Aetna’s Approach to Care

At Aetna Better Health®, we take a total approach to health and wellness. Because we understand that feeling healthy is more than just physical.

Where our members live, work, learn and play affects their health outcomes. So, we work to address the social, economic and the health care disparities that create barriers to healthy living.

Figure 1: Enrollee-directed Care Planning
Aetna’s care planning process meets enrollees’ unique needs.
Social Determinants of Health (SDoH)
Our innovative integrated system of care approach demonstrates our comprehensive focus on meeting enrollees’ needs and goals by wrapping around them with Aetna covered services, their circle of support, and community-based support while focusing on cultural sensitivity, recovery and resiliency, and adopting trauma informed practices.
Population Overview

Race & Ethnicity
- White: 8%
- Black: 8%
- Hispanic: 4%
- Two or more races: 2%

Educational Attainment
- Advanced College Degree
- College Degree
- Some College
- High School or GED
- Less than High School

Household Income
- Over $125K
- $75K - $124.9K
- $50K - $74.9K
- $30K - $49.9K
- $20K - $29.9K
- Less than $20K

Age & Gender
- 85 and Over
- 75 - 84
- 65 - 74
- 55 - 64
- 45 - 54
- 35 - 44
- 25 - 34
- 18 - 24
- 0 - 17

% RESIDENTS AT ELEVATED RISK
- Economic Climate: 40.6%
- Food Landscape: 36.0%
- Housing Environment: 32.0%
- Transportation Network: 19.5%
- Health Literacy: 21.5%
<table>
<thead>
<tr>
<th>State Intervent Rank</th>
<th>County</th>
<th>Total Residents</th>
<th>State Population Rank</th>
<th>Two or More</th>
<th>$</th>
<th>🍊</th>
<th>🌿</th>
<th>🛡</th>
<th>🚗</th>
<th>Median Household Income</th>
<th>SNAP Utilization</th>
<th>Life Expectancy</th>
<th>Median Home Value</th>
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<td>37.0%</td>
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<td>$50,060</td>
<td>13.2%</td>
<td>77.19</td>
<td>$159,300</td>
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Food Landscape
Identification of SDoH Needs

Enrollee Referrals
Multi source – Intake assessments, contact assessments, electronic referrals and tracking with external agencies
2021 SDoH Statistics

>18k SDoH Screenings

>14k SDoH Needs Identified

>4k SDoH Referrals Made
SDOH Referral Breakdown

2021 Top SDoH Referrals by Category

- **Food**: 30% (Traditional 30%, SKY 16%)
- **Housing**: 18% (Traditional 18%)
- **Clothing**: 17% (Traditional 17%)
- **Supplemental Benefits**: 8% (Traditional 8%)
- **Mentoring/Social Support**: 7% (Traditional 7%)

Legend:
- Purple bar: Traditional
- Pink bar: SKY
Intervention

Aetna Better Health seeks to provide services that are tailored to the Kentucky population’s health and social determinant needs.
Member Services staff screen for social needs related to enrollee status changes.

Community Health Workers (CHWs) are integral to meeting the social needs of enrollees identified during new member welcome calls, HRA/HRQ, HCE, and direct referrals. CHWs engage enrollees, caregivers and providers to provide social needs support through in-office coordination and community connections.

Care Management takes a member centered approach and focus on community relationships – integrating physical health, behavioral health and social economic status of enrollees.

Community Development establishes partnerships and builds community relationships to guide initiatives aimed to improve the health and well-being of enrollees and the communities in which they live.
Programs

Value Added Benefits
- Home delivered meals
- Transportation
- GED certification & job skills training
- Remote patient monitoring
- Prenatal/Postpartum support
- Eyeglasses and screenings
- Cell phone or laptop (SKY)

Care Management
- Integrated Care Management
- ER Initiative
- Start Strong Re-entry Program
- Homeless Outreach
- High Risk Obstetrics
- Neonatal Abstinence Syndrome (NAS)
- Neonatal Intensive Care (NICU)
- Transplant
- Lock-In
- Guardian Angel
- Readmission Avoidance Program
- CPESN

SKY Care Management
- Out of home care
- Committed to Juvenile Justice and/or DCBS
- Receiving Adoption Assistance
- Aging out of the DCBS system
- Regionally based teams to provide support to SKY enrollees in their designated region
SKY Community Resource Referrals – YTD 2021

3572 = Total # Community Resource Referrals Documented in Foster Care Events
1154 = Total # Unique Members with Documented Community Resource Referral

Behavioral Health
- Psychiatric Evaluation
- Therapists and Counseling Services
- ABA Therapy
- Biofeedback
- Trauma Therapy
- Play Therapy
- Substance Abuse
- Support Groups
- Opioid Lockbox VAB
- Autism Diagnostic and Screening
- Grief Counseling
- Mobile Crisis Team
- Dyslexia Testing
- Eating Disorder Treatment
- Community Mental Health Centers

Physical Health
- Physical, Occupational, Speech Therapy
- Dental, Orthodontics, Vision
- Specialists – Cardiology, Endocrinology, OB/GYN, Podiatry, Dermatology, Allergy, ENT
- Diabetes Education and Support, Nutritionists, BMI Clinics
- Smoking Cessation
- Maternal Health
- Deaf and Hard of Hearing
- COVID Vaccinations
- DME Vendors

SDOH
- Transportation, Food, Housing, Clothing, Utilities
- Family Peer Support Specialists
- Education – GED, Scholarships, Assistance
- Voc Rehab, Jobs Skills
- Community Activities, Sports
- Community Involvement
- Cell Phone VAB
- Record Expungement
- Respite Services
- Childcare Assistance
- Legal Aid
- Safe Place
- Community Action Center
- Extension Offices

Community Organizations
- Equine Therapy Volunteer Opportunity
- Big Brothers Big Sisters
- American Red Cross
- Sleep in Heavenly Peace
- OMNI FIT
- DV Shelters
- New Vista
- NICU Graduate Clinic
- LGBTQ Transform Clinic
- KY Spin, KY RISE
- Kids Spot
- Kentuckiana Works
- Centers for Arts
- Catholic Charities, Goodwill, Salvation Army
- Boys and Girls Club
- Child Advocacy Center
- TAYLOR Program
- Helping Hearts
- YMCA
- I Do Program
- NAMI
Traditional Community Resource Referrals – YTD 2021

1333 = Total # Community Resource Referrals Documented
529 = Total # Unique Members with Documented Community Resource Referral

- Behavioral Health:
  - Psychiatric Evaluation
  - Therapists and Counseling Services
  - ABA Therapy
  - Biofeedback
  - Substance Abuse
  - Support Groups
  - Opioid Lockbox VAB
  - Autism Diagnostic and Screening
  - Grief Counseling
  - Mobile Crisis Team
  - Dyslexia Testing
  - Eating Disorder Treatment
  - Community Mental Health Centers

- Physical Health:
  - Physical, Occupational, Speech Therapy
  - Dental, Orthodontics, Vision
  - Specialists – Cardiology, Endocrinology, OB/GYN, Podiatry, Dermatology, Allergy, ENT
  - Diabetes Education and Support, Nutritionists, BMI Clinics
  - Smoking Cessation
  - Maternal Health
  - Deaf and Hard of Hearing
  - COVID Vaccinations
  - DME Vendors

- SDOH:
  - Transportation, Food, Housing, Clothing, Utilities
  - Maternity Matters VAB
  - Education – GED, Scholarships, Assistance
  - Voc Rehab, Jobs Skills
  - Community Activities
  - Sports
  - Community Involvement
  - Cell Phone VAB
  - Homeless Shelters
  - Respite Services
  - Childcare Assistance
  - Legal Aid
Collaborative Partnerships

Unite Us
Unique collaboration to address the full spectrum of SDOH. The partnership establishes innovative models that improve the engagement between enrollees, traditional health care providers (e.g., PCPs), and social services providers. This SDOH services integrated model connects enrollees to community-based organizations who participate in the closed-loop referral network, including all types of social service agencies.

Pyx Health
Scalable, 24/7 technology platform that reduces loneliness and social isolation by connecting enrollees outside of their traditional care setting. Pyx offers screening for loneliness, anxiety, depression and SDoH.

Avesis
Avesis screens members for SDoH needs and provides the member referral to the health plan population health team.
### Unite Us Referrals – YTD 2021

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
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<tbody>
<tr>
<td>Total Number of Referrals</td>
<td>615</td>
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<tr>
<td>Unique Members Referred</td>
<td>234</td>
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<tr>
<td>Referrals Resolved</td>
<td>46.8%</td>
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</table>
Avesis SDoH Referrals-YTD 2021

Social Needs by Category

- Housing: 5%
- Job Security: 10%
- Financial: 14%
- Transportation: 24%
- Food Security: 24%
- Access to Quality Services: 24%
Pyx Health

155
Total Members Onboarded

124
Members Completed UCLA-3 Screening

28.6%
Members Screened With an SDoH Need
Email Referrals:
Population Health Management Team
PHM_ABHKY@aetna.com

Traditional Care Management Team
CCofKYCaseMGMT@aetna.com

SKY Care Management Team
AetnaBetterHealthofKYSKYCM@AETNA.com