Bluestone Physician Services Integrated Care

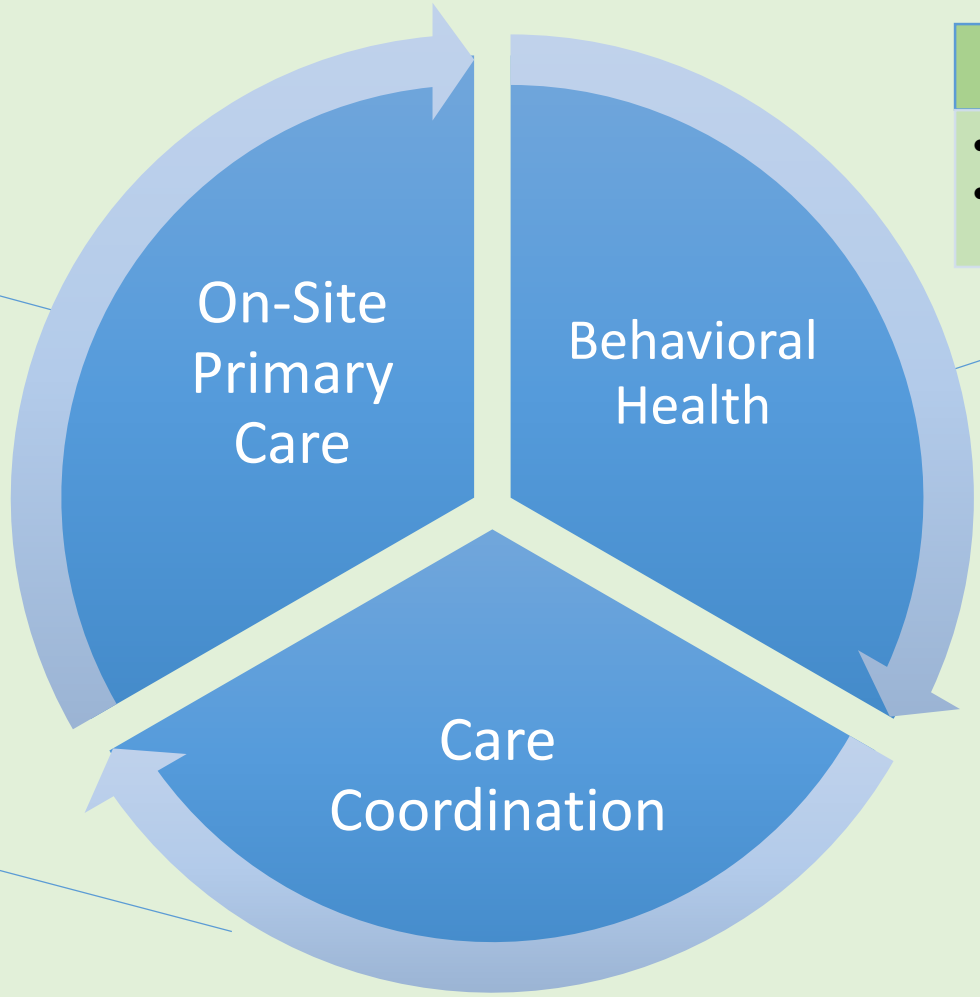
Bluestone Physician Services

On-Site Primary Care

- Founded in 2006 to serve chronic care patients in community settings
  - Currently serve 10,000+ patients in residential settings
- Health Care Home- 2011
  - NCQA PCMH-2017, in process
- MN service area- greater Mpls/St. Paul/St. Cloud
- Expansion to Milwaukee/Madison- 2014
- Expansion to Tampa/Orlando/Jacksonville- 2015

Care Coordination

- Began 2011
- 5 MCOs-Dual Eligible/Medicaid
  - Currently serve 5400+ members in 42 counties
- Clinic Without Walls
- Medicaid ACO -MN 2015 start



Psychiatric Care

- Psychiatry services - 2011
- Focus on Tele-health and Integration

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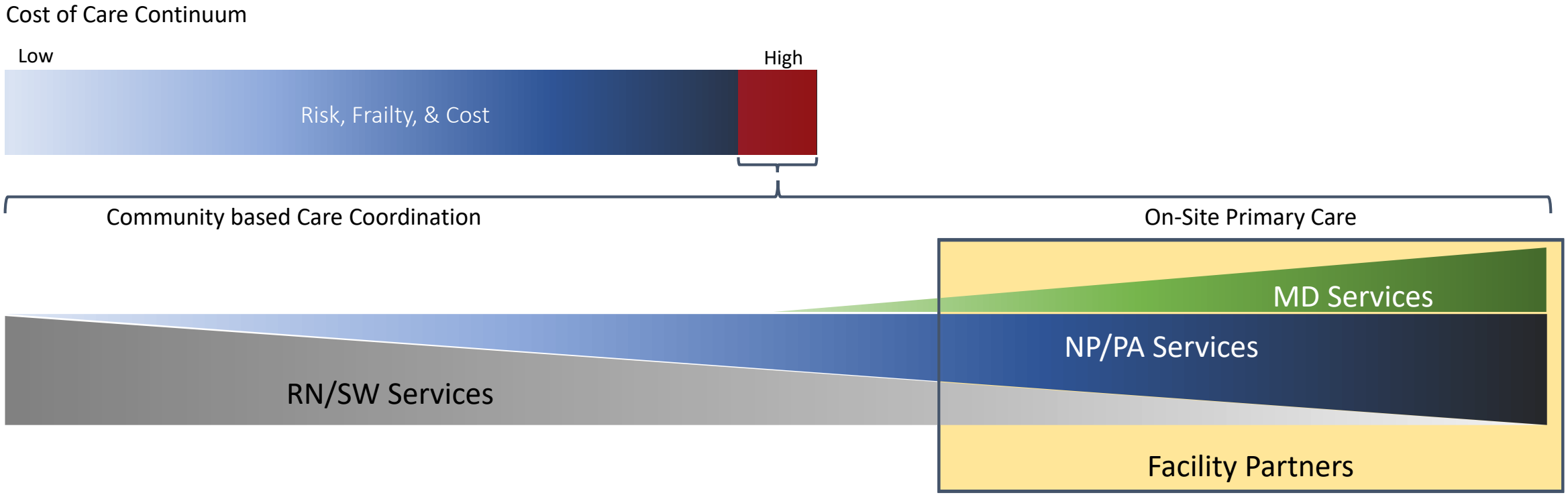
Care on the Continuum

Different resources are needed at different times for optimal care



The Bluestone model applies the appropriate provider resource across the care continuum for maximum value to the patient, health system and payer.

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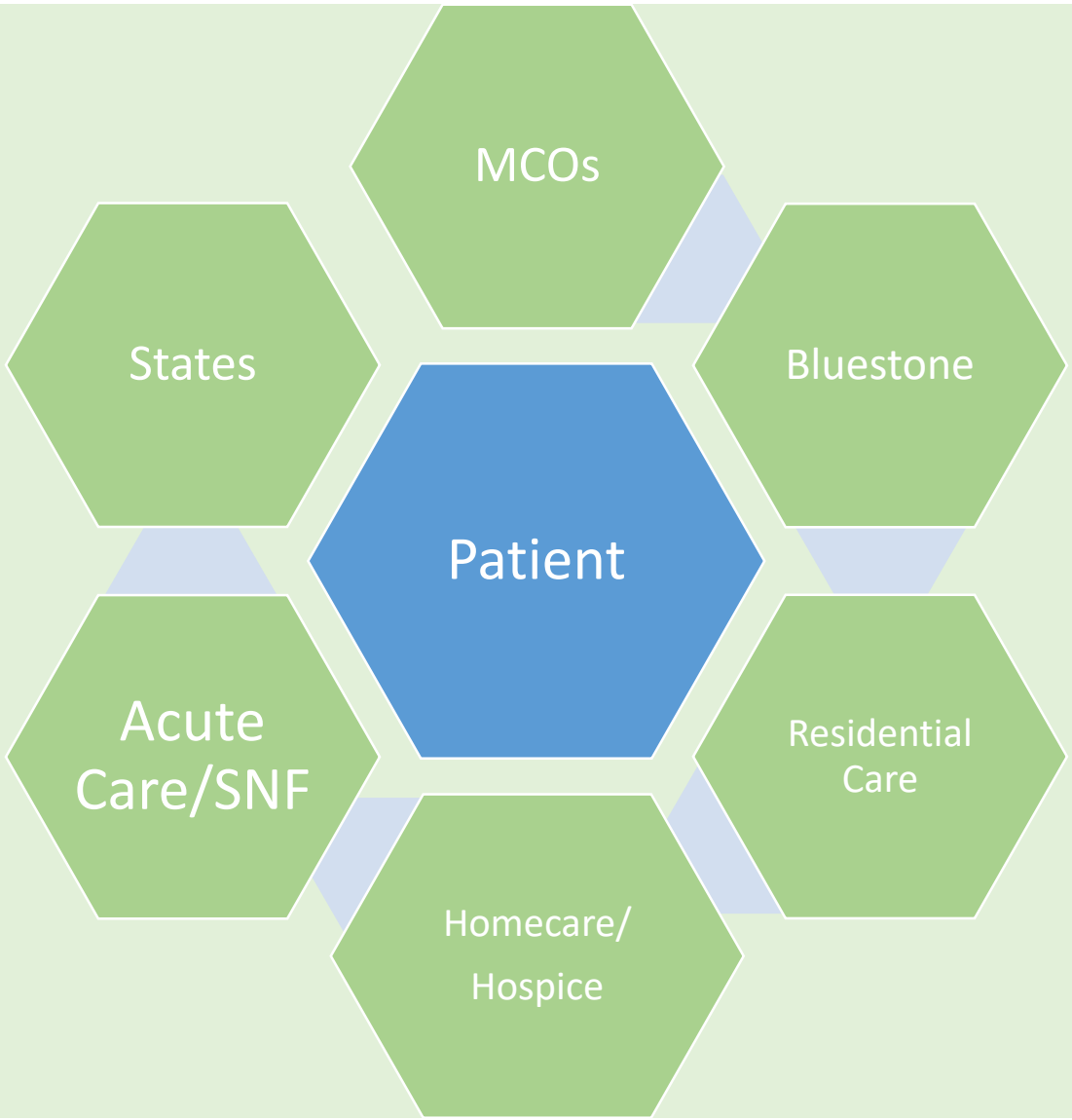
Bluestone Patients-Chronic Care

	Assisted Living and SNF > 65	Group Home < 65	Community Based < 65
NUMBER OF PATIENTS	10,000+	500+	5200+
AVERAGE AGE	87	53	62
AVERAGE NUMBER OF CHRONIC CONDITIONS	7.25	4+	2.70
ADL/IADL DEFICITS	3/6	3/6	2/2
% OF PATIENTS ACCESSING HCBS	42%	100%	86%
% DUALLY ELIGIBLE	42%	81%	52%
% WITH FRAILTY FACTOR (VIA PAYER)	82.2%	—	14.86%

Bluestone Model of Care Pillars

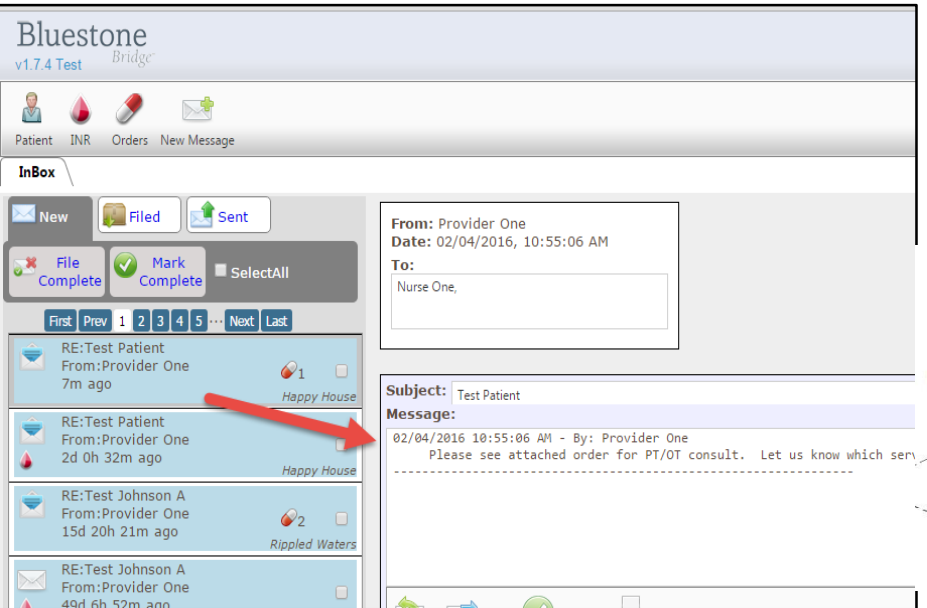
- Mission - To serve those not served well through traditional healthcare
- Preventative Chronic Care
- Community Based Care
  - Integration into residential care
- Patient Centered Education and Relationships
  - Advance Care Planning
  - Bluestone Bridge
  - Shared decision making
- Team-Based Care
- Sustainable Business Model
  - Move to APM
- Evidence Based Best Practice

Key Partners



Technology Platform

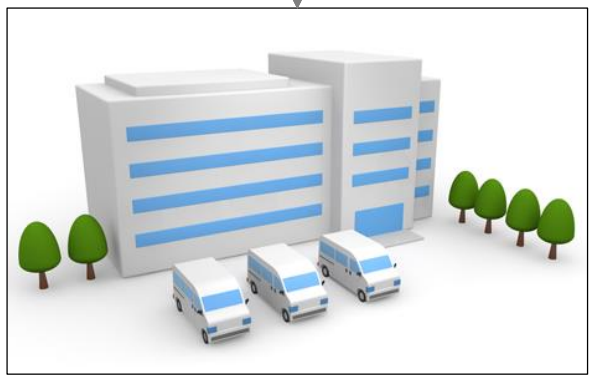
- Bluestone Bridge
  - Secure, online platform links providers, community staff, families and community partners
  - Provides a record of communication for patient related action
  - Request and receive orders online
  - Chronic disease monitoring - INR flowsheets
  - Most efficient way to communicate with providers teams 24/7



Bluestone Integrated Care Modules

Modules of Integrated Care can be delivered to patients without location constraints.

Primary Care | Disability Care | Coordinated Care | Specialty Care



Assisted Living/Group Homes

Community
In-Home & CWOW Sites

Virtual

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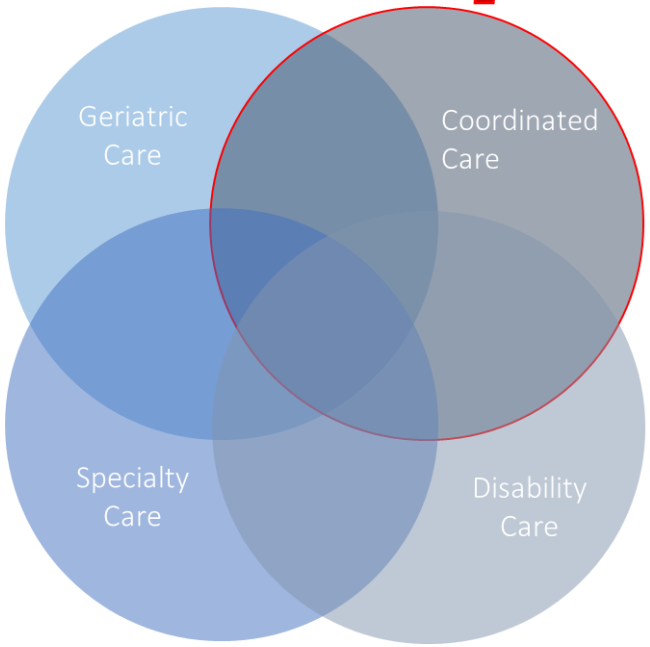
High Risk Patient Management

- Patient Identification
  - Health Risk Assessment
  - Data analytics
  - Social determinants of health
- Where are patients aggregating?
  - Living setting as a predictable risk factor
- What resources can be deployed
  - Care Coordination systems
  - Population based programs
  - Assurance of primary care
  - Clinic Without Walls

Bluestone Integrated Care



Integrated Care

Episodic Event Management/Screening

- Population Analysis and Stratification
- High Risk Patient Identification
- Patient Assessments
  - ADL/IADL
  - Med History
  - Social Factors
  - Existing Caregiver Evaluation
  - Nutrition
  - Existing Care Accessibility
  - Non-Medical Service Accessibility
- TCM Services

Active Population Management

- HRPM (High Risk Patient Management)
- Assessment and Care Planning
- Communication Technologies
- Assurance of Care (Primary/Specialist)
- Utilization & Benefit Management
  - Hospitalization Mitigation
  - DME Management
  - Housing & CL Tool Administration
  - Referral Coordination
  - Falls Management & Prevention
- TCM Services
- IDT (InterDisciplinary Team) Sessions

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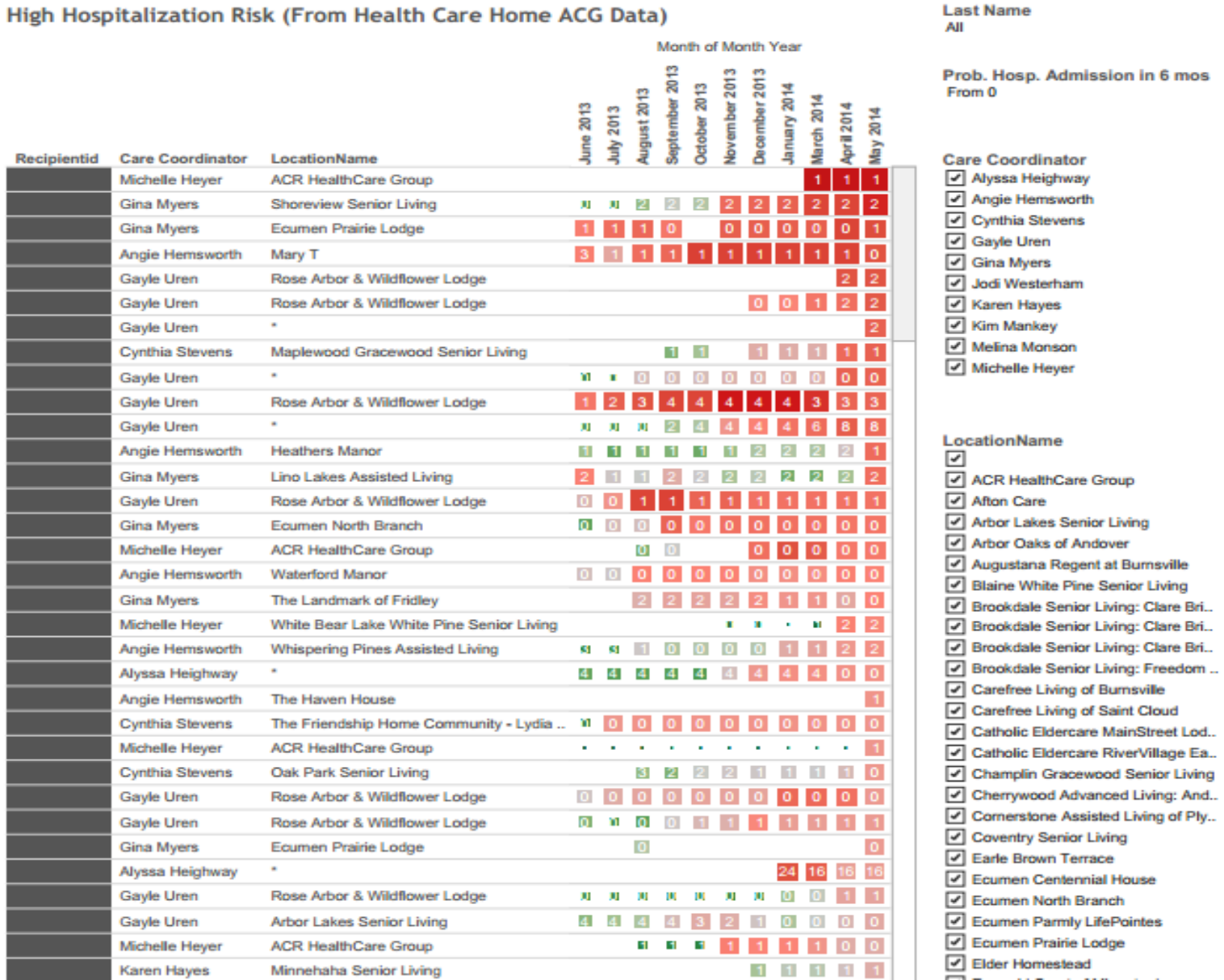
Determining Risk



Primary Care Engagement

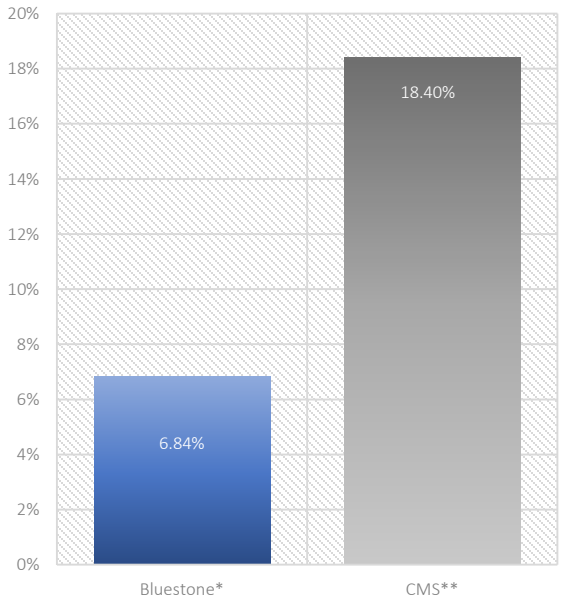
- Value added - How do programs assist in plan of care?
  - Care Coordination
    - Medication Management
    - In-home coordination and information
  - Relationships

- Best Practice Development
  - Provider Champions
  - Special Needs Populations

- Aligning Incentives
  - ED Reduction
  - Stars
  - Coding

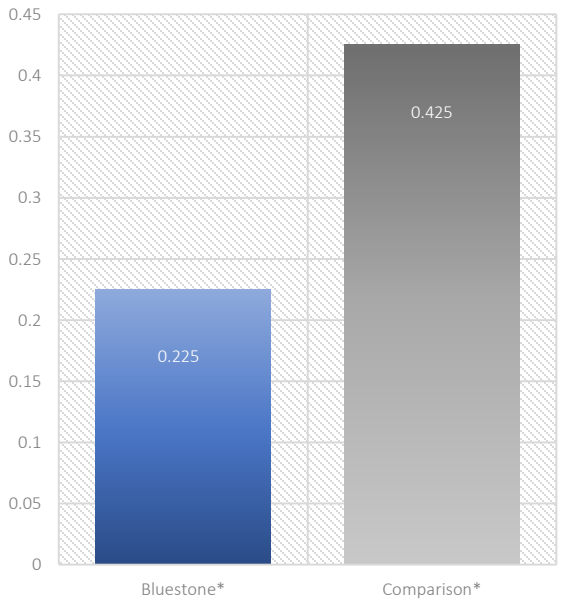
Bluestone Results

Lower Readmission Rates



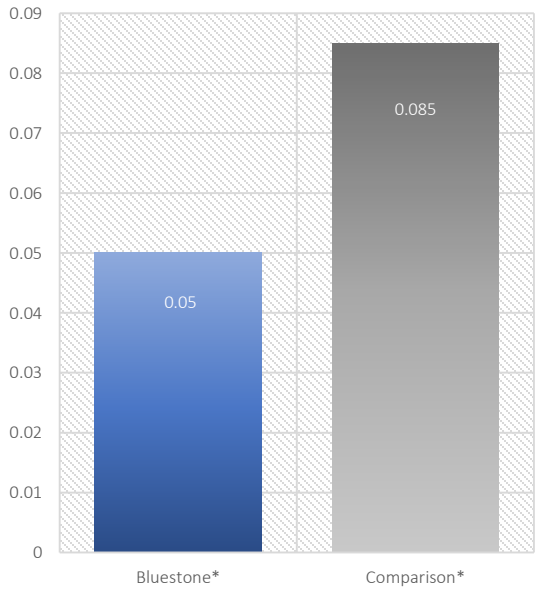
*Self-reported results based on 6 month measurement period in 2H 2013.
**Results based on CMS internal data from self reporting entities during 2012.

Reduced ER Visitation



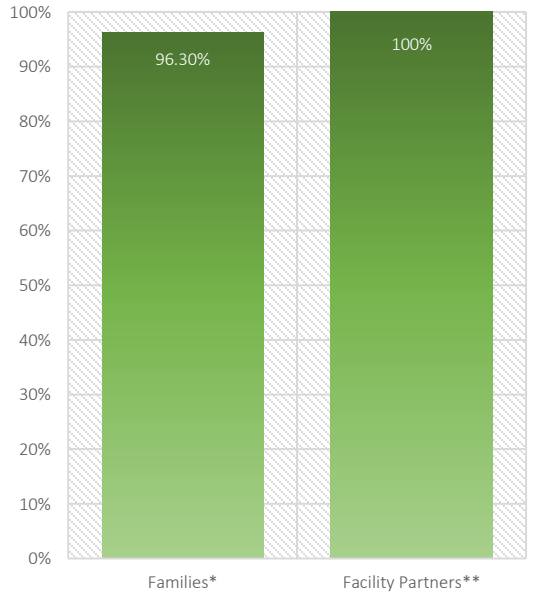
*Results from Medica© on per capita ER Visitation for Care Coordination patients over a 6 month period in 2012.

Reduced Inpatient Stays



*Results from Medica© on inpatient stays for Care Coordination patients over a 6 month period in 2012.

Excellent Satisfaction Rates



*% of "True" survey responses to "I would recommend BPS to others." from over 550 family member responses to online survey.
**% of "True" survey responses to "I would recommend BPS Services to others." from over 130 facility staff members at partner facilities.

Bluestone Physician Services

Thank You

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