondent's surveys, the two organizations to be displayed will be the Providers and HRS, and vice versa for the HRS respondents. To avoid the ambiguity of a variety of definitions among respondents, the term "coordination" will be explicitly defined at this point in the questionnaire. That definition will be the Morrisey, Hall, and Lindsey (1982, pp. 96-97) definition given above.

The definition of goal congruence given in the previous section by Morrisey, et al., 1982 will be used in this study. In past studies (Levine, et al., 1963; Goldman, et al., 1980), interorganizational goal congruence has been measured as an index of agreement between the respondents' perceptions in each organization with other agencies. Rather than use a simple rank order correlational approach (Kendall's Tau), we propose to ask respondents to rank the goal statements and to place them on a visual metric scale from 0-50. Thus, we obtain the rank-ordering and also the perceived relative importance of each goal statement. This approach garners more information. For example, two goals might be ranked as third and fourth, but placed at the 40-point and 5-point positions respectively. The addition of the relative metric scale provides a more quantifiable approach to the subjective and limited ordinal analysis.

Domain consensus as it is used in this study is defined in the previous section. This concept can most easily be measured as an index of agreement. Past researchers have used similar approaches (Van de Ven, et al., 1984). A score of the number of agreements among one agency's respondents and another's provides the simplest index.

This score can then be converted to a percentage of agreement and tested for association with other variables. Respondents will be asked to assume that the goals stated in the previous question are appropriate, so that implicit goals might be less operative in these responses.

The frequency, method, and reason for **communication** will be analyzed as well as the individual contacted and his or her level in the organization. Other aspects of communication believed to be important are the organizational levels of (1) the most frequent contact in each agency, and (2) the individual respondent. Each respondent will be asked to identify the most frequently contacted individual in the other two agencies. From these responses and the position-level, the difference in levels can be ascertained and used as a covariate.

Also of importance to future replications is the allocation of the respondent's time across planning, problem solving, implementation, and other categories. Descriptive data will be collected on these allocations.

The measure of **conflict resolution** is acquired by requesting specific issues of current conflict from each respondent and following those same issues six months later. Going beyond prior work, we propose measuring the favorability of the resolution for the respondent's agency in a five-point scale. This will separate the effect of favorability of the resolution from the quality of the process of resolution. That is to say, the respondent may feel that the conflict was fairly well resolved, but was more favorable to the other agency. In the individualized follow-up we will obtain the current status of the resolution, the activity leading to potential resolution, its quality and favorability. Our approach is to capture specific information which can be made useful for management of subsequent replication while at the same time capitalizing on the longitudinal data collection strategy and the ability to return these specific items to the respondent for information about their resolution.

## Conclusion

We had hoped to share the results of early findings regarding the TEACH project today, however as you might imagine a project this complex has some delays. Services are now planned to begin in October. Hopefully by conference time next year we will have those early results, and we plan to bring them to you then.

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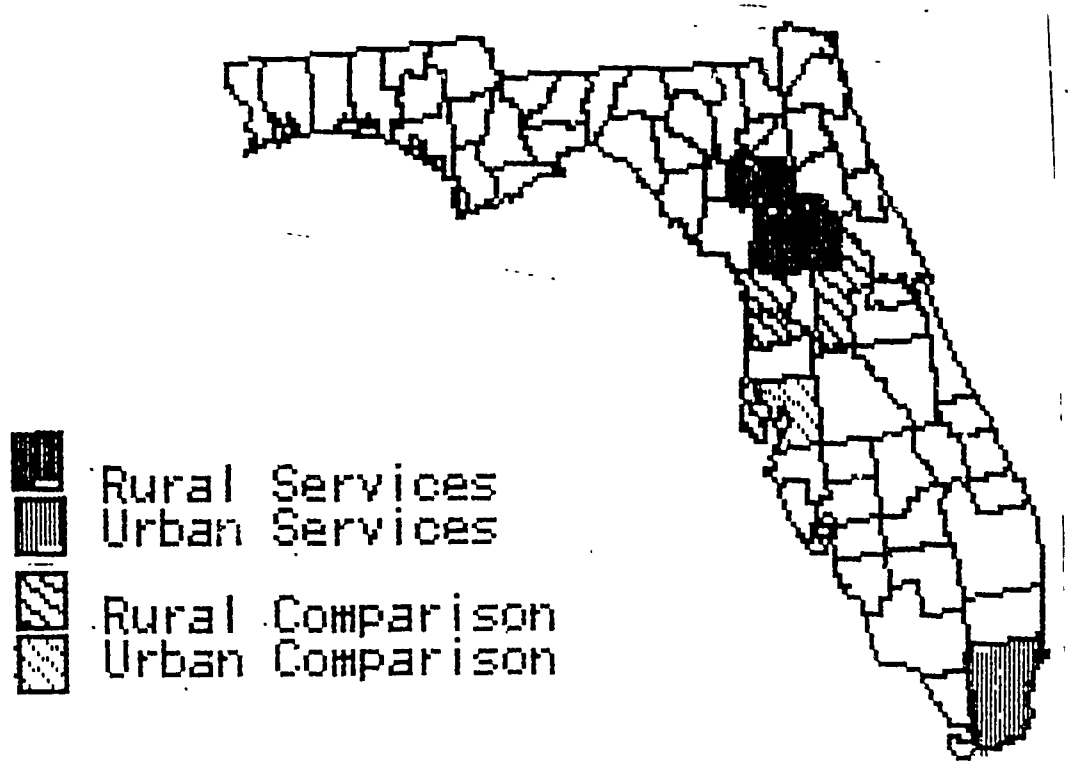
FIGURES:



The slides used in this presentation are cited in the text and are available from the authors upon request.

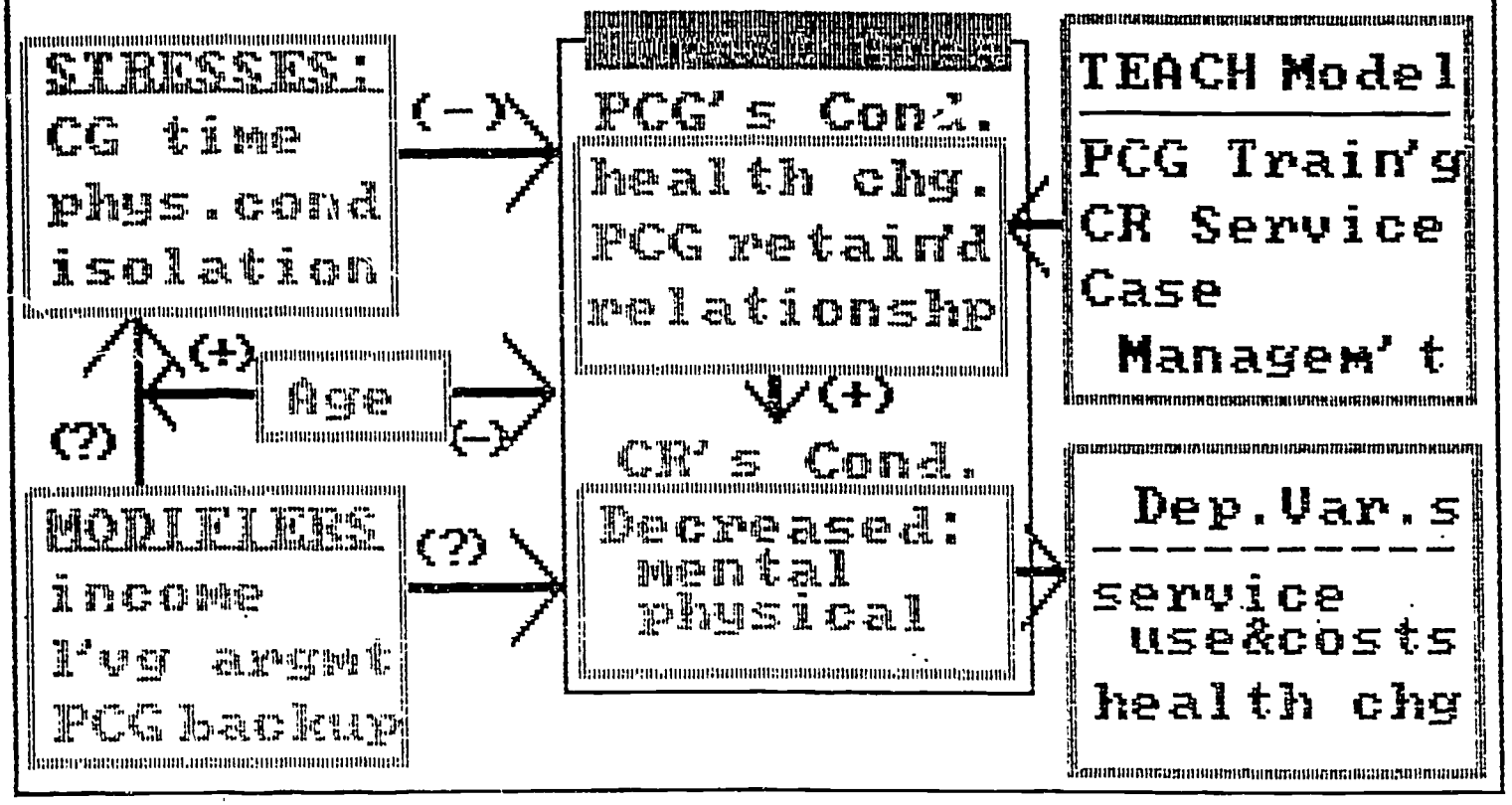
# FIGURE 1

## TEACH Demonstration Sites



# FIGURE 2

## Expected Impact of TEACH Model



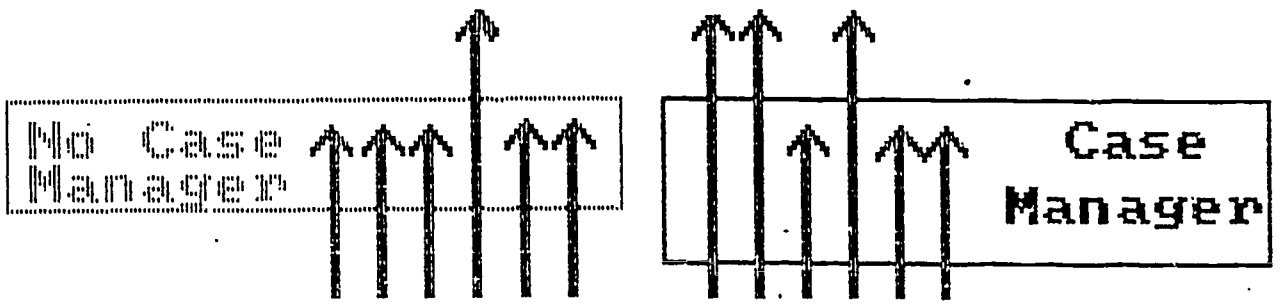
# FIGURE 3A

## END-PRODUCT COORDINATION
### Case Management

Ind. Lv'g. ⟨------- LTC Spectrum -------⟩ Inst'l Lv'g

| self care | PCG ass't | home health | nurs home | acute hosp. |
|---|---|---|---|---|

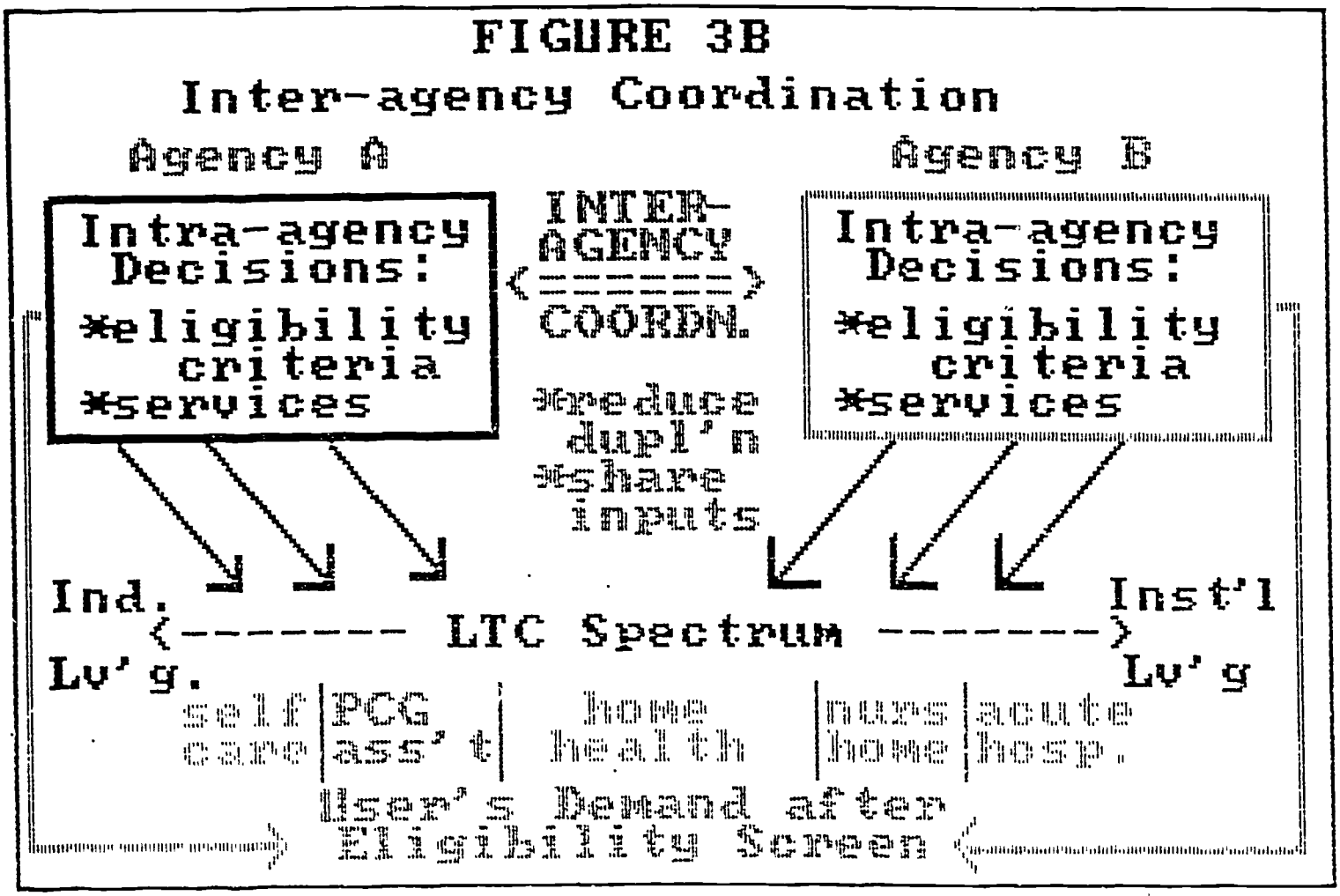
User's Demand after Eligibility Screen




User's Demand or "NEED" before screens

# FIGURE 3B

## Inter-agency Coordination



# FIGURE 4
## Inter-agency Coordination Influences Under Study