

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



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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

Audience Notes

- 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
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

Learning Objectives Overview

After the webinar, participants will be able to:

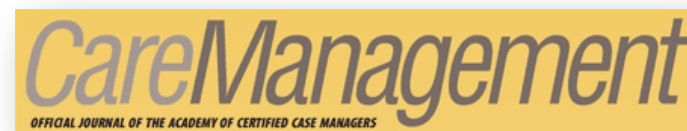
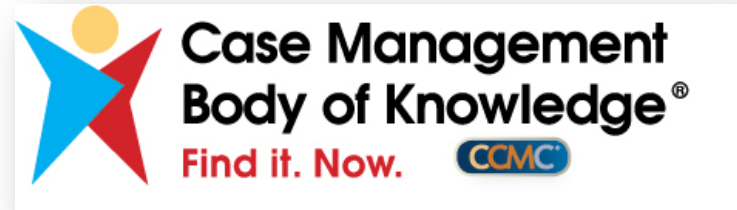
- Describe the potential value of collaboration, specifically in Medicare Advantage programs;
- Explain how collaboration works to better align incentives and resources: What is important? What is the end game?
- Discuss the importance of care management and data;
- Explain the value of collaboration 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

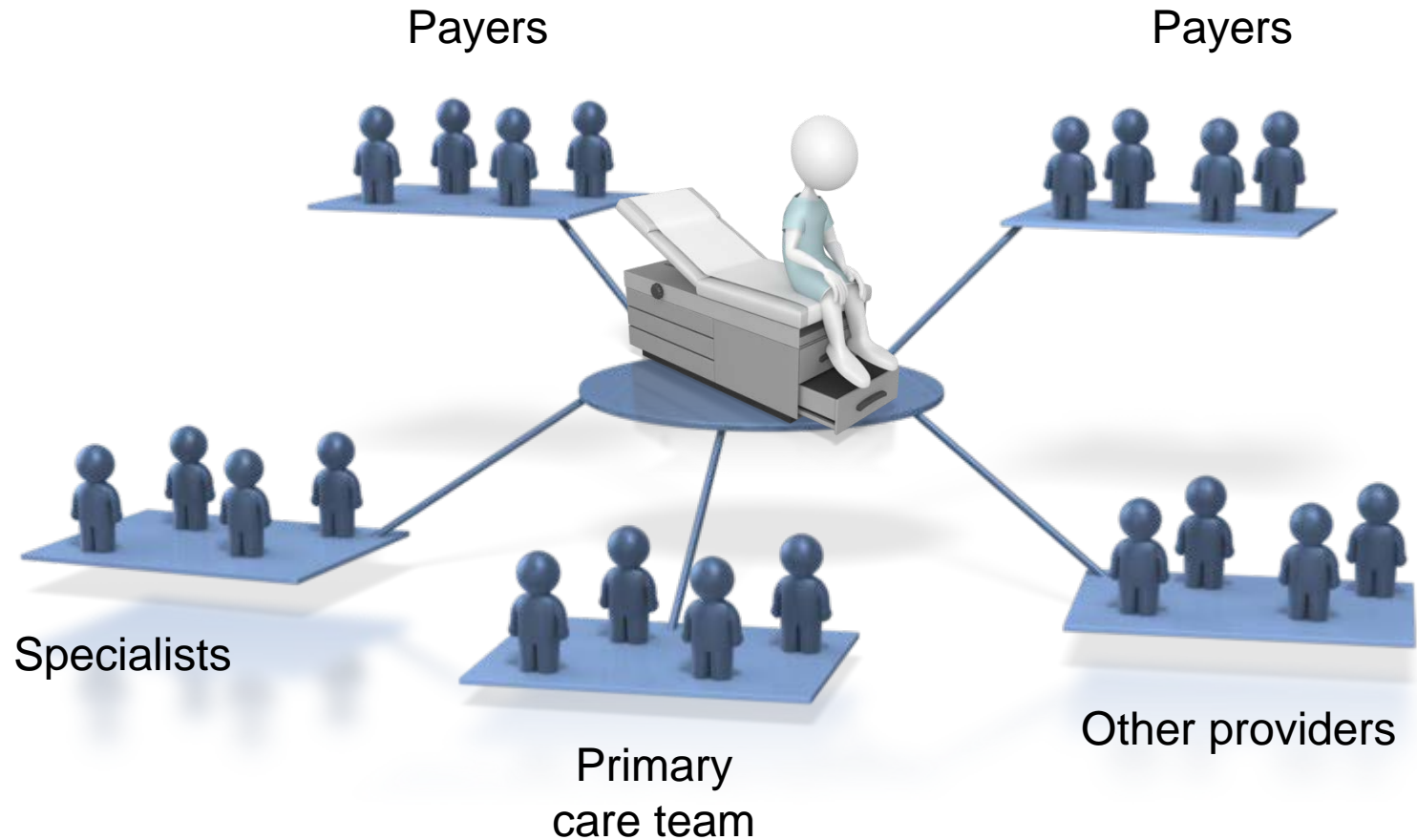


Patrice Sminkey
Chief Executive Officer
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Collaborating for care



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



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Aetna Medicare Physician Collaboration



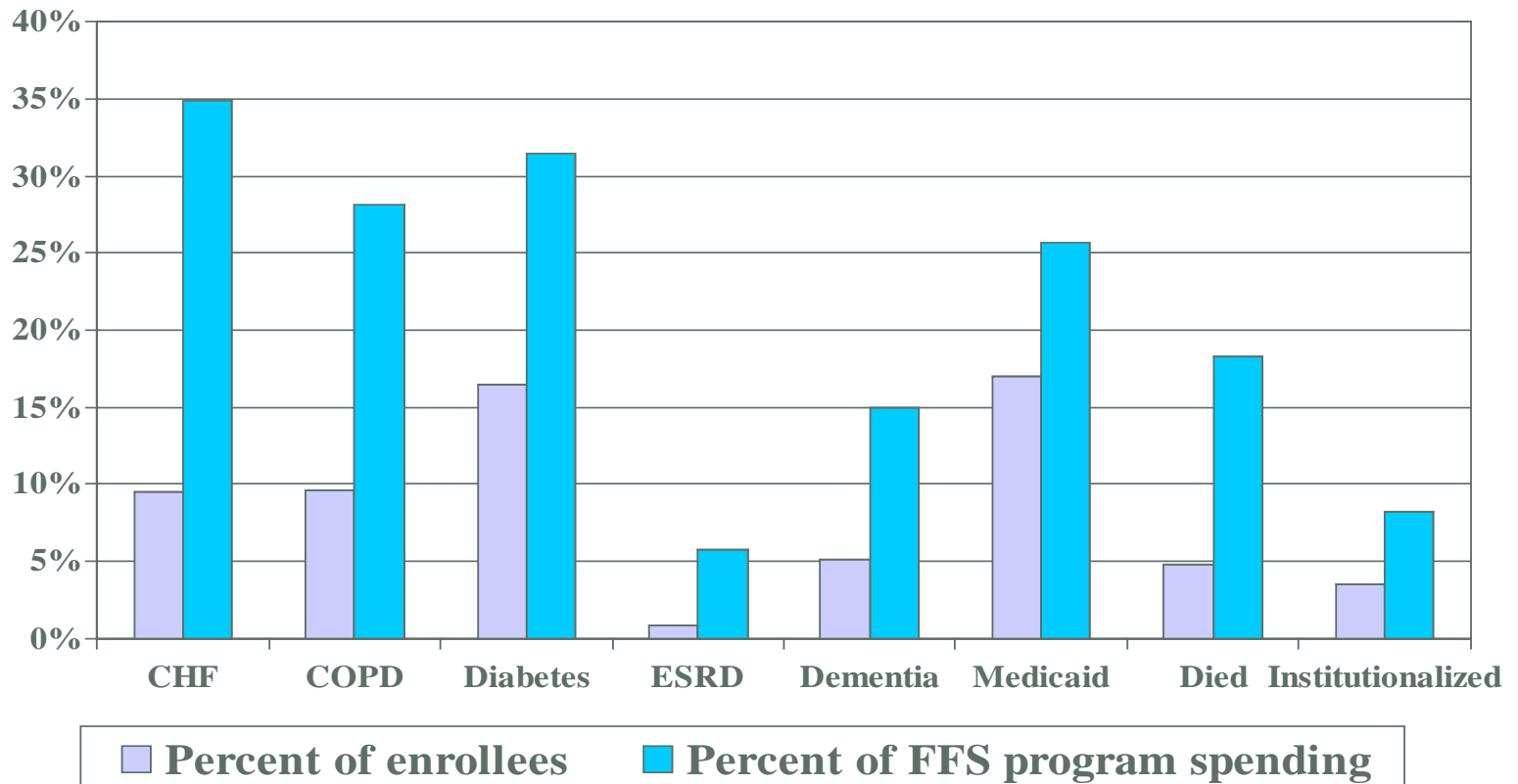
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Medicare Medical Management: “Round up the Usual Suspects”



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.



Chronic Conditions & Cost Distribution in Medicare Beneficiaries

In the elderly conditions occur in combination: cost and quality is driven by a population with multiple concurrent conditions

Chronic Co-Morbid Conditions	Percent of the Population	Percent of Total Cost	
> 4	20%	66%	
3-4	27%	23%	
0-2	53%	11%	

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.



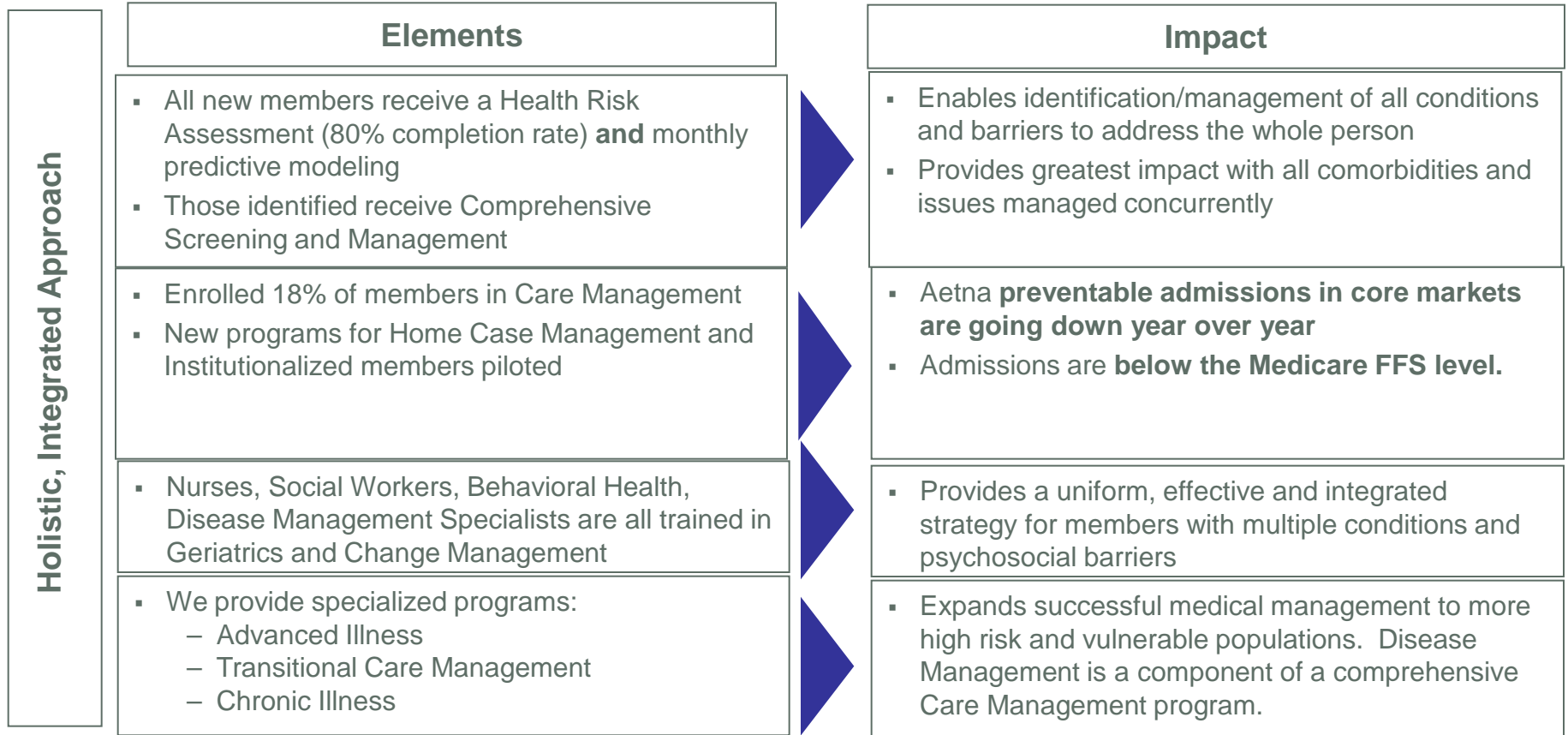
Factor Impact

- | | |
|--|--|
| <ul style="list-style-type: none">▪ 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 | <ul style="list-style-type: none">▪ 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

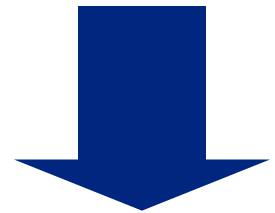
Enabling effective care of seniors with multiple conditions and reducing preventable hospital admissions





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?

Hammurabi 1700 BC

OUTCOMES-BASED FEE SCHEDULE

This chart outlines fees and penalties for successful and unsuccessful procedures. There are no fees for unsuccessful bone setting and sinew mending because outcomes are usually not fatal; operations can be repeated until the result is satisfactory. Omission of fees for mushkenum (the middle class) indicate that the scribe failed to copy a section containing a penalty. Awelum were the upper class; wardum were slaves.

Successful operations	Awelum	Mushkenum	Wardum
Setting bone or mending sinew	5 shekels	3 shekels	2 shekels
General operation	10 shekels	5 shekels	2 shekels
Operation on eye	10 shekels	5 shekels	2 shekels
Unsuccessful operations			
Setting bone or mending sinew	—	—	—
General operation	loss of hand	—	slave for slave
Operation on eye	loss of hand	—	slave's price

Changing the emphasis from volume to value

Volume Value

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

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



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.



Collaboration Model Overview

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.



Importance of Dedicated/ Embedded Case Managers

- 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:
 - Working environment, privacy rules
 - Connectivity to Aetna systems and group's EMR
 - 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
 - Enhanced care management for Aetna MA plan members through on-site or dedicated Aetna case managers
 - Physician groups will have the benefit of a collaborative relationship with an Aetna Medicare Case Manager dedicated to their practice
 - 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:
 - Case identification through automation and review of weekly inpatient admission census
 - Face-to-face relationship with the physician group's clinical support staff and clinicians
 - Facilitation of timely post-discharge office visit
 - Having an extensive familiarity with local member resources and contacts that can enhance overall support and efficiency
 - Helping to achieve clinical outcomes for MA members and address Star/quality measures



Impact of Provider Collaboration

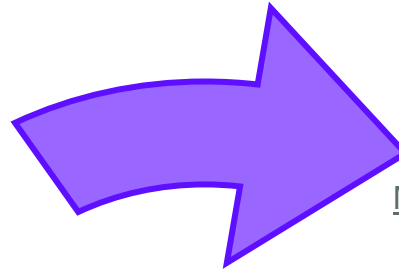
- Goal is incremental value in terms of Quality (Stars) and Efficiency (MBR)
- Reduction in acute admissions per 1,000 versus Market Results:
 - For some groups we see a reduction in acute days of 60% compared to the region for Medicare, and reduction in cost of > 25%
 - Days that do not happen = an 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



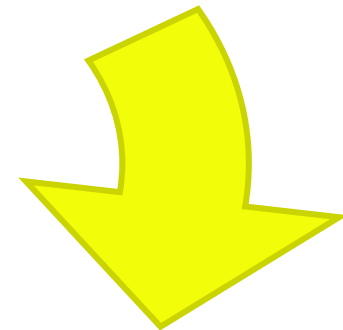
Case Management (CM)

Complex/Catastrophic
Proactive Outreach
Predictive Model
At Risk Members
Compassionate Care
DM Integration
BH Integration



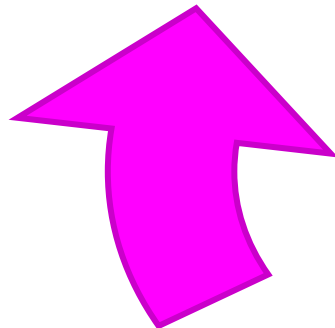
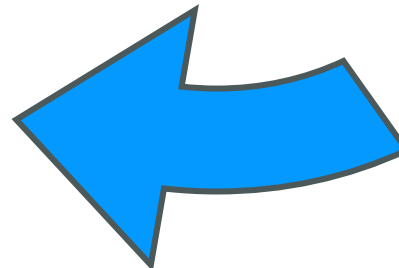
Medical Management

Hypertension
Fracture Prevention
Diabetes



Disease Management (DM)

Stars-aligned DM
Integrated with CM



Wellness Coaching
Smoking Cessation
Weight Management
Stress Management

By Thomas F. Claffey, Joseph V. Agostini, Elizabeth N. Collet, Lonny Reisman, and Randall Krakauer

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.



Health Affairs 2012;31:2074-2083



Published Experience: Aetna Provider Collaborations



2011 Overall Utilization Management					
	NOVA	Aetna Maine	NOVA VS Aetna Maine	Maine CMS	NOVA VS Maine CMS
Acute Admits	143.5	205.1	-30.0%	259.0	-44.6%
Acute Days	657.0	982.3	-33.1%	1,316.0	-50.1%
Sub-Acute Admits	44.2	51.4	-14.0%	n/a	n/a
Sub-Acute Days	782.6	925.9	-15.5%	n/a	n/a
ER	225.0	201.5	11.7%	n/a	n/a
Readmit Rate	8.7%	14.9%	-41.6%	19.6%	-55.6%

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

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



Peer Reviews



Quality Matters

August/September 2010 A Research Report on Innovations in Health Care

In this Issue

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In Focus: Using Pharmacists, Social and Nurses to Improve the Health Quality of Primary Care

by Leah Han

Summary: Studies of interdisciplinary health care teams have demonstrated that improvements in the quality of primary care, but that still exist, have not met optimal patient outcomes. The authors believe that teams may help extend the health system's capacity to provide primary care to a shortage of physicians and other primary care to require the financial support of federal, state, and private payers, a health care possibility.

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International Journal of Public Health Policy and Health Services Research

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High-value transitional care: translation of research into practice

Mary D. Naylor PhD RN FAAN,¹ Kathryn H. Bowles PhD RN FAAN,² Kathleen M. McCauley PhD RN ACNS-BC FAAN FAHA,³ Maureen C. Maccory RN MBA,⁴ Greg Malslin MS MA,⁵ Mark V. Pealy PhD⁶ and Randall Krakauer MD FACP FACC⁷

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Impact of Medicare-Specialized Nurse Case Management: Favorable Hospital and Emergency Utilization Outcomes for a Medicare Advantage Population Compared to Unmanaged Transitional Medicare Experience

Authors: Marcus Wade MD FACP MHA, Healey Kurland, Clare Spethell, Jeffrey Stock, Richard Park, Robert Finkler MD FACP FACC

Case Management for the Elderly

Objective: We compared the impact of a Medicare-specialized nurse case management program (compared with the standard unmanaged population of Medicare beneficiaries) on hospital and emergency department (ED) utilization rates.

Results: The population represented significantly better outcomes than the comparison group in each region for acute hospital inpatient days as well as emergency visits.

Medicare population served by our Medicare-specialized case management program (compared with the standard unmanaged population of Medicare beneficiaries):

- 14% fewer acute hospital inpatient days per thousand members per year
- 15% fewer emergency department visits per thousand members per year

FFO population served by our Medicare-specialized case management program (compared with the standard unmanaged population of Medicare beneficiaries):

- 21% fewer acute hospital inpatient days per thousand members per year
- 24% fewer emergency department visits per thousand members per year

The results were uniformly positive for all regions, with Aetna lead customer membership (more than five thousand members).

Regional Outcomes for Medicare Advantage Members Compared with Traditional Medicare Service Lineages (Percentages)

Region	Aetna	FFO	FFO Benchmark
Aetna-Midwest	~80	~100	~100
Aetna-Northeast	~70	~100	~100
Aetna-South	~70	~100	~100
Aetna-West	~70	~100	~100

Utilities are installing millions of smart meters, but more consumers are trying to just say no

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PERSPECTIVE

Opportunities To Improve The Quality Of Care For Advanced Illness

An Aetna pilot program shows how it can be done.

by Randall Krakauer, Claire M. Spethell, Lanny Reisman, and Marcia J. Wade

ABSTRACT: Many studies describe a sizable chasm between the care Americans consider optimal for advanced illness and what we actually experience. Aggressive or curative measures may be pursued to the exclusion of comfort, pain relief, and psychosocial support. We briefly describe a care management program that gives people culturally sensitive supportive information, to make informed choices and obtain palliative services in a timely manner. In the sample population, more members chose hospice care; acute care utilization declined. It is possible to assist Americans with advanced illness and remove barriers to accessing hospice care, if that is their choice, without adverse financial impact. [Health Aff (Millwood). 2009;28(5):1357-59; doi:10.1377/hlthaff.28.5.1357]

BACKGROUND: A 2009 survey by RAND Health in 2009, *Assessing Care of Vulnerable Elders (ACOVE)*, described a stable chasm between the type of care Americans consider optimal for advanced illness and what we actually experience.¹ Too often, aggressive or curative measures are pursued to the exclusion of palliative care with its focus on comfort, pain relief, and psychosocial support. Changing this approach will require conversations about choices and options beginning early in the course of advanced illness. Now, these conversations begin late or not at all.

Hospice election rates have been increasing for two decades. By staying hospice, patients are opting for care that emphasizes comfort and social support, as opposed to heroic medical efforts to "cure" disease in spite of limited potential benefit.² Although the increase in patients benefiting from hospice support is encouraging, there is room for improvement. Too often, the choice of hospice does not occur until the last few days or hours of life, long after the patient would have benefited from this type of care. Opportunities for improving the quality of care for advanced illness include better coordination of care, better training for physicians and health care providers in the care of terminal illness, empowerment of patients beginning early in the course of advanced illness, and requirements that advance directives be recorded and adhered to.

Although all of these endeavors are valuable, improved care management may be one of the best ways to reach people early with culturally sensitive, supportive information and access to palliative services. In a relatively

Invictus: Increasing Patient Choice in Advanced Illness and End-of-Life Care

RANDALL KRAKAUER, MD, FACP, FACC

HUMANS' KNOWLEDGE of our own mortality creates a conflict with our human desire to live. Cultures have grappled with this conflict throughout history. In *The Epic of Gilgamesh*, one of the earliest known works of literature, the character wrestles with the concept. The Greek philosopher Epicurus is quoted to define death in context: "Death does not concern us, because as long as we exist, death is not here. And when it does come, we no longer exist." Knowledge of our own demise should provide us with the means to influence some circumstances, and our choice might not be futile pursuit of the unattainable. Indeed, surveys have shown that when people are asked about such preferences, a majority indicate they would prefer death in hospice, with pain and with the support of loved ones, to death in hospital (last Acts 2004). However, too frequently, these preferences are not honored. In many cases of advanced illness, people are given the choice of where to die too late, or not at all.

Few people would aspire to end their lives in intensive care units, various forms of life support, in pain and isolated from loved ones. We are rightly proud of our medical technology, skills, and capabilities and of the passion our concern bespeaks; however, do we view knowledge of our mortality as a challenge to be defeated at all costs, despite the certainty that we will die? Is there a better path? Is the laudable Talmudic precept to preserve life a lute, or is the realization and gracious acceptance of a point of inevitability a better way? Can we transcend the emotional and physical pain by dying the emotional and physical support of our loved ones and trusted health providers? Can we reconcile the goals of preserving life and accommodating pain-free death that is supportive to all concerned? This reconciliation will require us to identify points at which decisions and transitions are appropriate.

Randall Krakauer, MD, FACP, FACC, is the national Medicare medical director at Aetna. He is responsible for medical management nationally for Medicare members, including program development and administration. Other key areas of responsibility include the complex geriatric case management program; care management and care coordination programs including Compassionate Care; and evaluation and implementation of new medical management opportunities.

RANDALL KRAKAUER • 43

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Life

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Chapter 16

The Challenge of Non-Communicable Diseases and Geriatric Conditions

Randall Krakauer and Randall Krakauer

An Historical Perspective

Until the 20th century, average life expectancy worldwide at birth was 50 years. Since the incidence of non-communicable diseases increased with age, there was less opportunity for individuals to compete—and die before—non-communicable diseases like diabetes or heart disease. Today, individuals tend to die at relatively young ages from non-communicable diseases, although maternal mortality was also high prior to the 20th century.

Developments in public health and medicine—better sanitation, safe drinking water and improved maternal care, among others—increased the average life expectancy, particularly in developed countries. By 2000, there were almost 500 million people age 65 and older worldwide. By 2020, that number is expected to rise to 1 billion, or one in every eight people. While many seniors are healthy and active, nearly half of all have at least one non-communicable condition, including heart disease, hypertension, stroke, diabetes and Alzheimer's disease, among others.

Non-communicable diseases are by the leading cause of mortality in the world, representing 60% of all deaths. The death toll from non-communicable diseases is already pronounced in Africa and Middle Eastern countries. To ease longevity, there are things that people can do to reduce their risk of non-communicable diseases, representing both scientific contribution and scientific cost.

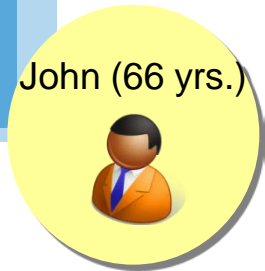
The critical question is whether they developed countries, namely the United States, that is used to achieve the most through an Affluence path. To be sure, there is a need to improve diet, exercise, sanitation and public health services in less developed countries, but should we, or any other country, have more, and/or increase in the quantity and corresponding cost in illness and health care beyond what has been necessary to achieve that?



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

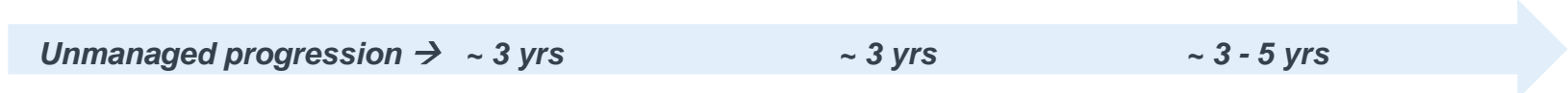


I need help ... I have -

- Hypertension
- Obesity
- High Cholesterol
- Gout
- Heart disease

... and this can get worse

- Multiple chronic conditions
- Advanced Illness
- Modifiable risk factors
- Transitional care
- Pharmacy management
- Ongoing follow up
- Ongoing risk evaluation



1 Pre-Diabetic

2 Diabetic

3 End Organ Involvement

4 Advanced Illness



John's Impact Interventions

<ul style="list-style-type: none"> • Define health goals • Customize plan to modify risk factors • Review medications • Work on adherence and continuous feedback 	<ul style="list-style-type: none"> • Onsite annual health risk assessment • PCP care coordination • Monitor Blood sugar, A'C, etc. • Continuous feedback 	<ul style="list-style-type: none"> • Care coordination for care completion • Long term case management • Holistic management 	<ul style="list-style-type: none"> • Follow up, education, and support • Choices, options, psychosocial support
<ul style="list-style-type: none"> • Progression to Diabetes is delayed by ~ 10 years, OR • Diabetes does not occur in the lifetime! 	<ul style="list-style-type: none"> • Progression to organ damage is delayed by 10 years, OR • Organ damage does not occur in lifetime! 	<ul style="list-style-type: none"> • Organ damage does not progress • Organ damage does not result in terminal illness! 	<ul style="list-style-type: none"> • Long term engagement facilitates Compassionate Care • Effective impact on Advanced Illness

Question and Answer Session



Randall Krakauer, MD, FACP, FACR
Vice President, National Medical Director
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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.
- A recording of today's webinar and slides will be available in one week at <http://ccmcertification.org>

