Social Care Services Evidence Summary: Coordination Functions

This evidence summary includes a broad range of research/resources on coordination functions and is primarily focused on health care impact. It is not intended to be an exhaustive compilation of research/resources on this topic. The information presented in this summary can inform the value proposition of partnering with a community-based organization (CBO) or a network of CBOs to offer these services and supports as part of a strategy to address social determinants of health (SDOH).

Care coordination synchronizes the delivery of an individual's health and social care from multiple providers to reduce fragmentation of care and support and to cohesively meet the individual's support needs. Care coordination has been shown to reduce preventable hospital admissions, reduce costs for both the patient and health care system, and improve the quality of care for high-risk, high-cost individuals.[1]

Person-centered planning, like care coordination, is a function that prioritizes and focuses on the specific needs and preferences of each individual. Person-centered planning is a guided process for learning how someone wants to live at home, at work, or in the community and developing a plan to help make it happen[2]. Person-centered planning is a widely used, process-oriented approach that empowers the consumer to select and organize the services and supports that they may need to live in the community.[3]

While aging and disability networks across the nation vary in services and functions provided, care coordination and person-centered planning are widely adopted functions that are increasingly being used to shift to a more integrated, person-centered, and coordinated health and social care system.[4]

Research and resources related to care coordination and person-centered planning functions provided by aging and disability networks are included below.

[1] https://www.rwjf.org/en/library/research/2014/02/engaging-patients-improves-health-and-health-care.html
[2] https://ddsd.vermont.gov/person-centered-thinking
[3] https://acl.gov/programs/consumer-control/person-centered-planning
[4] https://academic.oup.com/ppar/article-abstract/29/2/67/5485004?redirectedFrom=fulltext

Care Coordination Research

Study	Population Studied	Objective of Study	Type of Analysis	Findings / Results
Amjad et al. (2018)	303 community-dwelling adults 70 years or older with a cognitive disorder in Baltimore, Maryland	To investigate the effects of a novel dementia care coordination program on health service utilization.	Single blind randomized control trial	Home and community-based service utilization significantly increased from baseline to 18 months in the intervention compared to the control. There was no impact on acute care and inpatient services, however.
Berkowitz et al. (2018)	2,154 Medicare beneficiaries and 2,532 Medicaid beneficiaries	To determine whether the Johns Hopkins Community Health Partnership (J-CHiP) was associated with improved health outcomes and lower spending.	Nonrandomized acute care intervention (ACI) and community intervention (CI)	For the CI group, there was a total cost of care reduction of $24.4 million and overall reduction in hospitalizations, emergency department visits, 30-day readmissions, and avoidable hospitalizations. For the ACI group, there was a total cost of care reduction of $29.2 million with decreases in hospitalization and practitioner follow up.
Counsell et al. (2007)	951 adults 65 years or older with an annual income less than 200% of the federal poverty limit	To test the effectiveness of the Geriatric Resources for Assessment and Care of Elders (GRACE) model on improving the quality of care for low-income seniors in primary care.	Randomized control trial	Significant improvement in general health, vitality, social functioning, and mental health in intervention patients compared to those receiving usual care. The cumulative 2-year emergency department visit rate was lower for intervention patients in the second year.
Counsell et al. (2009)	951 low-income seniors aged 65 years or older in	To provide a cost analysis of the GRACE model	Randomized control trial	For patients at high-risk of hospitalization, the GRACE model

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	community-based primary care health centers	intervention for the health care delivery system.		intervention is cost neutral from the healthcare delivery perspective.
Jack et al. (2016)	This systematic analysis included 2,941 studies; 34 studies met the inclusion and methodological criteria.	To systematically review existing studies on the impact of community health workers on the use of healthcare services.	Systematic review	The findings suggest that it is possible to achieve reductions in care utilization and cost savings by integrating community health workers into chronic care management, however, community health workers alone do not make interventions successful.
Leff et al. (2009)	49 physicians and 904 of their chronically ill patients aged 65 years or older	Evaluate the preliminary effects of the Guided Care model for care coordination on health service utilization and costs.	Cluster-randomized controlled trial	Patients that received the Guided Care model experienced fewer hospital days, skilled nursing facility days, emergency department visits, home healthcare episodes, and specialist visits than those that did not receive the care coordination model. Overall, the intervention resulted in decreased utilization and cost.
Nelson et al. (2019)	152 children aged 12 to 42 months old who receive well-child care at a community health center serving predominantly Hispanic families	To test the efficacy of telephone-based developmental screening and care coordination through 2-1-1 Los Angeles County.	Intention-to-treat analyses	Significantly more children assigned to the intervention group were referred and were receiving services within 6 months compared with children assigned to usual care alone.

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Rowe et al. (2016)	Patients cared for by social workers	To examine the mean utilization of costly health care services for older adult patients after implementation of the Ambulatory Integration of the Medical and Social (AIMS) care coordination model.	Exploratory, retrospective evaluation	Patients who received the intervention had a lower mean utilization of 30-day hospital readmissions and emergency department visits than the general patient population.

Care Coordination Resources

Resource Author	Description of Content	Target Audience
Code of Federal Regulations	This government webpage outlines general requirements for health care quality and lists a number of activity requirements to improve health care quality, touching on factors like activity design, programs to prevent hospital readmission, implementation of health care activities, and activity expenditures.	Any organization interested in federal guidelines and regulations as they plan and implement health care related activities.
Rowe, et al. (2016)	This article explains the four different areas critical to the health and well-being of older adults who require further advancement (enhancing care delivery for chronic conditions, strengthening the elder care workforce, fostering engagement in late life, and advanced illness and end-of-life care).	General audience, any individual or organization interested in learning more about the different facets of older adult care and how the field is expanding.
National Quality Forum (2017)	This technical report provides an in-depth review of performance measures for care coordination conditions.	General audience, appropriate for anyone interested in a detailed review of National Quality Forum's care coordination portfolio.
The Commonwealth Fund (2016)	This report provides an overview of the Guided Care model and shares the results of a number of studies that test the effectiveness of the model.	General audience, anyone interested in learning about the program features and effectiveness of this particular care coordination model.

Person-Centered Planning Research

Study	Population Studied	Objective of Study	Type of Analysis	Findings / Results
Gosse et al. (2017)	Persons receiving an individualized planning process and the traditional planning process	This study compares traditional planning to individualized planning on supports obtained and personal objectives accomplished using a randomized between-group design.	Randomized between-group design; when the traditional planning group subsequently received individualized planning, they replicated the results of the first individualized planning group.	Persons receiving an individualized planning process improved in both supports and personal outcomes as compared to the traditional planning group. When the traditional planning group subsequently received individualized planning, they replicated the results of the first individualized planning group. The findings support implementation of an individualized planning approach in service agencies for individuals with ID.
Ha & Park (2020)	The study participants included 40 community-dwelling older adults aged 65 years or older living in South Korea.	To examine the effects of a person-centered nursing intervention program for frailty (PNIF) in older adults.	Quasi-experimental pretest–posttest design	The findings showed that the group that received the person-centered intervention had significantly improved frailty, physical function, grip strength, depression, and nutritional status compared to those that did

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				not receive the intervention.
Hughes (2013)	6 case managers and social workers that implement the person-centered planning model with individuals with intellectual or developments disabilities (I/DD) in Minnesota	Research the benefits and barriers to implementing the person-centered planning model for adults with I/DD and other populations as applicable.	Qualitative exploratory design	Person-centered planning allows for increased self-determination, allows for the individual receiving care to have choice in their living arrangements, work, and how they spend their free time. Challenges to planning and implementing person-centered planning include limited time, funding, and resources.
Hughes (2013)	Experts who are implementing the person-centered planning model	The purpose of this study was to explore the benefits and barriers to implementing Person-Centered Planning as a replacement for, or in addition to traditional service planning for adults with developmental disabilities.	A qualitative exploratory design was used to hear from the voices of people who have first-hand knowledge and experience with using person centered planning for individuals with I/DD.	The strongest theme that emerged from this study is that person-centered planning is individualized planning that puts the client into the role of expert over his or her life. This expert role allows for increased self-determination because it increases choices in areas such as types of living arrangements, type of employment, and leisure activities. The circle of support may be the most important component of

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				helping the focus person achieve their future vision.
Kaehne & Beyer (2013)	44 individuals with disabilities in the United Kingdom	To review the efficacy of person-centered planning as part of school transition.	Documentary analysis	The data shows an increase in the participation of young people at review meetings and a significant shift in topics discussed during the transition planning process compared with previous programs.
Menchetti (2003)	83 supported employees	This study examined effects of person-centered planning on career choice and employment outcomes attained by supported employees.	Choice was measured by analyzing degree of match between employees' career preferences and their current employment.	High and moderate levels of preference match were attained by 72 (83%) of employees studied. Wages and length of employment did not differ significantly by level of match. These employment outcomes tended to favor employees in high and moderate match groups, however. Implementation and evaluation issues related to person-centered planning were further examined through a focus group of service providers. Responses identified measuring effectiveness of person-centered planning,

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				supporting training and commitment of service providers, collaborative problem solving, and continuous process improvement as issues requiring further research.
Oregon Department of Human Services (2018)	Oregon Aging and Disability Resource Centers (ADRCs)	To make the business case that the benefits of ADRC services, including options counseling/person-centered counseling, exceed the cost to run ADRC programs.	Social return on investment	The analysis concluded that there is a strong business case for Oregon's ADRCs. The estimated social return on investment of the ADRCs in Oregon is 11.1 to 1. The benefits in Oregon totaled $39.8 million at a cost of $3.6 million in 2016-2017.
Poey et al. (2017)	The study participants included 6,214 nursing home residents in 2013-2014 and 5,538 nursing home residents in 2014-2015 in Kansas.	To examine if person-centered practices promote satisfaction, quality of life, quality of care, and services among nursing home residents.	Longitudinal, retrospective cohort study using an in-person survey	The results of the study showed that after controlling for facility characteristics, patients' satisfaction with quality of life and quality of care was higher in nursing homes that implemented person-centered practices than those that did not.
Reid et al. (1999)	The study participants were four individuals with	To evaluate the degree to which items and activities reported to	A sample of the reported preferences of the participants was	The results of the study showed that individuals may want or require more

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	profound and multiple disabilities.	be preferred in person-centered plans represented accurate preferences based on how individuals responded when presented with the items and activities.	systematically assessed by observing each participant's approach and avoidance responses to the items and activities.	than what is outlined in their person-centered care plan.
Stanhope et al. (2013)	10 community mental health centers randomly assigned to receive training in person-centered planning and collaborative documentation or provide usual treatment	Examine the impact of person-centered planning and collaborative documentation on service engagement and medication adherence within community mental health centers (CMHCs).	Randomized control trial	Person-centered planning and collaborative documentation were associated with significantly greater engagement in services and higher rates of medication adherence.
Yasuda & Sakakibara (2016)	The study participants included 40 care staff members at a geriatric nursing home.	To assess the effects of care staff training based on person-centered care and dementia care mapping on the quality of life (QOL) of residents with dementia in a nursing home.	The effects of the staff training on the QOL of residents with dementia were evaluated three times at roughly one-month intervals (baseline, pre-intervention, and post-intervention).	The results of the study showed that the person-centered care training intervention improved the overall well-being of the geriatric nursing home residents. The findings of the study support the effectiveness of person-centered care and suggest that nursing home staff

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				should be trained in person-centered practices.
Zimmerman et al. (2015)	Eight residents and staff participated in cognitive testing, and 228 residents and 123 staff participated in field testing	Develop self-administered questionnaires of person-centeredness for completion by residents and staff in assisted living (AL), in response to concerns that AL is not person-centered; also, demonstrated person-centeredness is necessary for Medicaid support as a home- and community-based services provider.	Community-based participatory research partnership among a research team, a consortium of 11 stakeholder organizations, and others; methods included literature review, item generation and reduction, cognitive testing, field testing, exploratory factor analysis, and convergent and discriminant validity testing.	The final resident questionnaire included 49 items and 4 factors: well-being and belonging, individualized care and services, social connectedness, and atmosphere. The staff questionnaire included 62 items and 5 factors: workforce practices, social connectedness, individualized care and services, atmosphere, and caregiver-resident relationships. Staff scored person-centeredness higher than did residents, reflecting their different perspectives.

Person Centered Planning Resources

Resource Author	Description of Content	Target Audience
J.E. Taylor & J.A. Taylor (2013)	This article examines the historical development and evidence base, as well as the current challenges and potential of person-centered planning for adults with I/DD.	Researchers and various practitioners interested in the evolution and data behind person-centered planning and how it may be effectively used for adults with intellectual disabilities.
Robert Wood Johnson Foundation (2014)	This issue brief outlines the importance of person-centered planning and provides an overview of various initiatives and frameworks used across the country that help health systems better engage patients in their health.	Health plans and systems interested in testing or adopting a potential framework or initiative to improve person-centered care in their system.
The SCAN Foundation (2016)	This issue brief details the effectiveness of person-centered programs in improving the care and quality of life of patients while also reducing medical expenditures and provides information on compensation methods and the return on investment.	Health plans and systems interested in understanding the cost benefit of implementing person-centered practice programs.