Quick Reference Guide to Promising Care Models for Patients with Complex Needs

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The Quick Reference Guide summarizes the target populations, key features, and evidence of impact for 28 promising care models for adults with complex needs. The guide was updated in January 2019 using the original version of the Quick Reference Guide developed in December 2016, data from a survey of promising care models conducted by the Center for Health Care Strategies for the Better Care Playbook's State Map, and targeted literature searches.

Models were included if they targeted adults with complex needs, provided at least one element of person-centered care, and had strong, moderate, or promising evidence on at least one outcome related to quality, utilization, or cost. Links are provided under the Models and Outcomes columns for additional information and references. In some cases, the number of sites was obtained from sources other than those listed above, which are detailed in footnotes as applicable.

The authors thank Meredith Brown and Jamie Ryan who helped to develop the original Quick Reference Guide in December 2016, as well as Allison Hamblin, senior vice president; Jim Lloyd,program officer; and Sarah Rabot, program analyst from the Center for Health Care Strategies for assistance collecting and verifying information for the guide.

Model	Target population	Population segments	Elements of person-centered care*	No. of sites	Outcomes	Learn more
Bridges to Care	Medicaid eligible high users of the emergency department	✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	2	A peer-reviewed analysis found participants in this "hotspotting" intervention had 28% fewer ED visits and 114% higher primary care utilization compared to controls (learn more).	Roberta Capp, MD Assistant Professor of Emergency Medicine, University of Colorado School of Medicine e: roberta.capp@ucdenver.edu
CareMore	Medicare Advantage plan members in California, Nevada, Arizona, Virginia, Ohio, and Medicaid managed care plan members in Tennessee and Iowa	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	56	The Medicare Advantage plan has shown, compared to the overall Medicare fee-for-service population, lower 30-day hospital readmission rates (13.8% vs. 19.6%) and shorter hospital length-of-stay (3.2 days vs. 5.6-day average) (learn more). The Medicaid plan has shown 10%–17% fewer days in the hospital, 21%–22% fewer ED visits, and 23%–28% fewer specialist visits than other Medicaid managed care beneficiaries in the same area (learn more).	Sachin H. Jain, MD, MBA President and CEO, CareMore Health System e: Sachin.Jain@caremore.com

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Care Management Plus	Originally designed for age 65+ adults with multiple comorbidities such as diabetes, frailty, dementia, depression, and other mental health needs; the model has been adopted for nonelderly patients with complex needs	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	~400	RCT of the model showed 3.2% lower hospitalizations and, for patients with diabetes, 4.4% lower mortality compared to controls (learn more).	David Dorr, MD, MS Professor and Vice Chair, Medical Informatics, Oregon Health Science University e: dorrd@ohsu.edu
Care Transitions Intervention	Community-dwelling adults with at least one acute or chronic condition requiring posthospital care (excludes psychiatric conditions)	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ One lead point of contact ✓ Education for providers and patient	800[1]	RCT showed intervention patients had significantly lower rehospitalization rates at 30 days and 90 days than control patients. Mean hospital costs were lower for intervention patients than control patients at 180 days (learn more). Summary review shows intervention yields return on investment of 131% per year and annual savings of $2,311 per enrollee (learn more).	Eric A. Coleman, MD, MPH Professor of Medicine and Head of the Division of Health Care Policy and Research, University of Colorado Anschutz Medical Campus e: Eric.Coleman@ucdenver.edu
Chronic Disease Self-Management Program	Adults with one or more chronic conditions	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Education for providers and patient ✓ Performance measurement/CQI	n/a[2]	RCT of patients with chronic conditions found intervention group experienced fewer hospitalizations, shorter hospital stays, more energy, less fatigue, and greater improvement in self-reported health compared to controls (learn more). National survey of 1,170 intervention participants in 17 states found significant reductions in ED visits (5%), hospitalizations (3%), and potential net savings of $364 per participant after accounting for cost of program (learn more).	Coleen Travers, LCSW, LMSW Licensed Clinical Social Worker, Stanford Coordinated Care e: ctravers@stanfordhealthcare.org

[1] Number of sites provided by Eric Coleman, principal investigator of Care Transitions Intervention, in January 2019.
[2] Chronic Disease Self-Management Program is widespread; there is no numeric estimate of sites available.

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Commonwealth Care Alliance	Dual-eligible age 65+ adults enrolled in Senior Care Options Program (a Medicare Advantage Special Needs Plan in Massachusetts) and dual-eligibles age 64 and younger in Massachusetts One Care Program	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ One lead point of contact ✓ Education for providers and patient ✓ Interdisciplinary care team ✓ Active care coordination ✓ Continual data-sharing ✓ Performance measurement/CQI	1[3]	Unpublished data for Senior Care Options enrollees have found positive results including decreased hospital admissions, decreased hospital readmissions, and a decrease in overall expenses for acute care needs (learn more). Results not yet available for OneCare.	Christopher D. Palmieri President and CEO, Commonwealth Care Alliance e: cpalmieri@commonwealthcare.org
Community Aging in Place—Advancing Better Living for Elders (CAPABLE)	Low-income people who need assistance with at least one activity of daily living like self-feeding or two instrumental activities of daily living like managing money	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Multiple chronic conditions	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient	17	Studies have shown a 67% decrease in average ADL problems (learn more), reduced readmissions (learn more), and 11% lower probability of having expenditures for health care services which contributed to average Medicaid savings of $867 per month per participant (learn more). In one study, 94% of intervention group participants thought program made life easier for them (learn more).	Sarah Szanton, PhD, ANP, FAAN Professor, Johns Hopkins School of Nursing e: sszanto1@jhu.edu
Community Care Behavioral Health Organization: Behavioral Health Home Plus	Individuals with serious mental illness	✓ Multiple chronic conditions ✓ Behavioral & social needs	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	52	A formal study indicated nearly 2-point overall increase in patient activation scores, 36% overall increase in primary and specialty care use, and decreased behavioral and medical inpatient use (learn more).	Patricia Schake, MSW Senior Director of Program Innovations, Community Care Behavioral Health Organization e: schakepl@ccbh.com
Consistent Care Emergency Department Reduction Program	Frequent users of the emergency department	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	5	A pre–post convenience sample study demonstrated 71% reduction in ED visits and 55% decline in hospital treatment costs among frequent users of the ED (learn more).	Darin Neven, MS, MD President and Founder, Consistent Care Services e: darin@neven.us

[3] The Commonwealth Care Alliance operates in sites throughout the state of Massachusetts.

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Duke Outpatient Clinic HomeBASE	Likely high-users of emergency and inpatient care	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	1	A study found this proactive intervention focused on patient engagement contributed to a 43% reduction in both ED visits and hospital days among enrollees and $839,892 in total direct cost savings over the first year (learn more).	Marigny Manson Bratcher, RN Nursing Program Coordinator, Duke University Medical Center e: marigny.manson@duke.edu
Geriatric Resources for Assessment and Care of Elders (GRACE) Team Care	Low-income elderly with multiple diagnoses	✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Performance measurement/CQI	22[4]	RCT of intervention in a Veterans Affairs Medical Center showed a 7.1% reduction in ED visits, 14.8% fewer 30-day readmissions, 37.9% fewer hospital admissions, 28.5% fewer total bed days of care, and lower costs (learn more). RCT in other settings showed similar reductions in ED visits and hospitalizations (learn more).	Dawn Butler, MSW, JD Director, GRACE Training and Resource Center e: butlerde@iu.edu
Guided Care	Older adults with multiple chronic conditions who are at risk of high health expenditures in the next year	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient	8	Studies have shown intervention participants had twice greater odds of rating the quality of their chronic care highly (learn more) and 29.7% reduction in the use of home care compared to controls (learn more). Another study found physicians participating in Guided Care reported significantly increased satisfaction with family communication compared to controls (learn more).	Cynthia Boyd, MD, MBA Professor, Johns Hopkins University School of Medicine e: cyboyd@jhmi.edu
Health Quality Partners Advanced Preventive Care	Chronically ill, older adults	✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	2	RCT of this care coordination and disease management intervention showed all-cause mortality reduced 22%–34% depending on risk group and duration (learn more). Other research has shown reduced hospitalizations, ED visits, and Medicare costs after program fees for appropriately targeted higher-risk populations (learn more).	Ken Coburn, MD, DrPH, FACP CEO and Medical Director, Health Quality Partners e: coburn@hqp.org

[4] The GRACE model has been replicated nationally, but only 22 sites are operated by GRACE Team Care.

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Homeless Patient Aligned Care Team (H-PACT)	Homeless veterans	✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	65	A number of detailed studies have found those participating in this comprehensive care and housing support intervention were significantly less likely to use ED (learn more) and cost on average $9,379 less per year compared to homeless veterans enrolled in traditional primary care services (learn more).	Erin Johnson Supervisor, U.S. Department of Veteran Affairs e: Erin.Johnson4@va.gov
Hospital at Home	Older patients with a targeted acute illness that requires hospital-level care and who meet validated medical eligibility criteria and live within the designated geographic catchment area	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	12	Studies have found 19% lower patient costs and overall greater patient satisfaction with intervention patients compared to similar inpatients (learn more). In addition, program has demonstrated reduced complications and greater patient and caregiver satisfaction (learn more).	Bruce Leff, MD Professor, Johns Hopkins University School of Medicine e: bleff@jhmi.edu
Hospital Elder Life Program (HELP)	Older adults in a hospital setting with delirium or risk factors for delirium and/or functional decline	✓ Frail older adults ✓ Advanced illness	✓ Interdisciplinary care team ✓ Education for providers and patient	200[5]	Multiple studies have found improved outcomes including 40% lower odds of developing delirium and 56 fewer days of delirium among those in intervention group that received personalized, comprehensive care (learn more). One test hospital site saved approximately $2,181 per case by preventing delirium (learn more).	Sarah Gartaganis, LCSW, MPH Project Director, Aging Brain Center, Harvard University e: sarahdowal@hsl.harvard.edu
Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	Individuals with behavioral health needs	✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	~1,000[6]	RCT of adults age 60+ with major depression, dysthymic disorder, or both, found after 12 months, about half of IMPACT patients had 50% or greater reduction in depressive symptoms from baseline assessment compared to 19% of patients receiving usual primary care (learn more). Over a four-year period, total health care costs for IMPACT patients were approximately $3,363 lower per patient on average than those of patients receiving usual primary care, even after accounting for cost of providing intervention (learn more).	Jürgen Unützer, MD, MPH, MA Founder, AIMS Center e: unutzer@uw.edu

[5] Number of sites obtained from the Hospital Elder Life Program website.
[6] Number of sites provided by Jürgen Unützer, founder of the AIMS Center, in November 2018.

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Independence at Home	Medicare beneficiaries with multiple chronic conditions and functional limitations	✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	147	Enrollees had fewer hospital readmissions within 30 days and lower use of inpatient hospital and ED services for such conditions as diabetes, high blood pressure, asthma, pneumonia, and urinary tract infection (learn more). In addition, program produced savings for Medicare (learn more).	Brent Feorene Executive Director, American Academy of Home Care Medicine e: bfeorene@aahcm.org
Interventions to Reduce Acute Care Transfers (INTERACT)	Residents of long-term care facilities	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	264	Among the 25 nursing homes that completed the project, there was a 17% reduction in all-cause hospitalizations (learn more).	Joseph Ouslander, MD Chair of the Department of Integrated Medical Science and Senior Associate Dean of Geriatric Programs, Florida Atlantic University e: jousland@health.fau.edu
Johns Hopkins Community Health Partnership	Adults and the elderly with complex medical and social needs	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	1	Evaluation of this intervention, which emphasizes partnerships with community organizations, found reductions in hospitalizations and ED visits for Medicare and Medicaid patients and decreased total cost of care (learn more).	Melissa Sherry, MPH Director, Population Health Innovation and Transformation, Johns Hopkins HealthCare e: msherry@jhhc.com
Maximizing Independence at Home (MIND)	People with dementia and other memory disorders	✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	1	Studies have found participants in this home-based care coordination intervention saw delay of nursing home entry, better self-reported quality of life, and fewer hours of direct care per week compared to controls (learn more).	Constantine G. Lyketsos, MD Elizabeth Plank Althouse Professor, Department of Psychiatry, Johns Hopkins University School of Medicine e: kostas@jhmi.edu

[7] Number of sites obtained from the Independence at Home website.

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Center to Advance Palliative Care	The most seriously ill and those at end of life	✓ Major chronic conditions ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	~1,744[8]	Palliative care hospital patients discharged alive had adjusted net savings of $1,696 in direct costs per admission and $279 in direct costs per day, including significant reductions in laboratory and intensive care unit costs compared with usual care patients (learn more). In addition, palliative care and hospice services have been shown to reduce depression, pain, and other symptoms; improve patient and family satisfaction; and may even prolong life compared to usual care (learn more).	Diane Meier, MD, FACP Director, Center to Advance Palliative Care (CAPC) e: diane.meier@mssm.edu
Partners Healthcare Integrated Care Management Program (iCMP)	Individuals who are high-cost and/or have complex conditions	✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	1	An independent evaluation of this care coordination effort found that after three years the intervention group, compared to controls, had rates 20% lower for hospital admissions and 13% lower for ED visits. Program achieved 7% annual net savings, after accounting for intervention costs (learn more).	Eric Weil, MD Medical Director, Mass General Care Management Program e: eweil@mgh.harvard.edu
Program of All-Inclusive Care for the Elderly (PACE)	Age 55+ adults who have Medicare and/or Medicaid, have chronic conditions and/or functional and cognitive impairments, live in service area of local PACE organization, and are Medicaid-certified as eligible for nursing home level care	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	233	Recent review of literature found PACE enrollees experienced fewer hospitalizations, but more nursing home admissions; better quality for certain aspects of care, such as pain management (learn more). Subsequent study found PACE enrollees had 31% lower risk of long-term nursing home admission compared to home- and community-based waiver participants (learn more). PACE appears to be cost-neutral to Medicare and may have increased costs for Medicaid; more research is needed to reflect current payment arrangements (learn more).	Robert Greenwood, MA Senior Vice President of Public Affairs, National PACE Association e: Robertg@npaonline.org

[8] Number of sites obtained from the Center to Advance Palliative Care website.

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Support and Services at Home (SASH)	Seniors and individuals with special needs, throughout the state of Vermont	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	155[9]	An independent evaluation found that participants had improvements in self-reported physical and mental health status and statistically significant lower rates of growth in Medicare expenditures (by $1,227 per beneficiary per year) compared to controls (learn more).	Molly Dugan, MPA Director, Cathedral Square Corporation Support and Services at Home e: dugan@cathedralsquare.org
10th Decile Project	The top 10% highest-cost, highest-need homeless individuals in Los Angeles County	✓ Adults <65 w/ disabilities ✓ Frail older adults ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing	4	A program evaluation of this housing intervention found average annual health care and public sector cost reductions of $54,106 per person, per year, 71% decrease in ED visits, and 84% decrease in hospital admissions (learn more).	Susan Lee, MBA Senior Program Manager, Corporation for Supportive Housing e: susan.lee@csh.org
Transitional Care Model (TCM)	Hospitalized, high-risk adults with chronic conditions	✓ Frail older adults ✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs ✓ Advanced illness	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	342	RCT of this time-limited coordination intervention found that, one year after hospital discharge, intervention group had fewer readmissions and lower mean total costs ($7,636 vs. $12,481). Intervention group also experienced short-term improvements in overall quality of life and patient satisfaction (learn more).	Karen Hirschman, PhD, MSW Research Associate Professor, University of Pennsylvania e: hirschk@nursing.upenn.edu
Virginia Commonwealth University Health System Complex Care Clinic	Uninsured individuals with complex medical and social needs	✓ Major chronic conditions ✓ Multiple chronic conditions ✓ Behavioral & social needs	✓ Individualized care plan ✓ Ongoing care plan review ✓ Interdisciplinary care team ✓ One lead point of contact ✓ Active care coordination ✓ Continual data-sharing ✓ Education for providers and patient ✓ Performance measurement/CQI	1	Internal evaluation found Complex Care Clinic — which addresses holistic, nonmedical needs of patients — achieved 44% decline in inpatient admission, 38% decrease in ED use, and 49% reduction in total hospital costs in first year. A formal external evaluation is currently being conducted (learn more).	Kimberly Lewis, M.Ed, MCHES Director of Outreach and Administration, Virginia Commonwealth University Health System e: kimberly.lewis@vcuhealth.org

[9] Number of sites obtained from the Support and Services at Home website.

* Key characteristics of person-centered care include:

- Individualized, goal-oriented care plan based on person's preferences.
- Ongoing review of person's goals and care plan preferences.
- Care supported by interprofessional team in which person is integral team member.
- One primary or lead point of contact on health care team.
- Active coordination among all health care and supportive service providers.
- Continual information sharing and integrated communication.
- Education and training for providers and, when appropriate, for person receiving services and those important to that person.
- Performance measurement and quality improvement using feedback from person receiving services and caregivers.

Data: American Geriatrics Society Expert Panel on Person-Centered Care, "Person-Centered Care: A Definition and Essential Elements," *Journal of the American Geriatrics Society* 64, no. 1 (Jan. 2016): 15–18.