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New care model spreads across the country — keeping high-risk patients healthier at home

Shared-savings success: Landmark extends quality of life as it lowers cost for polychronic patients

Landmark Health serves patients who have multiple chronic conditions and who often require more comprehensive health care services. They bear risk for over 170,000 high-risk patients in 52 metro areas across the United States. They have over 500 medical providers, 50 of whom specialize in behavioral health.

C-Suite takeaways

1

Patients prefer receiving care in the home. Higher satisfaction levels, increased engagement and improved outcomes provide the clinical rationale for reimagining in-home care models.

2

Value-based arrangements can and should stimulate breakthrough care models. Landmark's in-home primary care is an example of a new risk-sharing model that is proven to better meet the needs of complex and polychronic patient populations.

3

By extending integrated, data-driven, preventive services into the home, health plans can immediately bend the cost curve for high-need, high-cost patient populations.

Complex and chronic conditions cost over $3 trillion each year

Today more than 40% of people in the U.S. have two or more chronic conditions such as arthritis, asthma, cancer, heart disease, COPD or diabetes. For those over age 65, that rises to 68%. In fact, 23% of people over age 65 have three or more chronic conditions. The economic burden of treating these conditions in the U.S. is over $3 trillion per year.[1]

In their efforts to reduce costs, health plans look for complex or polychronic patients with high utilization rates. They identify patients who have just left the hospital, mark them as high risk and deploy care management solutions to support them. But Landmark's research discerned that many patients — with or without the added care management — stabilize at a fairly common rate. They concluded this approach was not focused on the drivers of future utilization: the diseases themselves.

Landmark's clinical goal was to offer proactive, physician-led medical care that could guarantee a reduction in emergency room, inpatient and post-acute spend for populations with multiple chronic conditions.

Achieving Landmark's goal would require two components:

1. A fully integrated, clinical model that could bring patient-centric care into the homes of the complex and chronically ill. Landmark determined this would require a multidisciplinary team, in-home diagnostics and interventions, behavioral and social health, and palliative and end-of-life services. It would also depend on a data-driven infrastructure that could help them identify, anticipate, and coordinate resources for a patient's health needs.

2. Shared savings arrangements that will allow Landmark to take full risk of patients' care. The complex and polychronic populations are expensive to serve and consistently run at a very high medical loss ratio (MLR). Landmark wanted to be able to enter into full-risk contracts that measure improvement against a plan's historical MLR and offer shared savings in return.

A model that rewards providers and health plans when patients stay well at home

Landmark's approach is to identify the most medically complex patients with the highest chronic disease burden. This includes reaching people who are currently stable but are at risk for being high utilizers in the future. They have designed a new way to manage these members that lifts consumer satisfaction, prevents disease advancement and reduces cost.

Landmark physicians or advance practice providers conduct **six to eight in-home visits per patient per year.**

Exclusive in-home medical care drives consumer satisfaction

Landmark is not home health care. Landmark brings screening, interventions and ongoing treatment into the home. Landmark physicians or advance practice providers conduct six to eight in-home visits per patient per year. And each of those visits is 45 to 60 minutes in duration.

Landmark's in-home approach helps to increase the number of healthy days that these people can spend in their home and in their communities. Their consumer satisfaction index is in the mid-to-high nineties.

Targeting the disease before utilization leads to better clinical outcomes

Landmark identifies their population using underlying disease markers rather than historic utilization patterns. The goal is to intervene before disease advancement or any complications arise. This prevents the need for emergency medicine or inpatient care.

Landmark's longitudinal clinical model delivers 100% of their visits in the patient's home. In each market, they develop coordinated, interdisciplinary teams that support each patient individually. Led by physicians, the team includes behavioral health providers, pharmacists, dieticians, social workers and nurse care managers to supplement the patient's existing primary care provider. The Landmark team is supported by a unique care coordination platform that shares data and information across the patient ecosystem. This infrastructure allows the team to address long-term physical, social and mental health concerns.

If a patient is having a health concern, the team is able to meet them at home and help prevent an emergency. Landmark measures their clinical success by tracking reduced hospitalization, reduced utilization of skilled nursing and lower rates of disease onset or progression.

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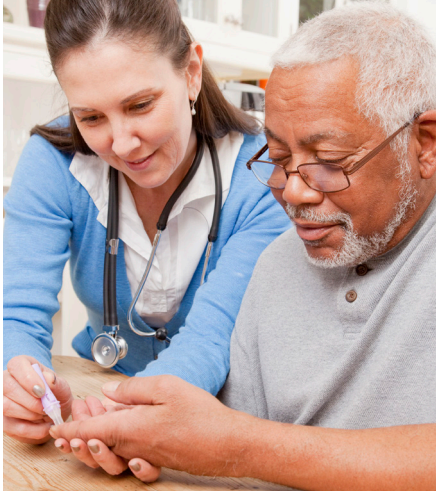
Data analytics, engagement engines, clinical workflows drive success

Landmark is able to sustain this model with an underlying infrastructure of data and analytic insight. This unique platform helps identify new patients, spot hidden conditions, anticipate disease advancement and measure levels of acuity. These insights not only support decision-making and workflows but also help offset the amount of time Landmark team members spend traveling to patients. It allows them to prioritize their visits and spend more time with patients. Landmark currently bears risk for over 170,000 patients. And the more patients they see, the smarter their clinical workflows become.



Reaching 170,000 members

The first metric that Landmark tracks is patient engagement. Landmark prioritizes outreach — ensuring that they are connecting with all patients who are eligible for their services in the community. This requires combined clinical and operational expertise. Operational expertise enables them to conduct the outreach and clinical expertise to ensure they have the capabilities and the capacity to effectively serve them.

15%–25% reduction in inpatient admissions per thousand

The next set of metrics is reduced utilization and admissions. Landmark looks for patients who might have undiagnosed or underserved health concerns to make sure they are reaching the full scope of need. Landmark has a 24/7 call center staffed by providers and nurses who triage urgent patient needs and deploy providers quickly to the home when necessary. They also work to strengthen partnerships in the community. They help acute care facilities discharge patients directly to them so they can manage post-acute activity in the home.

Landmark delivers 20%–25% in gross MLR improvement

Medical loss ratio is the key metric for health plan profitability. And the complex, polychronic population is where most payers see their numbers turn upside down.

For some plans, this can represent a significant portion of their portfolio. To overcome any hesitation plans might feel about allowing Landmark to manage the risk for such a significant group, Landmark guarantees them savings. They start with a plan's historical MLR and project out a year-over-year savings percentage. It's basically risk-free for the plan partners with Landmark taking downside risk and guaranteeing savings.

26% reduction in mortality within 12 months

97% of members say Landmark has helped them stay out of the hospital or emergency room

Once in the home, Landmark monitors disease onset and progression. They combine predictive analytics with onsite interactions to ensure their patient assessments are current and validated. This use of data also helps anticipate the need for palliative services and ensures that the care planning conversations are being had with patients and their caregivers.

Landmark's financial model means they don't generate revenue by seeing patients. They do not submit claims for reimbursement. They generate revenue only by generating savings for the partner. Keeping patients out of the hospital and out of post-acute care settings is a win-win for patients, Landmark and their health plan partners.

"A model like ours is very intensive. But we don't make revenue by seeing patients. We identify conditions early and help prevent downstream hospitalizations and any sub-acute rehab from ever happening. This type of care management reduces a health plan's medical loss ratio, helps keep patients healthier and generates savings that can be shared.

A factor in our model's success is scalability. Our infrastructure is designed so that our clinicians can anticipate risk and our workflows can coordinate and expand across a broad geographic footprint."

— Chris Johnson, Chief Executive Officer, Landmark Health

Source

National Council on Aging. The top 10 most common chronic conditions in older adults. April 23, 2021.

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