IAH FACTS
(INDEPENDENCE AT HOME)

WHO?

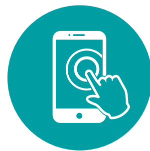
Up to **10,000** Medicare patients with severe chronic illness and disability served by medical teams

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)

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%**

WHAT?

In Years 1 and 2, IAH sites successfully cared for more than 10,000 patients with savings totaling more than **$35 million**

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

9 of 17 exceeded minimum savings thresholds for either or both years. Practices **received shared savings payments** of nearly $17 million with medicare receiving nearly $19 million in two years.

All reduced ER visits and hospitalizations and 30-day readmissions.

FUTURE?

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

A national IAH program could bring **$10 to $15 billion** in savings over the next 10 years.

www.aahcm.org

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