



# Aetna Better Health<sup>®</sup> of Illinois

## Collaborative care management

To support collaborative care management with provider partners and reduce care fragmentation, Aetna Better Health<sup>®</sup> of Illinois and participating providers will share responsibility for delivering coordinated, patient-centered care. Each party will work collaboratively to ensure timely communication, clear accountability, and seamless transitions across care settings in support of patient outcomes and experience. Roles and responsibilities are outlined below and will be reviewed at least annually or when processes change. This collaborative approach is intended to help reduce patient frustration, improve accountability, and support improved health outcomes.

<b>Role / Function</b>	<b>Health plan responsibilities</b>	<b>Provider partner responsibilities</b>
Designated Point of Contact	Assign care management contact(s) and provide contact information.	Assign practice contact(s) and ensure availability for coordination activities and timely response.
Identification & Outreach	Identifying populations and stratifying members based on risk, clinical needs, and social drivers of health.	Support outreach by validating member status, encouraging engagement, and coordinating with the member's care team as needed.
Referrals to Care Management	Maintain a defined referral intake process and confirm receipt, triage, and assignment. Communicate enrollment status and next steps to the provider partner.	Refer eligible members using the defined process and provide relevant clinical context.
Care Plan Development & Updates	Develop an individualized care plan with the member / caregiver and share relevant care plan components and goals with the provider partner.	Engaging patients in recommended care plans and reinforcing care management interventions.
Documentation & Sharing Information	Maintain documentation of care management activities and communicate relevant updates to provider partners consistent with privacy, consent, and data-sharing requirements.	Accurately document care coordination and follow up activities in the medical record and provide requested clinical information to support coordinated, patient-centered care.
Social Determinants of Health (SDOH) Coordination	Provide SDOH resource navigation and community referrals.	Screen for social risks when appropriate; coordinate referrals and document outcomes.

Gaps in Care Coordination	Communicating care gaps and care management engagement status to provider partners.	Review care gap reports shared by the health plan and take appropriate clinical action within the scope of practice.
Transitions of Care	Coordinate post-discharge outreach, medication reconciliation support, and share discharge-related information with provider partners when available.	Schedule timely follow-up visits, review discharge instructions and reconcile medications as clinically appropriate.