

IAH FACTS

(INDEPENDENCE AT HOME)

WHO?

Up to **10,000** Medicare patients with severe chronic illness and disability served by medical teams



Medicare Demonstration since 2012

17 IAH practices

which provide Home-Based Primary Care

The **IAH practices** provide:



Interdisciplinary medical and social services at home



24/7 access and visits within 48 hours of discharge from hospital or ER



a mobile electronic health record (EHR)

WHAT?

In Year 1, IAH sites successfully cared for more than 8,400 patients with savings totaling more than

\$25 million

8,400



All 17 practices met at least three of six major quality metrics and four sites met all six.



9 of 17 exceeded the 5% total savings threshold (range of 6-31% and \$2,600-\$12,800/patient-year) and **received shared savings payments** of nearly \$12 million.



All produced an **average cost reduction** of \$3,070 per patient/year.

WHY?

Many elders with severe chronic illness and disability have difficulty getting to the doctor's office, forcing them to rely on the ER or hospital due to:



Cognitive



Physical



Social

B A R R I E R S

IAH teams are required to meet quality metrics:



better medication management and advance care planning



follow-up visits within 48 hours after any hospital stay or ER visit



fewer ER visits and hospitalizations and 30-day readmissions



IAH teams **provide better care** and reduce total Medicare costs by

up to 30%

FUTURE?

1-2 million Medicare patients with severe chronic illness and disability could benefit from national IAH program

A national IAH program could bring **\$21 to \$34 billion** in savings over the next 10 years.

www.aahcm.org

