Building a Bridge to Better Health through Home-Based Care

Bringing Complex Clinical Care and Social Supports to High-Risk Members

Disenfranchised Populations Slipping through the Cracks

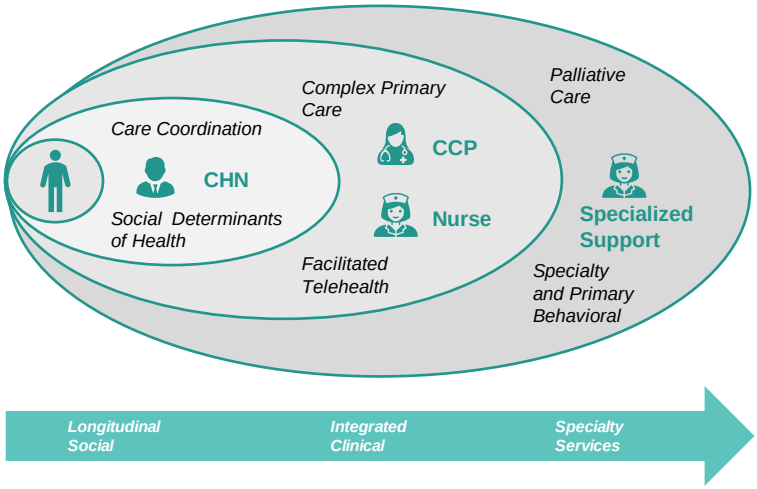
COVID-19 has laid bare the reality of deep and persistent health inequities in many communities and brought new awareness of the importance of addressing social determinants of health (SDoH) for vulnerable populations. Nowhere is this more urgent—or more difficult—than for complex, high-risk individuals in underserved areas.

Many of these individuals not only struggle with multiple, chronic clinical and behavioral health conditions, but also experience numerous barriers to accessing and fully engaging in their own care. Navigating the fragmented delivery system of providers, health plans and community and home-based resources, and even existing telemedicine services is complicated and often deeply frustrating, leading to a pattern of poor health, primary care avoidance, and high hospital utilization. These individuals, while representing only five percent of patients, account for 50 percent of health care expenses

Untangling and Prioritizing Multiple Determinants of Health

MedZed focuses exclusively on these high-need individuals and aims to understand and address the interplay of their unique clinical, social, and behavioral health drivers.

A multidisciplinary team develops a comprehensive, personalized care plan of targeted interventions that address social determinants of health and provide fully integrated, home-based clinical care, including specialized support as needed.



Community Health Navigators (CHNs) serve as a single point of contact, coordinating and guiding patients through their care plan, connecting them with clinicians, referring them to targeted social and community services, and providing individual and family support and education. *Nurses* provide hands-on clinical care in the home, linked to a remote MedZed *Complex Care Provider (CCP),* either a nurse practitioner or physician, via a telehealth platform. The *CCPs* perform complex primary care, acute, and preventive care visits; they also complete medication reconciliation and adjust and fill prescriptions. *Behavioral health* and other specialists, e.g., palliative care may also participate in selected cases.

Cracking the Code on True Engagement

MedZed deploys a team of culturally competent, locally-based CHNs who excel at finding and enrolling hard-to-reach individuals who have not responded to traditional outreach efforts. Using multi-modal engagement strategies, an extensive network of connections with local organizations and resources—and plenty of determination and creativity—CHNs successfully **enroll > 50% of referred members.**

CHNs truly engage and support the whole person. They meet their urgent needs, help them overcome obstacles, and coach and motivate them. They create a path forward and build a bond of trust that empowers individuals to reengage in all facets of improving their health and well-being.

Addressing Social and Clinical Needs Drives Down Excess Costs[1]

53% ⬇	Inpatient Admissions	50% ⬇	Total Medical Cost (PMPM)
35% ⬇	ER Visits	>3x	ROI

[1] Results based on panel of 252 members in California-based Medicaid Managed Care Plan across 12 months.

Partnering with Managed Medicare and Medicaid Plans

- **Customizable, layered solutions** weave together targeted interventions and align with health plan objectives for the identified population, e.g., long term support, or a time-limited intervention:
  - *Longitudinal Social Care*: community-based care management addresses SDoH (satisfies Medicaid Health Homes/Enhanced Care Management program requirements) and connects unmanaged patients to PCPs. Staffed by CHNs and overseen by Clinical Consultants (RNs).
  - *Integrated Clinical Care:* technology-enabled, in-home primary care and behavioral health support for complex patients, includes all elements of our longitudinal social care program. Can be used to supplement plan's provider network in underserved and/or rural areas. Staffed by multidisciplinary team of CHN, nurse, and CCP.
- **Scalable, innovative cost-effective model** powered by an integrated telehealth platform and centralized systems that seamlessly coordinate care for complex patients and enable high-touch service across geographies.
- **Shared accountability** for patients with plans through regular clinical rounds and coordinated case management.
- **Experienced community-based provider** delivered 500K+ visits 30K+ to patients in the location of their choice across seven states.

Contact us to learn how MedZed can support you in serving your high-risk members

Jonathan Perez
VP, Business Development
(470) 487.3671
Jonathan.Perez@mymedzed.com

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