



identify



stratify

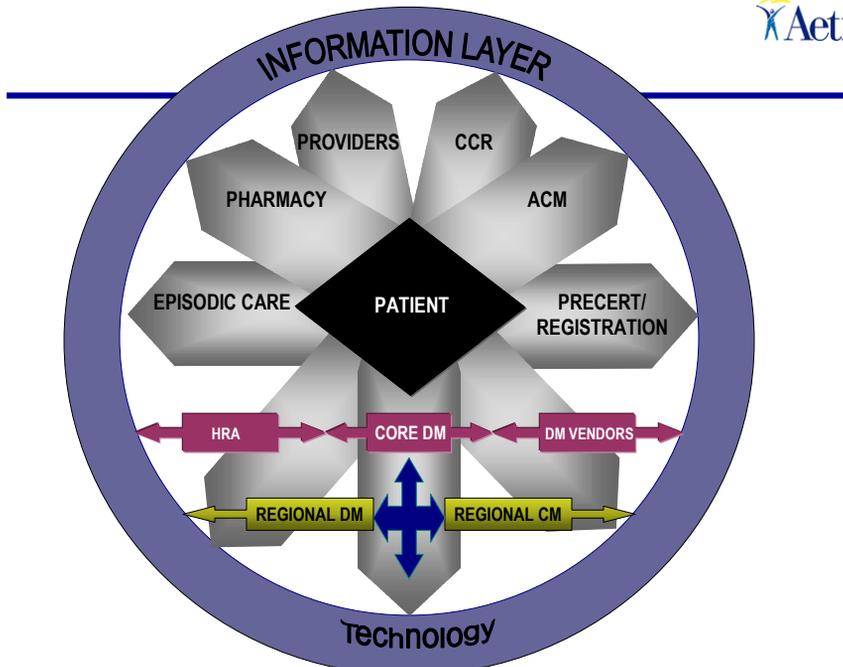


assess



impact

Case and Disease Management
David Hamburger, MD



Disease Management Programs

- **Asthma**
- **Congestive Heart Failure**
- **Coronary Artery Disease**
- **Diabetes**
- **End Stage Renal Disease**
- **Low Back Pain**

Disease Management Programs

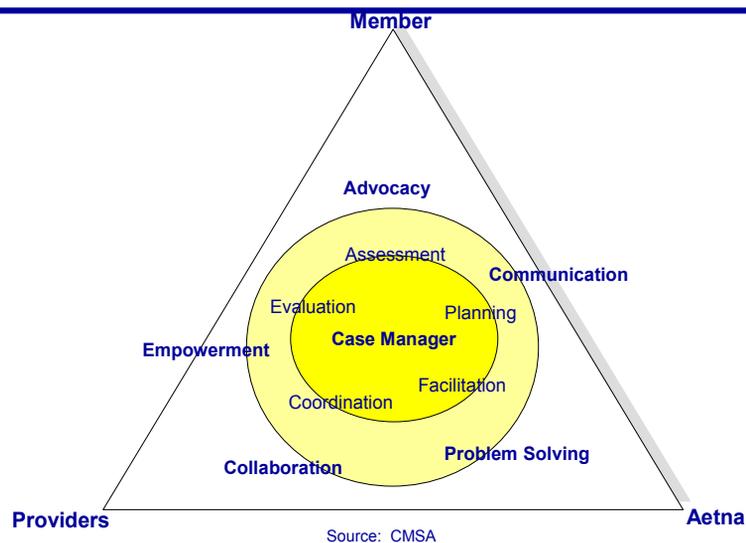
- **IDENTIFY** most “actionable” members
- **FOCUS** interventions early
- **EMPLOY** evidence-based clinical guidelines
- **FACILITATE** member/physician communication

Disease Management Programs

Member Identification

- Real-time pharmacy data
- Hospitalization/discharge data
- Referrals from case managers, concurrent reviewers & discharge planners

What is Case Management?



Aetna Case Management Goals and Objectives

Collaborate with the member, the member's family, physician(s) and other healthcare providers to develop and implement a Case Management plan that meets members' needs

Coordinate quality, cost effective sequencing of care

Work to return members to optimal level of health with maximum level of independence and optimal level of function

Increase member and provider satisfaction through collaboration on development and implementation of the Case Management plan

Develop targeted interventions for Case Management populations

Provide support and assistance to members and their families when dealing with end of life issues

CM Planning

A collaborative process involving the member, family or significant other, care provider(s) and treating physician

Includes short and long-term goals

Based on interventions identified through assessment of member needs

Interventions may include, for example

- **Coordinate benefits, e.g., DME**
- **Identify and arrange community services**
- **Arranging care as needed**
 - **Home health**
 - **Outpatient infusion treatment**
 - **Meals on Wheels**

CM Planning (Cont'd)

Identify and address member and care giver needs for education

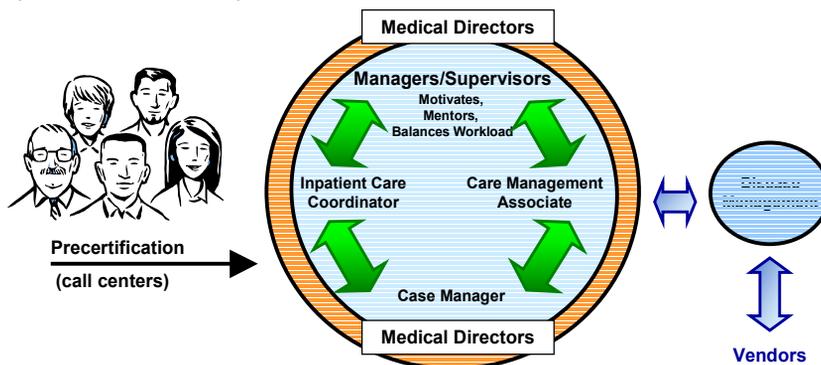
- Management of symptoms and treatments
- Understanding of medications
- Nutritional needs
- Supportive services – both member and care giver

Focus on

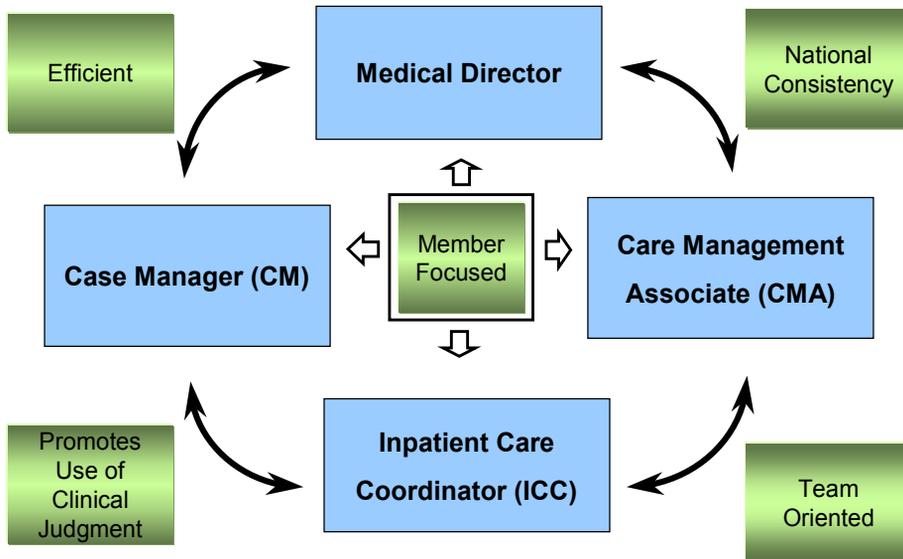
- Arranging appropriate level of care
- Coordinating multiple providers

Key concepts of a Care Management Team

- Care Management Teams will be organized geographically and are responsible for the member's continuum of care
- Each member will be managed by the team member that makes the most difference in quality outcomes
- The streamlined approach will decrease the number of Aetna staff contacting members and providers and increase operational efficiencies



Attributes of a Care Management Team



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Teamwork was identified as a fundamental attribute of the medical services model



Open communication between care management team members is fundamental to the new medical services model
 Critical thinking and clinical judgment

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