Building a Bridge to Better Health through Home-Based Care

Clinical Care and Social Supports for High-Need Members

Cracking the Code on Underserved Populations

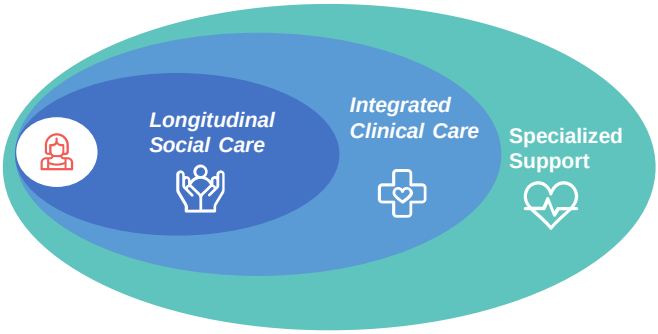
Meeting the complex health needs of vulnerable, high-risk members has never been more challenging, or more urgent. These individuals struggle with multiple, chronic conditions and extensive social determinants of health. They face numerous barriers to accessing care, and often lack a connection to—or even a sense of trust in—the health care system. For them, navigating the fragmented delivery system of providers, health plans and community and home-based resources is complicated and often deeply frustrating, leading to a pattern of poor health, primary care avoidance, and high hospital utilization.

Finding and engaging these high-need, high-cost members can be extremely difficult. It takes a dedicated approach to truly meet them where they are: locally based, multi-modal outreach strategies, hands-on clinical care via facilitated telehealth delivered in in their homes and communities, integrated social supports, and a commitment to building and nurturing meaningful relationships of trust.

Untangling and Prioritizing Multiple Determinants of Health

MedZed collaborates with plans to identify a target population, pinpoint their needs, and enroll them in a program to provide an extra layer of intensive support.

MedZed's multidisciplinary teams develop and deliver a comprehensive, personalized care plan of fully integrated, home-based clinical care and wraparound social supports to address each member's interrelated clinical, social, and behavioral health drivers.



For **Longitudinal Social Care** programs, Community Health Navigators (CHNs) serve as a single point of contact, coordinating and guiding members through their care plan. They connect members with clinicians, help them access social and community services, and provide individual and family support and education. **Integrated Clinical Care** programs layer in hands-on clinical care provided by a Nurse in the home, linked to a remote MedZed Complex Care Provider (CCP), via our telehealth platform. The CCPs diagnose and treat complex clinical conditions. They perform primary care, acute, and preventive care visits; complete medication reconciliation, write prescriptions and adjust and fill prescriptions and coordinate referrals specialists, e.g., behavioral health. **Specialized Support** programs such as Palliative care services are also available.

Building True Engagement

MedZed deploys field teams 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 > 40% 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 and connects members to PCPs. Staffed by CHNs and overseen by Clinical Consultants (RNs).
  - *Integrated Clinical Care:* technology-enabled, in-home primary care for complex members, 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 members and enable high-touch service across geographies.
- **Shared accountability** for members with plans through regular clinical rounds and coordinated case management.
- **Experienced community-based provider** has delivered 500K+ visits 30K+ to members in the location of their choice across eight states.

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

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