Aetna Better Health℠ Care Management

Progression of Care

Learning opportunities from Aetna developed with **you** in mind

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We Believe in Our Values

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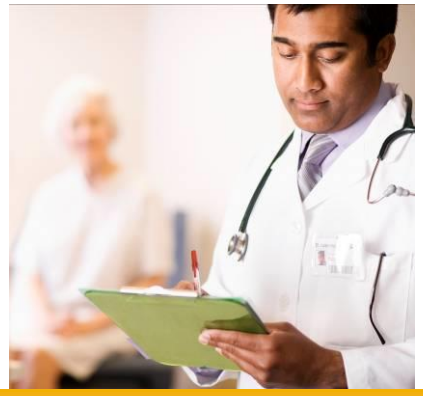
Integrated Care Management

- We help improve collaboration among members, providers, and healthcare systems by establishing innovative programs using medical management processes that view the member as a whole person.
- By comprehensively addressing members' physical, behavioral, and social needs, we help members become more effective in managing their overall health.

Focusing on the Right Members and The Process To Care Management

Member self-reporting
- Health risk questionnaire
- Member request



Outreach and referrals
- Provider requests
- Admissions/readmissions data
- Referrals by utilization staff

Predictive modeling

Assigned to professional care manager or coordinator

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Right Staff – Right Skills

- Professional care managers (RNs, LCSWs) and care coordinators
- Complexity of cases and specialization of staff considered when assigning cases
- Case load adjustment and focus on “single point of contact”-individualized, relationship-based
- Training through frequent in-services, clinical “rounds”

Aetna Better Health's Biopsychosocial Approach to Care Planning

Medical Model	Biopsychosocial Model
Diagnosis: The injury or disease	Formulation: Person with the injury or disease
Primary vs. secondary	Co-occurring
Compliance/adherence	Engagement/commitment
Decrease modifiable risk factors	Enhance protective factors/resiliency
Decrease signs and symptoms	Promote recovery
Task accountability	Outcome accountability

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Aetna Better Health's Biopsychosocial Approach to Care Planning

- Consider physical, behavioral and social factors as root causes in developing the member's care plan
- Include other care providers and stakeholders
- Reach a consensus with the member on goals and action items that are most important to them for their own care
- Formulate a care plan that the care manager and member agree is sensible and actionable
- Share the care plan with the member, the member's primary care physician, other providers, caregivers and family support

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Addressing Behavioral Health Concerns

- Collaboration with the Connecticut Behavioral Health Partnership (CTBHP) monthly clinical “rounds” of co-managed cases
  - Monthly “operational” meetings
- Behavioral health clinical consultant
- Educating staff through in-service learning opportunities

Addressing Social Concerns

- Use member advocates who focus on inspiring resilience with each member:
  - Direct members to community organizations that can assist with critical issues such as housing, food, finances, etc.
- Educate staff through in-service
- Collaborate with dental/vision providers, transportation vendors and community resources
  - Resource database

Perinatal Program

- Pregnant members are followed by care management through 90 days post partum
- Member condition drives level of care management
- Perinatal outcomes are measured
- Incentive program to encourage care management enrollment and medical visits
- Text4baby

Program In Action

Step 1: Concurrent review nurse refers member's case to care management – unnecessary hospital admission could have possibly been prevented with proper supports

Step 2: Care manager contacts member then member's PCP -- discovers member is concerned about pending eviction, has neglected medical condition and reports behavior that suggests she may be experiencing depression

Step 3: Care manager works with member advocate to resolve housing issue

Step 4: Care manager refers member to CTBHP

Step 5: Care manager works with member, in consultation with PCP to manage medical condition

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Progression of Care

- Care managers adapt the intensity of care management to the member's needs as the member moves through recovery toward self-management and autonomy.