



Landmark Health Spotlight on Innovation

BY BETTER MEDICARE ALLIANCE
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Landmark Health

Improving Health Outcomes for
Medicare Advantage Beneficiaries
Through Team-Based, In-Home Medical
Care

Better Medicare Alliance's President and CEO, Allyson Y. Schwartz, participated in a house call with Landmark Health (Landmark) and its affiliated medical group in Pennsylvania. Landmark partners with health plans, systems, and medical groups to provide in-home medical care for Medicare Advantage beneficiaries with multiple, difficult to manage chronic conditions. During the house call, Congresswoman Schwartz met with Mr. and Mrs. Law, a couple from Hershey, Pennsylvania. Dr. Stark, one of Landmark's in-home physicians, has been treating the couple for two years and helps manage each of their eight chronic conditions.



Landmark is always one phone call away, but Dr. Stark also routinely visits Mr. and Mrs. Law to check in on them. During this visit, Dr. Stark, an emergency room physician by training and experience, takes a moment to clear wet leaves from the Laws' path leading to their front door. A simple act, but one that can reduce the risk of a fall. Once inside, Dr. Stark takes a blood pressure reading and checks their heart and respiratory rates—a physical examination from the comfort of their home. He works to monitor and track the progress they are making toward their health goals, whether that be to lose weight or manage depression. He reviews the array of prescription medications each is taking and answers numerous questions they have about their health. This removes the burden on family members and the patient from having to drive to the doctor's office. Additionally, by providing essentially the same services as an urgent care facility, Landmark's in-home treatments can help patients like the Laws avoid unnecessary visits to the emergency room.

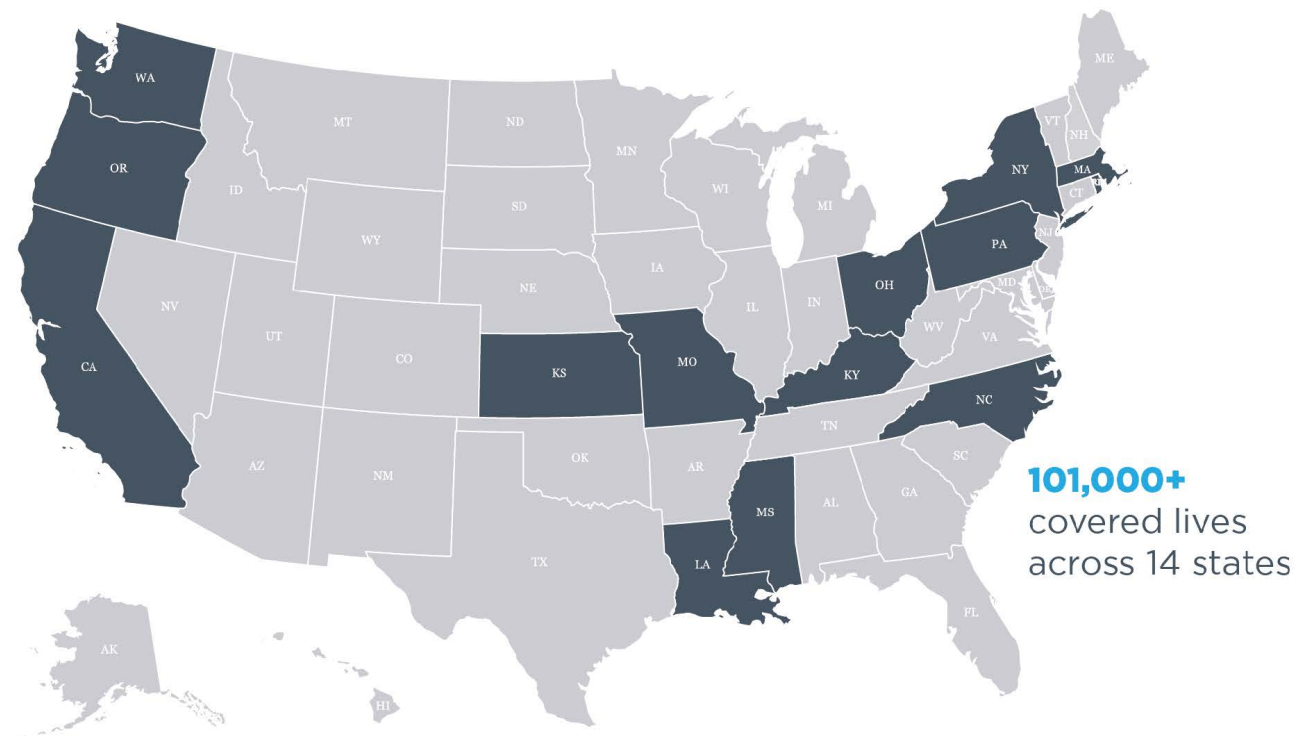
Further, Landmark not only manages their conditions, the team of health professionals helps ensure that Mr. and Mrs. Law's entire care is coordinated, and the process is seamless. Landmark does not let anything go unnoticed and communicates with Mr. and Mrs. Law's primary physicians and other specialists working with them. They also arrange other services, as needed.

The Laws say they are benefiting from “an old fashion doctor who comes into the home and takes the time with them.” Mrs. Law told Congresswoman Schwartz that Dr. Stark has served them beyond what they could have imagined and saved her husband's life. Congresswoman Schwartz saw firsthand the powerful impact of Landmark's in-home care model and the difference it makes on the engagement between patient and provider.

Landmark's Story and Model: In-Home Medical Care

Landmark is the largest risk-bearing, home-based medical group in the country. Since its inception in 2013, they have grown significantly. Today, Landmark medical groups consists of 440 clinicians that are accountable for 101,000+ covered lives in 46 metropolitan areas nationally. Importantly, Landmark collaborates with the patient's primary care physician to deliver coordinated, comprehensive medical care. As of 2019, Landmark has conducted over 400,000 in-home visits for chronically ill patients across the nation. The company anticipates making 335,000+ house calls in 2020.



LANDMARK: A SCALABLE MULTI-SPECIALTY MOBILE MEDICAL PRACTICE



There is a growing clinical consensus that mobile solutions are necessary to properly manage care for individuals with complex chronic conditions. The clinic-based setting of care simply does not work for homebound, frail patients. America is aging, and the number of seniors with complex chronic conditions is rapidly growing. Landmark provides care for patients who need it most, with the average Landmark patient having six to eight chronic conditions.

Landmark’s care model offers both longitudinal care and urgent care for patients in their homes. Longitudinal care includes condition documentation, patient health education, dietary evaluations, home safety assessments, medication reconciliation, advance directive discussions and much more. Urgent care services include on-site lab draws, wound care, IV antibiotics or fluids, and catheter assistance, among other services.

EXAMPLE OF LANDMARK HEALTH’S CARE MODEL

IN-HOME LONGITUDINAL CARE 	IN-HOME URGENT CARE 
Medication management and adherence	IV Lasix for heart failure exacerbation
Patient and caregiver education	IV fluids for dehydration
Symptom detection and management	IV antibiotics for serious infections
Diet and lifestyle adjustments	Urinalysis to check for UTI
Discussions with patient and caregivers to establish and follow advance care plans	Catheter insertion, surveillance and removal
Home safety checks	Steriods for clinically treatable needs
Screening for behavioral and social health	Acute wound care
Referral to other Landmark clinicians	Nebulizer treatment for COPD exacerbation
	On-site lab draws

This model allows for ongoing, continuous support and care that leads to improved health outcomes and decreased health care utilization (i.e., hospitalizations, readmissions, etc.).

Further, Landmark employs a diverse health care workforce. Their care team includes physicians and advanced practice providers, but Landmark also employs nurse care managers, behavioral health specialists, social workers, pharmacists, dietitians, care coordinators, and health care ambassadors. Through this team-based approach, Landmark offers services including routine visits, 24/7 phone care, care coordination, urgent visits, and post-discharge care (i.e. medication adjustments, follow ups on labs, and communication with PCP). The diverse workforce allows Landmark to treat the whole patient, in place.

Landmark also provides behavioral and social health services, such as universal screening, intervention, and treatment of behavioral health and substance use disorders. Finally, Landmark offers palliative and end-of-life planning services, which may include aggressive symptom control management and timely hospice referrals.



How Medicare Advantage Enables the Landmark Model

Medicare Advantage is the public-private partnership in which health plans have the ability to align the financial incentives of the payers, providers, and patients to improve health outcomes in ways that are not possible in Traditional Fee-For-Service (FFS) Medicare. Medicare Advantage is paid through a prospective, capitated system in which health plans have responsibility for the provision of all Medicare benefits, including hospital and medical services, and plans are at full financial risk for the cost of care for each beneficiary enrolled in their plan. Medicare Advantage provides coverage for over 24 million beneficiaries.

Landmark Health contracts with health plans, health systems, and medical groups in value-based arrangements to manage the client's most complex Medicare Advantage members. Landmark takes full risk on all assigned members which guarantees its health plan partner upfront savings.

Landmark partnered with Humana in 2018 to offer in-home medical, behavioral, and palliative care coordination to their Medicare Advantage members with multiple chronic conditions in select regions. Humana is committed to increasing the number of members seeing primary care physicians in value-based contracts, which is currently over 66%. The collaboration with Landmark will allow Humana to reach and better manage their chronically ill enrollees and improve their health outcomes. The integrated care model utilized by Landmark allows for treatment of the whole patient, and augment patients' care from their regular doctors.

Landmark's Integrated Care Model

Landmark attributes its success in delivering meaningful results to its comprehensive care model. Treating complex patients goes beyond episodic care and requires an ongoing, high-touch effort, in coordination with internal teams, external providers, caregivers and resources. By integrating medical, behavioral, palliative and social services, along with care coordination, documentation collection and management, 24/7 availability, member engagement, predictive analytics, and innovative operations, Landmark has been able to replicate its outcomes nationally. Highlights of how Landmark is going beyond medical care follows:

BEHAVIORAL HEALTH CARE TEAM

Mental health is becoming a serious concern in the aging population and understanding the link between physical and mental health is critical to addressing the need. Today, approximately 15 percent of older adults are impacted by behavioral health problems and 4.8 percent of older adults are living with a serious mental illness.

Currently, Landmark employs 27 behavioral health specialists, inclusive of psychiatrists, psychiatric nurse practitioners, psychiatric physician assistants, and social workers. The social workers are fully employed by Landmark and are part of local interdisciplinary care teams. For Landmark, social workers are a pillar of the behavioral health mission, bringing a unique perspective and care to the patient population.

Additionally, the behavioral health care team collaborates closely with health care ambassadors, non-traditional health care workers who are part of Landmark's overall interdisciplinary care team. Health care ambassadors visit patients in the home when a clinician may not be needed, acting as a touchpoint for connection.

Landmark's team-based care model is all about the patient. One patient noted:

"Landmark is not just one doctor, it is a team of people, like social workers and health ambassadors, and no matter what time of day you call, someone will answer."



ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN THE MEDICARE ADVANTAGE POPULATION

An important aspect of Medicare Advantage is the ability to address social determinants of health (SDOH), which encompasses needs such as transportation to and from doctors' offices and pharmacies, meal delivery services, and even refrigerators for medications. According to numerous studies, when SDOH are not addressed as part of patient care, the likelihood of missed appointments or failure to adhere to prescriptions increases, resulting in hospitalizations or avoidable hospital readmissions, which leads to unnecessary and increased patient health costs.ⁱ While four in five physicians report patients' social needs are as important to address as their clinical conditions to improve health outcomes and overall health, they note that they are not confident in their ability to solve these social needs, thus impeding their ability to provide quality care.ⁱⁱ

Landmark is well positioned to address patient needs related to SDOH for patients with both complex economic and social conditions by focusing on longitudinal outcomes and immediate medical services. Essential to their model, Landmark sees people in the home, thus enabling a comprehensive assessment of SDOH, such as food in the fridge or pantry, medication storage and adherence, and social networks.

Landmark recognizes that addressing SDOH is critical to ensuring that patients reach their health goals and have made impactful investments in the model to ensure that happens. Landmark uses evidence-based screening tools and a comprehensive psychosocial assessment to identify unmet social and behavioral health needs. Additionally, all new Landmark patients undergo a depression and substance use screening. These screenings are re-administered at least annually.



By employing social workers and non-clinical workers, called health care ambassadors, Landmark can help patients and their caregivers navigate available resources. Through strong local partnerships with community-based organizations, Landmark helps address whole patient, non-medical health needs.

In the near future, Landmark will be adding new domains to their screening tools to capture additional SDOH issues, such as food security and housing stability, and will focus on identifying loneliness, a common experience for older adults. In addition, Landmark plans to add new features to link patients' answers to action, ensuring the right resources are brought in when needed, on a timely basis. Ultimately, the long-term goal is to have enough data to pinpoint local trends and build targeted, strategic partnerships with community organizations.

During a house call with a Landmark doctor, Congresswoman Schwartz said,
"We are proud of the new rules that allow Medicare Advantage plans to offer in-home health visits that enhance the ability of providers to see – and treat – the whole patient."

AIMS MODEL

Landmark uses the AIMS Model, or the Ambulatory Integration of the Medical and Social Model, which is rooted in core social work competencies and focuses on assessing the needs of complex patients and providing risk-focused care coordination by social workers. The model follows a five-step process to create a care plan and follow-through with the patient to attain their goals:

1. **Patient Engagement:** The social worker establishes rapport and trust with the patient and caregiver, ensures the patient understands the need for care coordination, and identifies the patient's needs.
2. **Assessment and Care Plan Development:** The social worker conducts a comprehensive psychosocial assessment using a multidimensional tool that assesses patient strengths and identifies nonmedical factors that may affect utilization of health care services and health care outcomes. With the results of the assessment, the social worker develops a mutually agreed upon care plan.
3. **Care Coordination Activities:** The patient is provided care to address their needs, which may include providing information or education on available resources, coordinating activities, and linking the patient with community resources. If needed, social workers may also utilize a variety of brief interventions such as motivational interviewing, cognitive behavioral or solution-focused techniques
4. **Goal Attainment:** The social worker will connect the goals with the desired health outcome identified by the patient.
5. **Providing Ongoing Care:** The social worker will acknowledge the patient's status of goal achievement and determine whether continued follow-up from social work is needed.

The AIMS Model, used by Landmark, has been shown to be a highly effective model. Studies found a high satisfaction rate among beneficiaries, providers, and caregivers, specifically finding caregivers to be less stressed, improved support for beneficiaries, and better-informed patients and caregivers. Further, the AIMS Model has shown lower rates of admission, 30-day readmission, and emergency department visits for those receiving care under the AIMS model as compared to beneficiaries who receive care in a non-AIMS model.ⁱⁱⁱ

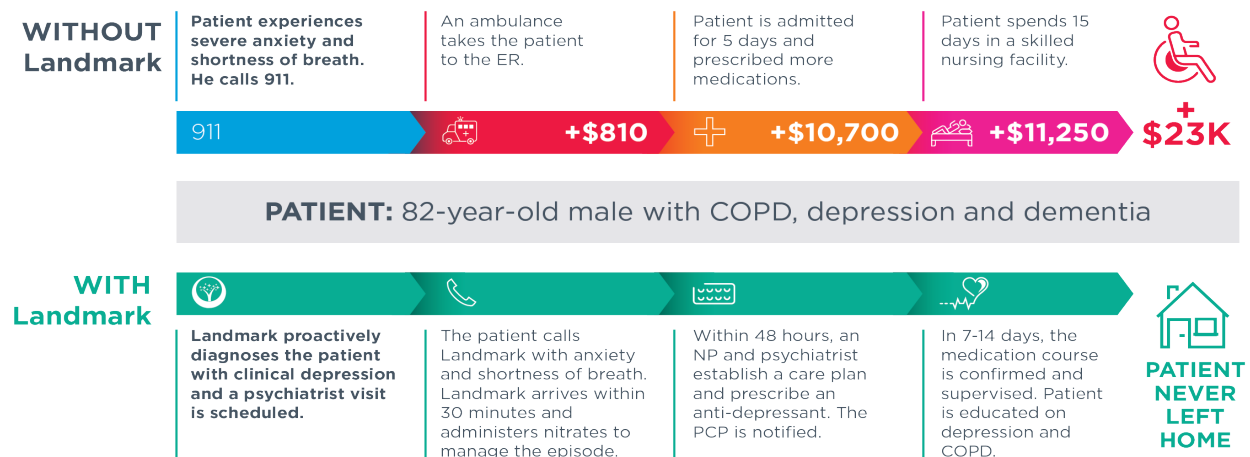
TELEHEALTH

Telehealth is the use of digital information and communication technologies to access health care services remotely and manage health care. This can include using technology in the home or technology that a provider uses to improve or support health care services. Overall, the goals of telehealth are to make health care more accessible and services more readily available to those with limited mobility, time, or transportation options.

Landmark First is Landmark's 24/7 call center staffed by providers to help triage patients' urgent needs on evenings, weekends and holidays. All Landmark patients are given in-home tools with the 24/7 number to ensure they have easy and quick access to the line.

Currently, Landmark is actively piloting innovative telehealth initiatives such as remote monitoring. For this pilot, medical devices are provided to patients to use for a daily health check of their vitals, which are monitored by a licensed nursing care team. The nurses can answer medical questions and set up a Landmark visit or follow-up care as needed. The potential benefits to such a program include more complete tracking of patients' vital signs, improved ability to care for semi-rural patients, and improved flow of information to Landmark to know when a patient may need preventive attention – even before they feel symptoms. This information is not only shared with the Landmark clinical team, but also made available to the patients' primary care providers for improved collaboration.

TIMELINE OF CARE



CARE COORDINATION

Care management is a team-based, patient-centered approach designed to assist patients in managing medical conditions more effectively. When care management coordinates both health care and social services, it can effectively address beneficiaries' SDOH and improve health outcomes.

Care coordination is at the core of Landmark's model, which allows them to deliver high-quality, value-based care. Landmark's social workers achieve this with use of the AIMS Model, and effective communication with patients' PCPs. The health care team also includes a nurse care manager to ensure each enrollees' information is properly shared with the entire care team, as well as the PCP. The nurse care managers work with patients over the phone and in collaboration with the Landmark provider to act as an advocate for patients' health and life goals.

Landmark communicates with the PCPs and integrates care plans, seeking to ensure that nothing goes unnoticed throughout the process. Landmark can communicate directly with PCPs through direct messaging, a means of delivering messages into their Electronic Medical Records using a direct message address. After each home visit, the PCP receives a summary which includes the date, visit notes, and current medications. In addition, the PCP is sent a continuity of care document outlining the demographics, advance directive status, functional status, vitals, medications, smoking status, a problem list, allergies, and surgery history of each patient under Landmark's care.

Conclusion

As the nation's population continues to age, and the portion of those with multiple chronic conditions increases, there is an opportunity for Medicare Advantage to best meet the needs of all Americans. In partnership with Medicare Advantage plans and providers, Landmark's in-home care model has proven to effectively care for enrollees and decrease inappropriate or unnecessary medical care. In a matched cohort study, researchers found that Landmark patients have a 28 percent lower inpatient admittance rate, 39 percent lower ER and observation rate, and a 26 percent lower mortality rate than non-Landmark patients. Landmark is reducing health care spending while providing high-value, longitudinal care through their disruptive care delivery model to patients with multiple chronic conditions, offering a successful model for care of high need Medicare beneficiaries.

This document was written by the Better Medicare Alliance, a community of over 140 Ally organizations, along with 460,000 beneficiaries, who value Medicare Advantage. Together, our alliance of health plans, provider groups, aging service organizations, and beneficiaries share a commitment to ensure the future of Medicare Advantage as a high-quality, cost-effective option for Medicare beneficiaries.

- i. Landmark, Healthify
- ii. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/>
- iii. <https://www.theaimsmodel.org/aims-2/#results>

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