MEDZED

Inspiring and Enabling Better Health

Field-based Care Management & Social Support for High-Need Members

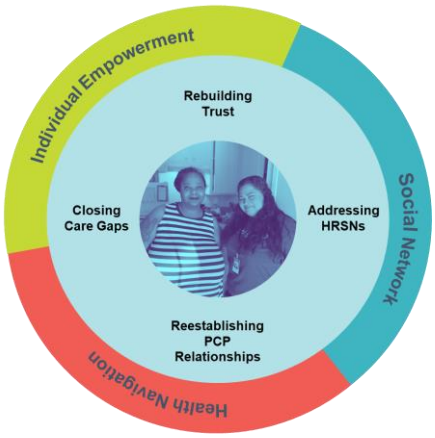
Cracking the Code on Underserved Populations

Meeting the complex health needs of vulnerable, high-risk individuals has never been more challenging, or more urgent. Many struggle with multiple, chronic conditions and extensive health-related social needs (HRSNs). 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 emergency department and hospital utilization.

MedZed deploys field teams of culturally competent, locally-based Community Health Navigators (CHNs) dedicated to finding and enrolling these hard-to-reach individuals who have not responded to traditional outreach efforts. Using multi-modal engagement strategies, an extensive network of local connections—and plenty of determination and creativity—our CHNs successfully reach 50% of referred members and subsequently enroll 80% of these individuals. They are supported by a sophisticated operational and technology backbone that enables MedZed to scale efficiently and cost-effectively and continuously monitor and improve performance.

Comprehensive, Coordinated Interventions for Improving Health

MedZed collaborates with plans to identify a target population and determine key goals for improving health and well-being, enhancing quality of care, and reducing inappropriate utilization. MedZed takes a whole person approach to understanding each member's complex needs and develops a personalized care plan of interventions.



It begins with building a relationship of trust that enables members to reengage in all facets of improving their health and well-being. CHNs work in person, one-on-one with members to address their health-related social needs (HRSNs), (re)establish a connection to their PCP, and close key care gaps. At the same time, MedZed works to develop members' own capabilities and support systems that empower them to independently manage their conditions and needs and navigate the healthcare system and access related resources.

Across the last nine years, MedZed's extra layer of intensive support has transformed high need members' ability to improve and maintain their health in their home and communities, avoiding hospital-based care and driving down costs. Members regain the confidence and control they need to lead happier, healthier and more hopeful lives.

38% ⬇ ED Visits

54% ⬇ Inpatient Admissions

54% ⬇ Total Medical Cost (PMPM)

[1] per 1,000 members, results from 2015-2023

MEDZED

©2024 MedZed. All rights reserved. mymedzed.com

Navigating the Path to Better Health

Community Health Navigators serve as lead care managers for individuals, developing and coordinating a comprehensive, personalized care plan. They untangle and prioritize a member's unique, interrelated needs and help them understand and access supports and resources. They also provide individual and family support, as well as health education and coaching to enable individuals to "own" their health journey. They offer compassionate support and guidance every step of the way and together forge a path forward. For some populations, CHNs are also supported by RNs, who review care plans, deliver clinical education and training, perform medication reconciliation.

Partnering with Managed Medicare and Medicaid Plans

- **Intensive, in-person support for highest-need members:** CHNs untangle and prioritize interrelated health and HRSNs, coordinate comprehensive interventions, and provide compassionate support
- **Proven strategies for finding and engaging hard-to-reach members:** rigorous training and processes support locally-based field teams in finding and enrolling members in challenging urban and rural areas, and in building relationships of trust
- **Focus on reintegrating members into healthcare system and controlling costs**: teams help members identify and access community-based medical providers and social support resources, and provide education and guidance for members to manage their health and avoid ED and hospital visits
- **Technology-driven operations and performance**: scheduling and routing systems optimize staffing efficiency, allow teams to deploy quickly and scale capacity—up and down—to meet member needs. Member and population-level data tracking enable performance monitoring and reporting, and support continuous improvement and innovation
- **Flexible and Collaborative Partnerships:** programs are tailored to align with health plan objectives for a targeted population, with the option to include RN services

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

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

MEDZED

©2023 MedZed. All rights reserved. mymedzed.com