Evernorth Home-Based Care

The right care. Right at home.

Improved outcomes, affordability and patient satisfaction for your chronically ill population starts in the home

A COSTLY PROBLEM

80%

of the Medicare population have 2+ chronic conditions.

The most chronically comorbid —**the top 5%**—account for a disproportionately high percentage of costs (+50%).[1]

Patients with multiple chronic conditions need individualized care for their post-acute, preventative and primary care needs

To improve and maintain the health of aging populations, it's imperative to reduce inequities and disparities across the board, while recognizing the unique health care needs of each individual. Fragmented health care systems further complicate these patients' journeys due to unaddressed challenges, frequent readmissions, and escalating costs.

This population is underserved and in the most need for in-home primary care. Their challenges are unique and require the right guided support. Many health plans need reliable partners to help navigate this new world. Evernorth has more than 25 years of experience providing comprehensive, in-home population health and clinical services and solutions—all ready to implement.

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1. Agency for Healthcare Research and Quality, Concentration of Health Expenditures in the U.S. Civilian Noninstitutionalized Population, https://meps.ahrq.gov/data_files/publications/st497/stat497.pdf

PATIENT-CENTRIC

Our whole-person, home-centered approach to care

Evernorth Home-Based Care helps improve each patient's unique health journey with comprehensive in-home care solutions, including direct patient care and care enablement services.

We work closely with 30+ clients (health plans, Medicare, dual eligible special needs plans (D-SNPs), commercial and more)—serving more than 26 million lives—to improve quality measures, reduce hospital readmissions, and upgrade the patient experience and care delivery coordination.

Our goal is to provide the right care to benefit both the patient and the plan. Evernorth is always willing to partner with your existing vendor relationships and clinical pathways to avoid disruption. This approach leverages our expertise and solutions while integrating our clients' capabilities and third-party resources to maximize overall effectiveness.

Our care enablement suite of solutions:

+ **Post-Acute Care:** Management of patient-centric services from hospital to home
+ **Transition of Care:** Efficiently get patients home safely and avoid readmissions
+ **Primary Care:** Comprehensive clinical, social and behavioral support
+ **Comprehensive Health Assessments:** Annual visits to uncover risks, opportunities and gaps in care
+ **Sleep Therapy:** End-to-end solution from testing to treatment
+ **Durable Medical Equipment (DME):** Ensuring timely delivery, training and management of DME
+ **Home Health:** General home nursing and caregiver help
+ **Sleep Management:** End-to-end support following episodes of care for sleep apnea patients to manage ongoing compliance with treatment

PROVEN IMPACT

A quality patient experience

To begin, we always listen to and understand each patient's situation, in a personal way. Then, we formulate tailored care plans that recognize and remove barriers to getting the right care, such as health disparities and social determinants of health (SDOH) gaps.

Caring for these chronically ill patients needs a personalized, high-touch approach. We help health plans stay competitive by:

- Improving quality metrics + lowering costs
- Identifying risk via home health assessments
- Measuring outcomes with data-driven reporting, targeted results + integrated care
- Optimizing networks for effective utilization management
- Guaranteeing savings with our risk-based model

Ready to improve your patients' health journeys and in-home care experience?

Visit us at

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Contact us at

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