INNOVATIONS IN COMPLEX PATIENT CARE

WA STATE OF REFORM CONFERENCE

JANUARY 4, 2018

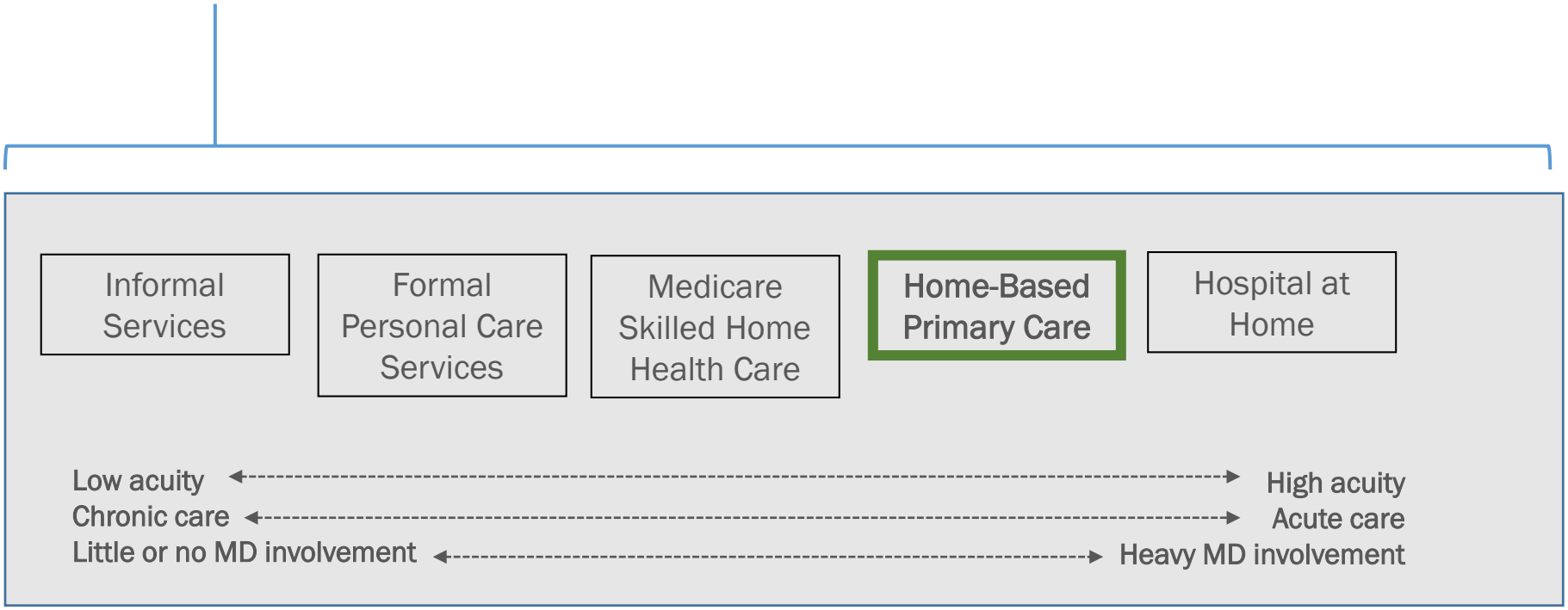
Landmark

Introducing Landmark Health

- Nation's leading risk medical group focused exclusively on the most chronically ill patients
  - Employed, risk-bearing provider that delivers in-home primary care with 24/7 availability
  - We identify patients for our program based on their number of chronic conditions (Medicare Advantage, Medicaid, Duals, Commercial)
- Medical model effectively integrates behavioral, social and palliative care
  - Interdisciplinary clinical teams led by medical and behavioral doctors, nurse practitioners, and physician assistants
  - Medical teams are specially trained on palliative and end of life care
  - 15-20% of visits each month are urgent visits, completed day or night
  - Highly engaged patient base; exceeds 50% at maturity
  - Complements and augments— does not replace —the existing primary care network and is designed to integrate with existing physician risk-sharing arrangements
- Solution to critical barriers for the most complex patients:
  - 24/7 availability with complete urgent care capability
  - Option for home-bound and home-limited patients
  - In home setting, providers obtain information not otherwise available to office-based providers
  - Coordination among many providers and across transitions
  - In-home post-discharge care and medication reconciliation identifies risks and allows for shorter acute/post-acute stays
  - Need for multi-disciplinary focus: medical, social work, pharmacy, nutrition, palliative care, behavioral health

Where Landmark and home-based services fit into the long term care continuum

Home-based services | Adult day care | Assisted living | LTC/Nursing home | Skilled nursing | Hospice



Source Home-based Care Continuum graphic: Bruce Leff, MD, Landmark Clinical Advisory Board and Professor of Medicine/Director, Center for Transformative Geriatric Research, in the Division of Geriatric Medicine at Johns Hopkins University School of Medicine

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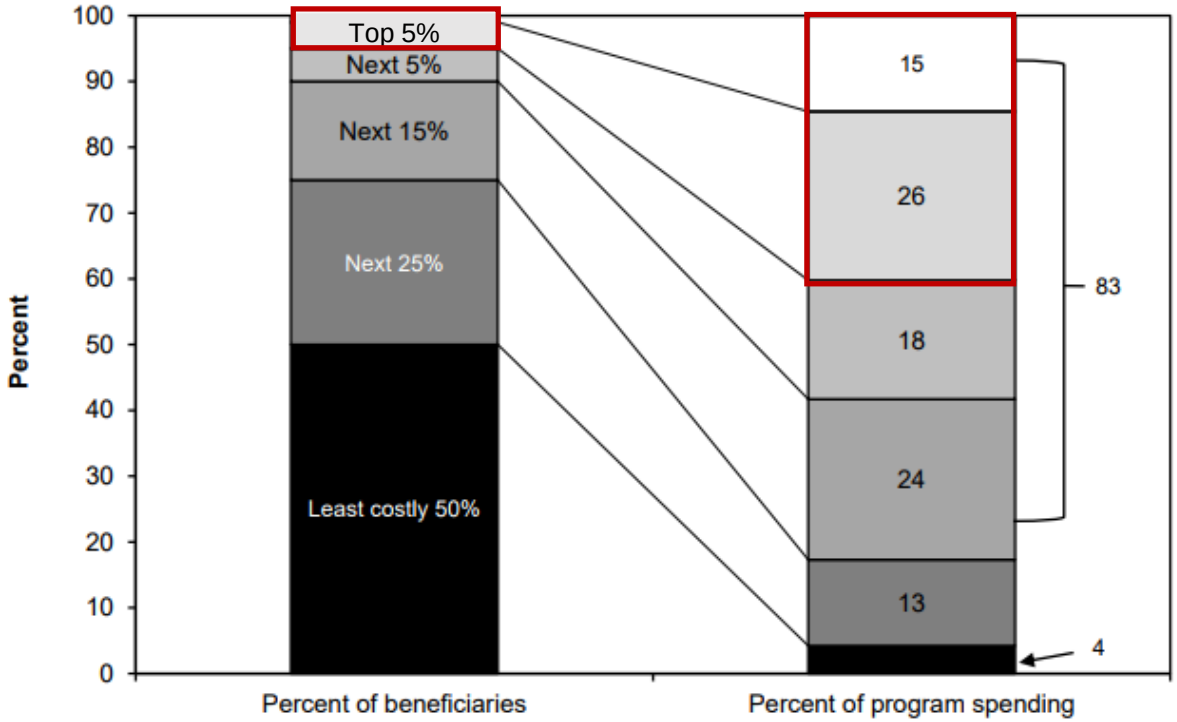
The problem Landmark is solving

- 5% of the Medicare-age population drives 41% of all costs.
- These beneficiaries tend to: have multiple chronic conditions; multiple inpatient events; be in their last year of life; have complicated social and behavioral issues; struggle to access in-office care; and overwhelm the resources of PCMH and telephonic care management models.
- Many of the costs incurred for their care do not improve patient outcomes or meet patient goals. And many are simply avoidable.



Notes & Source: FFS. All data for CY 2012 and excludes beneficiaries with any group health enrollment during the year. MedPAC analysis of Medicare Current Beneficiary Survey, Cost and Use files 2012.

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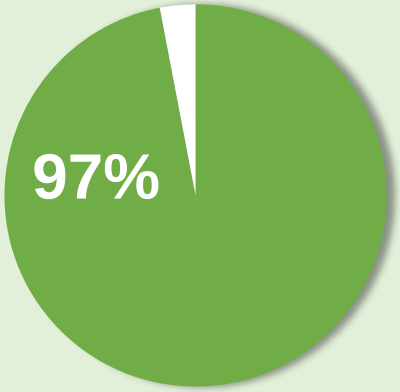
Landmark Outcomes

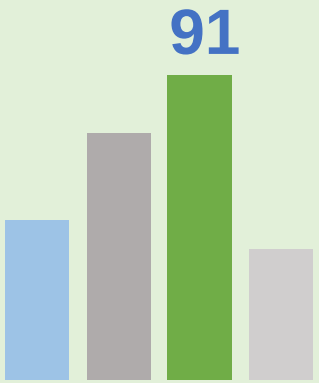
30% 30% reduction in hospital admissions for Landmark patients in their first six months of engagement

97% of our patients responded that “Landmark has helped me stay out of the hospital or emergency room.”



Landmark commonly achieves 4- and 5-star metrics from CMS STARs program, while caring for the most complex patients.

Landmark has achieved a Net Promoter Score of 91 with our patient panel, among the highest of any healthcare company in the nation.



70% of engaged Landmark patients have advance directives on file. 90% are engaged in end of life discussions with the Landmark team.

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Notes: Data from Landmark’s mature markets. Patient satisfaction survey conducted using a five-point Promoter Scale.

Extending the Landmark value proposition

- In order **to reach a broader group of frail and complex patients**, Landmark has launched a new arm of its business – Landmark Connect.
- **Landmark Connect** cares for all patients in Skilled Nursing, Long term care, and Assisted Living Facilities.
- **Long term care facilities and ALFs drive a disproportionate share of Medicare spending**, with relatively high rates of hospitalizations/readmissions, emergency room visits and SNF admissions. The majority of hospitalizations coming from these facilities could be prevented with more effective interventions.
- Approximately 20% of Medicare discharges from acute care hospitals are referred to skilled nursing facilities (SNFs), making **coordination protocols with SNFs and other post-acute providers an imperative** to avoid readmissions and lower total cost of care.

Source: Kaiser Family Foundation, Medicare Spending and Use of Medical Services for Beneficiaries in Nursing Homes and Other Long-Term Care Facilities," October 2010.

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Solutions to improve post-acute care

Post-acute Market Needs

Post acute facilities (PACs) are facing a **surge in patients with higher acuity levels** and it is becoming more difficult to **treat in place** without proper medical support

Providing high quality care is becoming table stakes as SNFs begin to face readmission penalties and as patients, providers, and payors become increasingly selective

Cost pressure is **straining community physicians,** inhibiting their ability to spend sufficient time at PACs while **PAC staff** are asked to do more without sufficient support

Payment reform and the shift from volume to value will necessitate SNFs and other LTC facilities to have the **capabilities to take on risk**

Landmark Connect Solution

We embed highly experienced MDs and/or APPs trained to provide high-touch care for complex patient needs, monitor and quickly address changes in patient status, and treat-in place with 24/7 provider support

By being present in the facility every day, Landmark Connect providers are able to spend adequate time with patients and families, and significantly improve quality of care

Embedded Landmark MDs/APPs establish regular communication protocols with community physicians to keep them informed of patient status while providing a high level of support to SNF staff and RNs

While the Connect model currently relies on fee-for-service billing, our processes, workflows and provider incentives build upon our value-based care program and focus on reducing readmissions and driving other high quality outcomes, positioning facilities to move to risk and bundled models