



ABIM
FOUNDATION
FORUM

MAY 2008

FROM FORUM TO FUNCTION
Bringing Care Coordination Home



May 2008

The 2007 ABIM Foundation Forum, “[Coordination of Care: Missed Opportunity?](#)” brought together more than 120 influential leaders from all sectors of health care. We were delighted that you took part in the Forum and shared your meaningful insights with each other. Together, you discussed successful models, organizational strategies and structural and financial changes needed for the health

care system to improve care coordination. At the Forum, we issued a challenge to each other – take the lessons learned from the discussion and apply them to our educational, research, advocacy and practice efforts.

How are participants continuing to address the issue of care coordination? In February 2008, the ABIM Foundation staff followed up with participants and asked the following questions:

1. Since Forum 2007, what has been implemented in your practice to influence coordination of care?
2. What specific action steps have been taken and who was involved in the implementation of these changes?
3. Were there any outcomes as a result of these actions? If so, please describe.

We have learned that many of you used the information from the Forum to inform your ongoing educational, research, advocacy and practice activities. The comments you shared with us are presented in this document.

Another noteworthy outcome of the 2007 Forum is that an adaptation of the Kimball Lecture presented by Thomas J. Bodenheimer, MD, “[Coordinating Care – A Perilous Journey through the Health Care System](#),” appeared in the March 8, 2008 issue of the *New England Journal of Medicine*. Dr. Bodenheimer’s important article captures the issues around coordination of care that are so important to our current and continuing work.

On behalf of the ABIM Foundation, I again want to thank you for joining us at the 2007 Forum and engaging in a discussion of coordination of care.

I look forward to hearing from you and communicating with you as the ABIM Foundation continues to focus on this important and vital area of care delivery.

Sincerely,

Christine K. Cassel, MD
President & CEO
ABIM & ABIM Foundation

JOHN A. BENSON, JR.

President Emeritus, ABIM
Professor of Internal Medicine
University of Nebraska
Medical Center


In February 2008, University of Nebraska Medical Center students from all five colleges (nursing, pharmacy, dentistry, medicine and allied health professions, and public health) underwent an afternoon of interprofessional discussion of two quality issues: poor hand-washing and poor communication. The planning had been by a large interprofessional faculty and student committee, and an analysis of results is forthcoming. Dr. Benson also co-chaired a large task force appointed by the Nebraska Medical Association, which has developed and published recommendations for comprehensive health care reform. Among the task force's recommendations is the implementation of insurance fostering the "medical home" concept of coordinated care.



JOHN TOOKER

Executive Vice President and
Chief Executive Officer
American College of Physicians

The Transitions of Care Consensus Conference (TOCCC) paper has been approved by the boards of six organizations: American College of Physicians (ACP), Society of General Internal Medicine (SGIM), Society of Hospital Medicine (SHM), American Geriatrics Society (AGS), American College of Emergency Physicians (ACEP) and Society for Academic Emergency Medicine (SAEM). The Stepping Up to the Plate (SUTTP) document served as a beginning point for the conference and most of the principles in the SUTTP were reaffirmed by the TOCCC. The paper will be submitted for publication, and the AMA's Physician Consortium for Performance Improvement® (PCPI) has started a work group that will be co-chaired by ACP and SHM and will include representation from all of the organizations that signed on to the TOCCC.



CLARION JOHNSON

Medical Director
Global Medicine and Occupational Health
ExxonMobil

Dr. Johnson reports that, "the hospitalist concept changed my approach to evaluating hospitals." As a result, he now includes hospitalists in his hospital screening profile for purchasing of hospital services.

FORUM GOAL 1

"Increase awareness of the problems patients with multiple chronic medical conditions face when receiving care in the United States."

JOHN G. HAROLD

ABIM Board of Directors
Past Chief of Staff and
Member Board of Directors
Cedars-Sinai Medical Center

Dr. Harold is working with Cedars-Sinai Health System and their Enterprise Information Services to facilitate deployment of low-tech strategies for care coordination, including more effective utilization of secure e-mail between referring physicians. He is also working to improve communications with referring physicians and more clearly define rules of engagement.

JOEL S. LEVINE

Professor of Medicine
Division of Gastroenterology -
Hepatology
Senior Associate Dean of
Clinical Affairs
University of Colorado School
of Medicine

As a consequence of his Forum presentation, the University's primary care group negotiated a contractual relationship with their endocrinologists on the co-management of care transitions in patients with diabetes.

CHARLES KILO

CEO
GreenField Health

GreenField Health has initiated a community discussion among various physicians representing different physician groups about how they work together. GreenField has also continued implementation of a community-wide practice and physician secure e-mail communication system. They have also developed an automated electronic feed from several laboratories and radiology centers in their community directly into their electronic health record.



DOUGLAS WOOD

Vice President
Department of Medicine
Mayo Clinic College of Medicine

Mayo Clinic College of Medicine has developed an improved hand-off process back to the primary care physician or the referring physician outside Rochester and communication tools for patients and physicians. They are also undertaking a collaboration with regional skilled nursing facilities, in partnership with StratisHealth (Mayo's quality improvement organization) to reduce the frequency of re-admissions and emergency room visits after hospitalizations. For outpatient care, Mayo is creating a standardized episode summary visit and communication tools, including direct access to the Mayo record for non-Mayo physicians and new packets for patients to manage their summaries and medication lists. Mayo is anticipating results later this year on metrics such as reductions in deaths, readmissions and emergency department visits after hospitalization.

HOLLY J. HUMPHREY

ABIM Foundation Board of Trustees
Dean for Medical Education
University of Chicago

The University of Chicago's Urban Health Initiative seeks to coordinate care for patients living on Chicago's south side. The project has used focus groups from the community and has community members on their advisory board. Dr. Humphrey notes that care coordination remains a huge challenge and "there are profound rate-limiting steps in the equation when patients are uninsured or are poorly insured."

FORUM GOAL 2

"Examine successful practice models of coordinated care and their effects on quality and cost."

JANET M. CORRIGAN

President and CEO
National Quality Forum

The National Quality Forum (NQF) has launched a care coordination initiative: their Spring Implementation Conference is devoted to care coordination; each of their member councils will develop action plans for improving care coordination; and NQF hopes to start a consensus development project to endorse best practices and more care coordination measures. Also, NQF is working in partnership with 27 other national organizations to establish national priorities and goals for quality improvement, which will likely have an emphasis on care coordination.

VIRGINIA TILDEN

Dean and Professor
University of Nebraska
Medical Center
College of Nursing

Dr. Tilden has spoken frequently in many venues about the Forum and about the importance of care coordination to the quality and outcomes of patient care. She is also active in the Institute for Healthcare Improvement (IHI) Health Professions Education Collaborative (HPEC) and within that work has championed interprofessional training at her university. According to Dr. Tilden, "My goal is that the next generation of trainees will be vastly more insightful about and proficient in care coordination. The Forum did an excellent job of moving us to this goal."

JOSEPH STANKAITIS

Chief Medical Officer
Monroe Plan for Medical Care

The Monroe Plan has moved forward to facilitate and support physician practices in obtaining the National Committee for Quality Assurance (NCQA) Diabetes Physician Recognition Program designation. Since August, the Rochester area now has 11 primary care physicians with this designation. The Plan is also exploring how to support the patient-centered medical home concept.

NETTIE ENGELS

Member, Patient Advisory Council
and Family Faculty
Medical College of Georgia

As a family faculty member at Medical College of Georgia (MCG), Ms. Engels has spoken to four groups of first-year medical students, one class of clinical nurse managers and two classes of critical care nurses about the Forum, and she challenged them to be a part of the solution in developing a practical, reliable method of coordinating care on a small scale which could then be expanded. Ms. Engels also serves as a patient advisor with the Physicians Practice Group (PPG) at MCG. She presented an overview of the Forum and the group accepted her recommendation that care coordination be added to the PPG's agenda.

MARTÍN J. SEPÚLVEDA

Vice President,
Global Well-being Services
& Health Benefits
IBM Corporation

IBM Corporation is continuing their care coordination program with five health plans in their regional IBM markets. Patient response to the program has been the most positive of any clinical care intervention in their portfolio. They are currently evaluating a number of coordination outcome measures, including patient comments and surveys, and process measures including time to contact a patient discharged from an inpatient institution.

DONALD GOLDMANN

Senior Vice President
Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI)'s "portfolio of work, as well as our repertoire of expert faculty, has grown considerably since the Forum, in part because of the passion, ideas and contacts I brought back," reported Dr. Goldmann. The Forum gave Dr. Goldmann a greater appreciation for caregivers and their role.

FORUM GOAL 3

"Identify strategies to create the needed structural and financing changes to support radical improvements in care coordination."

BERTHA SAFFORD

Medical Director of Quality Performance
Family Care Network

The Family Care Network continues to expand the number of their service agreements. In addition, they are piloting a program where consultant notes are delivered directly to an electronic medical record via secure Web-based e-mail. They hope these changes will result in better coordination and communication with their consultants.

GREGORY W. ROUAN

Richard W. and Sue P. Vilter
Professor of Clinical Medicine
Associate Chair for Education
Department of Medicine
University of Cincinnati
College of Medicine

The University of Cincinnati (UC) Division of Resident Ambulatory Practice has now implemented an electronic medical record, which will help coordinate the care of all patients to include those admitted to the hospital. Processes are being developed to include contacting admitted patients subsequent to their discharge to ensure that each has a visit to the practice. They will continue to track re-admission rates as well as unplanned emergency department visits. UC continues to collaborate with other Educational Innovations Project (EIP) sites by examining hand-offs and other inpatient transitions of care.



LAWRENCE G. SMITH

ABIM Board of Directors
Dean
North Shore-Long Island
Jewish Health System

Dr. Smith distributed a white paper to the medical director at each of the system's 15 hospitals regarding responsibilities of attending physicians and consultants and asked for an outline of their initiatives to improve coordination of care. A select group of medical directors then presented their initiatives to the System Medical Executive Committee. A document titled "Who's In Charge?" outlined the initiatives and includes a list of proposed measurements. The System Medical Executive Committee selected five measures to prioritize and track.



JOSEPH E. CRAFT

ABIM Board of Directors
Professor
Yale University School of Medicine

Dr. Craft is working to hire a nurse practitioner to aid in care coordination for his academic section's clinical activities.

FORUM GOAL 4

"Identify and coordinate the role of organizations that can foster changes in care coordination."

JOHN ROTHER

Director
Legislation and Public Policy
AARP

AARP has made chronic care coordination from the patient's perspective the subject of a major new research initiative, results of which are to be published this year. AARP is also supporting the medical home concept within Medicare, and has focused on the needs of chronic patients in the design of a new Web-based decision support tool, which will be implemented this year.

LARRY WELLIKSON

Chief Executive Officer
Society of Hospital Medicine

The Society of Hospital Medicine (SHM) has been an active participant in The Transitions of Care Consensus Conference (TOCCC) and Stepping Up to the Plate (SUTTP). The SHM Board has recently endorsed the reports of both of these groups. SHM is now actively working with AMA's Physician Consortium for Performance Improvement® (PCPI) on a process to develop standards and measures for transitions of care. Additionally, SHM has a grant from the Hartford Foundation to develop discharge planning tools to ensure improved transitions of patients from the hospital to the outpatient environment. Technical support programs for the toolkit were launched in April 2008.

ROBERT M. WACHTER

ABIM Board of Directors
Professor and Associate Chair
University of California,
San Francisco

University of California, San Francisco (UCSF) began hospitalist co-management of their neuro-surgery patients in an effort to improve coordination. When asked if "hospitalists improve the coordination and quality of care," nurses overwhelmingly agreed – giving the question a score of 4.88 (on a 1-5 scale). UCSF is preparing results for publication.



LEWIS SANDY

Senior Vice President
Clinical Advancement
UnitedHealth Group

Dr. Sandy reported that the Forum gave him insight into the problems related to care coordination, potential solutions and the maturation of the hospitalist movement. This information has informed the ongoing evolution of UnitedHealth Group's care coordination and disease management programs, as well as their hospital discharge to home transition program, Welcome Home. UnitedHealthcare has also further developed the Patient-Centered Medical Home™ model in collaboration with the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Osteopathic Association (AOA) and American Academy of Pediatrics (AAP) and has been one of the leaders in the broader Patient-Centered Medical Home™ collaborative initiated by IBM Corporation and others. UnitedHealthcare has also revamped its approach to inpatient medical management, focusing on the risks of transition from hospital to home, and has reduced re-admission rates.

TROYEN A. BRENNAN

ABIM Foundation Board of Trustees
Senior Vice President and
Chief Medical Officer
Aetna Inc.

Aetna has deployed a new clinician desktop (ATV) for medical management programs and launched a Case Management module at the end of 2007. ATV presents all relevant member information in a 360° view, providing a comprehensive member profile for planning, and it delivers a toolbox for use by clinicians. Aetna has also enhanced its disease management program by adding pediatric hypertension and obesity. Aetna has focused on improving engagement rates through multiple channels by implementing Healthy Lifestyle Coaching. This program provides participants with one-on-one support from a primary health coach for the purpose of making one or more lifestyle changes related to quitting tobacco, managing weight and stress, and/or improving physical fitness and nutrition. Aetna also has redesigned its maternity program (Beginning Right) to improve identification of pregnant members, stratify members by risk to ensure that high risk members receive focused care coordination, and has added postpartum outreach calls for depression screening.



KAREN DAVIS

President
Commonwealth Fund

The Commonwealth Fund continues to fund work on care coordination, including a commitment to a new initiative on helping safety net practices become patient-centered medical homes and an initiative to assist hospitals in reducing hospital re-admissions. They are also funding evaluations of patient-centered medical home initiatives in Rhode Island, New York and Louisiana. Dr. Davis added that the Fund is particularly pleased that the National Committee for Quality Assurance (NCQA)'s Physician Practice Connections® Patient-Centered Medical Home™ standards, developed with their support, are being used by Bridges to Excellence® to provide per-enrollee per-year compensation to practices meeting those standards.



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Cover and interior art: Sonia Delaunay-Terk, Rythme Couleur, 1969