Evernorth Transitions of Care

Providing smooth patient transitions from care facilities to the home to reduce the risk of readmission

Repeat hospital admissions for many with chronic conditions are costly, but often preventable

As they continue their health journey outside of a hospital environment, it's important that members receive prompt and comprehensive guidance.

Evernorth's Transitions of Care program supports members in making a safe return home following acute hospitalization, post-acute care or emergency department (ED) visits. Our clinicians and social workers help members identify and manage medical, behavioral, functional and social risk factors that could lead to readmission.

Our program helps provide a clear path to improving health

We will help lead your members through the next steps to help them **safely transition to an effective home-based care plan** when they are faced with the uncertainty of sustaining wellness after discharge.

+ **Engaging patients in a timely manner**
  Outreach within the first 48 hours of hospital or ED discharge, with multiple touchpoints in the first 30 days.
+ **Coordinating care and connecting to resources**
  Our nurses will follow up with the member's primary care physicians (PCPs) and specialists to help manage their care and assist them in reaching their goals. They'll also create personalized care plans that can include in-home visits to address access-to-care challenges.
+ **Tailoring as needed to prevent readmission**
  Flexible design, we can adjust the duration of our program—30, 60 or 90 days—based on client need.

Readmission rates are high among the Medicare population

$15,000
average cost of each readmission episode[1]

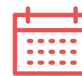
12%
of Medicare patients return to the hospital for an avoidable reason within 30 days[1]

Our offerings provide members the support at every turn

Comprehensive risk assessments

Review of discharge guide to prevent gaps in care

Continuous clinician access



Appointment scheduling assistance

Social worker engagement

Medication reconciliation, adherence and education

Remote patient monitoring tools

Care summaries and referrals for ongoing services

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HEALTH SERVICES

Post-ED Patient Engagement

Individualized engagement for higher-risk patients

In compliance with Healthcare Effectiveness Data and Information Set (HEDIS) and Star requirements, our Post-ED patient engagement option helps Medicare Advantage plans fulfill required follow-up with high-risk, polychronic patients. With this expedited version of our traditional program, all outreach, assessment and care coordination is performed within 14 days of discharge.

Transitions of Care + Post-Acute Care

Our solution can be offered as a standalone service or as a part of the Post-Acute Care program for members in acute care recovery, which is shown to have even greater outcomes in reducing readmission.

Built to meet unique plan and member needs

With our multi-modal offerings, robust network and open architecture, **we'll help build a transitions of care program** that works best for your population.

+ **Flexible structure**
  We support patients transitioning home from multiple settings—acute, post-acute, and ED care—and offer both in-home and virtual engagement models.

+ **Unique position**
  We work at the intersection of utilization management, network management and home-based care delivery. Paired with our Post-Acute and Home Health solutions, our transition of care nurses help members navigate their entire health journey.

+ **Scalability**
  We're equipped to support large patient populations and serve higher-risk members as directed by health plans.

+ **Measurable performance**
  We can send HEDIS documentation codes, including medication reconciliation and care coordination to health plans, as well as care statements for providers to include in members' outpatient medical records.

Improved health outcomes lead to higher cost savings[2]

In-home Transition of Care
5.6% lower readmission

Virtual + Post Acute Care
8% lower readmission

$1,000 savings per member

Partner with Evernorth to help your members make safe transitions home from the hospital that can help reduce their need to go back.

Visit us at
Home-Based Care | Evernorth

Contact us at
homebasedcare@evernorth.com

1. McIlvennan, Colleen K et al. "Hospital readmissions reduction program."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4439931/. Page last reviewed: February 3, 2023
2. In-Home Transitions of Care program data 2019-2020

EVERNORTH HEALTH SERVICES

Evernorth Home-Based Care is a suite of health care service solutions provided by various Evernorth affiliates. Clinical services are provided by licensed health care providers through medical practices managed and/or contracted with Evernorth Home-Based Care's health services management organization, as well as by other network providers. Clinical services delivered through MDLIVE's virtual care platform are provided by medical practices affiliated with MDLIVE, Inc. Medical management, utilization management/utilization review, network management, and third party administrator services related to the Evernorth Home-Based Care suite of solutions are provided by eviCore healthcare MSI, LLC, an Evernorth affiliate.
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