Once upon a time, payers and clinicians often worked at cross purposes. But as delivery and reimbursement models have gradually changed, so has that dynamic. What’s emerging is a collaborative model of patient-centered, accountable care working toward creating a system that offers better care, better population health and lower costs.

Case managers are proving to be a major component of that change. Patrice Sminkey, CEO of the Commission for Case Manager Certification, offers the following vision: “Imagine what would happen if a health plan worked with a group of physicians to embed dedicated case managers within those practices to help patients navigate the complex health care maze, better manage medications and make informed choices about their treatment and care.”

No need to imagine: It’s happening now. One of the most successful models is Aetna’s Medicare Advantage Provider Collaboration Program launched in 2007. It’s an effort that’s changing the payer/provider dynamic for the better; about 150 practices are participating. In a large and growing number of groups, the program also includes embedded case managers.
“We need to manage the person, not the disease—something not everyone grasps.”  
— RANDALL KRAKAUER, MD, FACP, FACR, AETNA VICE PRESIDENT, NATIONAL MEDICAL DIRECTOR, MEDICARE STRATEGY

Aetna-funded case managers, embedded in the practice, collaborate with physicians and assist in coordinating care for members. Because they have access to actionable member-level reporting, they are equipped to facilitate identification of members’ needs and provide follow-up care support. In developing an effective relationship with physicians and staff, they become valuable to the members (patients) and the physicians and staff.

**Targeting the right population**

The program encompasses Medicare Advantage enrollees, currently serving more than half of Aetna’s Medicare Advantage members. The use of embedded case managers might expand to commercial customers, but “starting with the Medicare population provides the greatest opportunity to make a difference and demonstrate measureable improvements in cost and quality,” says Randall Krakauer, MD, vice president and national medical director for Medicare Strategy at Aetna.

Many of the elderly have multiple chronic conditions. (See Figures 1 and 2.) For example, more than two-thirds of Medicare beneficiaries—or 21.4 million people—have two or more chronic conditions.1

It’s not merely the number of conditions, however; many factors make the impact of illness greater for an older patient than a younger one with a comparable condition, he explains:

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**FIGURE 1.** Percentage of Medicare FFS Beneficiaries with the 15 Selected Chronic Conditions: 2010

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>58%</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>45%</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>31%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>29%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>28%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>16%</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>15%</td>
</tr>
<tr>
<td>Depression</td>
<td>14%</td>
</tr>
<tr>
<td>COPD</td>
<td>12%</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>11%</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>8%</td>
</tr>
<tr>
<td>Cancer</td>
<td>8%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>7%</td>
</tr>
<tr>
<td>Asthma</td>
<td>5%</td>
</tr>
<tr>
<td>Stroke</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition
Reduced ability to recover from injury or condition means greater need for preventive condition management.

Less family and social support means increased need for outside help.

Less ability to follow a medical regimen means greater intensity of medical management.

Because multiple, comorbid conditions often interact in deleterious ways, traditional disease management that focuses on a single condition often isn’t effective, he says. “We need to manage the person, not the disease—something not everyone grasps.”

Case managers, however, do grasp it, understanding the importance of a person-centered vs. a disease-based approach. And they can deliver additional value when they are embedded in the physicians’ practices.

Why embed?

The most obvious reasons to deploy embedded case managers (ECMs) are that they improve quality and decrease unnecessary utilization. Not all of Aetna’s Medicare Advantage Provider

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**FIGURE 2.** Percentage of Medicare FFS Beneficiaries with the 15 Selected Chronic Conditions by Age: 2010

<table>
<thead>
<tr>
<th>Condition</th>
<th>Less than 65 years</th>
<th>65 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>61%</td>
<td>41%</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>48%</td>
<td>31%</td>
</tr>
<tr>
<td>Ischemic heart disease</td>
<td>34%</td>
<td>22%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>31%</td>
<td>22%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>Depression</td>
<td>27%</td>
<td>12%</td>
</tr>
<tr>
<td>COPD</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>9%</td>
<td>2%</td>
</tr>
<tr>
<td>Cancer</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Asthma</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Stroke</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition
Collaboration Program sites use ECMs, but the most successful ones do, Krakauer says.

“Embedded case managers enhance the collaborative care management process, the relationship with the practice and the impact of care management,” he explains. Trust emerges from frequent contact—preferably face-to-face contact with the practice. Moreover, physicians know care plans are more likely to succeed. In a hospital, doctors can be confident that if they write an order, it will be followed because hospital staff will work with a patient throughout their stay. In an outpatient or practice setting, it’s less certain that patients will fill the prescription or follow the instructions or get the blood test. They may not even understand the instructions. Working with a case manager makes it more likely patients and their caregivers will understand the instructions and take the appropriate follow-up actions.

The level of support differs from the hospital setting, but it’s much better coordinated than it would be otherwise, says Krakauer.

“Professional case managers are ideally positioned to engage patients in their care, and the Commission’s board-certified case managers are working in all practice settings, across the full continuum of care,” says Sminkey.

Moving beyond incentives: How data sharing makes it work

Aetna hires, pays and trains the case managers, then works with participating practices to place them. Practices have incentives to meet quality targets. For example, Aetna and practices track the number of hospital admissions and the number of acute-care days for participating patients among other metrics.

“We expect reduction in avoidable admissions and readmissions compared to what we could do alone. We are looking for incremental value,” Krakauer says. Other targets vary across practices, but all must include measures of recommended health care processes and at least one outcome metric. Aetna works with each practice to come up with mutually agreed-upon measures.

“Financial incentives are important—especially at the beginning—but they are only one aspect of the program,” he says. “Incentives are the beginning, not the end.”

The process begins with aligning Aetna’s interests and the physicians’, while moving from volume to value. “We believe this collaborative and positive working relationship with the physician group helps facilitate optimal care and outcomes for our members,” he says. It also provides practices the opportunity for enhanced reimbursement through better identification of chronic conditions.

The program’s success depends on the appropriate use of data. “Aetna shares immediate, actionable, member-level data with practices,” Krakauer says. That includes claims information and process and transaction data for the individual. Aetna also provides practices with information on their Medicare Advantage populations. “This is what it takes to move the needle. It’s far more effective than dropping incentives and expecting something to happen quickly.”

Building a program, building trust

Many Aetna-participating practices now have an embedded case manager, and a few of the larger practices have more than one. To be eligible, a practice needs to have at least 1,000 Aetna Medicare Advantage
members, although the health plan hopes to expand the program to all practices serving these members.

Aetna also has a successful corporate case management program in place that preceded the embedded case manager program. Krakauer points to the results of the Compassionate Care initiative as an early—and ongoing—example. (See sidebar on page 6.)

Implementing the program isn’t the sort of effort that lends itself to immediate results. “The program needs time to come up to speed. Sometimes it takes a few months, sometimes a year or two. But impact has always been seen in the practices with embedded case managers.”

The hardest part is getting a practice started.” “I’m from Aetna, and I’m here to help you’ doesn’t always work the first time you say it,” he says. But now that the program has been in place for several years, it’s easier to bring physicians on board; they are reading about the results and—perhaps more important—hearing from colleagues who are pleased with the program and its results.

The selection, hiring and training of case managers also takes time. “We’re building a new infrastructure for care management,” he says. Most of the ECMs are nurses; a few are social workers. All are specially trained for this program and participate in a mentorship program before being assigned to a practice. Each is also trained in Aetna’s Compassionate Care program for end-of-life care. (See sidebar.)

The embedded case managers aren’t there as on-site Aetna representatives, but as integrated members of the practice team. It’s this—often face-to-face—relationship that builds trust and fosters success, he says. “We have a rule for our embedded case managers: You may be an Aetna employee, but your goal is to become indispensable to the physician practice,” Krakauer notes. “Everything they do should help the practice recognize their value in improving patient outcomes.”

It also means they are actually doing case management, not traditional utilization review. For example, ECMs don’t issue denials.

Because the role of the case manager in each practice is unique, the specific case management activities may vary. Generally, however, they include the following:

- Identify patients based on data analysis and review of weekly inpatient admission census;
- Facilitate timely post-discharge office visits;
- Connect patients with local community resources and contacts that can help support them beyond the walls of the practice;
- Work with the practice team to better integrate behavioral health, disease management and wellness with medical management; and
- Help the physician practice achieve better clinical outcomes and meet or exceed quality measures.

Positive results driven by case managers

Some of the Provider Collaboration Program practices are more successful than others, Krakauer acknowledges, but the positive results are significant—the most successful participating practice groups had an Aetna ECM. Using a professional case manager at the practice level enhances patient care and fosters collaboration across the care team, he explains.
Case managers and advanced illness: Aetna’s Compassionate Care

Advanced illness—a portion of which used to be termed “terminal” illness—provides a striking example of how a case manager can make a difference. Aetna Compassionate Care is a specialized, high-touch care management program for members with advanced illness.

Trained Aetna case managers address the physical, emotional, spiritual and culturally diverse needs of these patients. They work with the patient on advance-planning issues, provide emotional support and pain management, and discuss available options and choices, including hospice. They continue to offer support to the member and family as long as the support is desired and effective.

Annually, Aetna engages .5 percent to 1 percent of its entire population in Compassionate Care, according to Krakauer.

It’s a much-needed approach, and one that’s not widely embraced, says Sminkey. “Patients with advanced illness often get intensive, aggressive care, but that’s not necessarily the care they would prefer. When patients with advanced illness have the information to decide for themselves, what they often want most are comfort, pain relief and psychosocial support.”

The problem is a painful one: Across the country, patients with chronic illness in their last two years of life account for about 28 percent of total Medicare spending, much of it going toward physician and hospital fees associated with repeated hospitalizations. And this may be care they don’t even want. Among those who indicated they preferred to die at home, 55 percent nonetheless died in the hospital. Moreover, more intensive inpatient care is not associated with improved survival, better quality of life or better access to care.

Making a difference

“The results have been dramatic,” Krakauer reports. He offers a snapshot of patient preference-guided results:

- 81 percent elected hospice care
- 18 percent of deaths occur in acute or sub-acute facilities
- 82 percent reduction in acute days
- 88 percent reduction in intensive care days
- High level (90+ percent) of member and family satisfaction
- $12,900 savings per engaged member

“If you are looking for an opportunity at the intersection of quality and cost, particularly in Medicare, this is the mother lode,” he says.

“We’ve been doing this for more than 10 years. It’s disappointing that long after our results and others’ were published, we’re not seeing this widely adopted, even where extant incentives should encourage it. This is a tremendous opportunity to improve lives that’s largely not being realized.”

2 End of Life Care, Dartmouth Atlas of Health Care
2 Dartmouth Atlas, op. cit.
Some of Aetna’s earliest results with the program came from Portland, Maine, and were published in *Health Affairs*. Patients in that program—which included ECMs—had 50 percent fewer inpatient hospital days, 45 percent fewer hospital admissions and 56 percent fewer readmissions than unmanaged Medicare populations statewide.

- More than 99 percent of these members visited their doctors in 2011 to receive preventive and follow-up care.

- Total per-member, per-month costs for the program’s members were 16.5 to 33 percent lower across all medical cost categories than for Aetna Medicare Advantage members in other practices.

And, he emphasizes, this was accomplished without denial of coverage. “These are not denied admissions; these are admissions that didn’t happen. That addresses both quality and cost issues.”

Other Aetna ECM sites are reporting similar results, he says. Among the improvements across practices:

- Increased the percentage of Aetna Medicare Advantage members who have an office visit in the practice each calendar year;

- Encouraged office visits every six months for members with congestive heart failure, chronic obstructive pulmonary disease or diabetes;

- Encouraged HbA1C tests each calendar year for members with diabetes; and

- Confirmed that members scheduled follow-up visits with the practice within 30 days of being discharged from an inpatient stay.

In addition to demonstrable incremental improvement on cost and quality measures, participants report high satisfaction among practices and patients.

**A long journey with results**

After eight years, Krakauer has had the opportunity to examine what the most successful practices have in common. The most obvious commonality is the use of embedded case managers—and effective case management will be an important feature of the model going forward.

There’s no secret to what Aetna has accomplished, he says. “Much of it has been published, but it takes a lot of work.”

Both parties must transform themselves and work together and separately to make the program successful. That’s what’s happening: Practices and Aetna don’t see each other as adversaries, but as professionals working toward the solutions that improve the health of their patients—Aetna’s members.

“We look to combine the best of what they do and what we do,” he says. “Collaboration has changed the nature of our relationship with participating physicians. We’re building something that’s better than we could have done ourselves or the practice could have done itself. The improvements are greater than the sum of what they and we could have accomplished separately.”

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4 Claffey TF, Agostini JV, Collet EN, Reisman L, Krakauer R. “Payer-provider collaboration in accountable care reduced use and improved quality in Maine Medicare Advantage plan.” *Health Affairs* 2012 Sep; 31(9):2074-83.


6 Claffey TF. *Health Affairs*, op. cit.
Patrice Sminkey, Chief Executive Officer, The Commission for Case Manager Certification

Sminkey comes to the Commission from URAC, where she most recently served as senior director of sales. Prior to that, she was senior vice president, operations and client management, Patient Infosystems in Rochester, N.Y. She brings a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. She has extensive experience in client management and coordination, including marked improvement in client retention, timely and fiscally sound program implementation and an expanding book of business.

As chief executive officer, Sminkey oversees the management of all activities related to the Commission’s operations, including all programs, products and services; and the provision of quality services to and by the Commission. She is a direct liaison to the Commission’s Executive Committee. She works with CCMC’s volunteer leadership to evaluate and develop potential new products for implementation by CCMC, and she establishes and maintains communication and working relationships with other organizations, agencies, groups, corporations and individuals.

She holds a diploma of nursing from the Chester County School of Nursing.

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

Krakauer has more than 30 years of experience in medicine and medical management. At Aetna, he is responsible for medical strategy, planning, clinical policy and communications nationally for Aetna Medicare. Krakauer has been instrumental in Aetna’s innovative approaches to identifying where coordinated care management can make a difference, including national initiatives for advanced illness and the placement of Aetna-funded case managers into medical groups the insurer contracts with for services. He is also co-author of the book, Essentials of Embedded Case Management: Hiring, Training, Caseloads and Technology for Practice-Based Care Coordination.

Krakauer graduated from Albany Medical College and is board certified in internal medicine and rheumatology. He trained in internal medicine at the University of Minnesota Hospitals and in rheumatology at the National Institutes of Health and Massachusetts General Hospital/Harvard Medical School, and earned an MBA from Rutgers. He is a fellow of the American College of Physicians and the American College of Rheumatology, and professor of medicine at Seton Hall University Graduate School of Medicine. He is past chairman of the American College of Managed Care Medicine.