Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna℠

Health Monitoring

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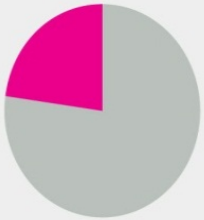
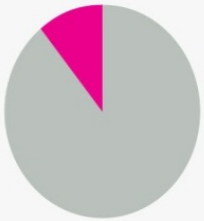
Chronic Conditions & Cost Distribution in Medicare Beneficiaries

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

A holistic, integrated experience

A long-term strategy for support
… at every stage of retiree health

Relatively healthy

Approach:
Wellness programs and resources to help maintain health, prevent conditions

Risk factors and early-stage chronic disease

Approach:
Advanced programs and attention to help address most common risks/ conditions

Complex medical needs/advanced illness

Approach:
Targeted one-on-one attention from case managers working with members and doctors

Example of Health Monitoring: Aetna Hypertension Program

Approach

- Automated blood pressure monitor provided at no cost
- Monthly outbound Interactive Voice Response (IVR) calls - Recording of blood pressure (BP) on monthly basis
- Member educational material mailings
- High BP alert for Case Management outreach and education
- Goal is to improve member self-management and awareness of disease by actively participating in blood pressure measurements

Example of Health Monitoring: Aetna Hypertension Program

Results

- 18% net reduction in participants with blood pressure "out of control"
- 87%-91% increase in LDL (i.e. "bad cholesterol") screening rates
- 87% of survey respondents said they knew more about controlling their blood pressure as a result of the program
- Based on economic modeling for 8% participation, managing blood pressure could result in 23 fewer strokes, 22 fewer coronary artery disease events and 16 fewer deaths per 100,000 annually

(Source: *J Invest Med.* 2010)

Health Monitoring through IVR: Lessons

Barriers

- Adherence rates over time
- Acceptability of non-human interaction
- Personalization vs. motivational interviewing based conversations

Opportunities and Facilitators

- Acceptance of low-tech interventions vs. internet-based
- Scalability for population health medicine
- Live nurse case management back-up: efficient use of higher cost resources

Health Monitoring:
Congestive Heart Failure Telemonitoring

- **Objective**: Assess impact of supplementing nurse case management with Internet-connected telemonitoring on clinical outcomes in an elderly heart failure (HF) population.
- **Study Design**: RCT of high-risk HF subjects; telehealth system with case management vs. case management (CM) alone.
- **Methods**: 6 month intervention. Primary outcome measure was a composite of all-cause hospitalization, emergency department visit, or death.
- **Results**:
  - No impact on primary composite outcome (P = .22).
  - Telehealth alerts prompted frequent telephonic contact, increasing case managers' workload.
  - The participant population overall had 42% fewer inpatient days during the intervention period compared with the previous year.

(Source: *Am J Manag Care.* 2011;17(3):e71-e79)

Example of Telemonitoring: Congestive Heart Failure Lessons

Barriers

- Participation rates
- Device installation/maintenance, infrastructure requirements
- Patient selection factors (Who? Illness severity?)

Opportunities and Facilitators

- Evolving technology and devices
- Improving cost of technology and connectivity
- Case management nurses: to engage patients over time, address alerts, promote education and self-management skills
- Closer collaboration between patient/case manager/physician through ACO-like arrangements

Summary

- Aging patients increasingly have multiple chronic conditions: complex, costly, increased care coordination needs
- Use of technology as a tool: a means to an end
- Goal is to improve quality/cost intersection by:
  - Increasing patient engagement
  - Improving clinical outcomes

Thank You