



HEALTH FORWARD:

# How Modern Home-Based Care Is Helping to Transform Polychronic Patient Experiences



**EVERNORTH**<sup>SM</sup>  
HEALTH SERVICES

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By 2030, the number of Americans living with three or more chronic conditions is projected to reach 83.4 million, more than doubling the polychronic patient population since 2015.<sup>1</sup> The growing number will drive increased complexity of care, capacity concerns and costs.

Out of the \$4.3 trillion spent on health care in 2021,<sup>3</sup> an estimated 85 percent was attributed to patients with chronic diseases.<sup>4</sup> Among Medicare patients, 18 percent are living with six or more chronic conditions, which accounts for more than half of the total Medicare spend.<sup>5</sup>

The dual challenge of an aging population and advances in treating chronic diseases is exposing gaps in the traditional health care system.<sup>6</sup> Addressing the care needs of the rising polychronic patient population will require new approaches beyond traditional fee-for-service, condition-by-condition care models. This report explores the viability and advantages of home-based care as a solution.

### CHRONIC CONDITIONS:<sup>2</sup>

- + Last one year or more
- + Require ongoing medical attention and/or
- + Limit activities of daily living



### WHAT'S DRIVING THE RISE IN POLYCHRONIC PATIENTS?

Download the companion report in our Health Forward series, [\*The Evolution of Polychronic Patient Care.\*](#)

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<sup>1</sup>Waters H, Graf M. [The Costs of Chronic Disease in the U.S.](#), Milken Institute, August 2018.

<sup>2</sup>[Chronic Diseases in America](#), Centers for Disease Control and Prevention, December 2022.

<sup>3</sup>[National Health Expenditure Data](#), Centers for Medicare & Medicaid Services, December 2022.

<sup>4</sup>Holman H. [The Relation of the Chronic Disease Epidemic to the Health Care Crisis](#), National Library of Medicine, March 2020.

<sup>5</sup>[Chronic Conditions among Medicare Beneficiaries](#), Centers for Medicare & Medicaid Services, 2018.

<sup>6</sup>[New Poll Reveals Less Than Half of Chronic Disease Patients Are Happy with Their Health Care](#), Global Health Living Foundation, March 2023.

# The emerging role of home-based health care

The American health care system is built primarily for acute care, such as conditions with a single cause, rapid onset and defined duration. The traditional model creates challenging experiences for polychronic patients, their caregivers and providers, creating a cycle of non-integrated care management, increased hospitalizations and added costs.<sup>7</sup>

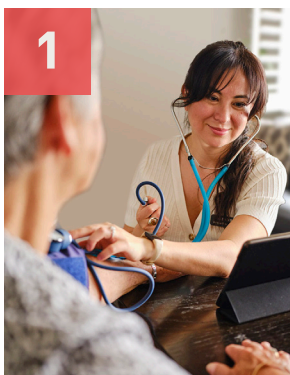
As a result, whole-person care models have gained traction in recent years to help improve care efficiencies, enhance patient experiences and manage costs. Instead of focusing on one condition at a time, whole-person care encompasses the full range of factors that help determine health, including socioeconomic circumstances, lifestyle behaviors, food insecurity, social support and genetics.

**For Medicare Advantage members with multiple serious illnesses, whole-person care coordinated by primary care physicians improves overall health outcomes.**

Regions with larger primary care physician populations have lower hospitalization rates, fewer emergency department visits and reduced Medicare spending.<sup>8</sup>

Home-based health care is an increasingly effective and efficient option within the patient-centered, whole-person care model, especially for the most medically complex polychronic patients.

There are three main types of home-based care:



## In-home primary care

provides the same primary care patients would receive in a provider's office but in the comfort of their home. With this type of patient-centered care, the primary care physician or nurse practitioner monitors the patient's chronic conditions through regular visits. They also provide routine wellness checks and preventive care and prescribe medications and other treatments to improve the patient's health and manage their chronic conditions effectively.



## Post-acute and transitional care

offers individualized care post-hospitalization to monitor recovery and facilitate the patient's transition back home following treatment.



## Home health care

Home health care provides skilled nursing services and therapeutic services for homebound patients, including patients recovering from an injury or surgery.

In recent years, the COVID-19 pandemic accelerated the adoption of home-based care models. As a result, patients and providers are more familiar with care-at-home options. Looking ahead, patient care journeys are likely to include a mix of in-office or facility, in-home and virtual experiences. The consulting firm McKinsey & Co. estimates that \$265 billion in care services for Medicare fee-for-service and Medicare Advantage patients will shift from traditional facilities to home-based care by 2025. The shift represents approximately 25 percent of the total cost of care for these populations.<sup>9</sup>

Technology is a key driver behind the increasing viability of home-based care models. Continuing advances in technology and electronic data management improve care delivery and make care at home more accessible for more patients.

## Technology opens new doors to home-based care



### TELEHEALTH COMES OF AGE

The pandemic accelerated the adoption of telehealth visits, also known as virtual care. Post-pandemic, the increased usage rates are projected to continue.

**38x** increase in telehealth usage in 2021 vs. pre-pandemic levels<sup>10</sup>

**40%** of patients plan to continue using telehealth options post-pandemic<sup>11</sup>



### WEARABLE TECHNOLOGY MONITORS PATIENTS AROUND THE CLOCK

Wearable devices enable providers to remotely monitor chronic disease progression and identify significant health changes.

- + Glucose monitors
- + Heart-monitoring devices
- + Biosensors that track temperature, respiration and sleep



### POINT-OF-CARE TESTING BRINGS THE LAB TO THE PATIENT

Sophisticated portable equipment makes it possible to administer medical tests in a patient's home. In some cases, test results are available in near real-time without requiring processing in a lab.

- + Blood glucose
- + Blood gas
- + Coagulation
- + Urinalysis tests



### DIGITIZED DATA TRANSFORMS EXPERIENCES FOR PATIENTS AND CLINICIANS

Digital technology continues to streamline how health care information is captured, shared and accessed by all stakeholders along the care journey.

Going forward, increased data interoperability among health systems, providers and patients will further enhance care coordination and transparency for polychronic patients.



<sup>7</sup> Skinner HG, Coffey R, Jones J, Heslin KC, Moy E. [The effects of multiple chronic conditions on hospitalization costs and utilization for ambulatory care sensitive conditions in the United States: a nationally representative cross-sectional study](#). BMC Health Serv Res., March 2016.

<sup>8</sup> Ankuda CK, Petterson SM, Wingrove O, Bazemore AW. [Regional variation primary care involvement at the end of life](#). Annals of Family Medicine, 2017.

<sup>9</sup> Bestsenny O, Chmielewski M, Koffel A, Shah A. [From facility to home: How healthcare could shift by 2025](#), McKinsey & Co., February 2022.

<sup>10</sup> Id.

<sup>11</sup> Id.

# The definitive advantages of home-based care

Home-centered health care offers a convenient—and increasingly viable—way to effectively provide individualized whole-person care for polychronic patients. Delivery of care in the home environment gives providers and health plans a more complete view of the patient's needs and challenges, setting the stage for better care coordination, improved outcomes and better cost management.

### + Advantage: Better care coordination

Navigating multiple chronic conditions requires advanced primary and integrated care beyond what traditional health care models can accommodate. Today's fee-for-service models often leave much of the care coordination to the patient and their caregivers, which often creates gaps, conflicts and complications across concurrent treatments. In contrast, value-based, home-centered primary care delivery helps take the coordination burden off the patient.

In-home primary care enhances individualized care while giving primary care providers a more holistic view of the patient's needs from behavioral, environmental and economic perspectives. The increased insight into these social determinants of health (SDOH) enables providers to better integrate care across conditions. In turn, the enhanced integration helps providers proactively address risks, prevent complications from concurrent treatments or medications and provide specialized support, such as physical therapists, behavioral therapists or social workers. In addition, home-based care actively engages patients and their families as core members of the care team, partnering with them to establish and implement care plans.

### + Advantage: Improved outcomes

Home-based care enables individualized, holistic care focused on enhancing overall health and improving the patient experience. In addition to tailoring the level of care to match the patient's needs and preferences, home-based care models offer opportunities for providers to deliver enhanced patient education across conditions.

A lack of health literacy can be a barrier for polychronic patients, with older adults, minorities and lower-income populations less likely to be health literate. Among the Medicare patient population, individuals living in counties with the highest health literacy levels experience better health outcomes than those living in counties with lower health literacy.<sup>12</sup>

Research shows that home-based primary care and post-acute care following a hospitalization improve continuity of care and reduce hospital readmissions and mortality.<sup>14</sup> Not surprisingly, researchers also report



a positive correlation between home-based care and patient satisfaction. Patients in a Veterans Affairs home-based primary care program for chronically ill patients reported high satisfaction with provider access, education and continuity of care. Overall, hospitalizations for the group were 25.5 percent lower than expected, and fewer emergency department visits were reported.<sup>15</sup>



Medicare patients living in counties with the highest health literacy experience better health outcomes than those in counties with the lowest health literacy levels.<sup>13</sup>

## + Advantage: Better cost management

Improved care coordination drives greater efficiencies and, in turn, results in significantly improved cost management.

The Independence at Home Medicare program, which began in 2012, is a prominent example of the impact of home-based care. The program is designed to test the ability of a home-based primary care model to improve care and manage costs for complex, chronically ill patients. In its first five years, it generated \$100 million in savings, an average of \$1,840 per patient per year.<sup>16</sup> More recently, the program led to a 10.7 percent decrease in total monthly Medicare spending per beneficiary.<sup>17</sup>

Avoiding hospital readmissions is key to managing polychronic patient costs. One in five Medicare patients is readmitted to the hospital within 30 days of discharge.<sup>18</sup> Experts estimate that approximately 75 percent of these readmissions could be prevented or mitigated.<sup>19</sup> For example, transitional care coordination has been shown to cut the hospital readmission rate by 30 percent among high-risk patients.<sup>20</sup>



1 in 5

Medicare patients is readmitted to the hospital within 30 days.<sup>21</sup>

Transitional care coordination cuts the readmission rate for high-risk patients by 30%.<sup>22</sup>

↓ 30%

<sup>12</sup> Balasubramanian S., [New Study Reaffirms: Increased Health Literacy Leads To Better Health Outcomes](#), *Forbes*, October 2020.

<sup>13</sup> Id.

<sup>14</sup> Edes T, Kinoshian B, Vuckovic N. et al. [Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care](#), *Journal of the American Geriatrics Society*, October 2014.

<sup>15</sup> Id.

<sup>16</sup> Leff B, Boling P, Taler G, Kinoshian B. [To Strengthen The Primary Care First Model For The Most Frail, Look To The Independence At Home Demonstration](#), *Health Affairs*, February 2020.

<sup>17</sup> [Medicare's Independence at Home Demonstration Likely Reduced Health Care Spending in 2020](#), *Mathematica*, February 2023.

<sup>18</sup> Rennke S, Shoeb MH, Nguyen OK, et al. [Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices](#), *National Library of Medicine*, 2013.

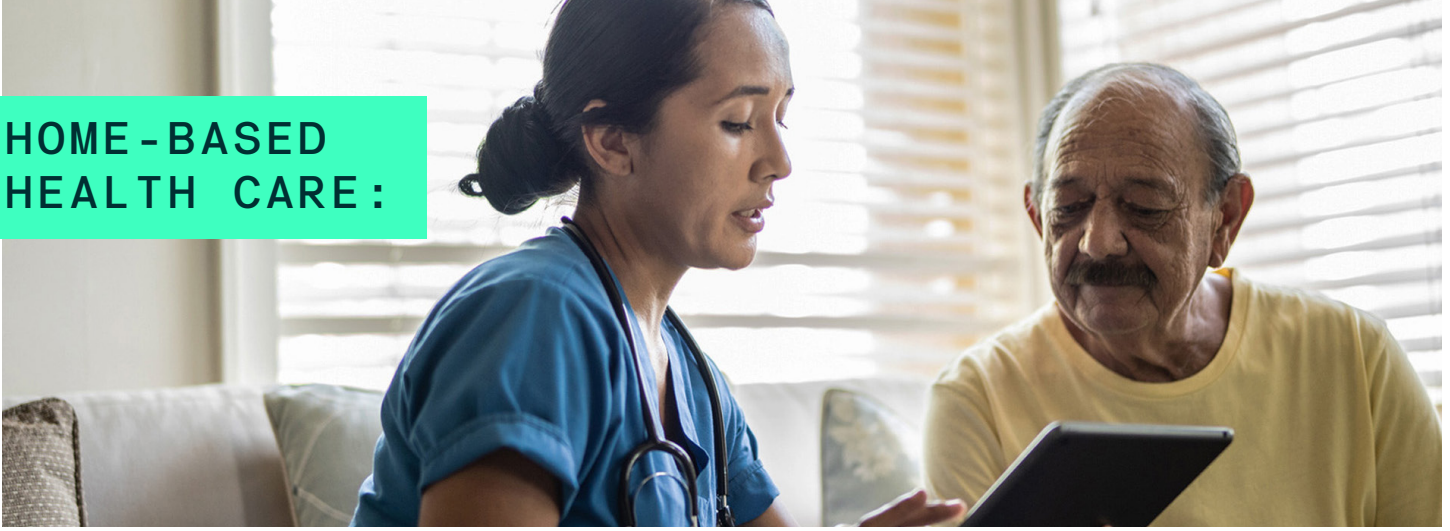
<sup>19</sup> Id.

<sup>20</sup> [Readmissions and Adverse Events After Discharge](#), *PS Net*, September 2019.

<sup>21</sup> Rennke S, Shoeb MH, Nguyen OK, et al. [Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices](#), *National Library of Medicine*, 2013.

<sup>22</sup> [Readmissions and Adverse Events After Discharge](#), *PS Net*, September 2019.

## HOME - BASED HEALTH CARE :



# Jack's story\*

Jack, age 70, lives with COPD and requires chronic oxygen therapy. He has been admitted to the hospital frequently for treatment.

Through home-based primary care, several barriers preventing Jack from optimizing his treatment and quality of life were identified and addressed.

SDOH barriers	With home-based primary care
<b>Mobility limitations</b> prevented Jack from leaving the house for health care appointments without ambulance transport.	The care comes to Jack. Improved access helps identify issues early and take action as soon as symptoms begin.
<b>Literacy challenges</b> made it difficult for Jack to follow medication instructions and schedules.	The team implemented color-coded medications and set up pill boxes to help Jack better manage his medications.
<b>Financial concerns</b> about copays and costs sometimes prompted Jack to delay care.	Affordable alternatives were identified and utilized.

## The home-based care impact

### 4 months prior to enrollment:

Jack saw his primary care physician once and was admitted to the hospital 11 times.

### 8 months post-enrollment:

Jack had 19 in-home visits from his primary care physician and nurse practitioner and was admitted to the hospital five times.



Increased access to coordinated primary care



Reduced utilization



Reduced costs

\* This example is for illustrative purposes only, based on an actual customer experience. Information has been changed to protect privacy. Customer results will vary.

# Take the next step to elevate health by partnering with Evernorth Home-Based Care.

Contact Brendan Kerrigan, Senior Director, Business Development at [Brendan.Kerrigan@Evernorth.com](mailto:Brendan.Kerrigan@Evernorth.com) or email us at [HomeBasedCare@Evernorth.com](mailto:HomeBasedCare@Evernorth.com)

Learn more at [evernorth.com](http://evernorth.com)

## About Evernorth Home-Based Care

In response to the changing tides in health care, Evernorth leverages more than 25 years of experience providing comprehensive, in-home primary care, post-acute care (PAC) management and advanced analytics to provide a game-changing offering: Evernorth Home-Based Care.

Today, Evernorth Home-Based Care works with 30+ clients (health plans, Medicare, dual eligible special needs plans, commercial and more) to solve complex challenges and bring care home — to the whole person — for more than 26 million members.

**Our home-centered care delivery and enablement organization focuses on improving each patient's unique health journey through integrated care solutions, including:**

- + In-home primary care
- + Home health
- + Post-acute care
- + Transition of care
- + Comprehensive health assessments
- + Sleep management
- + Durable medical equipment

We work closely with our clients to improve quality measures, reduce hospital readmissions and upgrade the patient experience and care delivery coordination.

**Our flexible, evidence-based care plans produce:**

- + Value-based care with data-driven measurable improvements
- + Targeted planning through early identification and proactive gap closure
- + Better coordination and smart utilization management optimization



## EVERNORTH'S HEALTH FORWARD SERIES

*The Evolution of Polychronic Patient Care*

*How Value-Based Care Can Change the Trajectory of Health Care Costs*

## About Evernorth

Evernorth Health Services creates pharmacy, care and benefits solutions that includes Home-Based Care, 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.



## Meet the Authors Behind Evernorth's Health Forward Series



**Yvette LeFebvre, DO**  
Chief Medical Officer  
Evernorth  
Home-Based Care

Yvette LeFebvre serves as Chief Medical Officer for the Evernorth Home-Based Care business. As the clinical leader for home-based care services, Dr. LeFebvre oversees the strategy, development and implementation of innovative clinical programs that ensure the delivery and enablement of high-quality in-home care and services for the 26 million patients the business manages.

Since joining the company in 2016, Dr. LeFebvre has progressed through roles of increasing responsibility, including serving as Associate Chief Medical Officer of Post Acute Care, Durable Medical Equipment and Sleep Management Services where she was responsible for clinical performance and oversight of patient care guidelines. Prior to this, she served as a medical director for Anthem's Medicare Advantage East Region. She has been a practicing physician for nearly 20 years and is an experienced physician and health care leader, having spent the first 10 years of her medical career as an attending Emergency Department physician, urgent care staff physician and physician training manager.

Dr. LeFebvre currently sits on the national board of directors for ecoWomen and is a member of the University of New England College of Osteopathic Medicine (UNECOM) Deans Advisory Council on Wellness.

Dr. LeFebvre completed her undergraduate studies in Biology at Boston College and earned her Doctor of Osteopathic Medicine (DO) from the University of New England College of Osteopathic Medicine. She is board certified in Emergency Medicine by the American Osteopathic Board of Emergency Medicine.



**Melissa Steffan**  
President  
Evernorth  
Home-Based Care

Melissa Steffan serves as President, Home-Based Care for Evernorth.

In her role, Melissa oversees Evernorth's portfolio of home-based care solutions, which provide in-home primary care and post-acute care enablement for millions of patients, including comprehensive care for those with multiple chronic conditions and complex care needs. She is responsible for leading Evernorth Home-Based Care's strategic direction and growth, and driving differentiated value for the patients and clients they serve.

Melissa joined Evernorth in 2022 and is an experienced leader who is deeply committed to serving underserved populations and has a strong track record for driving business growth. Her extensive care delivery experience spans home and senior care services, independent medical groups, and large regional health systems where she was responsible for new business development, client retention, M&A and operations.

Prior to joining Evernorth, she served as a Regional Vice President for The Evangelical Lutheran Good Samaritan Society, one of the largest not-for-profits providing senior care and services, where she oversaw operations and revenue strategy for the southwest region. Prior to this, she held leadership roles at Propeller Health and Presbyterian Healthcare Services.

Melissa is actively involved in her community and global missions that help impoverished countries, and she serves on the board of directors for Healing Haiti.

Melissa has a Bachelor's degree from the University of New Mexico and earned both a Master of Healthcare Administration (MHA) and a Master of Business Administration (MBA) in Finance from Grand Canyon University.