Medicare
Medical
Management

Quality Impact of Geriatric Care Management:

An Evaluation with Medicare Advantage Population

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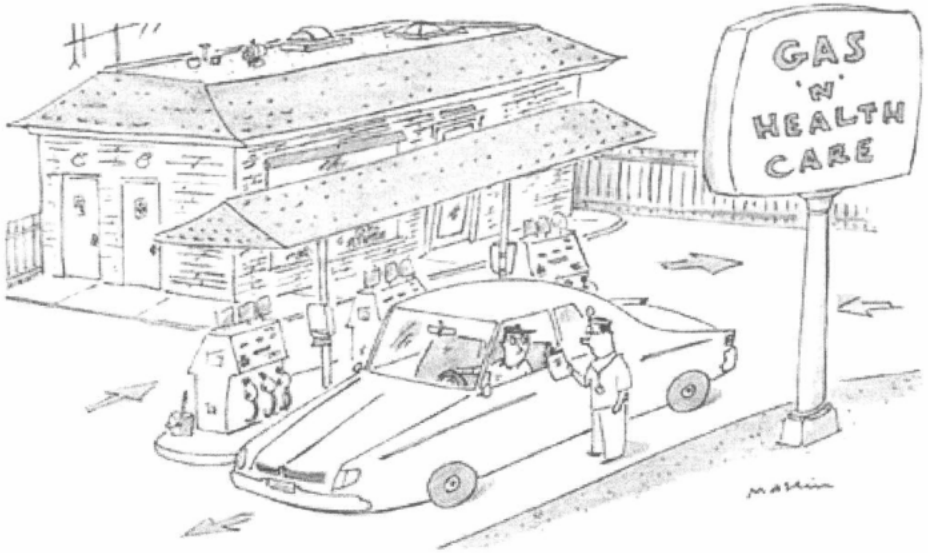
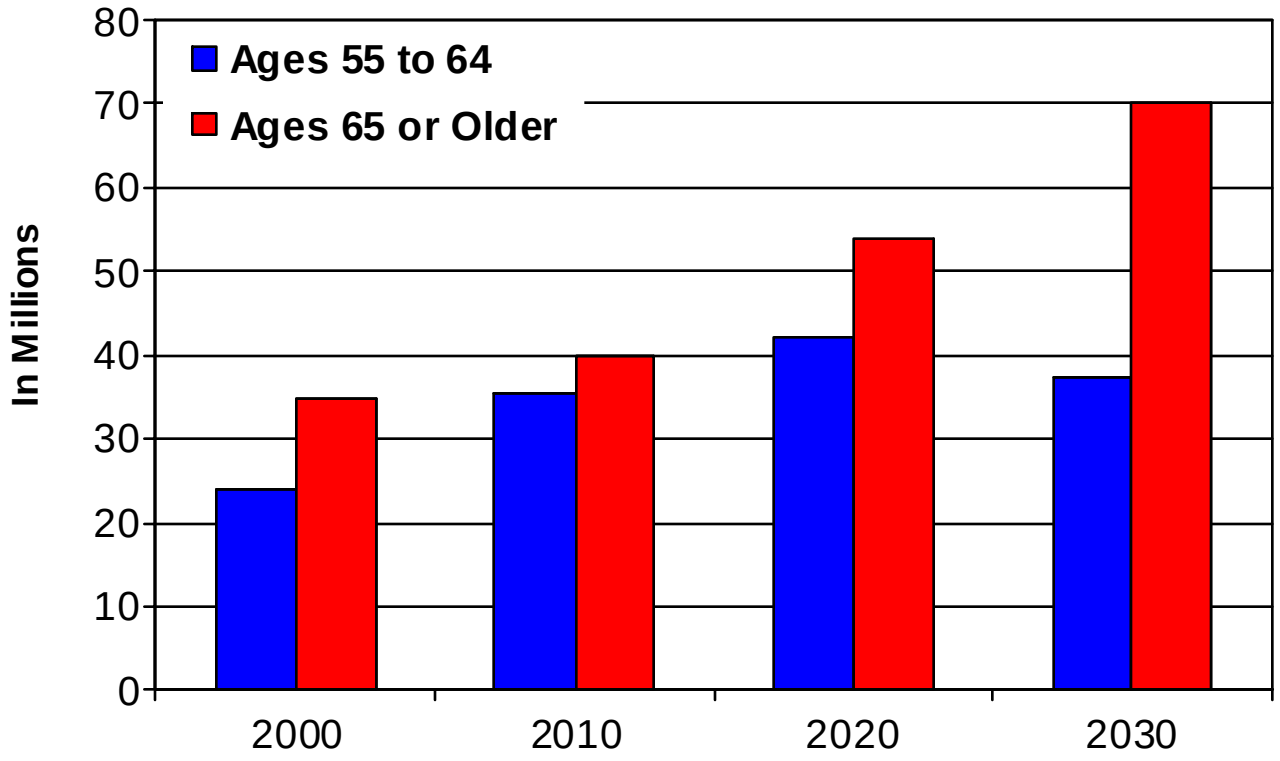


"Your oil's fine, but your blood-sugar level's a little low."

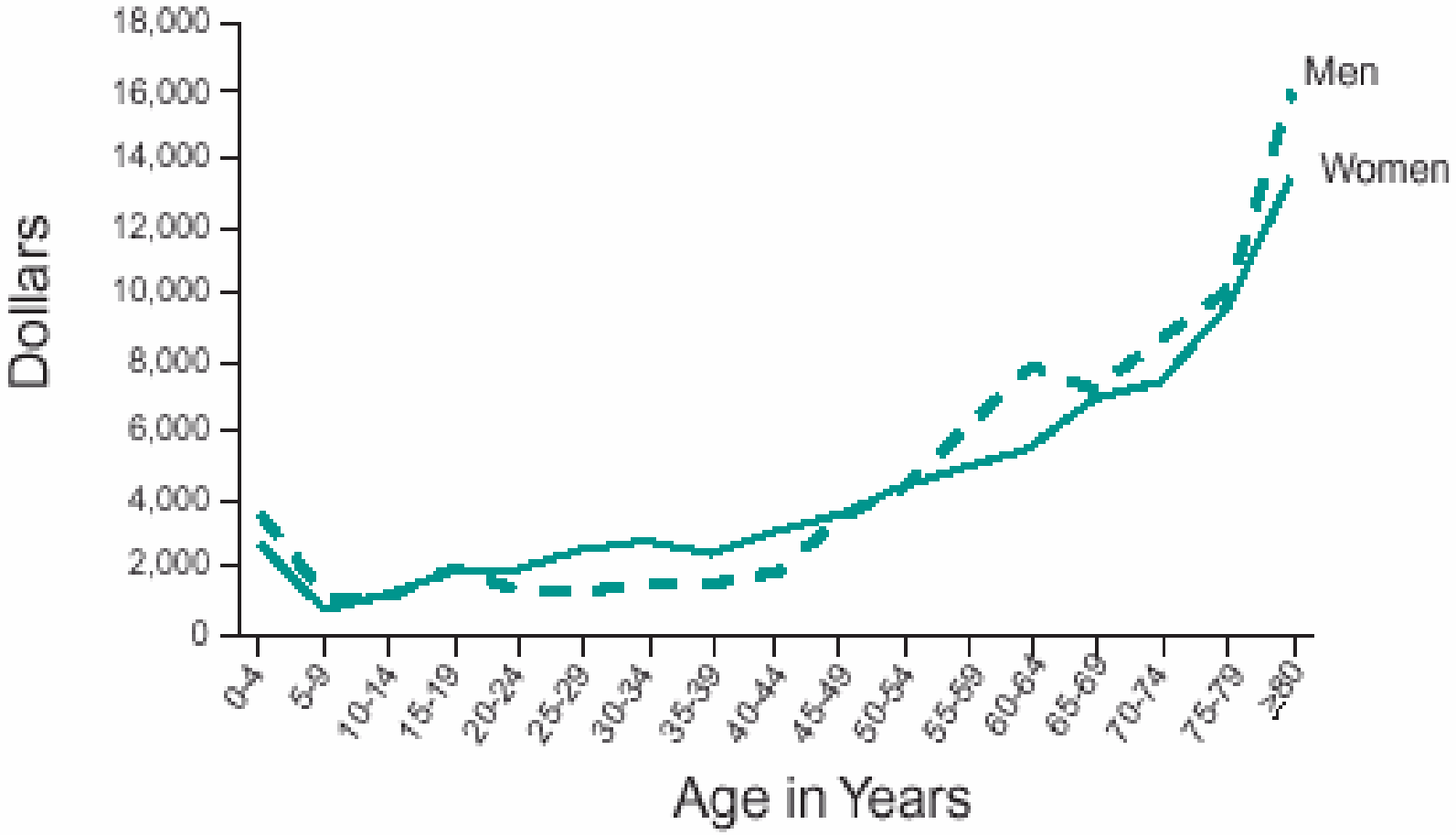
- An Unhealthy America: The Economic Burden of Chronic Disease – Milken Institute 10/02/2007

The Elderly and Near-Elderly Population

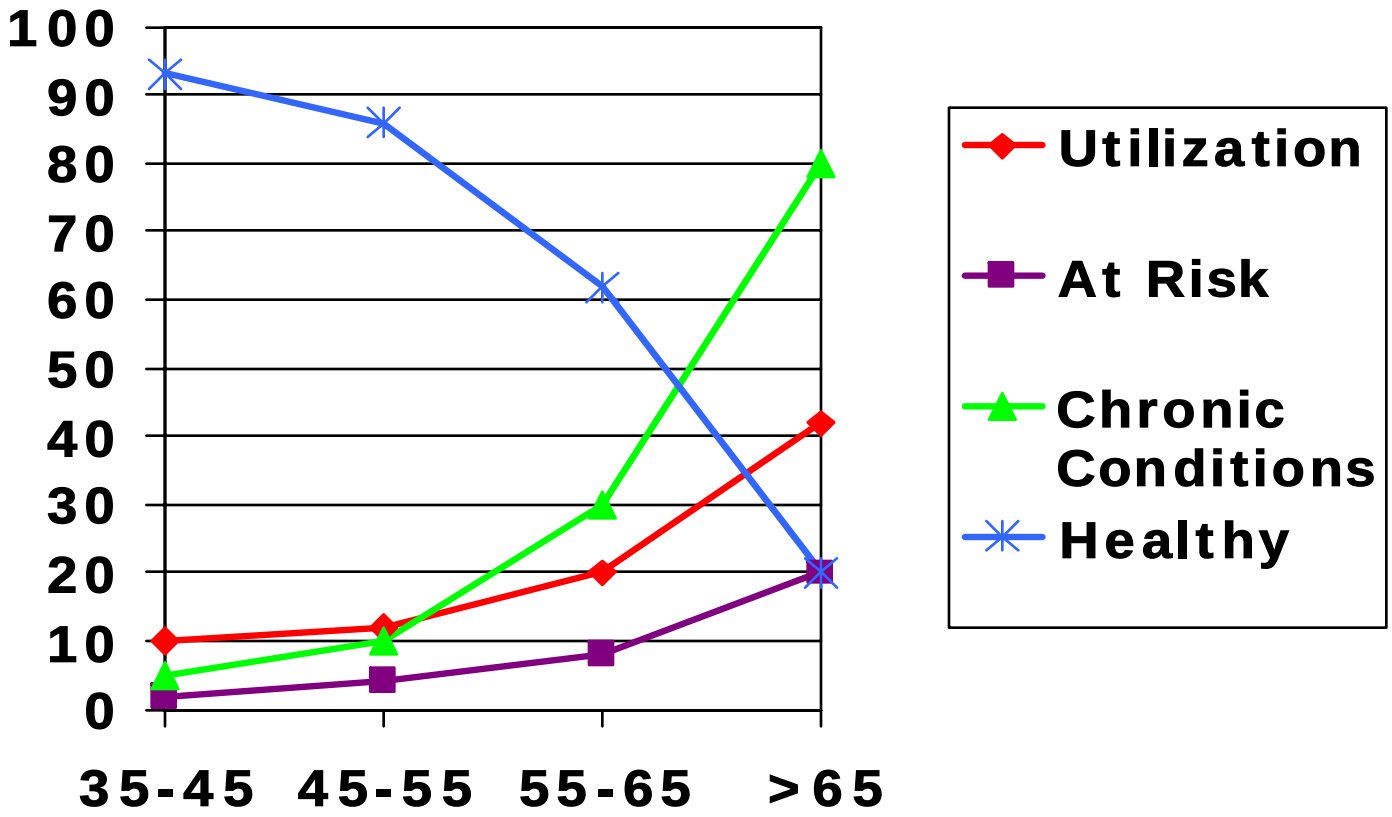


Source: U.S. Census Bureau

Medical Costs increase dramatically with age for a variety of reasons



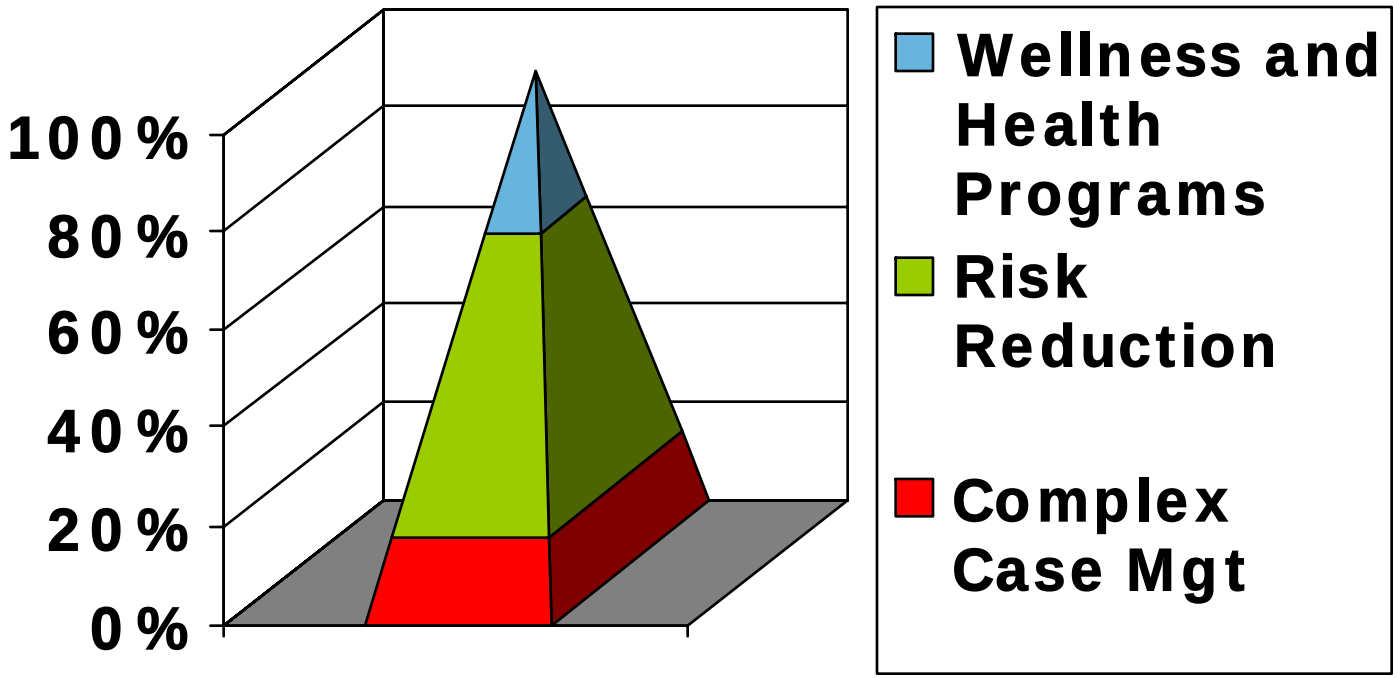
The Dynamics of Utilization Associated with Aging



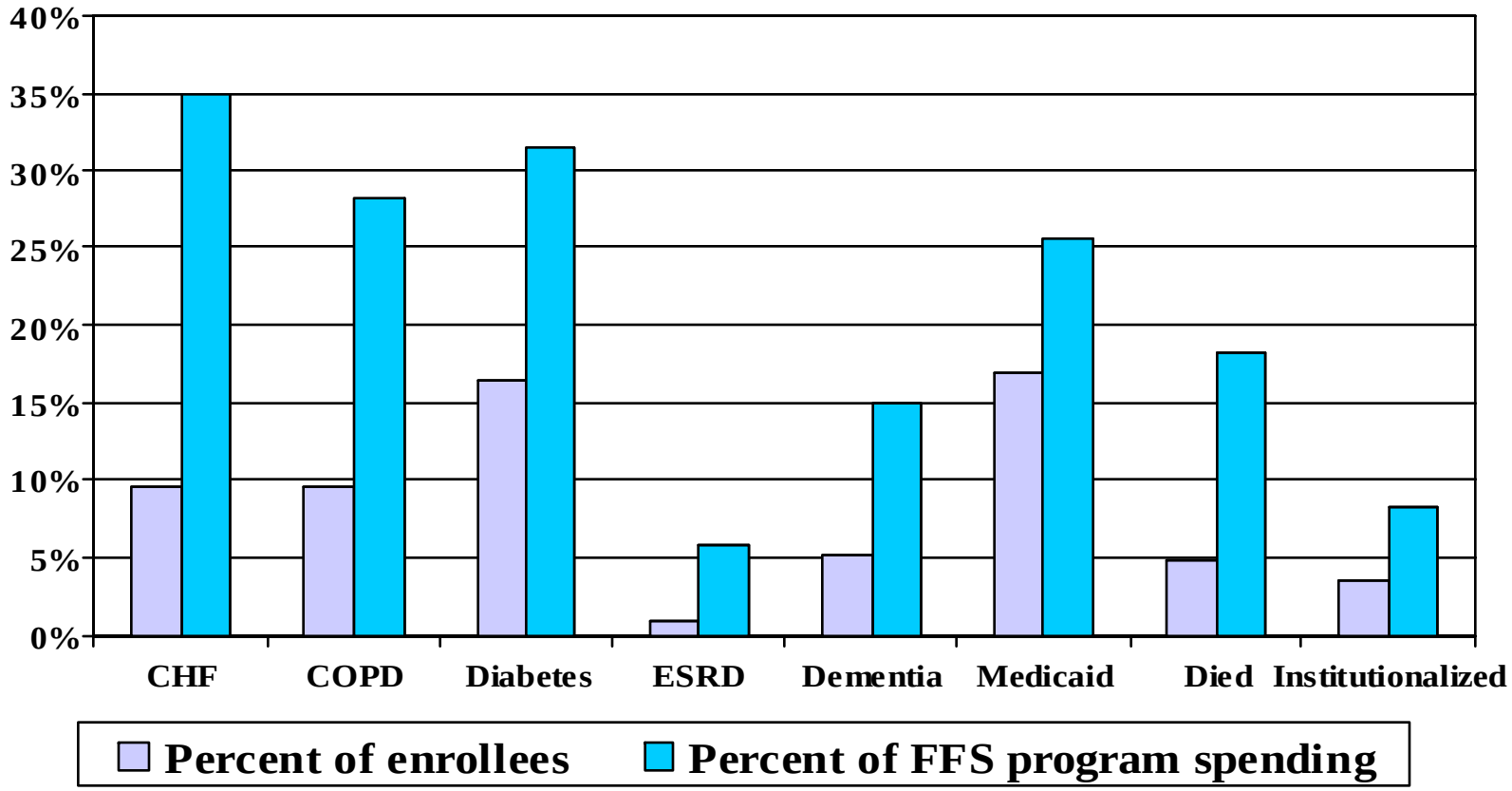
Foundational Capabilities: Care Management

Complex case management for multiple Chronic Conditions

Risk Reduction for simple condition or risk factors

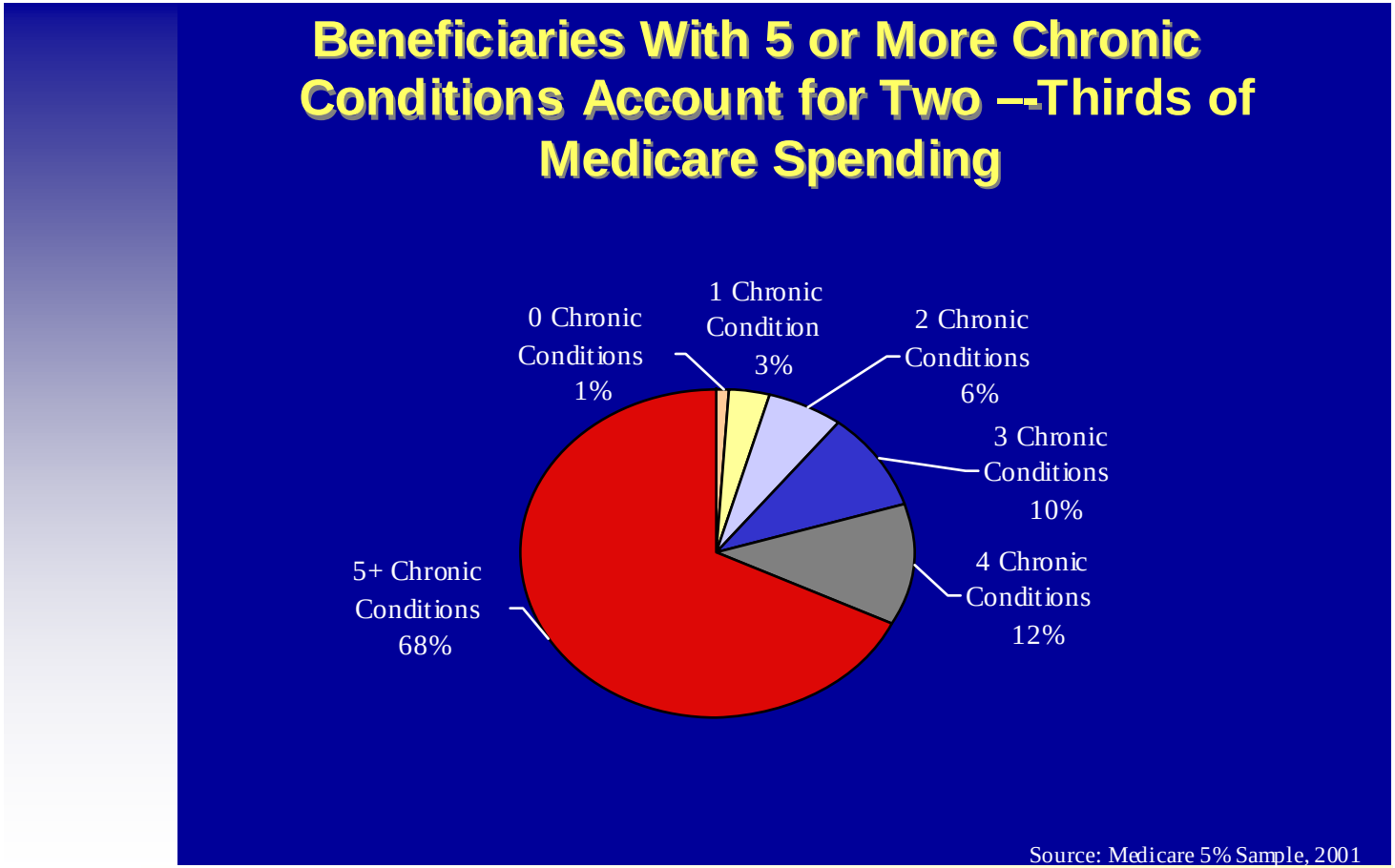


2002 Data



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.

Fee for Service Medicare Data



High Risk Member Resource Consumption

- **10% of Members account for:**
  - 81% of inpatient costs
  - 61% of admits
  - 59% of total costs
- **3% of Members account for:**
  - 48% of inpatient costs
  - 27% of admits
  - 33% of total costs

The Opportunity: Effectively identify and manage at least the top 10% of senior members accounting for 81% of inpatient & 59% of total cost! Managing co-morbid conditions is the KEY to impact quality and cost.

# Chronic Co-morbid Conditions	% Pop	Relative Cost per Member	% total Cost	Relative Acute Admits	Mean Rx per Year
>4	20%	3.2	66%	5.2	49
3-4	27%	0.9	23%	1.3	26
0-2	53%	0.1	11%	<0.1	11

What is the impact of chronic illness in the Medicare population?

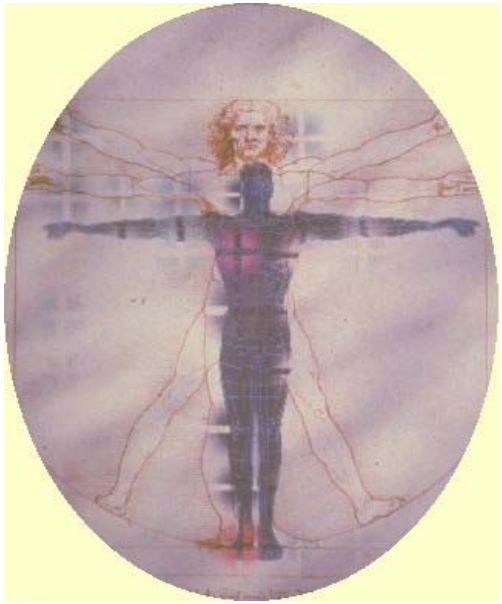
- **Chronic conditions are a leading cause of illness, disability, and death among Medicare beneficiaries and account for a disproportionate share of health care expenditures.**

What is the prevalence of the chronic illnesses managed by these programs?

- **About 14 percent of Medicare beneficiaries have congestive heart failure but they account for 43 percent of Medicare spending.**
- **About 18 percent of Medicare beneficiaries have diabetes, yet they account for 32 percent of Medicare spending.**

Why Older Patients Require More Medical Management

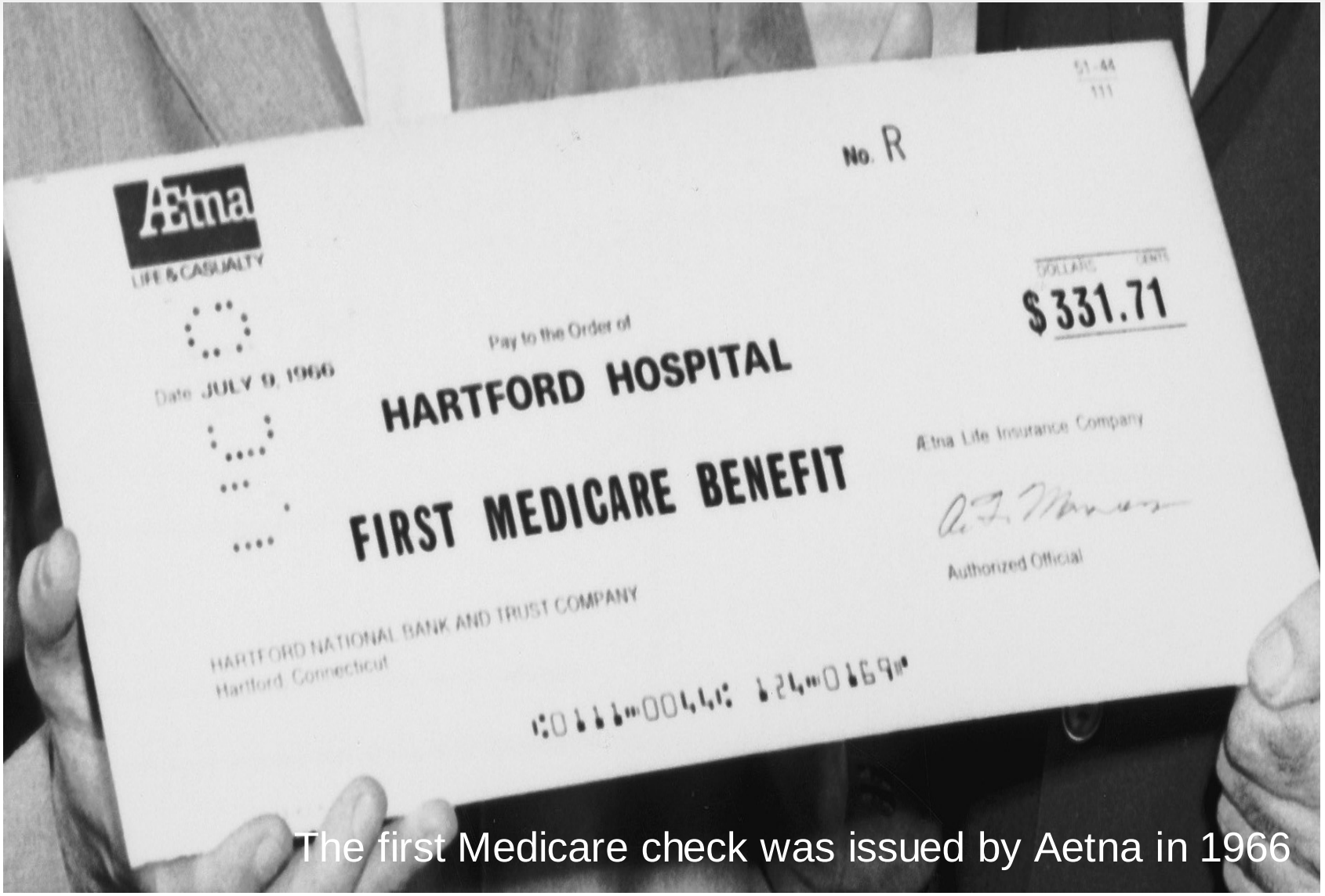
Many factors make the impact of illness greater for an older patient than a younger patient with a comparable condition. All factors must be identified and managed.



Factor	Impact
• Prevalence of high-risk conditions	• Greater burden of disease
• Greater incidence of comorbidities	• Increased need for medical care
• Less identifiable symptoms	• Greater need for surveillance
• Greater potential for damage from injury or condition	• Increased need for condition management
• Reduced ability to recover from injury or condition	• Greater need for preventive condition management
• Less ability to follow a medical regimen	• Greater intensity of medical management
• Less family and social support	• Increased need for outside help

The Medicare Geriatric Care Management Program – 4 years progress

- Identification of Cases with opportunity for better management
  - Aggressive outreach program to complete a simple HRA on new members – 80% completion rate (2002 less than 10%)
  - Predictive Modeling monthly to identify cases with risk and opportunity developed and implemented.
- Comprehensive assessment of all identified cases initiated
  - Identify all conditions and care gaps
  - Identify all psychosocial barriers to care
  - Comprehensive care management plan
- Dedicated Geriatric Case Management accomplished
  - Nurse Case Managers with additional training in Geriatrics and Change Management
  - Social Worker case managers
  - Behavioral Health Case Managers
  - Disease Management for selected conditions integrated into program
  - Specialized programs: Compassionate Care Management; Dementia
  - All programs integrated – not “stand alone.”



The first Medicare check was issued by Aetna in 1966

Multiple comorbidities and barriers identified and managed concurrently

We have developed an effective and leading Geriatric Care Management Program. We will enhance it to impact more of our high risk and vulnerable members

Factor	Impact
• Members in Case Management 16% with effective identification of cases by HRA and predictive modeling	• These members represent >50% of total cost, > 75% of variable cost, and most quality issues
•Comprehensive assessment, identification and management of all issues/conditions is critical	•Little impact unless all comorbidities and issues are managed concurrently and successfully.
• Nurses, Social Workers, Behavioral Health, Disease Management Specialists – all trained in Geriatrics and Change Management	•A uniform, effective and integrated strategy – comprehensive and holistic – effective on elderly with multiple conditions. Disease Management is a component of the program.
•Special Care Management Programs •Compassionate Care •Institutionalized Elderly •Home Care Management	•Expand a successful geriatric program to most populations that can benefit

Quality – Medical Management Approach

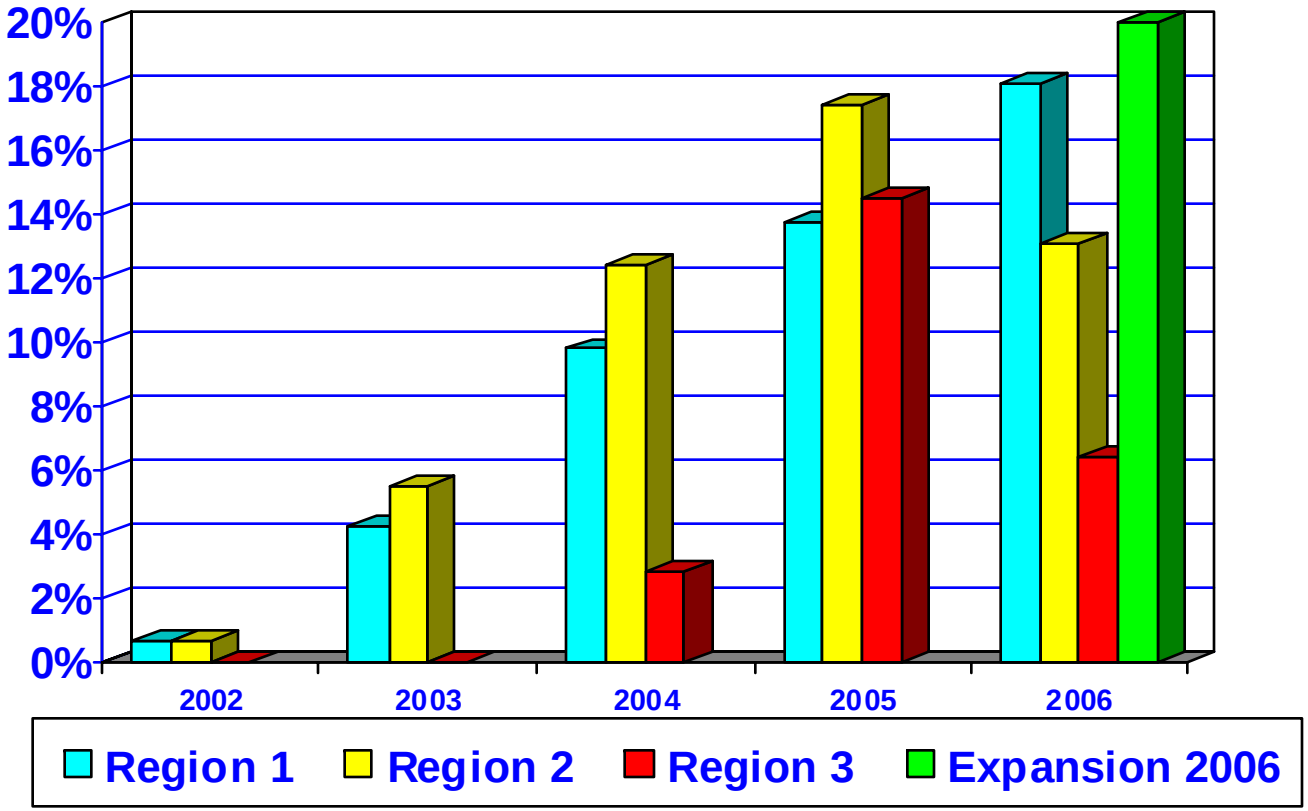
Aetna's approach to medical management is holistic and integrated, enabling effective care of seniors with multiple conditions and reducing preventable hospital admissions.

Holistic, Integrated Approach

Elements	Impact
▪ All new members receive a Health Risk Assessment (80% completion rate) **and** monthly predictive modeling ▪ Those identified receive Comprehensive Screening and Management	▪ Enables identification/management of all conditions and barriers to address the whole person ▪ Provides greatest impact with all comorbidities and issues managed concurrently
▪ Enrolled 15% of members in Case Management ▪ New programs for Home Case Management and Institutionalized members piloted	▪ Aetna **preventable admissions in core markets are going down year over year** ▪ Admissions are **below the Medicare FFS level** and the difference has been growing every year since 2002
▪ Nurses, Social Workers, Behavioral Health, Disease Management Specialists are all trained in Geriatrics and Change Management	▪ Provides a uniform, effective and integrated strategy for members with multiple conditions and psychosocial barriers
▪ We provide specialized programs: – End of life care management – Dementia – Institutionalized Elderly Management	▪ Expands successful medical management to more high risk and vulnerable populations. Disease Management is a component of a comprehensive Care Management program.

Medicare Care Management: Dedicated Geriatric Case Management Development

Members in Dedicated Geriatric Case Management



Medical

Behavioral Health

Rx

Labs

Demographics

Physician & Member Engagement

- Patient Safety/Medical Best Practices

Evidence-Based Clinical Rules

Evidenced-Based Clinical Rules

Physician Outreach

- Severity Levels 1,2,3

Physician Feedback

Enhanced Member Outreach for additional *Case Management* Opportunities

We want you to know℠

Aetna® Medicare

We want you to know™

Aetna Medicare

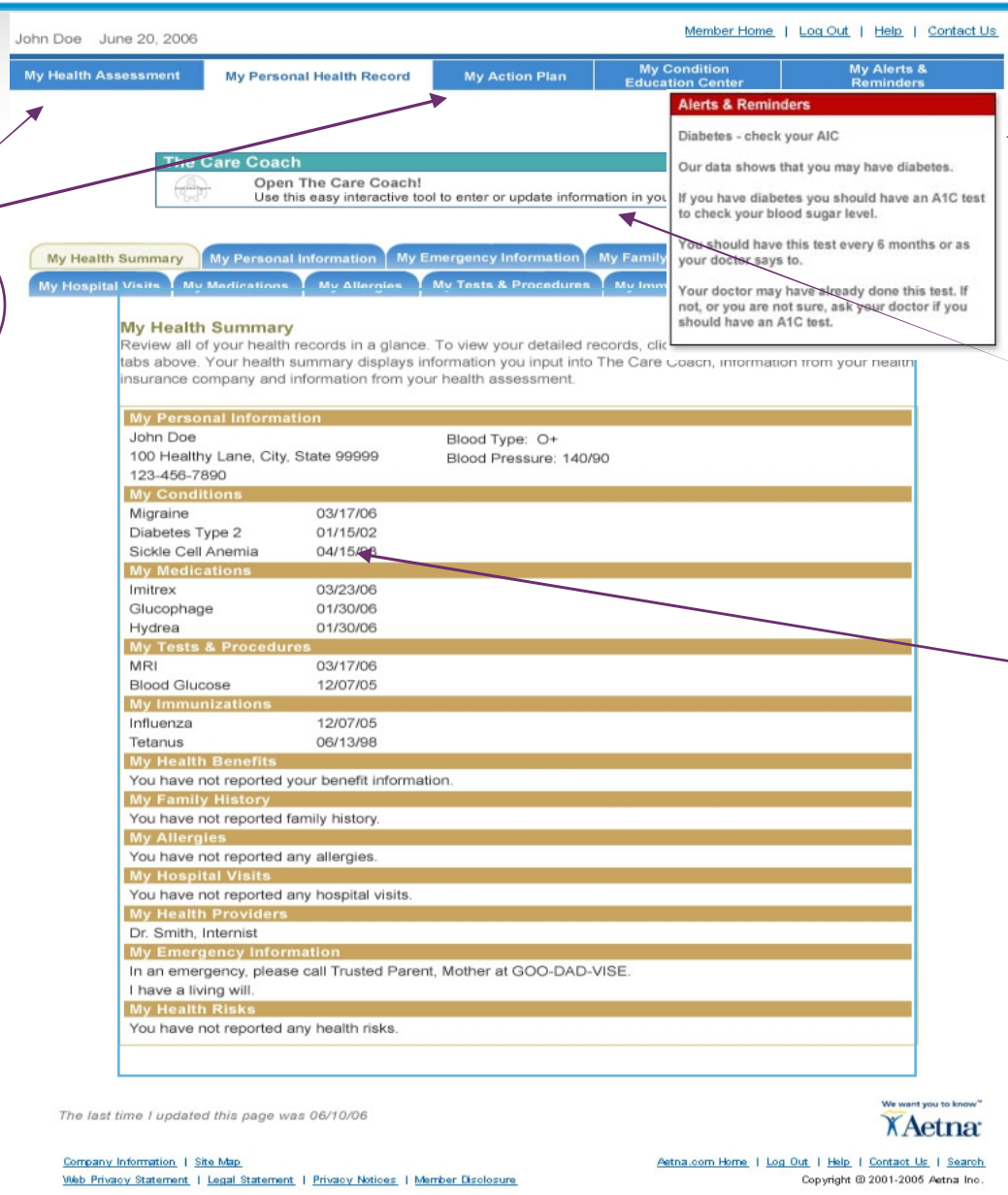
CareEngine®-Powered PHR

Direct access to Simple Steps To A Healthier Life® Health Assessment and Action Plan

Records of physicians, medications and conditions

Records of lab results, tests and procedures

Plain English diagnosis code translation



Direct access to Informed Care Decisions

Personalized messages and alerts

Guided tour to encourage employees to self report health information

Click for more details - detailed clinical information including content reviewed by Harvard Medical School

Print and take to next office visit

Categories & elements are AHIP compliant

We want you to know™

Aetna Medicare

Aetna Health Connections Disease Management Program

- ✓ 1 program; 34 conditions
- ✓ Customized assessments and action plans
- ✓ Single Nurse Model
- ✓ Provides 360º view of 100% of members, 100% of the time
- ✓ **Underlined conditions** are of special concern for a Medicare population, and receive enhanced emphasis
- ✓ Integrated into total care management process

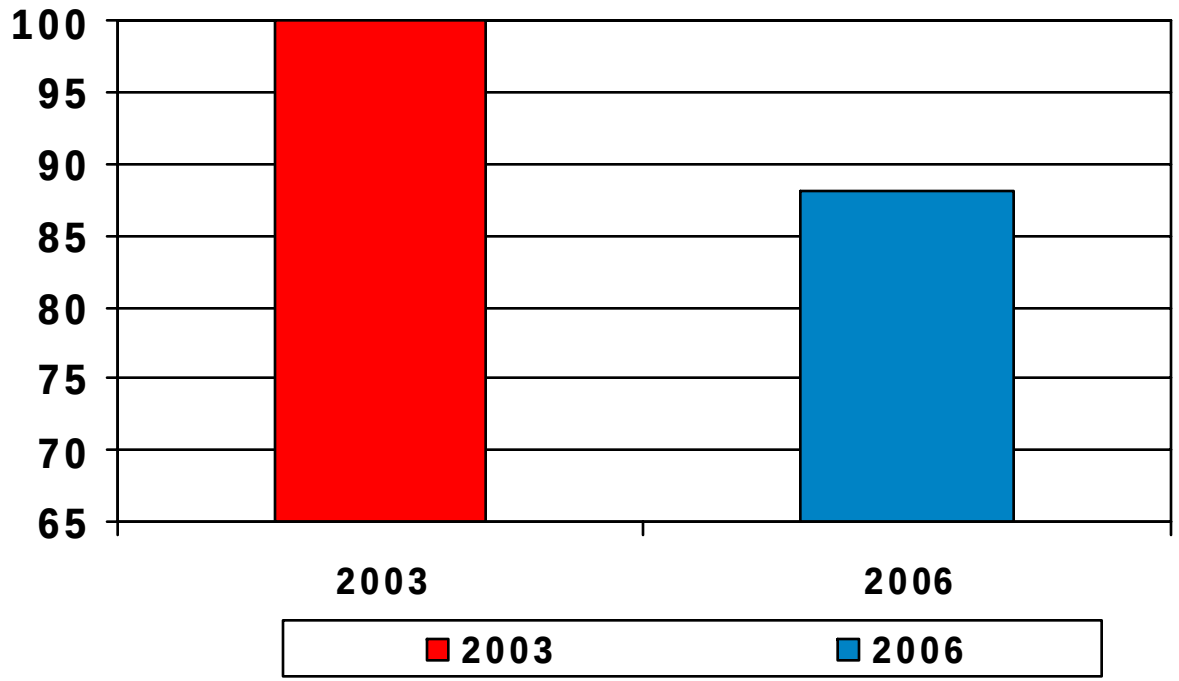
- **Vascular Cluster**
  - **Congestive Heart Failure**
  - **Diabetes (adult & pediatric)**
  - **Coronary Artery Disease**
  - **Peripheral Artery Disease**
  - **Hypertension**
  - **Cerebrovascular Disease/Stroke**
- **Pulmonary Cluster**
  - Asthma (adult & pediatric)
  - **COPD**
- **Orthopedic Cluster**
  - **Osteoporosis**
  - **Rheumatoid arthritis**
- **GI Cluster**
  - **GERD**
  - **Peptic Ulcer Disease**
  - IBD (Crohn's Disease & Ulcerative Colitis)
  - Chronic Hepatitis
- **Neuro Cluster**
  - **Geriatrics**
  - Migraines
  - Seizure Disorders
  - **Parkinsonism**
- **Oncology**
  - **Breast Cancer**
  - **Lung Cancer**
  - **Lymphoma/Leukemia**
  - **Prostate Cancer**
  - **Colorectal Cancer**
- **Other**
  - **Hypercoagulable state**
  - **Chronic Kidney Disease**
  - Sickle Cell Disease (adult & pediatric)
  - Cystic Fibrosis
  - **End Stage Renal Disease**
  - HIV
  - **Low Back Pain**

Potential Impact of Care Management on Medicare

- **Case Management of Complex Cases**
  - Admissions avoided by better care management in a population that represents 85% of all admissions
  - Improved quality of care and quality of life
- **Compassionate Care**
  - Mortality rate of near 5%
  - Assistance with Palliation, Support, Choices/Options
  - Dramatic improvement in quality of care and satisfaction drives this enterprise
- **Institutionalized Elderly**
  - Considerable opportunity for improved care management and prevention
  - Admission reduction 50% or more due to better prevention
- **Home/Transitional Care Management**
  - Reduce unsuccessful discharges
  - Better impact than telephonic for subpopulation
- **Disease Management**
  - Near 50% with significant chronic condition
  - Focus on evidenced based care for multiple conditions
  - Substantial improvement in quality
- **Dementia Care Management**
  - Significant comorbidity – 37% for over 85
- **Depression Case Management**
  - Significant comorbidity in Medicare population
- **Social Service issues**
  - Frequently dominate complex cases
  - Care management fails without this integrated capability

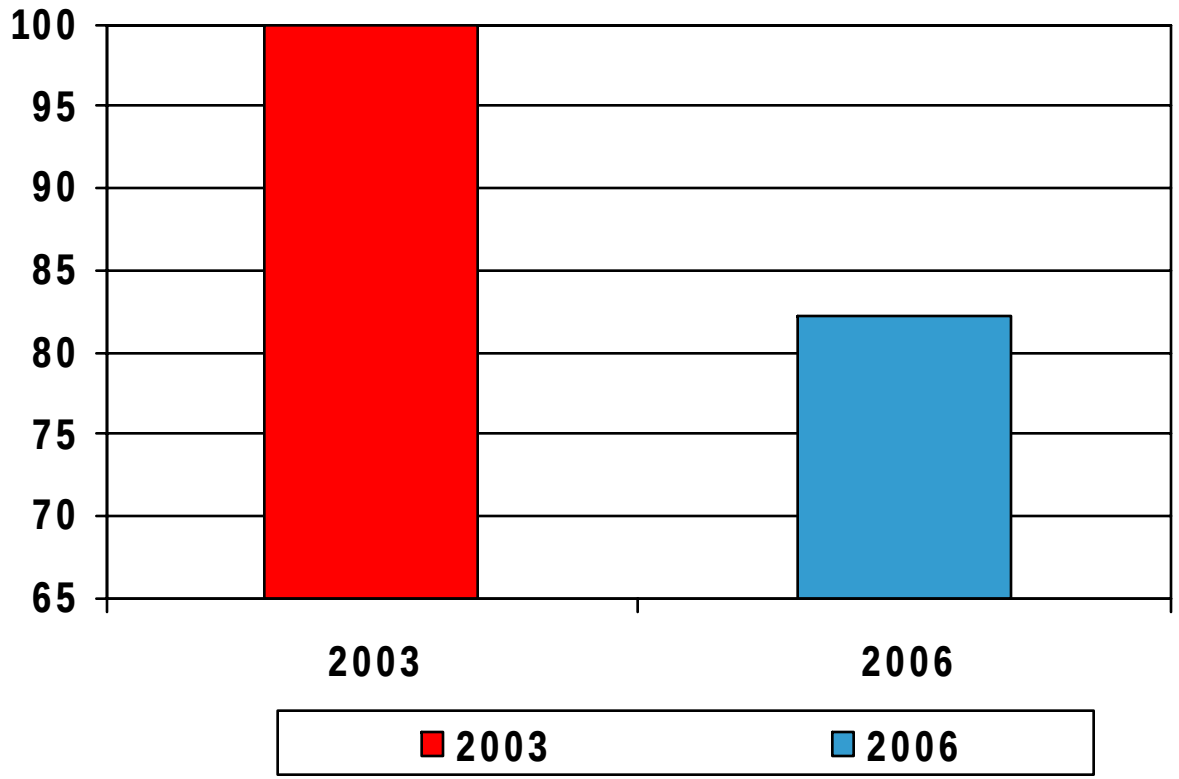
Impact from Geriatric Care Management

Reduction in Overall Admissions

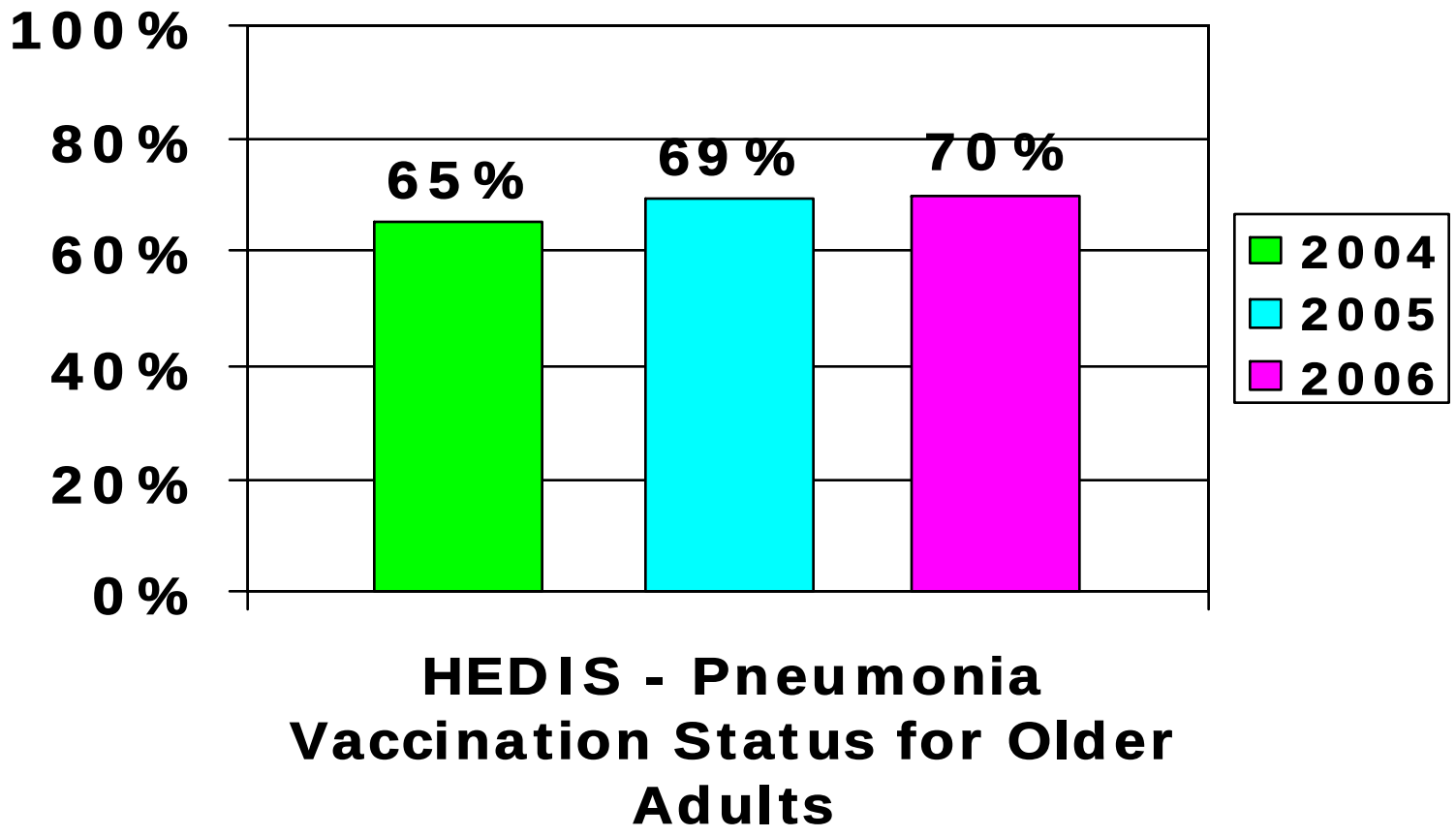


Impact from Geriatric Care Management

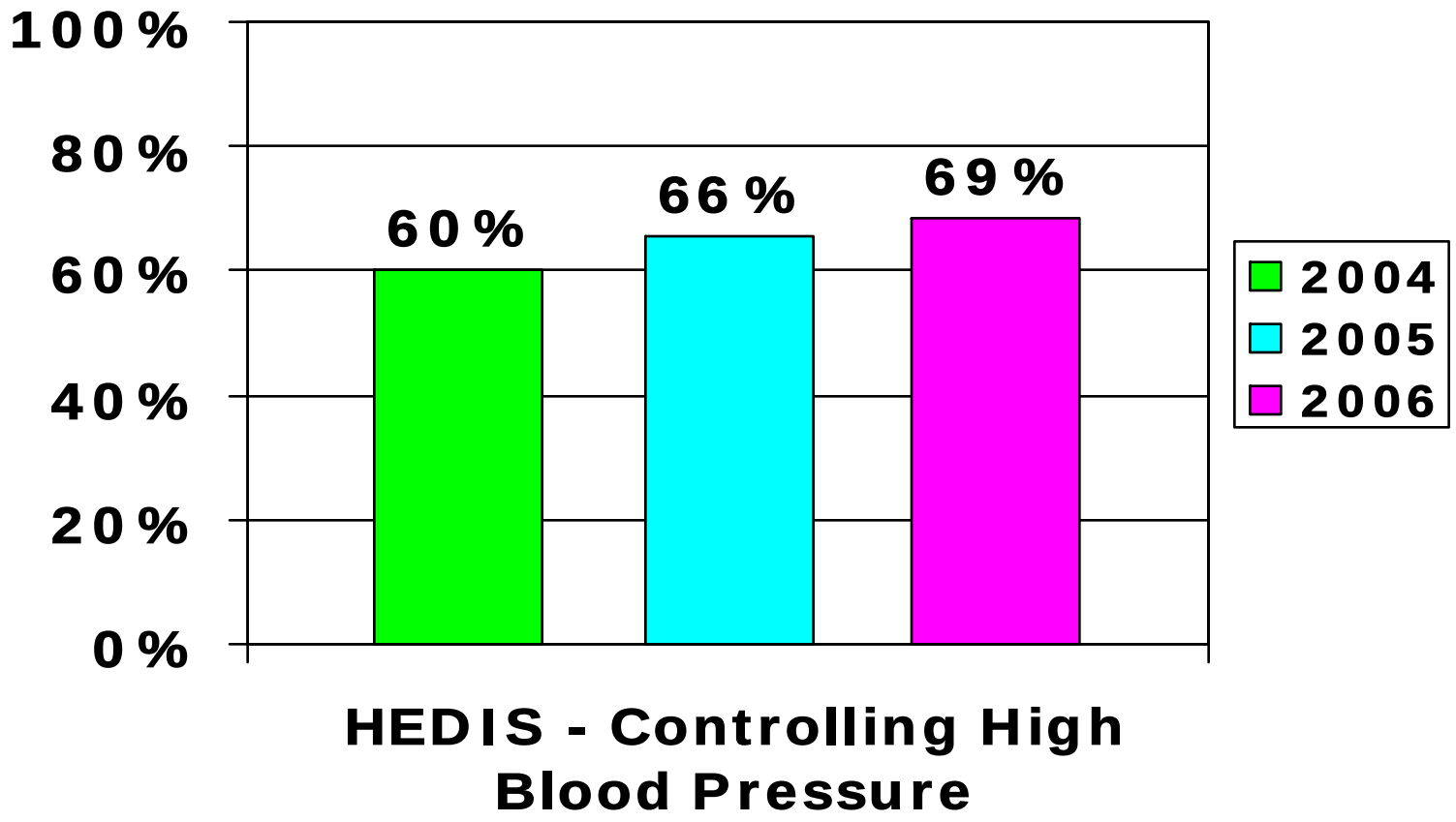
Reduction in Overall Sub Acute Bed Day Utilization



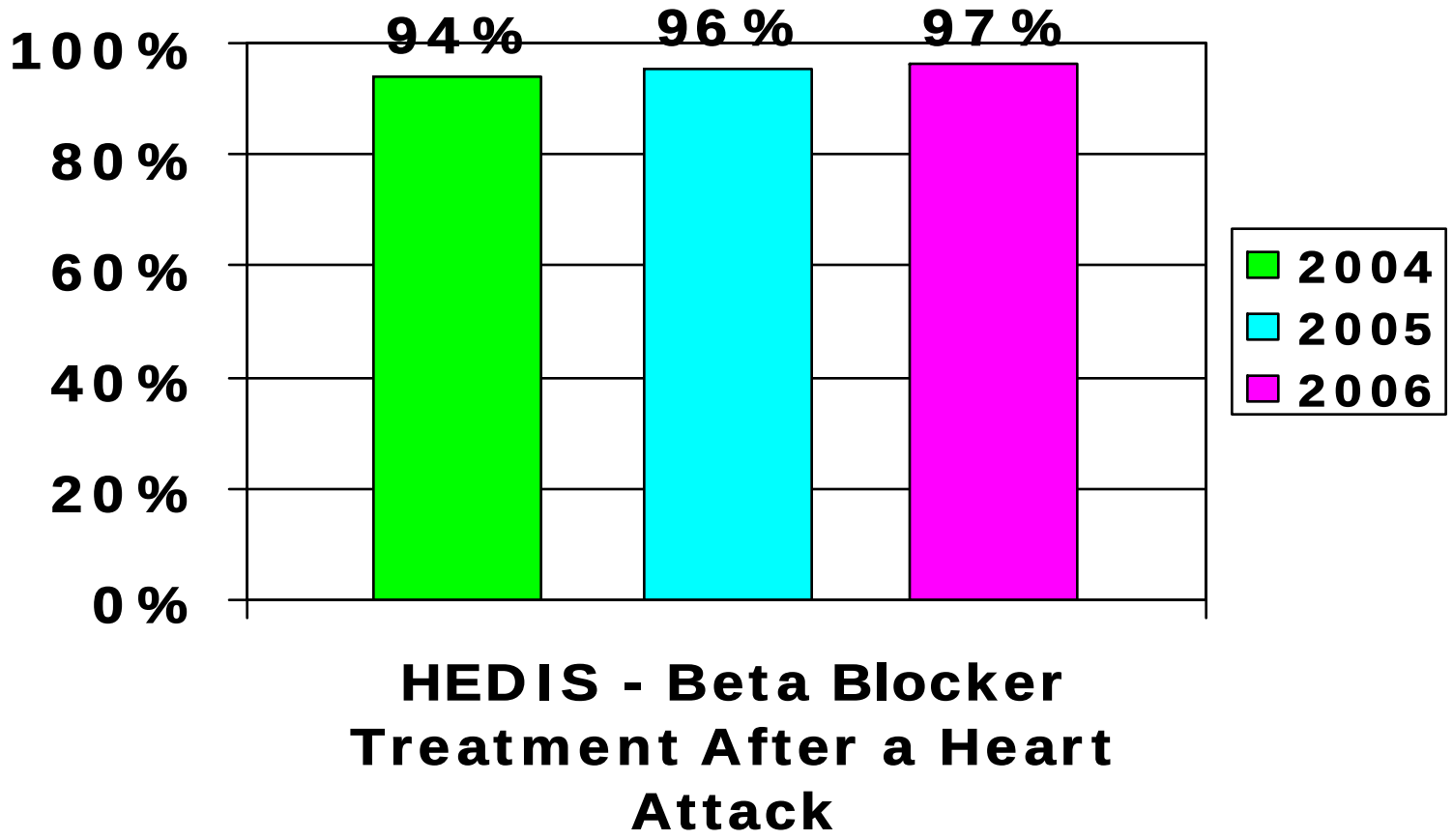
Aetna Medicare Care Management: HEDIS Measures



Aetna Medicare Care Management: HEDIS Measures



Aetna Medicare Care Management: HEDIS Measures



Aetna Medicare Compassionate Care Case Management 2006 Summary

- **A significant portion of members with terminal illness completed Compassionate Care Case Management**
  - More than ¾ of completed cases consistently elect Hospice
  - Most of these elected Home Hospice
  - Mean length of time in Hospice has increased
- **Fewer than 1 in 5 die in acute or subacute facilities, fewer than 10% die in acute facilities**
- **High level of member and family satisfaction**
  - This program generates considerably more member and family satisfaction than any other care management program
  - This represents our greatest opportunity to close "quality of care gaps."

Aetna Medicare Care Management of at-risk populations

- Institutionalized elderly are poorly managed by our existing care management process. Avoidable admissions and quality issues are common.
- A new program has been piloted in to provide comprehensive, on-site care management with Nurse Practitioners working in conjunction with case management.
- There is a population of home bound elderly that are difficult to impact with telephonic care management
- A new program has been piloted in MA region for Advanced Practice Nurses, in collaboration with the U. of Pennsylvania, to provide care management in the home.
- Care Management is more effective when done in close collaboration with physicians
- Develop collaborative care management arrangements, possibly with P4P, with interested physician groups

Quality Performance Measures: Unique Medicare Issues

- Quality considerations driven by a subpopulation with multiple comorbid conditions and psychosocial barriers.
- Greater subpopulation with serious or significant illness.
- Importance of measures applicable to multiple conditions and circumstances.
- Less reliance on public health process measurements: mammograms in elderly women with heart failure?

The ACOVE (Rand) study identified care of terminal illness as a particular quality problem for the elderly

Geriatric Conditions and Quality Scores

Condition	% QIs Passed
Malnutrition	47
Pressure Ulcers	41
Dementia	35
Falls and Mobility Disorders	34
Urinary Incontinence	29
End-of-Life Care	9

Learning Objectives

- **Describe what is geriatric care management is**
- **Articulate how geriatric care management is performed in a managed care setting**
- **Discuss the effects of a dedicated comprehensive geriatric care management program on quality of care and utilization of medical services by Medicare Advantage members**

Questions?