Collaborating for care: Embedded case managers, extending care management value

Randall Krakauer, MD, FACP, FACR
Vice President, National Medical Director
Medicare Strategy, AETNA

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification
Agenda

• Welcome and Introductions

• Learning Objectives

• Patrice Sminkey, CEO, the Commission

• Randall Krakauer, MD, FACP, FACR, vice president, national medical director, Medicare strategy, AETNA

• Question and Answer Session
• There is no call-in number for today’s event. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the tab to the left of your screen. Please refresh your screen if slides don’t appear to advance.

• Please use the “chat” feature below the slides to ask questions throughout the presentations. We will pose questions after the presentation and will address as many as time permits.

• A recording of today’s session will be posted within one week to the Commission’s website, [www.ccmcertification.org](http://www.ccmcertification.org)

• One continuing education credit is available for today’s webinar only to those who registered in advance and are participating today.
After the webinar, participants will be able to:
• Describe the potential value of collaboration, specifically in Medicare Advantage programs;
• Explain how collaboration works to better align incentives and resources: What is important? What is the end game?
• Discuss the importance of care management and data;
• Explain the value of collaboration and the clinical team, including the role of dedicated embedded case managers; and
• Discuss the impact on quality, patient satisfaction, provider satisfaction and costs of such a program, and how it can support better care, better population health and lower costs.
Introduction

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification
• Webinars
• Certification Workshops
• Issue Briefs
• Speaker’s Bureau
Collaborating for care
Collaborating for care: Embedded case managers, extending care management value

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Vice President, National Medical Director
Medicare Strategy, AETNA
Aetna Medicare Physician Collaboration
Medicare Medical Management: “Round up the Usual Suspects”

Source: C. Hogan and R. Schmidt, MedPAC Public Meeting, Washington, DC, 18 March 2004. Based on a representative sample of FFS enrollees and all their claims. Beneficiaries may be in multiple categories. Spending is for all claims costs, including treatment of beneficiaries’ co-morbid conditions.
In the elderly, conditions occur in combination: cost and quality is driven by a population with multiple concurrent conditions.

### Chronic Conditions & Cost Distribution in Medicare Beneficiaries

<table>
<thead>
<tr>
<th>Chronic Co-Morbid Conditions</th>
<th>Percent of the Population</th>
<th>Percent of Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 4</td>
<td>20%</td>
<td>66%</td>
</tr>
<tr>
<td>3-4</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td>0-2</td>
<td>53%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: Medicare 5% Sample, 2001
Why Older Patients Require More Medical Management

Many factors make the impact of illness greater for an older patient than a younger patient with a comparable condition. All factors must be identified and managed.

**Factor**
- Prevalence of high-risk conditions
- Greater incidence of comorbidities
- Less identifiable symptoms
- Greater potential for damage from injury or condition
- Reduced ability to recover from injury or condition
- Less ability to follow a medical regimen
- Less family and social support

**Impact**
- Greater burden of disease
- Increased need for medical care
- Greater need for surveillance
- Increased need for condition management
- Greater need for preventive condition management
- Greater intensity of medical management
- Increased need for outside help
## Quality – Medical Management Approach

Enabling effective care of seniors with multiple conditions and reducing preventable hospital admissions

<table>
<thead>
<tr>
<th>Elements</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>- All new members receive a Health Risk Assessment (80% completion rate) and monthly predictive modeling</td>
<td>- Enables identification/management of all conditions and barriers to address the whole person</td>
</tr>
<tr>
<td>- Those identified receive Comprehensive Screening and Management</td>
<td>- Provides greatest impact with all comorbidities and issues managed concurrently</td>
</tr>
<tr>
<td>- Enrolled 18% of members in Care Management</td>
<td>- Aetna preventable admissions in core markets are going down year over year</td>
</tr>
<tr>
<td>- New programs for Home Case Management and Institutionalized members piloted</td>
<td>- Admissions are below the Medicare FFS level.</td>
</tr>
<tr>
<td>- Nurses, Social Workers, Behavioral Health, Disease Management Specialists are all trained in Geriatrics and Change Management</td>
<td>- Provides a uniform, effective and integrated strategy for members with multiple conditions and psychosocial barriers</td>
</tr>
<tr>
<td>- We provide specialized programs:</td>
<td>- Expands successful medical management to more high risk and vulnerable populations. Disease Management is a component of a comprehensive Care Management program.</td>
</tr>
<tr>
<td>- Advanced Illness</td>
<td></td>
</tr>
<tr>
<td>- Transitional Care Management</td>
<td></td>
</tr>
<tr>
<td>- Chronic Illness</td>
<td></td>
</tr>
</tbody>
</table>
Example of Specialized Care Management Program: Aetna Compassionate Care

- Care management by specialty trained nurse case managers to handle physical, emotional, spiritual and culturally-diverse needs of patients in advanced stages of disease

- Provides:
  - Advanced planning, directives and support
  - Emotional support and pain management
  - Choices, alternatives, use of hospice care

Aetna Compassionate Care Results: Medicare
- Program transposes traditional acute and hospice numbers
  - 81% of Medicare members in Compassionate Care Program elected hospice care
  - 18% deaths in acute or sub-acute facilities
  - 82% reduction in acute days, 88% for intensive care days
  - High level of member and family satisfaction
Results: Member Discussion

Example of Why Compassionate Care Shows Impact

- Wife stated member passed away with Hospice. Much emotional support given to spouse. She talked about what a wonderful life they had together, their children, all of the people's lives that he touched - they were married 49 years last Thursday and each year he would give her a piece of jewelry. On Tuesday when she walked into his room he had a gift and card laying on his chest, a beautiful ring that he had their daughter purchase. She was happy he gave it to her on Tuesday - on Thursday he was not alert. She stated through his business he touched many peoples' lives, and they all somehow knew he was sick, and he has received many flowers, meals, fruit, cakes - she stated her lawn had become overgrown and the landscaper came and cleaned up the entire property, planted over 50 mums, placed cornstalks and pumpkins all around. She said she is so grateful for the outpouring of love. Also stated that Hospice was wonderful, as well as everyone at the doctors office, and everyone here at Aetna. She tells all of her friends that "when you are part of Aetna, you have a lifeline.” Encouraged her to call CM with any issues or concerns. Closed to Case Management.
Enhanced Value Compensation: Quality Measures

- Higher health care cost is not related to better quality (Baicker et al, Health Affairs 10/7/04)
- Will payment incentives alone (pay for outcomes) result in short-term change?
Changing the emphasis from volume to value

Volume

- Denied claims, un-reimbursed admissions and other penalties as payers manage utilization
- Encourages additional capacity and unnecessary care
- Provider revenues contingent on volume of services
- Payers and providers as adversaries

Value

- Quality improvement increases performance-based reimbursement
- Improved cost structure and efficiency increases profitability
- Re-aligned financial incentives create diversified revenue sources through shared savings
- Aligned incentives to provide appropriate care in the best setting
Aetna Medicare Advantage

Aetna’s Provider Collaboration Program aligns resources and incentives to improve outcomes, creating greater value for members and provider organizations.

Provider Collaboration

Collaborative Care Management
Provides onsite embedded care managers to collaborate with physicians and assist in coordinating care for members.

Performance-Based Reimbursement
Aligns incentives to engage providers in quality, identification and management of chronic conditions and reductions in avoidable utilization.

Analytics and Data Sharing
Provides actionable member-level reporting and promotes exchange of health information to facilitate identification of member needs and follow-up care.

Enhanced Value Proposition

Member
• Improved access to care and resources
• Increased care coordination across continuum
• Greater focus on quality and outcomes

Plan Sponsor
• Increased CMS revenue from identification and management of chronic conditions
• Improved medical cost trend

Provider
• Improved patient care coordination
• Alignment of financial incentives
• Access to actionable data

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Shared Value Through Better Quality Management

- $X pmpm for achieving all target measures. Exact measures to be mutually agreed upon. Some possible measures:
  - Diabetes Management: HbA1C at least each year
  - Follow-up visit within 30 days after a hospital discharge
  - 2x/year office visit for members with CHF, diabetes or COPD
  - Management of avoidable inpatient admissions measured against a total acute days target per 1,000
  - Annual office visit with each assigned member
  - Enhanced reimbursement through better identification of chronic conditions.
The Collaboration Model includes three components that are designed to better align incentives and resources for Medicare Advantage members

- **Medicare Risk Adjustment**
  - The Risk Adjustment provides the opportunity for enhanced reimbursement for management of Aetna Medicare patients with chronic conditions, which requires more time and effort.

- **Quality Measures**
  - The Quality Measures provide the opportunity for enhanced reimbursement for achieving defined quality measures for an Aetna Medicare patient population.

- **Collaborative Care Management**
  - Collaborative Care Management provides dedicated, funded Aetna resources for the management of an Aetna Medicare patient population.
• Every group has 1 (or more, depending on size) dedicated/single point of contact RN Case Manager
• Groups with ~1,000 Aetna MA members are eligible for a full-time, embedded case manager
• Embedding discussions are beginning earlier in the implementation process, and expectation is that it is preferential to pursue embedding, if possible
• Considerations for embedding include:
  o Working environment, privacy rules
  o Connectivity to Aetna systems and group’s EMR
  o Working relationships with group’s care coordinators/MDs/quality managers/mid-level providers, etc.
Provider Collaboration: Medicare Advantage Clinical Team

- Specially trained geriatric RN case managers (dedicated to a physician group)
- Managers and supervisors
- Post-acute and home care Aetna nurse case managers
- Non-clinical support team
- Dedicated medical social workers
- Local Medicare medical directors
Role of CM in Provider Collaboration

• Medicare Care/Case Management in Provider Collaboration
  o Enhanced care management for Aetna MA plan members through on-site or dedicated Aetna case managers
  o Physician groups will have the benefit of a collaborative relationship with an Aetna Medicare Case Manager dedicated to their practice
  o We believe that this collaborative and positive working relationship with the physician group helps facilitate optimal care and outcomes for our members

• Case Management activities may include:
  o Case identification through automation and review of weekly inpatient admission census
  o Face-to-face relationship with the physician group’s clinical support staff and clinicians
  o Facilitation of timely post-discharge office visit
  o Having an extensive familiarity with local member resources and contacts that can enhance overall support and efficiency
  o Helping to achieve clinical outcomes for MA members and address Star/quality measures
Impact of Provider Collaboration

• Goal is incremental value in terms of Quality (Stars) and Efficiency (MBR)
• Reduction in acute admissions per 1,000 versus Market Results:
  • For some groups we see a reduction in acute days of 60% compared to the region for Medicare, and reduction in cost of > 25%
  • Days that do not happen = an intersection of quality and cost
  • Historically, aim for 6-8% or greater improvement over the local market
• High level of member and physician satisfaction with the program
• Facilitates transition to fully accountable care, risk-based contracting
Role of Medicare Advantage Case Manager

Case Management (CM)
Complex/Catastrophic
Proactive Outreach
Predictive Model
At Risk Members
Compassionate Care
DM Integration
BH Integration

Wellness Coaching
Smoking Cessation
Weight Management
Stress Management

Medical Management
Hypertension
Fracture Prevention
Diabetes

Disease Management (DM)
Stars-aligned DM
Integrated with CM
INNOVATION PROFILE

Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan

ABSTRACT Patient-centered, accountable care has garnered increased attention with the passage of the Affordable Care Act and new Medicare regulations. This case study examines a care model jointly developed by a provider and a payer that approximates an accountable care organization for a Medicare Advantage population. The collaboration between Aetna and NovaHealth, an independent physician association based in Portland, Maine, focused on shared data, financial incentives, and care management to improve health outcomes for approximately 750 Medicare Advantage members. The patient population in the pilot program had 50 percent fewer hospital days per 1,000 patients, 45 percent fewer admissions, and 56 percent fewer readmissions than statewide unmanaged Medicare populations. NovaHealth’s total per member per month costs across all cost categories for its Aetna Medicare Advantage members were 16.5 percent to 33 percent lower than costs for members not in this provider organization. Clinical quality metrics for diabetes, ischemic vascular disease, annual office visits, and postdischarge follow-up for patients in the program were consistently high. The experience of developing and implementing this collaborative care model suggests that several components are key, including robust data sharing and information systems that support it, analytical support, care management and coordination, and joint strategic planning with close provider-payer collaboration.
## Published Experience: Aetna Provider Collaborations

<table>
<thead>
<tr>
<th></th>
<th>NOVA</th>
<th>Aetna Maine</th>
<th>NOVA VS Aetna Maine</th>
<th>Maine CMS</th>
<th>NOVA VS Maine CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Admits</td>
<td>143.5</td>
<td>205.1</td>
<td>-30.0%</td>
<td>259.0</td>
<td>-44.6%</td>
</tr>
<tr>
<td>Acute Days</td>
<td>657.0</td>
<td>982.3</td>
<td>-33.1%</td>
<td>1,316.0</td>
<td>-50.1%</td>
</tr>
<tr>
<td>Sub-Acute Admits</td>
<td>44.2</td>
<td>51.4</td>
<td>-14.0%</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Sub-Acute Days</td>
<td>782.6</td>
<td>925.9</td>
<td>-15.5%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>ER</td>
<td>225.0</td>
<td>201.5</td>
<td>11.7%</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Readmit Rate</td>
<td>8.7%</td>
<td>14.9%</td>
<td>-41.6%</td>
<td>19.6%</td>
<td>-55.6%</td>
</tr>
</tbody>
</table>

Data from Aetna Medicare-NovaHealth-InterMed collaboration in Portland, Maine
Impact for Groups with Embedded Case Managers

Results for 2013 - note acute admissions are exclusive of denials. Acute admissions that do not happen are a measure of quality with significant impact on cost

<table>
<thead>
<tr>
<th>Group</th>
<th>Effective date</th>
<th>Medicare Advantage Members</th>
<th>Acute admissions per 1000</th>
<th>Acute Admissions vs. CMS 2010</th>
<th>30 day all-cause readmission rate</th>
<th>Embedded case manager as of 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>ProHealth (CT)</td>
<td>10/1/07</td>
<td>2,210</td>
<td>193</td>
<td>-46%</td>
<td>6%</td>
<td>Yes</td>
</tr>
<tr>
<td>TriValley Primary Care</td>
<td>1/1/10</td>
<td>1,228</td>
<td>220</td>
<td>-48%</td>
<td>9%</td>
<td>Yes</td>
</tr>
<tr>
<td>Intercoastal</td>
<td>4/1/09</td>
<td>1,708</td>
<td>132</td>
<td>-63%</td>
<td>9%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Aetna Medicare Physician Collaboration: Summary

- Collaboration changes the nature of the relationship with participating physicians
- Embedded case managers enhance the collaborative care management process, the relationship with collaborating physician, and the impact of care management
- Demonstrable incremental positive impact
- High physician and member satisfaction
- Facilitates transition to accountable care
- Creates new strategic partnership opportunities
Chronic management of chronic illness: diabetes

John (66 yrs.)

I need help ... I have -
- Hypertension
- Obesity
- High Cholesterol
- Gout
- Heart disease
... and this can get worse

Unmanaged progression → ~ 3 yrs

1. Pre-Diabetic
   - Define health goals
   - Customize plan to modify risk factors
   - Review medications
   - Work on adherence and continuous feedback

2. Diabetic
   - Onsite annual health risk assessment
   - PCP care coordination
   - Monitor Blood sugar, A'C, etc.
   - Continuous feedback

3. End Organ Involvement
   - Care coordination for care completion
   - Long term case management
   - Holistic management

4. Advanced Illness
   - Follow up, education, and support
   - Choices, options, psychosocial support

John’s Impact

• Progression to Diabetes is delayed by ~ 10 years, OR
• Diabetes does not occur in the lifetime!

Anne

Interventions

• Define health goals
• Customize plan to modify risk factors
• Review medications
• Work on adherence and continuous feedback

• Onsite annual health risk assessment
• PCP care coordination
• Monitor Blood sugar, A'C, etc.
• Continuous feedback

• Care coordination for care completion
• Long term case management
• Holistic management

• Follow up, education, and support
• Choices, options, psychosocial support

• Progression to organ damage is delayed by 10 years, OR
• Organ damage does not occur in lifetime!

• Organ damage does not progress
• Organ damage does not result in terminal illness!

• Long term engagement facilitates Compassionate Care
• Effective impact on Advanced Illness

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Question and Answer Session

Randall Krakauer, MD, FACP, FACR
Vice President, National Medical Director
Medicare Strategy, AETNA
Thank you!

• Please fill out the survey after today’s session
• Those who signed up for Continuing Education will receive an evaluation from the Commission.
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