

Stay healthy with Population Health programs

As an Aetna® Michigan Medicare HIDE member, you're automatically paired with your own dedicated care manager. Your care manager is someone who's here just for you. They can support you in any of the five voluntary Population Health programs at no added cost. Your doctor or hospital discharge planner can make a referral for you. Or you can request to join. If you are eligible, you can begin or end these programs at any time.

Healthy adults

This program helps keep preventive care on track, including cancer screenings and routine checkups.

Your care manager will help you stay healthy by scheduling health screenings such as mammograms, colonoscopies, at-home colorectal cancer screening kits and preventive care visits. You'll get a yearly preventive screening checklist and helpful reminders, including text messages. This way important care is not missed. We're here to support you with timely recommended care you need.

Living with a chronic condition

This program can help manage diabetes and hypertension.

Your care manager will work with you, your doctors, and others who support you, to help you understand your chronic condition and how to manage it day to day. They'll help you focus on goals like keeping blood pressure and lab results in a healthy range, making lifestyle changes, and taking medications the right way.

If something comes up during your conversations, we're here to help — whether that's connecting you to community resources, helping you get monitoring equipment, or sharing educational materials about your condition.

You'll also get preventive care reminders, like checklists or text messages, to help you stay on track with things. Our goal is to support you and make it easier for you to manage your health condition.

Use of care settings

This program will help you stay in the place that best fits your needs, preferences and safety.



Your care manager will help you manage your health and make sure you get the right care at the right time. This may include:

- Explaining discharge instructions
- Helping you get prescriptions
- Scheduling follow-up care
- Coordinating other needed services (durable medical equipment or home care)
- Addressing social needs that could affect your health

Before any discharge, your care manager will contact you to provide support in discharge planning and post-admission care. They can also help with coordinating transition of services to another place of care or home care setting.

Caregivers can also get training and education when needed, so you and your support system feel confident and informed. Our goal is to make your care simple, coordinated and supportive.

Medication safety

This program will help you safely manage your chronic pain. It focuses on helping you use your benefits and explore options for pain management besides medications.

Your care manager will review your medications, assess your pain, and work with you to develop a care plan that fits your needs. If something comes up during your conversations, we're here to help — whether that's connecting you to resources or sharing educational information about your condition. We're here to support you every step of the way and help you stay healthy.

Complex case management

This program will give you more care management support to better meet your urgent or complex care needs.

Your care management team will find ways to address any unmet health care and service needs. The team includes nurses, social workers and support staff who will partner with you to create a personalized plan of care. We are here to help you stay in the place that best fits your needs, preferences and safety. If something comes up, we're here to help — whether that's connecting you to community resources, helping you coordinate care, or providing education to keep you informed.



For more information on how to use any of the Population Health programs, just call and ask for your Aetna care management team at **1-855-676-5772 (TTY: 711)**, 8 AM to 8 PM 7 days a week.

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