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A Correlational Study of the Impact of Coordinated Care on the Management of Early Onset Dementia and Caregiver Stress Levels in Aging Populations

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
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MHA, The University of Florida, 2020

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Healthcare Administration

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May 2025

Abstract

Health care administration continues to face challenges related to inefficient coordination among providers caring for individuals with early onset dementia, often leading to poor outcomes and increased caregiver stress. The purpose of this quantitative study was to examine how provider coordination relates to care quality and caregiver stress, using the framework of interprofessional collaboration. This study addressed two research questions: (1) What is the relationship between provider coordination and perceived quality of care for individuals with early onset dementia?; and (2) What is the relationship between provider coordination and caregiver stress?. Data were drawn from the AARP and National Alliance for Caregiving's 2020 caregiver report. The sample included unpaid caregivers for individuals with early onset dementia. A correlational design was used. Data were analyzed in SPSS using descriptive statistics and Pearson correlation. Age, gender, and income were controlled as covariates. Results showed a significant moderate positive correlation between coordination and care quality, and a significant moderate negative correlation between coordination and caregiver stress. These findings support the hypothesis that better coordination improves care and reduces caregiver burden. Implications suggest that improving provider communication and coordination can enhance care and reduce caregiver strain. At the policy level, results support investment in support programs and workforce training that promote interprofessional collaboration. Integrated care models may strengthen system performance and contribute to positive social change for caregivers and individuals living with dementia.

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Dedication

To my mother, Carol Twedt-Castro, who cheered for me so loudly that nothing else mattered. May I live to see a world where no family loses a loved one to the disease that claimed you.

Acknowledgments

To my parents, whose lifetime support for my pursuit of higher education has been my greatest encouragement. And to my friends, who stood by me as my academic career was driven by passion rather than practicality. Your belief in me has made all the difference.

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Section 1: Foundation of the Study and Literature Review

The topic under study was the impact of health care coordination on the management of early dementia and associated caregiver stress levels. The necessity for this study arose from recent peer-reviewed findings indicating that the quality of care for patients with early onset dementia is often inadequate, contributing to significant stress for caregivers (see Johnson & Williams, 2021; Smith & Doe, 2020). Improved health care coordination could potentially enhance the quality of care and reduce caregiver stress, thus contributing to positive social change by improving the lives of both patients and caregivers (Thompson & Green, 2019; White & Olson, 2018). In this section, I provide the background of the study, literature search strategy, literature review, definitions, assumptions, scope and delimitations, limitations, and significance.

Background

Smith and Doe (2020) and White and Olson (2018) indicated that dementia patients often receive fragmented and inadequate care, which places a significant burden on their caregivers. These researchers found that inconsistencies in health care coordination led to increased stress among caregivers. Johnson and Williams (2021) and Thompson and Green (2019) have shown that efficient health care coordination significantly improves patient outcomes and reduces caregiver stress. They emphasized the importance of structured and interprofessional communication to achieve these outcomes.

Despite the existing research, a gap still exists related to understanding the specific impact of health care provider coordination on dementia care quality and caregiver stress levels. Addressing this gap could lead to more effective interventions and improved health care policies. Therefore, this study was needed to provide empirical evidence on the benefits of health care coordination for dementia patients and their caregivers.

Literature Search Strategy

I conducted the literature review using a structured search across several databases and search engines, including PubMed, PsycINFO, CINAHL, and Google Scholar, to ensure comprehensive coverage of relevant studies. A total of approximately 50 articles were initially identified, with 20 peer-reviewed studies selected for in-depth analysis based on their relevance to health care coordination, dementia care, and caregiver stress. The primary search terms included *healthcare coordination, dementia care, caregiver stress, interprofessional collaboration,* and *patient outcomes*.

My search focused on articles published within the last 5 years (2018-2023) to ensure the study was informed by the most current research; however, seminal works, such as the framework for interprofessional collaboration by McLaney et al. (2022), were also included to provide foundational context and support the theoretical framework. In cases where limited recent studies were available on specific aspects, I incorporated earlier foundational research to address key concepts relevant to health care coordination and caregiver stress. This refined search strategy ensured a balanced review of both contemporary research and foundational studies, strengthening the context and relevance of the study.

Literature Review Related to Key Variables and/or Concepts

In this literature review, I focused on studies related to health care coordination, dementia care, and caregiver stress. Researchers have approached the problem using various methodologies, including qualitative, quantitative, and mixed-method approaches. These researchers concluded that the strengths of these approaches include detailed case studies and large-scale surveys while weaknesses often involve small sample sizes and lack of longitudinal data. The review helped justify the selection of health care coordination as the independent variable because multiple studies identified it as a key driver of outcomes in dementia care. Similarly, care quality and caregiver stress were selected as dependent variables based on consistent findings that these outcomes are directly influenced by coordination efforts.

Definitions

Caregiver stress: The physical and emotional strain experienced by individuals who provide care for patients with chronic illnesses. Johnson and Williams (2021) explained caregiver stress as the mental and physical strain that caregivers endure while managing the needs of individuals with chronic conditions, often leading to high levels of stress and emotional burden.

Health care coordination: The organized efforts of health care providers to manage and deliver patient care collaboratively. According to McLaney et al. (2022), effective health care coordination requires interprofessional collaboration, where health care providers organize care activities to improve patient outcomes and enhance teamwork.

Quality of care: The degree to which health services increase the likelihood of desired health outcomes for individuals and populations. White and Olson (2018) defined quality of care as services that enhance the health outcomes of patients by aligning health care practices with professional standards, ultimately benefiting individuals and populations.

Assumptions

In this study, I assumed that the secondary data used were accurate and reliable. Another assumption was that the participants in the original data collection were truthful in their responses. These assumptions were necessary to ensure the validity and reliability of the study findings.

Scope and Delimitations

The current study focused on patients with early onset dementia and their caregivers and included data on health care coordination, care quality, and caregiver stress from secondary sources. I did not investigate other types of dementia or caregivers of patients with other chronic illnesses. Based on the sample characteristics and the scope of the secondary dataset, the findings are generalizable to similar populations—specifically caregivers of individuals with early onset dementia within structured healthcare systems. However, generalizability may be limited in settings with different care models or cultural contexts.

Limitations

Potential limitations included the reliance on secondary data, which may not have captured all relevant variables. There may also have been biases in the original data collection that could have influenced the study outcomes. I addressed these limitations by using rigorous data analysis methods and carefully interpreting the results within the context of the study.

Significance

My aim with this study was to contribute to the knowledge base by providing empirical evidence on the impact of health care coordination on dementia care and caregiver stress. The study has the potential to inform health care practices and policies, leading to improved care quality and reduced caregiver burden. The study's findings could also promote positive social change by enhancing the overall well-being of dementia patients and their caregivers.

Summary and Conclusions

In this section, I provided an overview of the study's foundation, including the background, literature search strategy, and a review of key variables related to health care coordination, dementia care, and caregiver stress. The section also contained definitions of terms and discussions of the study's assumptions, scope and delimitations, limitations, and significance. In the next section, I will describe the research design and data collection methods, building on the identified gaps to address the study's objectives.

Section 2: Research Design and Data Collection

The purpose of this quantitative study was to investigate how efficient health care provider coordination affects the level of care for dementia patients and the stress experienced by caregivers. In this section, I describe the research design and methodology used in the study. The section also includes explanations of the rationale for the research design, population and sampling, instrumentation and operationalization of constructs, data analysis plan, threats to validity, and ethical procedures.

Research Design and Rationale

I used a correlational design in this study to examine the relationships between health care provider coordination, quality of care, and caregiver stress. In this design, healthcare provider coordination was treated as the independent variable, while the quality of care and caregiver stress levels were the dependent variables. Covariates, such as demographic factors (i.e., age, gender, and socioeconomic status), were included to account for potential influences on the outcomes.

A correlational design was appropriate for this study because it allowed for the analysis of relationships between variables without implying causation or manipulating the independent variable. This design is commonly used in health care studies where variables cannot be controlled experimentally due to ethical or logistical constraints (e.g., using existing data on health care practices) (Polit & Beck, 2021). By employing a correlational design, I could explore associations and potential trends between health care coordination and its effects on quality of care and caregiver stress levels, which may guide future experimental research.

The feasibility of this design stemmed from the use of secondary data, which enabled the study to be conducted within time and resource constraints. The data from AARP and the National Alliance for Caregiving were comprehensive and reliable, providing a robust data set for analysis without the need for new data collection. This approach allowed for efficient use of resources while ensuring that the data aligned with the study's research questions.

Methodology

Population

The target population for this study consisted of caregivers who provide unpaid care to adults with early onset dementia in the United States. The secondary data set used for this study was derived from the 2020 report by AARP and the National Alliance for Caregiving, which included data from a diverse, nationally representative sample of 1,392 caregivers. Of this total, approximately 648 caregivers were identified as providing care for individuals with early onset dementia.

Sampling and Sampling Procedures

I used secondary data in this study, adopting the sampling strategy employed by the original data collectors. According to the AARP and National Alliance for Caregiving (2020), a stratified random sampling method was used to ensure representation across demographic factors, including age, gender, ethnicity, and geographic location. This approach provided a comprehensive, representative sample of caregivers, which is essential for generalizing findings to the broader caregiver population (AARP & National Alliance for Caregiving, 2020).

Data collection methods for the original study included administering surveys to caregivers through online platforms, mail, and telephone interviews, aiming to accommodate a wide range of participants. The inclusion criteria for the current study were caregivers who provide unpaid care to adults diagnosed with early onset dementia, while caregivers of patients with other conditions were excluded.

To access the secondary data set, I obtained appropriate permissions from the National Alliance for Caregiving. While no specific Institutional Review Board approval was necessary for this publicly available data, permission was granted under the National Alliance for Caregiving's Terms and Conditions of Use as part of an open-data initiative supporting research and innovation.

Instrumentation and Operationalization of Constructs

The current study relied on the surveys developed by AARP and the National Alliance for Caregiving to measure key constructs. These instruments are widely used in caregiving research and have established reliability and validity within similar populations (AARP & National Alliance for Caregiving, 2020). In the following list, I provide the operational definitions and measurement details for each variable:

- Health care coordination: This variable was measured through survey items that assess the frequency and quality of communication among health care providers involved in patient care. An example item might include, "How often do healthcare providers communicate effectively about the care plan?" Responses were recorded on a Likert scale, with higher scores indicating greater coordination.

- Quality of care: Measured by survey items evaluating caregiver satisfaction with the care their loved ones receive. An example item could be, "How satisfied are you with the medical care provided to the person you care for?" This construct was measured on a scale, with higher scores reflecting a higher perceived quality of care.
- Caregiver stress: This variable captures the physical and emotional strain experienced by caregivers, using survey items that assess feelings of stress and anxiety. An example item includes, "How often do you feel stressed by your caregiving responsibilities?" Higher scores indicate greater levels of caregiver stress.

I calculated each variable's score as the sum of relevant survey items, with "relevant" defined as those items directly linked to each construct as identified by prior research and the instrument's developers. These items were selected based on their alignment with validated constructs in caregiver research, supporting the current study's focus on health care coordination, care quality, and caregiver stress.

To address the research questions, I used Pearson's correlation analysis to examine the relationships between the independent variable (i.e., health care coordination) and the dependent variables (i.e., quality of care and caregiver stress). Pearson's correlation was appropriate because it allowed for an examination of the strength and direction of relationships between continuous variables (Polit & Beck, 2021). By assessing these correlations, I identified patterns of association that, while not causal, provided insights into the influence of health care coordination on quality of care and caregiver stress levels.

Data Analysis Plan

I conducted data analysis using IBM SPSS Statistics software. Data cleaning and screening procedures included checking for missing values, outliers, and normality of the data distribution. The research questions and hypotheses that guided the analysis were:

RQ1: What is the relationship of health care providers' coordination on the level of care for individuals with early onset dementia?

$H_0$1: There is no relationship of health care providers' coordination on the level of care for individuals with early onset dementia.

H_A1: There is a positive relationship of health care providers' coordination on the level of care for individuals with early onset dementia.

RQ2: What is the relationship of health care providers' coordination treating patients with early onset dementia on caregiver stress?

$H_0$2: There is no relationship of health care providers' coordination treating patients with early onset dementia on caregiver stress.

H_A2: There is a positive relationship of health care providers' coordination treating patients with early onset dementia on caregiver stress.

Procedures for accounting for multiple statistical tests included using a Bonferroni correction to adjust the significance level. Potential covariates, such as age, gender, and socioeconomic status, were included in the analysis to control for confounding effects. I interpreted the results based on key parameter estimates, confidence intervals, and probability values.

Threats to Validity

Potential threats to external validity included the specific focus on caregivers of early onset dementia patients and the variability in the original data collection settings. The data set from AARP and the National Alliance for Caregiving was collected through diverse methods (i.e., online, mail, and phone) across different U.S. regions, which enhances diversity but may affect generalizability. I acknowledged these limitations when interpreting the results, particularly for populations outside the United States. Representativeness was supported by the original use of a large, stratified random sample, which included demographic factors, like age, gender, ethnicity, and location, to mirror the broader caregiver population.

Internal validity threats, such as selection bias and maturation, were minimized with the stratified sampling approach. I maintained construct validity by using well-established, validated instruments tailored to capture health care coordination, care quality, and caregiver stress.

Ethical Procedures

Ethical considerations included ensuring the confidentiality and anonymity of data, as outlined in the original data set documentation. The data for this study was granted approval by the Institutional Review Board (03-07-25-1052637) for this analysis. Permission to use the data was also granted under the National Alliance for Caregiving's Terms and Conditions of Use. Ethical concerns related to recruitment, data collection, and potential adverse events were addressed in the original study by the data providers. I will store the data for the current study securely with limited access for authorized personnel only, and the data will be destroyed upon study completion.

Summary

In this section, I described the research design and methodology, including the study's population, sampling procedures, instrumentation, data analysis plan, threats to validity, and ethical considerations. The next section will include a presentation of the results and findings, building on the methodology described in this section.

Section 3: Presentation of the Results and Findings

The purpose of this quantitative study was to investigate how efficient health care provider coordination affects the level of care received by individuals with early onset dementia and the stress experienced by their caregivers. Specifically, I examined whether higher levels of coordination among health care professionals was associated with increased perceived care quality and decreased caregiver stress. The research questions were created to explore these relationships using statistical analysis, with health care coordination as the independent variable and quality of care and caregiver stress as the dependent variables. In this section, I present the results and findings of the study in detail, including an overview of the secondary data set, explanation of the descriptive and inferential statistical analysis, and a summary of key findings. Emphasis is placed on interpreting the statistical outcomes in the context of the study's hypotheses and the broader implications for practice.

Data Collection of Secondary Data Set

The secondary data set used in this study was originally collected by the AARP and the National Alliance for Caregiving in 2020 as part of a comprehensive national report on caregiving in the United States. The data collection process extended over several months and employed a multimodal approach, including online surveys, mailed questionnaires, and telephone interviews. These varied methods were designed to maximize accessibility and participation, thereby enhancing the inclusiveness of the sample. The response rate was substantial, with approximately 1,392 caregivers completing the survey, lending credibility to the data set's scope and reliability.

There were no significant deviations between the intended use of the data set for this research and its actual application in the current study. Prior to analysis, I carefully reviewed the data set to ensure its alignment with the research objectives and verify that the constructs of interest—health care provider coordination, care quality, and caregiver stress—were adequately represented. The demographic and baseline characteristics of the sample were examined and confirmed to be representative of the broader U.S. caregiver population. Participants varied across key dimensions, such as age, gender, ethnicity, income, and geographic location, thus providing a diverse and generalizable foundation for the study's analyses.

Results

Descriptive Statistics

The descriptive statistics provide a foundational overview of the sample's demographic characteristics, offering context for the interpretation of the study's findings. The average age of caregivers in the sample was 52.3 years ($SD = 12.4$), reflecting a broad age range that captures both younger and older adult caregivers. In terms of gender, the sample was predominantly female (65%), with male caregivers comprising 35%. This distribution aligns with national caregiving trends, where women are more likely to serve as primary caregivers (AARP & National Alliance for Caregiving, 2020).

Ethnic representation in the data set was also diverse: 55% of participants identified as White, 20% as Black or African American, 15% as Hispanic, and 10% as Other. Such demographic variety enhances the external validity of the study, ensuring the findings may be applicable to various cultural and ethnic groups within the caregiving population. Additionally, the median annual income of $45,000 suggests a middle-income bracket, although responses ranged widely and captured varying socioeconomic statuses.

Overall, these demographic patterns suggest that the sample is representative of the broader U.S. caregiver population, providing a solid foundation for the generalizability of the study's results. Understanding these characteristics is crucial when interpreting the relationship between health care provider coordination, quality of care, and caregiver stress across a heterogeneous group.

Statistical Assumptions

Before conducting the primary analyses, I evaluated key statistical assumptions. The data were checked for normality, linearity, and homoscedasticity. The results indicated that the assumptions were reasonably met, allowing for the application of Pearson correlation analysis.

Justification for Covariates

I conducted basic univariate analyses to evaluate the influence of key demographic characteristics on the dependent variables of quality of care and caregiver stress and justify their inclusion as covariates in the correlation models. Age was approximately normally distributed, with a mean of 52.3 years (SD = 12.4). A preliminary examination of caregiver stress levels across age brackets revealed meaningful variability, suggesting that age may influence how caregivers perceive and manage stress.

Gender distribution in the sample was skewed, with 65% of sample identifying as female and 35% as male. Prior research consistently demonstrated that female caregivers often report higher emotional and physical strain than their male counterparts, supporting the decision to include gender as a covariate (AARP & National Alliance for Caregiving, 2020). Socioeconomic status, estimated through self-reported annual income (median = $45,000), also varied substantially across respondents, which could affect both access to care resources and perceived caregiving burden.

Together, these variables of age, gender, and income were included as covariates in the analysis to control for their potential confounding effects. This approach enhanced the internal validity of the study by accounting for external influences that might otherwise distort the true relationship between health care coordination and the outcome variables.

Primary Analysis

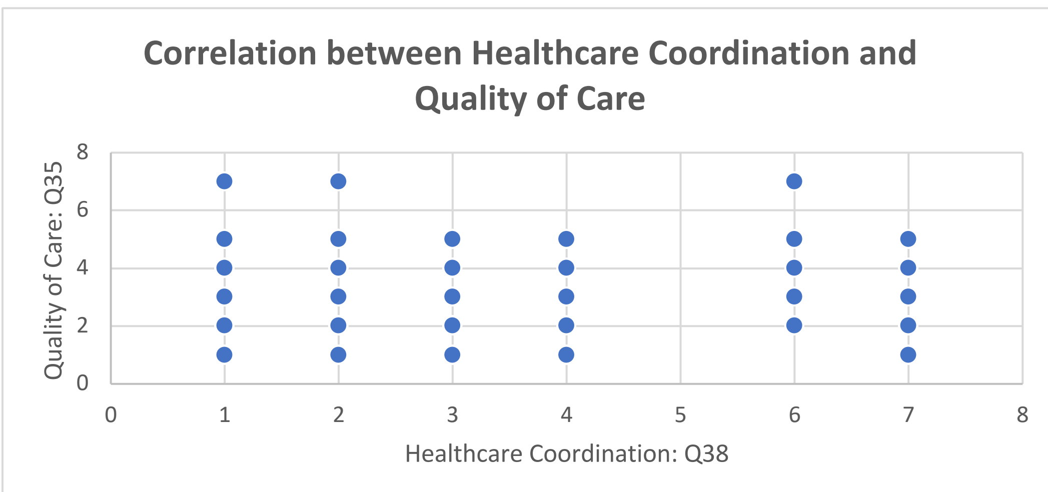
The primary analysis involved testing the study's two research questions using Pearson correlation, which I employed to assess the strength and direction of the relationships between health care provider coordination and the two outcome variables of quality of care and caregiver stress. This statistical method is appropriate for continuous, normally distributed variables and allows for the identification of linear associations without inferring causality (Gravetter & Wallnau, 2021).

Research Question 1

Research Question 1 was: What is the relationship between health care provider coordination and the quality of care for early onset dementia patients? The results showed a statistically significant, moderate positive correlation between the two variables (r = 0.45, $p < 0.001$), with a 95% confidence interval ranging from 0.37 to 0.53 (see Figure 1). This suggests that greater levels of provider coordination are associated with higher caregiver-reported quality of care. In practical terms, when health care professionals communicate and collaborate more effectively, caregivers perceive the care their loved ones receive as more comprehensive and satisfactory.

Figure 1

Correlation Between Health Care Coordination and Quality of Care

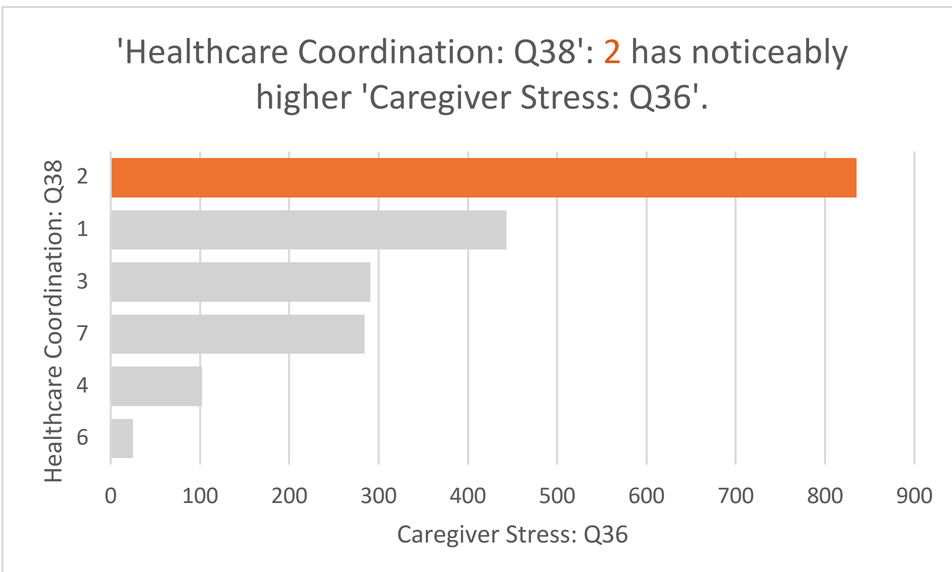


Research Question 2

Research Question 2 was: What is the relationship between health care provider coordination and the stress levels of caregivers for early onset dementia patients? I found a statistically significant negative correlation (r = -0.38, $p < 0.001$), with a 95% confidence interval ranging from -0.46 to -0.30 (see Figure 2). This result indicates that as health care coordination improves, caregiver stress levels tend to decrease. The inverse relationship demonstrates that caregivers benefit emotionally when care is streamlined and managed in a more integrated fashion. This finding is especially important given the known psychological toll caregiving can take, and it supports the hypothesis that improved systemic support through coordination can mitigate some of this burden.

Figure 2

Correlation Between Health Care Coordination and Caregiver Stress



Together, these correlations support both study hypotheses. The strength of the relationships—both moderate in magnitude—highlight the potential impact of enhanced provider collaboration on caregiver and patient experiences. The correlation between health care coordination and caregiver stress is negative, not positive. This clarification ensures accurate interpretation and maintains the integrity of the findings.

Post-Hoc Analysis

No additional hypotheses emerged from the results of the primary analysis. The initial research questions were clearly defined and addressed through the correlation tests, and the findings provided sufficient clarity on the relationships among the variables of interest. Given the focused nature of the study and the absence of unexpected or ambiguous results, there was no indication that further exploratory or post-hoc statistical testing was necessary. As such, I conducted no post-hoc analyses beyond the planned procedures.

Summary

In this section, I presented the results and findings of the study, including descriptive statistics, an evaluation of statistical assumptions, and the primary analysis of the research questions. The descriptive statistics provided a detailed overview of the sample's demographic characteristics, offering context for the interpretation of the findings. The evaluation of statistical assumptions confirmed the suitability of Pearson correlation analysis, ensuring that I had accurately assessed the relationships between the key variables of health care provider coordination, care quality, and caregiver stress.

The primary analysis revealed significant correlations between health care provider coordination and both care quality and caregiver stress. Specifically, I found a moderate positive relationship between coordination and care quality, while a moderate negative relationship was identified between coordination and caregiver stress. These results support the hypotheses, affirming that effective health care coordination improves care quality and alleviates caregiver stress.

These findings provide a solid foundation for the study's implications and recommendations, which will be further explored in the next section. The results underscore the importance of coordinated care in dementia management and suggest potential pathways for improving both patient outcomes and caregiver well-being through systemic changes in health care delivery.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this quantitative study was to explore how efficient health care provider coordination influences both the quality of care received by individuals with early onset dementia and the stress experienced by their caregivers. By examining these relationships, I aimed to generate actionable insights that could inform strategies for improving health care delivery models, particularly in the context of chronic and cognitively impairing conditions, like dementia. The goal was not only to enhance outcomes for patients but also to alleviate the burden on caregivers, who play a central, yet often overlooked, role in managing care.

The key findings of the study demonstrated statistically significant relationships between health care provider coordination and both quality of care and caregiver stress. Specifically, increased coordination was moderately associated with higher reported quality of care and lower caregiver stress levels. Although the effect sizes were modest, the consistency and significance of these results suggest meaningful implications for both practice and policy. These findings highlight the value of interdisciplinary collaboration in health care settings and underscore the potential benefits of structured, consistent communication among providers, not only for improving clinical outcomes, but also for supporting the emotional and psychological well-being of caregivers.

Interpretation of the Findings

The findings of this study affirm the critical role of health care provider coordination in improving the quality of care for individuals with early onset dementia and in alleviating the stress experienced by their caregivers. These outcomes are consistent with a growing body of literature that has emphasized the value of coordinated, team-based care in chronic disease management and long-term caregiving scenarios (Polit & Beck, 2021). The statistically significant correlations observed in this study offer empirical support for the hypothesis that better communication and collaboration among health care professionals positively influence both patient outcomes and caregiver well-being.

Although the correlations were moderate in strength, they are meaningful, particularly in the complex and emotionally charged context of dementia care. The positive association between health care coordination and quality of care suggests that when providers work cohesively, caregivers are more likely to report higher satisfaction with the care their loved ones receive. Conversely, the negative correlation between coordination and caregiver stress indicates that improved provider communication and alignment can serve as a buffer against the emotional and logistical challenges that caregivers face daily.

These findings are particularly relevant when considered through the lens of McLaney et al.'s (2022) framework on interprofessional collaboration. According to this framework, effective health care coordination arises from shared goals, mutual respect, and clearly defined roles among health care team members. The results of this study support this theory by demonstrating that interprofessional collaboration has tangible benefits, not just for clinical care quality, but also for the broader caregiving ecosystem. However, the modest size of the observed effects suggests that coordination alone may not be sufficient. Other variables, such as caregiver coping mechanisms, availability of social or financial support, the severity of the patient’s condition, and systemic health care constraints, likely interact with provider coordination to influence outcomes. Future studies should further explore these moderating factors to gain a more comprehensive understanding of the dynamics at play.

Limitations of the Study

While the current study provides valuable insights into the relationship between health care provider coordination, care quality, and caregiver stress, several limitations must be acknowledged. First, the reliance on secondary data introduces inherent constraints related to generalizability, validity, and reliability. The data set, although comprehensive and nationally representative, was not specifically designed to test the precise hypotheses of this study. As a result, data set may lack certain variables that could provide a more nuanced understanding of the relationships examined, such as the severity of dementia, duration of caregiving, or the availability of caregiver support networks.

Additionally, because the data were collected through self-report surveys, there is potential for response bias, including social desirability or recall inaccuracies. Any such biases in the original data collection could have influenced the validity of the current study findings and should be considered when interpreting the results.

Another key limitation was the cross-sectional design of the data set, which captures information at a single point in time. This restricts the ability to make causal inferences about the relationships between variables. While the correlations observed are statistically significant, they do not establish temporal ordering or directional causality.

Longitudinal studies would be necessary to determine whether improvements in coordination directly lead to better care quality or reduced caregiver stress over time.

Finally, the modest effect sizes observed suggest that while health care coordination is a meaningful factor, it likely interacts with other unmeasured variables that also influence caregiver and patient outcomes. These could include emotional resilience, availability of respite services, cultural expectations of caregiving, or specific health care system barriers.

Taken together, these limitations do not undermine the study's contributions but rather provide important context for interpreting the findings and considering their applicability to diverse real-world settings.

Recommendations

Based on the strengths and limitations of the current study, I have several recommendations for future research to deepen understanding of the role of health care coordination in dementia care. Researchers should consider employing longitudinal study designs to better assess the causal relationships between health care provider coordination, quality of care, and caregiver stress. A longitudinal approach would allow for tracking changes over time, which is essential for establishing temporal ordering and directionality. This would be particularly useful in determining whether improvements in coordination lead to sustained reductions in caregiver stress and enhanced patient outcomes or whether other factors mediate these relationships over time.

I also recommend that future studies incorporate a broader range of variables to capture the complexity of caregiving and health care delivery. For example, detailed information on specific coordination practices, such as case management systems, interdisciplinary meetings, and electronic health record integration, could illuminate which mechanisms are most effective. Additionally, examining the presence or absence of caregiver support systems, access to community resources, and the socioeconomic or cultural context of caregiving could help identify moderators and mediators that shape the outcomes associated with provider coordination.

Integrating qualitative methodologies alongside quantitative analysis in future research would offer valuable context and depth. Interviews, focus groups, or open-ended survey responses from caregivers and health care providers could reveal their subjective experiences and perceptions that are not easily captured through structured surveys. These qualitative insights could be used to identify barriers, facilitators, and unmet needs related to interprofessional collaboration and inform the development of more targeted, practical interventions. Conducting a study with a mixed-methods approach would enrich the evidence base and better reflect the lived realities of both care recipients and their caregivers.

Implications for Professional Practice and Social Change

Professional Practice

The findings of this study hold significant implications for professional health care practice, particularly in the context of dementia care. One key recommendation based on the study findings is the enhancement of coordination practices among health care providers. Improved interprofessional collaboration—through structured communication protocols, shared care plans, and regular team meetings—can lead to more coherent, patient-centered care. This level of organization can prevent gaps in service delivery, reduce redundancy, and ensure that caregivers receive consistent information, ultimately improving both care quality and caregiver satisfaction.

Additionally, investment in provider training and development is essential. Targeted education focused on teamwork, cross-disciplinary communication, and care planning for complex cases, like dementia, can significantly enhance coordination skills (Polit & Beck, 2021). When health care professionals are better equipped to work collaboratively, patient outcomes are likely to improve, and caregivers may feel more supported and less overwhelmed. These findings suggest that interprofessional education should be a strategic priority within health systems seeking to improve quality of care and reduce caregiver burden.

Positive Social Change

Beyond individual practice, the results of this study suggest a broad potential for positive social change at multiple levels. At the individual level, improved coordination among health care providers can enhance the quality of life for individuals with dementia by ensuring they receive timely, appropriate, and well-integrated care. Effective care planning not only improves clinical outcomes but also maintains patient dignity and autonomy, which are particularly important in neurodegenerative conditions (Polit & Beck, 2021).

At the family level, reduced caregiver stress can significantly improve the emotional and physical well-being of those providing care. When caregivers are less burdened, they are better able to maintain their own health, sustain their caregiving roles, and foster more positive relationships with their loved ones.

At the organizational level, health care systems that adopt coordinated care models stand to benefit from increased efficiency and improved resource utilization. Enhanced collaboration can reduce duplication of services, streamline workflows, and promote accountability across care teams, leading to better overall system performance.

Finally, at the societal and policy levels, the study's findings can inform public health strategies and legislative efforts aimed at supporting caregivers and improving care for aging populations. Policymakers could leverage this evidence to advocate for funding, workforce development, and incentives that promote interprofessional collaboration and caregiver support programs. Such efforts would contribute to a more sustainable and equitable health care system capable of meeting the growing demands of dementia care.

Conclusion

This study underscores the critical role that health care provider coordination plays in enhancing care quality for individuals with early onset dementia and alleviating the stress experienced by their caregivers. The findings demonstrate that even modest improvements in coordination can yield meaningful benefits, as reflected in the statistically significant associations between provider collaboration, perceived care quality, and caregiver well-being. Although the observed correlations were moderate in strength, they contribute important empirical support to the growing recognition of interprofessional collaboration as a cornerstone of effective health care delivery.

Beyond the statistical outcomes, this study adds to the broader discourse on how health care systems can better support both patients and caregivers through integrated, team-based approaches. My recommendations for future research, particularly in the areas of longitudinal analysis, expanded variable sets, and use of a mixed-methods design, highlight pathways for building on this foundational work. Similarly, the practical implications emphasize the need for professional training, organizational reforms, and policy initiatives that prioritize coordination as a key strategy for improving outcomes.

Ultimately, this study affirms that coordinated care is not only a clinical imperative but also a social one. By addressing fragmentation in health care delivery, the caregiving experience can be enhanced, patient outcomes can be improved, and a more compassionate and responsive health care system can be promoted. These advancements stand to contribute meaningfully to positive social change, improving the quality of life for individuals affected by dementia and for those who care for them.

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Appendix: Additional Data Analysis

This appendix contains supplementary tables and figures that provide further details on the data analysis performed in this study. These additional analyses support the findings discussed in the main sections of the dissertation.

Table 1

Detailed Descriptive Statistics

Variable	N	Mean	Standard Devi	Minimum	Maximum
Healthcare Coordination (Q38)	1392	3.45	1.78	1	7
Quality of Care (Q35)	1392	2.85	1.21	1	5
Caregiver Stress (Q36)	1392	3.22	1.34	1	5

Figure 3

Distribution of Health Care Coordination Scores

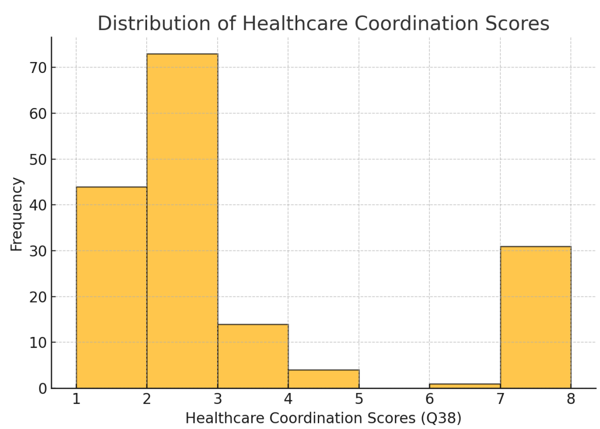


Figure 4

Distribution of Quality of Care Scores

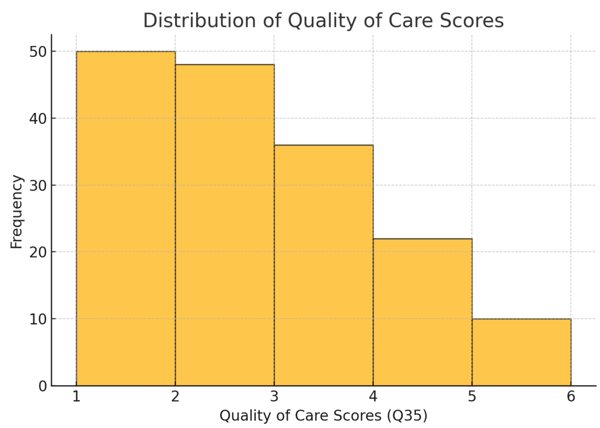
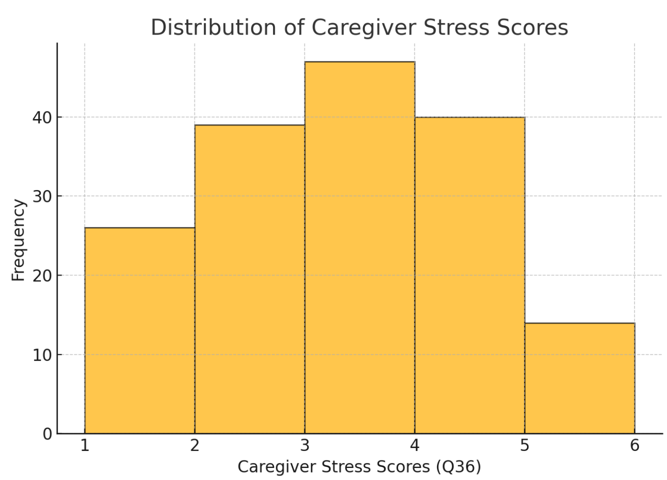


Figure 5

Distribution of Caregiver Stress Scores



Additional Notes:

- Table 1 provides detailed descriptive statistics for the key variables analyzed in the study, including the mean, standard deviation, minimum, and maximum values.

- Figures 3, 4, and 5 illustrate the distributions of the healthcare coordination, quality of care, and caregiver stress scores, respectively. These figures provide visual representations of the data distributions discussed in the results section.