41%

of US health care spend is driven by 12% of the population with 5+ chronic conditions.[1]

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What We Do

Vively Health™ partners with health plans and collaborates with local providers to care for the highest-risk, chronically ill members. We refer to these members as Most Vulnerable Patients (MVPs). We believe that house calls—our in-home primary care program—is the most impactful way to improve the quality of care for MVPs. Additionally, we take full risk for each member's total cost of care.

At Vively, we are committed to helping MVPs live healthier and more fulfilled lives, while also helping reduce their total cost of care. This supports patients, their existing providers, and our health plan partners.

MVPs Require a Different Care Model

The highest-risk patients with multiple chronic conditions and many issues related to social drivers of health require a fundamentally different care model. Solutions that only address a single co-morbidity or piece of the cost base are insufficient and often create misaligned incentives.

Patients who receive high-touch, personalized care are less likely to delay essential care and less likely to go to the emergency department for non-urgent care, thus less likely to accrue avoidable costs.[2]

Most Vulnerable Patient Insights[3]

1 in 3 visit ER at least once per year

1 in 4 have at least 1 hospital stay per year

1 in 5 are re-admitted within 30 days[4]

Our Teams Deliver In-Home Primary Care

Our multidisciplinary care teams provide supplemental primary care within a patient's home, including after-hours clinical support. These teams are physician-led and provide medical, pharmaceutical, behavioral, social and palliative care. Our legacy as a provider and medical group gives us unique sensitivity to working with local PCPs and specialists.

We have nearly 20 years of experience delivering scalable, comprehensive care programs to manage health plans' highest-risk members. As a result of our team's disciplined and accountable execution, our programs have improved the quality and cost of care for our nation's MVPs.

Right Member Identification

Our predictive analytics prospectively identify the right members for house calls. Traditional comorbidity identification models often misidentify up to 2/3 of the population, resulting in missed opportunities. Our model selects members based on expected future chronic conditions and cost.

Robust Clinicial Approach

We have fully developed clinical pathways, workflows, training and EMR integration for an interrelated set of chronic conditions. When members join our house calls program, we assess and document their needs, develop a care plan, and provide comprehensive care.

Scalable House Calls

Delivering a comprehensive house calls program requires relentless execution. We have cultivated the people, processes, and systems required to execute a scalable house calls program with rigor and accountability.

Proven Results[5]

91% patient satisfaction rating

46% lower SNF length of stay

64% lower SNF-to-acute 30-day readmission rate

35-40% fewer hospitalizations

10-15% fewer emergency room visits

15-20% lower cost of care

20 doctor visits each year

51 medications filled each year

Over the next decade, the U.S. population with multiple chronic conditions is projected to grow by more than 20%.[6,7]

A new care model for these patients is critical.

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