As a cornerstone of case management, care coordination services are essential for ensuring optimal health outcomes, especially for patients with complex or chronic medical conditions who see multiple health care providers. The significant value of care coordination has been recognized by influential organizations such as the National Quality Forum (NQF), the Agency for Healthcare Research and Quality, and many other stakeholders.

ABSTRACT

Purpose of Study: Care coordination, traditionally the purview of the case management field, is recognized as a national priority for improving health care delivery and patient outcomes. With reforms of the Affordable Care Act (ACA) of 2010, case managers face new challenges and opportunities in providing care coordination services. The evolving roles of case managers as members of interprofessional care teams will be influenced by new policies that enable physicians to be reimbursed for care coordination. This qualitative study aimed to evaluate case managers’ self-assessed readiness for ACA reforms of care coordination and their perceptions of physicians’ understanding of case management and ability to lead care coordination efforts in evolving models.

Primary Practice Settings: Provisions of care coordination in the ACA affect case managers in all practice settings. The majority of this study’s participants represented hospital and managed care settings.

Methodology and Sample: An invitation to complete an 11-item online survey was sent by e-mail to 8,110 case managers in an opt-in database maintained by a health care continuing education company. Survey questions were designed to assess respondents’ (1) self-reported levels of knowledge and preparation for ACA care coordination provisions and (2) beliefs about the readiness and abilities of physicians to administer care coordination services. In addition, demographic data and open-ended comments regarding physicians’ roles in conducting care coordination were collected. Over a restricted 9-day period, 834 case managers representing various health care settings responded to the survey.

Results: The majority of respondents (63%) indicated that more than 50% of their day is dedicated to performing care coordination activities. However, 80% of all respondents reported being “not at all knowledgeable” or only “somewhat knowledgeable” about the new care coordination provisions in the ACA. Only 8% admitted to being “very prepared” to implement ACA changes. The majority of respondents (68%) perceive their case management departments to be at least “somewhat prepared” to implement necessary changes. Whereas 67% of respondents expect physicians to have at least a “moderate role” in implementing care coordination services, only 12% believe that physicians have more than “some” understanding of the processes of care coordination and case managers’ roles.

Implications for Case Management Practice: These qualitative study findings suggest that case managers from multiple practice settings perceive a lack of preparedness, knowledge, and understanding among themselves and physicians regarding ACA reforms that may significantly affect the delivery of care coordination services. The findings call for new initiatives in interprofessional education to address the knowledge gaps and enhance understanding of the collaborative roles among case managers and physicians.

Key words: Affordable Care Act, care coordination, health care reform

Are We Prepared for Affordable Care Act Provisions of Care Coordination? Case Managers’ Self-Assessments and Views on Physicians’ Roles

Kathleen Moreo, RN-BC, BSN, BHSA, CCM, Cm, CDMS, Natalie Moreo, BS, BA, Frank L. Urbano, MD, FACP, Matthew Weeks, MA, and Laurence Greene, PhD

Address correspondence to Kathleen Moreo, RN-BC, BSN, BHSA, CCM, Cm, CDMS, PRIME Education, Inc., 8201 W McNab Road, Tamarac, FL 33321 (k.moreo@primeinc.org) or Laurence Greene, PhD, PRIME Education, Inc., 8201 W McNab Road, Tamarac, FL 33321 (l.greene@primeinc.org).

The authors report no conflicts of interest.

DOI: 10.1097/NCM.0000000000000004
involved in quality of patient care initiatives (NQF, 2010; Agency for Healthcare Research and Quality, 2011). Under the Affordable Care Act (ACA) of 2010, care coordination services have gained an especially prominent role in our health care system, becoming the focal point of accountable care organizations and the patient-centered medical home model. The ACA provides distinct billing codes for coordinated care services received by patients enrolled in Centers for Medicare & Medicaid Services (CMS) programs. Billable services include discussing care plans with patients, arranging community support, facilitating transitions of care from inpatient settings, and implementing strategies for preventing readmissions. The ACA provisions support the participation of physicians in care coordination services in emerging models such as accountable care organizations and patient-centered medical homes (American Medical Association, 2013; see Side Bar 1).

Effective 2014, the current CMS rule provides payment to physicians conducting primary care management services as part of face-to-face visits with patients (CMS, 2013). Under proposed CMS policy and payment changes in the Medicare physician fee schedule, the CMS intends to make further strides in 2014 to pay physicians for more complex care coordination services effective in 2015. The proposed rule would provide a separate Medicare payment for non-face-to-face complex chronic care management services for Medicare patients with at least two chronic conditions. The proposed rule includes requirements for a care management plan by the physician that encompasses components of care plans utilized by case managers. These elements include ongoing review and revisions to the plan of care, interprofessional communications with the treatment team, and medication management. Under the proposed payment, a single practitioner would provide the care management services with a maximum 90-day reimbursement, and eligibility criteria would include having the patient’s consent to receive services over a 1-year period as well as to attend annual wellness visits. The practitioner would also be required to have access to electronic health records that meet Department of Health and Human Services certification criteria. The practitioner must also demonstrate having written protocols/processes to successfully implement care management services, such as steps for monitoring the patient’s medical and functional needs. The anticipated effective date for the proposed CMS rule is January 1, 2014.

Whereas care coordination has traditionally been the purview of case managers, impending ACA changes afford opportunities for greater involvement of physicians as leaders of interprofessional

---

**SIDE BAR 1**

- The ACA calls for “…improved health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model.” (Patient Protection and Affordable Care Act [PPACA], 2010a)
- The ACA also calls for “…a payment structure that provides increased reimbursement or other incentives” for the activities above and for those that “prevent hospital readmissions…_improve patient safety and reduce medical errors.” (PPACA, 2010b)
- Through the ACA, states are called to negotiate “premiums, cost-sharing… and benefits… with offerors of a standard health plan for the inclusion of... care coordination and case management, especially for those with chronic health conditions.” (PPACA, 2010c)
- Also under the ACA, Title XIX of the Social Security Act was amended to include a new section delineating the delivery of “comprehensive case management, care coordination... and transitional care” to individuals with chronic conditions by “a team of health care professionals,” including physicians, nurse care coordinators, and other health professionals. (PPACA, 2010d)

Such care coordination provisions as listed above are delineated under the ACA for dual-eligible patients, Medicare Advantage patients, individuals who will be participating in health insurance exchanges or alternative state programs, patients receiving care from ACOs and PCMHs, and other patient groups. Undoubtedly, provisions for care coordination and extended case management services under the ACA are far reaching, affecting systems and patients across the nation.

---

*Excerpts from the affordable care act: Provisions for case management and care coordination. ACA = Affordable Care Act; ACOs = accountable care organizations; PCMHs = patient-centered medical homes.*

---

Copyright © 2014 Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.
care teams. The potential for this evolving model to achieve its promise depends in part on awareness and understanding of impending ACA reforms and evolving interprofessional roles in administering and providing care coordination services. Misunderstandings and role ambiguities will clearly undermine desired goals of enhancing health care delivery and quality, controlling costs, and ultimately improving patient outcomes (Sminkey, 2011).

To our knowledge, no formal study has been performed to assess levels of understanding and preparedness regarding ACA provisions for care coordination services among case managers. We thus conducted a survey to gain insights into case managers’ perspectives on their current knowledge and readiness for impending reforms as well as their beliefs and attitudes toward the potential roles of physicians.

METHODS

We developed an 11-item survey that included three questions asking case managers to self-assess their levels of knowledge and preparation for ACA provisions of care coordination. An additional four questions addressed case managers’ views on the roles, understanding, and interprofessional responsibilities of physicians in emerging care coordination models. These seven questions, along with their Likert scale measures, are presented in Figures 1–7. The survey also included items for indicating case management settings, years in practice, and extent of daily time devoted to providing care coordination services. A free-response item asked case managers to comment on the roles and capabilities of physicians in conducting care coordination in new models.

On August 22, 2013, the online survey was sent by e-mail to case managers (n = 8,110) who have opted in to receive communications and are registered in the learning management system database of PRIME Education, Inc., a national health care continuing education company. Recipients were invited to complete the survey by August 30, 2013.

Chi-square tests were performed to analyze the statistical reliability of differences in response frequencies for key comparisons. A p value less than .05 was considered significant.

RESULTS

By the closing date, 834 surveys were returned (overall response rate = 10.3%). All 834 case managers answered the first question in the survey; however, the number of responses varied for the remaining questions. Thus, the sample size for each question is indicated in the following tables and figures. The majority of respondents indicated that they work in managed care (42%) or hospital (20%) settings (see Table 1). As presented in Table 2, 63% reported that more than 50% of their day is dedicated to performing care coordination activities. Professional experience in case management ranged from 2 to 25 years (mean = 12 years; n = 37).

Self-Assessments of ACA Knowledge and Preparation

Case managers reported their extent of knowledge about ACA provisions for care coordination on a scale of 1 (not at all knowledgeable) to 5 (very knowledgeable). As shown in Figure 1, 54% of respondents indicated knowledge at Level 1 or 2, whereas only 20% reported Level 4 or 5 (p < .0001). Respondents indicated their readiness to implement ACA changes on a scale of 1 (not at all prepared) to 5 (very prepared). Significantly more case managers indicated low levels (1 or 2; 41%) versus high levels (4 or 5; 23%) of preparation (p < .0001; see Figure 2). In assessing the preparation of their case management
Perceptions of the Readiness and Roles of Physicians

The survey asked case managers to predict the extent of physicians’ involvement in implementing care coordination services under the ACA in the next 2 years. As shown in Figure 4, the response rates were 7% for “no role,” 38% for “moderate role,” and 13% for “primary role” ($p < .0001$). The majority of respondents (93%) perceived that physicians are, at most, only “somewhat comfortable/confident” in providing care coordination services for patients under the new legislation (see Figure 5). As shown in Figure 6, 88% responded that physicians have, at best, only “some understanding” of the role of case managers and the processes of care coordination. Case managers indicated their views on whether they would work directly under physicians in the next 2 years, assisting...
Negative

- Physicians will not have the time, knowledge, or experience needed to conduct adequate care coordination.
- Care coordination is a skill that requires time and commitment to events outside the patient's body. Medical school only focuses on care coordination within the body.
- Physicians spend limited time with patients. This behavior will be difficult to modify.
- This is a role I see as the responsibility of case managers.
- Physicians will only make time if legally required. Physicians are too busy unless they hire a case manager to take care of care coordination.
- Physicians simply view this task as "one more thing to do."
- Most physicians do not think this is a part of their job. Therefore, they will require significant guidance.
- Physicians have no experience with case management and have little understanding of the community or alternative resources available to patients. They are highly unlikely to take the time to research or problem-solve for patients that require it.
- Physicians do not have the time to coordinate care with patients, nor are they aware of recent Medicare guidelines.
- I do not believe physicians will place too much effort on care coordination. The care will be fragmented and the service will be reactive instead of proactive. Physicians will rely heavily on hospital care coordination services and attempt to find ways for their hospital partners to provide this service.
- This is a specialized role that physicians are not prepared to do in most instances.
- Physicians are sometimes not aware of the resources available.

Positive

- It is a great idea to have case managers working directly with physicians. This should have happened long before the ACA was implemented.
- Best case scenario, all physicians will have a case manager in their office.
- The more physicians conduct care, the more money they will make.
- Any change is difficult in the beginning. Once physicians see this is a necessary transition, it will go smoother.
- If physicians are given the time to learn more about the intricacies of care coordination, it can work well in the long run.
- It has always been the nurse’s role to be a liaison between physicians and patients. All of the future changes in health care will require a higher level of accountability and thus, an increased awareness for each role we take on.

FIGURE 8
What are your thoughts about physicians conducting care coordination?

Physician Commentary: Frank L. Urbano, MD, FACP, Medical Director of Care Management, Albert Einstein Medical Center, Philadelphia, PA

With the signing of the Affordable Care Act (ACA) into law in 2010, as well as its ongoing implementation, the importance of comprehensive care coordination has reached a level not seen in the collective lifetime of this discipline. For patients with chronic illnesses, care coordination may impact clinical outcomes, inpatient readmissions, medication adherence, and patient satisfaction, as well as the fiscal solvency of health care organizations. Effective care coordination efforts should, therefore, involve a multidisciplinary team, including nurses, case managers, pharmacists, patient educators, social workers, and physicians. While the
approach toward effective multidisciplinary care may appear intuitive, it is important to ensure that all members of the team are operating on a level playing field. Unfortunately, in many instances, the traditional “team leader”—the physician—may be the most ill prepared to manage the team’s collective efforts; however, as these efforts continue to be the focus of many ACA provisions, the physician’s role in this process has never been more important.

With this in mind, what is the best way to engage physicians in care coordination reform? The most effective organizational approach involves one key feature: Physicians must be involved in the process at each step of the way. First, identifying populations to be targeted with care coordination efforts is vitally important, and the physician should be deeply involved in this process. While it may seem altruistic to want to coordinate the care and impact outcomes of all patients, this is neither realistic nor practical. Thus, a specific organizational focus must be developed. For example, one organization might choose to focus on a specific patient type, such as high emergency department utilizers; alternatively, another organization might focus on a specific disease state, such as diabetes. Whatever areas are chosen for the organization’s initial focus, the physician’s expertise will be necessary for success in this phase of the process.

Once the focus is chosen, the next step is to design the program components. As the program is designed, important considerations, such as staffing of the care coordination model, the types of interventions carried out, and the intensity of the contact between providers and patients, must be addressed. Best practices from the literature or comparable models from other health systems may be utilized to develop program components. Although it might seem less important for the physician to be involved in program design, the contrary is true, because physicians will likely be leading the efforts of the chosen approach. Effective outcomes depend on leaders clearly understanding their roles along with those of the interprofessional health care team.

As the project is rolled out, ongoing monitoring for effectiveness can be achieved through careful data collection from outcome-specific interventions. For example, a care coordination model that focuses on diabetes might measure glycemic control, the rate of screening eye and foot examinations, and medication compliance. During this process, the physician’s participation can ensure that the correct measures are selected, the data are interpreted correctly, and the program processes are reevaluated and adjusted as necessary to achieve the desired goals.

Finally, as the program has reached a steady state, the physician(s) involved in the process can work to design and implement ongoing care coordination efforts. This might include different measures of program effectiveness within the current area of focus or entirely new areas that impact other populations. Physicians can help in analyzing population health data to select the most appropriate approach moving forward, as well as recommending organizational changes to achieve newer goals created in the evolving program structure.

As has been outlined previously, the involvement of the physician in the design and implementation of care coordination efforts at multiple steps during the overall process is essential. While it may seem that this merely involves obtaining physician buy-in, the scope of the physician’s involvement must be far greater. If active and ongoing participation by physicians in the ACA’s care coordination efforts occurs, the outcomes will mirror that of a successful voyage; without the physician’s involvement, the result may be a failure of “titanic” proportions.

### Table 1

<table>
<thead>
<tr>
<th>Health Care Setting</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed care</td>
<td>42</td>
</tr>
<tr>
<td>Hospital</td>
<td>20</td>
</tr>
<tr>
<td>Workers compensation</td>
<td>9</td>
</tr>
<tr>
<td>Military or government</td>
<td>4</td>
</tr>
<tr>
<td>Integrated delivery system</td>
<td>3</td>
</tr>
<tr>
<td>Clinic/community</td>
<td>3</td>
</tr>
<tr>
<td>ACO or PCMH</td>
<td>2</td>
</tr>
<tr>
<td>Employer</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation or long-term care</td>
<td>1</td>
</tr>
<tr>
<td>Home care</td>
<td>1</td>
</tr>
<tr>
<td>Academia, education, and research</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
</tbody>
</table>

Note: ACO = accountable care organization; PCMH = patient-centered medical home.

### Table 2

<table>
<thead>
<tr>
<th>Providing Care Coordination</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 90%</td>
<td>23</td>
</tr>
<tr>
<td>71%–90%</td>
<td>20</td>
</tr>
<tr>
<td>51%–70%</td>
<td>20</td>
</tr>
<tr>
<td>31%–50%</td>
<td>16</td>
</tr>
<tr>
<td>11%–30%</td>
<td>7</td>
</tr>
<tr>
<td>Less than 10%</td>
<td>14</td>
</tr>
</tbody>
</table>
While the approach toward effective multidisciplinary care may appear intuitive, it is important to ensure that all members of the team are operating on a level playing field. Unfortunately, in many instances, the traditional “team leader”—the physician—may be the most ill prepared to manage the team’s collective efforts; however, as these efforts continue to be the focus of many ACA provisions, the physician’s role in this process has never been more important.

**DISCUSSION**

The notion of care coordination as a viable part of effective health care delivery has been a national priority for several years. The NQF endorsed a definition and framework for care coordination in 2006 and, in 2010, released a portfolio of preferred practices and performance measures intended to delineate the structure, process, and outcome measures required to assess progress toward care coordination goals (NQF, 2010). The NQF (2010) identifies care coordination as “a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.”

As a result, care coordination models are evolving in several levels of care delivery across payer and provider settings with outcomes aimed at improving health care quality, patient outcomes, and cost containment—goals long associated with case management. Under health care reform, case management has become a team sport with a new scorecard, and the ACA is the game changer. In the near future, case managers may become coaches of an interprofessional team led by physicians who can achieve proficiency in care coordination. Through care coordination proficiency, patient outcomes will be improved and reimbursement will be maximized (Jeffers & Astroth, 2013).

Historically, interprofessional care coordination has been a key tenet of the Standards of Practice for Case Management (Case Management Society of America, 2010), first introduced in 1995. The most recent update to the Standards in 2010 expands the interdisciplinary team in planning care for individuals and recognizes the key role of the physician. The new after-ACA case management scorecard will track benchmark performance standards and quality measures that will fundamentally affect case management as a value proposition. As certified clinically licensed health care professionals adhering to national practice standards and ethical guidelines, many case managers are in a strong position to identify and develop the roles of physicians and other key stakeholders in new care coordination models across the health care continuum.

Are we ready? Results from the PRIME survey of 834 case managers suggest that most case managers are not sufficiently aware of new care coordination provisions promulgated under the ACA. Notably, theorists in adult education propose that the fundamental first step in practice change among adults involves promoting awareness. This is followed by agreement, adoption, and adherence in practice (Davis et al., 2003; Pathman, Konrad, Freed, Freeman, & Koch, 1996). The survey also suggests that case managers lack awareness of health care reform changes involving care coordination across different practice settings. Although the greatest percentage of survey respondents work in managed care and hospital settings, this is generally proportionate to the number of case management jobs in these type settings, indicating a representative sample of case manager opinions. Not surprisingly, a majority of survey respondents (63%) across practice settings indicated that at least 50% of their day is typically dedicated to providing care coordination for patients. Twenty-three percent of respondents indicated that more than 90% of their day is consumed by care coordination, whereas 20% responded that 71%–90% of their day is dedicated to these services. Thus, the survey respondents have a collective wealth of experience in providing care coordination.

The survey revealed low levels of self-assessed awareness and preparation for implementing ACA changes. Among 708 respondents, 41% indicated that they are poorly prepared to implement changes necessary to improve patient and system outcomes as a result of the ACA and its focus on care coordination; only 23% indicated that they are moderately or very prepared to implement changes. These findings support a call for continuing education aligned with Pathman’s model of knowledge transformation, in that enhancing awareness can engender agreement and adoption (Pathman et al., 1996).

The new era of quality reform emphasizes payment for value instead of volume (Jeffers & Astroth, 2013), and health care delivery systems will need to implement changes in their care coordination models to maximize reimbursement. Integrated care will likely be linked to performance and quality outcomes.
measures, which will be linked to payment models. Favorable outcomes will depend on development of best practices for care coordination and resource utilization that will significantly involve physicians (Maddux, McMurray, & Nessenson, 2013). Evolving models include embedded care management, in which case managers work side by side with primary care physicians in their practices to facilitate and maximize care coordination interventions (Hines & Mercury, 2013). When considering systems-based preparedness, 34% of 578 respondents indicated that their case management departments are moderately or very prepared to implement changes, although 32% indicated that their case management departments are poorly prepared (Level 1 or 2 on the 5-point Likert scale).

The case managers who responded to the survey perceived physicians to have relatively low levels of comfort and confidence in providing care coordination services under ACA reforms. In addition, the great majority of respondents indicated that physicians do not have a strong understanding of the role of case managers and the processes of care coordination. In order for new case management roles and models, such as embedded case management (Hines & Mercury, 2013), to be effective, physicians will clearly need to understand case managers’ roles, especially in providing care coordination services. Case managers have been identifying and improving care coordination processes for decades. To assess the physician’s ability to recognize case managers as effective allies in care coordination, Pathman’s model suggests that physicians will first need to be aware of the role of case management. These findings highlight the need for interprofessional education about roles in care coordination; this form of continuing education occurs when practitioners from two or more health care disciplines learn with, from, and about each other (Hammick, Freeth, Koppel, Reeves, & Barr, 2007).

The majority of respondents indicated that, consequent to ACA reforms, case managers are at least somewhat likely to work directly under physicians to assist with care coordination services for which physicians will bill for reimbursement. Regardless of apparent or perceived lack of knowledge among physicians pertaining to care coordination, changes under the ACA will require physicians to learn quickly and engage experts in care coordination in order to maximize reimbursement opportunities.

Several methodological limitations and potential biases of this survey study are noteworthy. The low response rate (10.3%) raises questions about whether the sample adequately represents the U.S. population of practicing case managers. The response rate may be partly explained by limitations of the database from which case managers were identified. The database includes contact information for individuals who, over many years, have opted into a mailing list for updates on health care education programs. We were not able to determine whether all 8,110 individuals who are identified as case managers in the database are currently practicing in the field. Despite the low relative response rate, however, the absolute number of respondents (n = 834) is fairly high, supporting the statistical reliability of the findings. In addition, a large percentage of respondents indicated devoting significant amounts of daily time to performing care coordination services. Given familiar anecdotal reports of gaps in knowledge and readiness regarding ACA reforms among U.S. health care professionals, our results may be viewed as representative.

Because all respondents did not answer every survey question, the findings for selected questions may have been influenced by response biases. The survey’s two open-ended questions, which asked for years of experience in case management and opinions about the readiness of physicians to conduct care coordination, yielded the fewest responses, 37 and 28, respectively. The low number of respondents indicating years in practice precluded a planned analysis to determine whether self-assessed knowledge and preparation for ACA reforms might vary with case management experience.

The survey findings should be taken at face value as self-reported, qualitative measures, beliefs, and attitudes. Nonetheless, we believe that the outcomes are relevant reflections of important gaps in the field of case management.
CONCLUSION

This study may contribute a call to action for case management associations and certifying bodies to implement interprofessional educational programs on provisions for care coordination in emerging models associated with ACA reforms. Study results may be considered by health care organizations intending to align their case management departments and services with health policy changes or to expand their models of care coordination. At the individual professional level, case managers can take a lead role in providing guidance and expertise to their employers and stakeholders regarding best practices in care coordination.

REFERENCES


Patient Protection and Affordable Care Act, 42 U.S.C. § 18001. (2010d). Title II. Role of Public Programs. Subtitle I: Section 2703. State option to provide health homes for enrollees with chronic conditions.


Kathleen Moreo, RN-BC, BSN, BHSA, CCM, CM, CDMS, is President and CEO of PRIME Education, Inc., a national continuing education health care company. She is a past president of CMSA and has authored many peer-reviewed journal articles as well as online and print books in case management and care coordination.

Natalie Moreo, BS, BA, is a 4th-year medical student at Ross University School of Medicine. She has been involved in qualitative medical research as well as the development of graduate medical education supplementary curricula for residents.

Frank L Urbano, MD, FACP, is Medical Director of Care Management at Albert Einstein Medical Center and Assistant Professor of Medicine at UMDNJ-Robert Wood Johnson Medical School. He also serves as Lead Physician Planner for PRIME Education, Inc.

Matthew Weeks, MA, is Medical Editor and Writer at PRIME Education, Inc. He is responsible for the editorial accuracy of PRIME’s programs and ensuring the validity of all scientific communications. In addition to analyzing health care trends through survey research, he also develops content for various continuing education programs.

Laurence Greene, PhD, is Director of Scientific Education and Outcomes at PRIME Education, Inc. His position involves designing surveys for assessing educational outcomes and health care trends. He is a coauthor of many continuing education programs on care coordination.