HEALTH FORWARD:

The Evolution of Polychronic Patient Care

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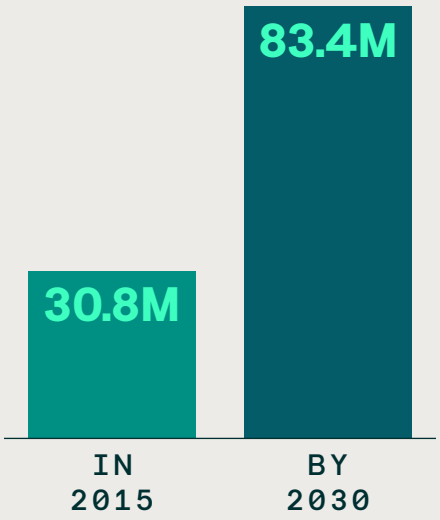
Today, six in ten adults in the U.S. are affected by chronic disease[1] — defined as requiring medical treatment, limiting activities of daily living and lasting one year or more. As people live longer and diseases become more treatable, the number of people living with multiple chronic conditions is increasing.

In the coming years, the polychronic patient population in the U.S. — those with three or more chronic conditions — is projected to increase significantly, from 30.8 million in 2015 to 83.4 million by 2030.[2] The increase will strain an already-stressed health care system through added complexity, capacity concerns and cost of care.

This report examines the drivers behind the increasing polychronic population, the implications for patients and providers and how care solutions are evolving.

POLYCHRONIC PATIENTS



WHAT'S INSIDE:

[1] Chronic Diseases in America, Centers for Disease Control and Prevention, December 2022.
[2] Waters H, Graf M. The Costs of Chronic Disease in the U.S., Milken Institute, August 2018.

BY THE NUMBERS:

What's behind the rise in polychronic patients?

A complex mix of demographic, lifestyle and socioeconomic factors drives the increase in people living with multiple chronic diseases.

People are living longer. And diseases are becoming more treatable.

Number of Americans age 65+[3]

2/3 of adults over 65 have 2 or more chronic conditions.[4]

Common chronic diseases: heart disease, cancer, diabetes, stroke, Alzheimer's disease, lung disease, kidney disease

[3] Vespa J, Medina L, Armstrong D. Demographic Turning Points for the United States: Population Projections for 2020 to 2060, U.S. Census Bureau, February 2020.
[4] The Top 10 Most Common Chronic Conditions in Older Adults, National Council on Aging, April 2021.

Poor lifestyle habits increase the risk of chronic disease

Lifestyle risk factors tracked by Centers for Disease Control and Prevention (CDC):[5]

Overweight and obesity, physical activity, nutrition, sleep, tobacco use, alcohol consumption

4 in 10

Americans have obesity (+37% since 2000)[6].

2 in 3

Americans don't meet minimum weekly physical activity guidelines.[7]

1 in 3

Americans is sleep-deprived.[8]

Social determinants of health are responsible for 80%–90% of a person's long-term health outcomes[9]

- + Economic stability
- + Education access and quality
- + Health care access and quality
- + Neighborhood and built environment
- + Social and community context

[5] Lifestyle Risk Factors, Centers for Disease Control and Prevention, October 2020.
[6] The State of Obesity: Better Policies for a Healthier America, Trust for America's Health, September 2022.
[7] Abildso CG, Daily SM, Umstattd Meyer MR, Perry CK, Eyler A. Prevalence of Meeting Aerobic, Muscle-Strengthening, and Combined Physical Activity Guidelines During Leisure Time Among Adults, by Rural-Urban Classification and Region — United States, Centers for Disease Control and Prevention, January 2023.
[8] Sleep and Chronic Disease, Centers for Disease Control and Prevention, September 2022.
[9] Magnan S. Social Determinants of Health 101 for Health Care: Five Plus Five, National Academy of Medicine, October 2017.

THE CHALLENGE:

Cost and complexity highlight the need for whole-person care

As the number of polychronic patients increases, patient care and how it's delivered are changing. While the need to reduce health care costs is a significant catalyst, the complexities of treating patients with multiple chronic conditions require new approaches beyond traditional care models.

From a cost perspective, chronic diseases account for the majority of U.S. health care spending. Of the $4.3 trillion spent on health care in 2021,[10] an estimated 85 percent can be attributed to patients with chronic diseases.[11] Among Medicare patients, people managing six or more chronic diseases account for 18 percent of the population but 54 percent of total Medicare spending.[12] These same patients make up 82 percent of hospital readmissions within 30 days, which is a notable cost driver.[13]

Complexity, amplified by a lack of coordination of care, is a primary driver of the costs. Treating and managing multiple chronic diseases complicates care for patients and providers alike.

Health care spending in 2021

$4.3 trillion, with 85% of the spending attributed to patients with chronic diseases.

$4.3 TRILLION

[10] National Health Expenditure Data, Centers for Medicare & Medicaid Services (CMS), December 2022.
[11] Holman H. The Relation of the Chronic Disease Epidemic to the Health Care Crisis, National Library of Medicine, March 2020.
[12] Multiple Chronic Conditions, Centers for Medicare & Medicaid Services (CMS), December 2021.
[13] Id.

Traditional health care models are transactional, designed to provide care on a fee-for-service and condition-by-condition basis. That means polychronic patients must manage multiple specialist provider relationships, care plans and medications. Clinicians often have limited time to spend with patients, preventing them from having a complete understanding of the potential effects of the patient's different conditions and treatment plans.

Polypharmacy risks

46% of adults 65 and older use 5 or more prescription medications,[14] increasing the risk of adverse drug interactions.[15]

A lack of coordination between primary care practitioners and specialists can limit care delivery and cause suboptimal outcomes. Nearly one in five Medicare patients is readmitted to the hospital within 30 days, often for adverse drug effects or conditions unrelated to the initial hospitalization.[16] From a patient perspective, complexity and gaps in coordination can lead to stress and dissatisfaction. Only one in three patients with chronic diseases is satisfied with their care.[17]

In response, polychronic care models are shifting from transactional approaches to patient-centered, whole-person care. Whole-person care considers the whole person rather than a single condition. The patient becomes the center of care, with additional consideration given to the coordination of care delivery based on physical, behavioral, emotional and socioeconomic factors.

Most important, whole-person care allows for patient-centered goals, including short- and long-term outcomes, quality of life and affordability. Patient-centered care can be structured to assess socioeconomic factors more effectively, such as the patient's social needs, health literacy and barriers to access.

By considering concurrent treatments and patient preferences, whole-person care addresses treatment priorities, helping to improve patient experiences and outcomes. For example, post-hospitalization transitional care coordination for polychronic patients has been shown to reduce readmission rates by 30 percent.[18] Overall, the approach helps to enhance ongoing care, increase efficiencies and reduce costs.

The impact of care coordination

1 in 5 Medicare patients is **readmitted to the hospital within 30 days** of discharge.

Transitional care coordination **reduces hospital readmission rates by 30%** among high-risk patients.

Source: Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices, National Library of Medicine, 2013.

[14] Van Wilder L, Devleesschauwer B, Clays E, Pype P, Vandepitte S, De Smedt D. Polypharmacy and Health-Related Quality of Life/Psychological Distress Among Patients With Chronic Disease, Centers for Disease Control and Prevention (CDC), August 2022.
[15] Ruscin J, Linnebur S. Aging and Medications, Merck Manual, November 2022.
[16] 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.
[17] New Poll Reveals Less Than Half of Chronic Disease Patients Are Happy with Their Health Care, Global Health Living Foundation, March 2023.
[18] 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.

WHAT'S NEXT:

The evolution of polychronic patient care

Health services providers are reimagining care delivery to meet the needs of polychronic patients. Looking ahead, there is a growing recognition that medical care alone can't ensure better health outcomes. In response, U.S. health care is shifting to more holistic, patient-centered care. Taking a relationship-based approach, patient-centered care establishes a partnership with patients and their caregivers that aligns with their needs, culture and preferences.

The benefits of patient-centered, whole-person care are becoming clear. Along with better integration of care across chronic conditions, care can be personalized to address the patient's physical, behavioral and social health needs. The individualized care is focused on enhancing overall health and building increased resilience, which help to drive better patient experiences.

Home-based care delivery is emerging as a vital element of patient-centered care models. With home-based health care, patients are able to remain in their residences where they are most comfortable for skilled care and therapy. For chronically ill patients, home-based care, paired with virtual care and digital telehealth innovations, can help to improve affordability, satisfaction and health outcomes.

The COVID-19 pandemic accelerated the adoption of new technologies and care-at-home models. Today, the home care ecosystem is moving beyond post-hospitalization care to also include primary care, hospital-at-home care, infusions, dialysis, diagnostic testing and ongoing monitoring.

Research shows that home-based care following a hospitalization or institutional post-acute care improves continuity of care and reduces hospital readmissions and mortality.[19] An extensive study by the Cleveland Clinic found that when patients receive home health care in advance of or following a hospital stay, the average savings is $6,433.[20]

As patient-centered care continues to evolve to better integrate resources and services, the potential for further enhancing care, improving health outcomes and realizing savings is expected to increase. Most significantly, reimagining care for polychronic patients creates opportunities to better coordinate treatment and personalize care while delivering improved patient experiences.

Opportunities to optimize the value of home-based care

PATIENT EXPERIENCE

+ Integrated, whole-person care resulting in better coordination and quality of care
+ Identification of social determinants of health barriers paired with resources and support to address them
+ Medication reconciliation

OUTCOMES

+ Reduced hospital readmission rates
+ Improved quality metrics for HEDIS and CAHPS measures
+ Increased patient satisfaction

COSTS

+ Shorter hospital, inpatient rehab and skilled nursing facility stays
+ Decrease in emergency department visits
+ Risk-based funding options

[19] Xiao R, Miller JA, Zafirau WJ, Gorodeski EZ, Young JB. Impact of Home Health Care on Health Care Resource Utilization Following Hospital Discharge: A Cohort Study, National Library of Medicine, April 2018.
[20] Id.

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

Learn more at evernorth.com
Contact us at HomeBasedCare@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

NEXT IN EVERNORTH'S HEALTH FORWARD SERIES

How Modern Home-Based Care Is Transforming Polychronic Patient Experiences

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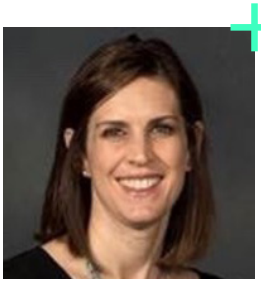
Yvette LeFebvre serves as Chief Medical Officer for the Evernorth Home-Based Care business. As the clinical leader for home-based care services, Dr. LeFebvre oversees the strategy, development and implementation of innovative clinical programs that ensure the delivery and enablement of high-quality in-home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

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