Evernorth's innovative care model: Addressing social determinants of health among older adults – in their home

Older patients who lack a primary care physician tend to piece together their care, consulting specialists for chronic conditions and visiting acute-care facilities for routine or urgent needs. This lack of a "primary care thread" to coordinate and align provider visits, diagnoses, and treatments can have medical and financial repercussions, said Dr. Yvette LeFebvre, chief medical officer for Evernorth Home-Based Care.

Dr. LeFebvre spoke during a session at Outcomes 2024 that focused on innovating to meet the evolving and complex needs of older adults.

Melissa Steffan, president of Evernorth Home-Based Care, contributed a concerning statistic to the panel discussion: In any Medicare Advantage population or Medicare population, on average, 12%– 15% of the population would meet the definition of polychronic. That percentage of the population generates over 54% of the cost to the plan.[1]

"On top of that, social determinants of health (SDOH) account for up to 80% of a patient's long-term health outcomes," Dr. LeFebvre said.[2] To address that, she said, "We need a care model to address the sum of their issues at one time, including social determinants of health."

Sarah O'Neill, senior director of physician engagement for Accredo by Evernorth, outlined a unique interdisciplinary care model that surrounds Accredo's polychronic patients with care providers.

While specialty pharmacists in Accredo's condition-specific Therapeutic Resource Centers (TRCs) support and educate these older patients about their medicines, the TRCs also coordinate with social workers from Evernorth Home-Based Care who can visit patients to screen for SDOH and to assess how adverse factors impact their health.

"Bringing the social worker into the home is really important," Dr. LeFebvre said. "Yes, you can do SDOH screening in the office and most patients are going to be mostly transparent. But when you walk into the home, and it's freezing in there, you know there's a problem. Or when you're discussing food stability and you've established their trust, they actually open the refrigerator and say, 'yeah, there's food here,' but we can see it's not the healthiest food. So, we have conversations about how to get healthier food – especially if they live in a food desert."

Social workers are integral to this health care engagement model, where polychronic patients are surrounded by providers and by an Accredo care team that keeps everybody in the loop. "For the Accredo nurse to say, 'let's call your case manager,' then for the case manager to call the primary care team – pretty soon you just get into that loop of all of us understanding what's going on," Dr. LeFebvre said.

When social workers can visit an older adult's home, they become an extra set of eyes to better assess a situation and gather real, face-to-face knowledge that can help address SDOH factors and lead to improved outcomes. Read more about how Evernorth Home-Based Care and Accredo by Evernorth are helping seniors who have multiple chronic conditions and face SDOH challenges.

Sources

1. Evernorth Health Systems, Evernorth Claims data, 2024.

2. National Library of Medicine (NIH), "Social Determinants of Health Data Quality at Different Levels of Geographic Detail." May 2023.