MedZed Expands Capability to Support Medicaid **Health Homes**

Medicaid Health Homes – provided for by the Affordable Care Act – is a program targeting the social determinants of health through a community-based care model. These initiatives are rapidly increasing in adoption, due to the significant benefits to high-risk populations they have demonstrated.

For over 6 years, MedZed has been finding, engaging, and providing vulnerable Medicaid populations with the exact services in the Health Homes scope, generating as much as a 9:1 ROI for clients, and significantly decreasing leading indicators such as ED utilization and IP costs. Timing and experience will be critical factors in determining the success of a Health Homes program- leverage MedZed's turnkey solution to deliver rapid results.

CLIENT RESULTS

- 33% Inpatient utilization
- 32% ER utilization

Required Health Homes Services

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care
- Individual and family support services
- Linkage and referral to community and social support services
- Use of HIT as feasible and appropriate

Critical Factors for Success

- Vulnerable and hard-to-find population – requires experience in best-of-breed outreach and engagement strategies
- Ability to rapidly deploy diverse, multidisciplinary and culturally sensitive teams to achieve best results
- Integrated logistics management to manage workflows and integrate complex care across providers and systems
- Ability to interface with Plan systems – HIE, EHR, etc.

OUTREACH & ENGAGEMENT

- Target lists or direct referrals
- Multi-channel engagement methodology; telephonic to community- based outreach
- 50%+ engagement rate with Medicaid high-need population
- Language and culturally sensitive - Community Health Workers hired from the communities they serve

INTERVENTION FOCUS

- Expanded care management approach; experienced multi-disciplinary team
- Health Risk Assessment and housing insecurity assessment
- Assistance scheduling and completing appointments with providers
- Self-management tools & personalized Health Action Plan

WHOLE PERSON INTEGRATION MODEL

- Seamless integration of members into existing provider ecosystem
- Extensive use of community and social support to enable healthcare navigation
- Wraparound programs specifically developed for Transitions of Care and ED Reduction
- Technology and workflows custom-built for serving this population's needs

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