



Bluestone Physician Services
Integrated Care

Bluestone Physician Services

On-Site Primary Care

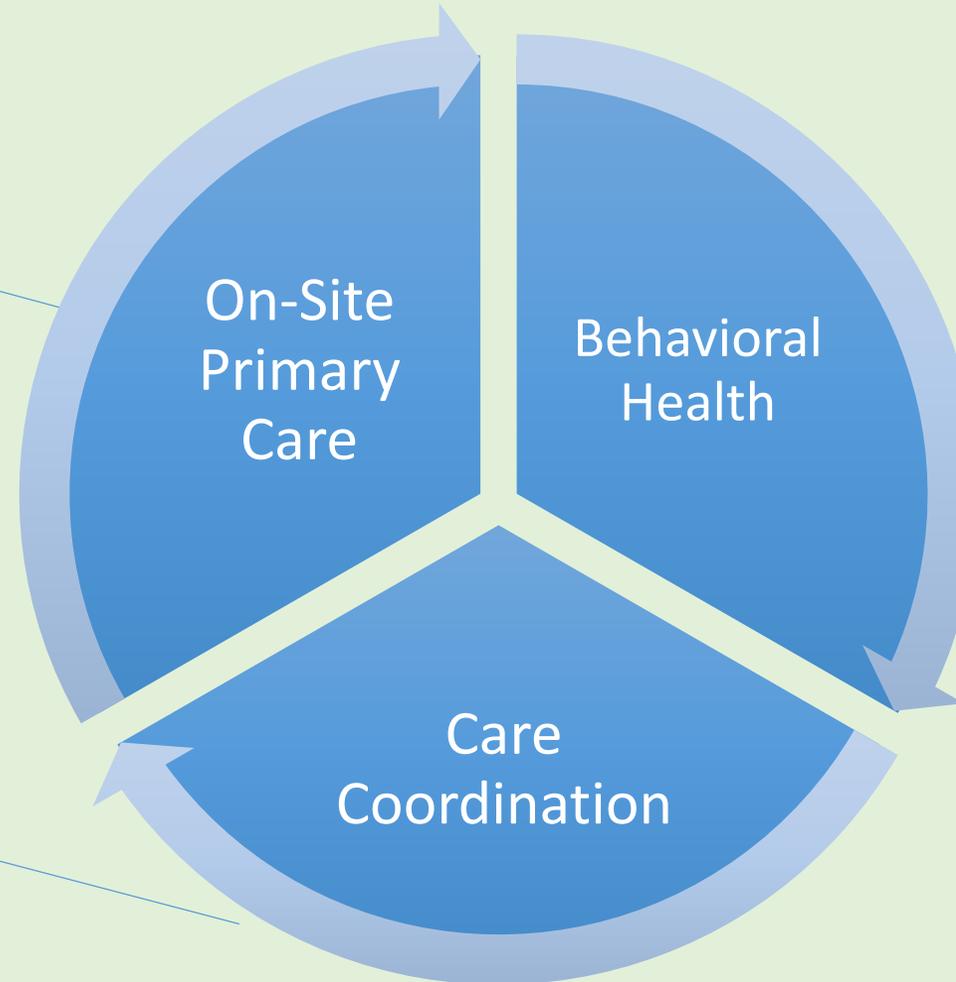
- Founded in 2006 to serve chronic care patients in community settings
 - Currently serve 10,000+ patients in residential settings
- Health Care Home- 2011
 - NCQA PCMH-2017, in process
- MN service area- greater Mpls/St. Paul/St. Cloud
- Expansion to Milwaukee/Madison- 2014
- Expansion to Tampa/Orlando/Jacksonville-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

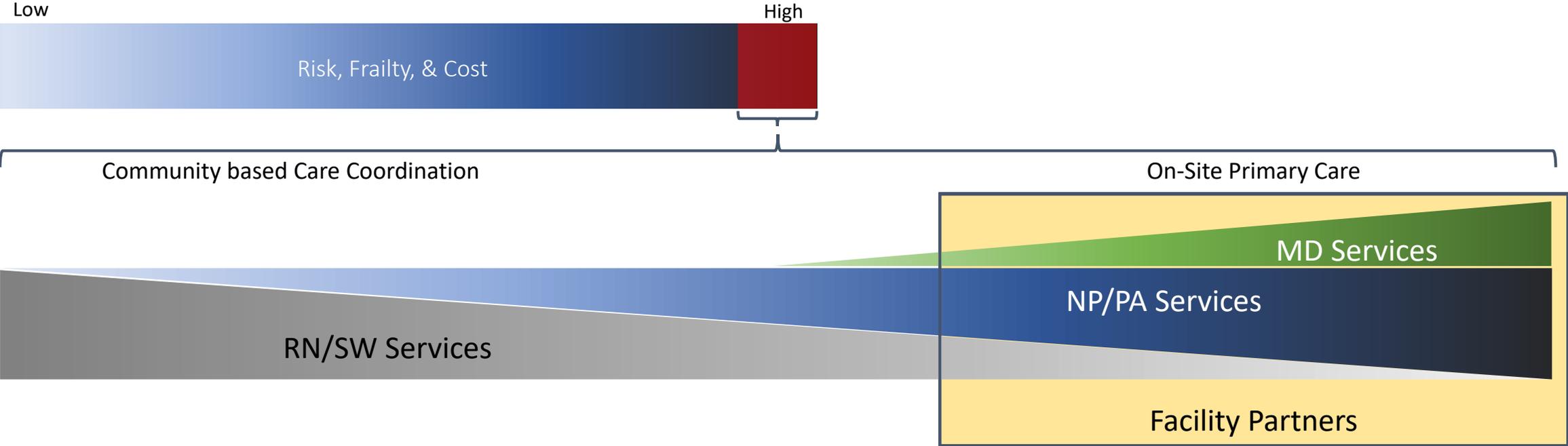
- Psychiatry services - 2011
- Focus on Tele-health and Integration



Care on the Continuum

Different resources are needed at different times for optimal care

Cost of Care Continuum



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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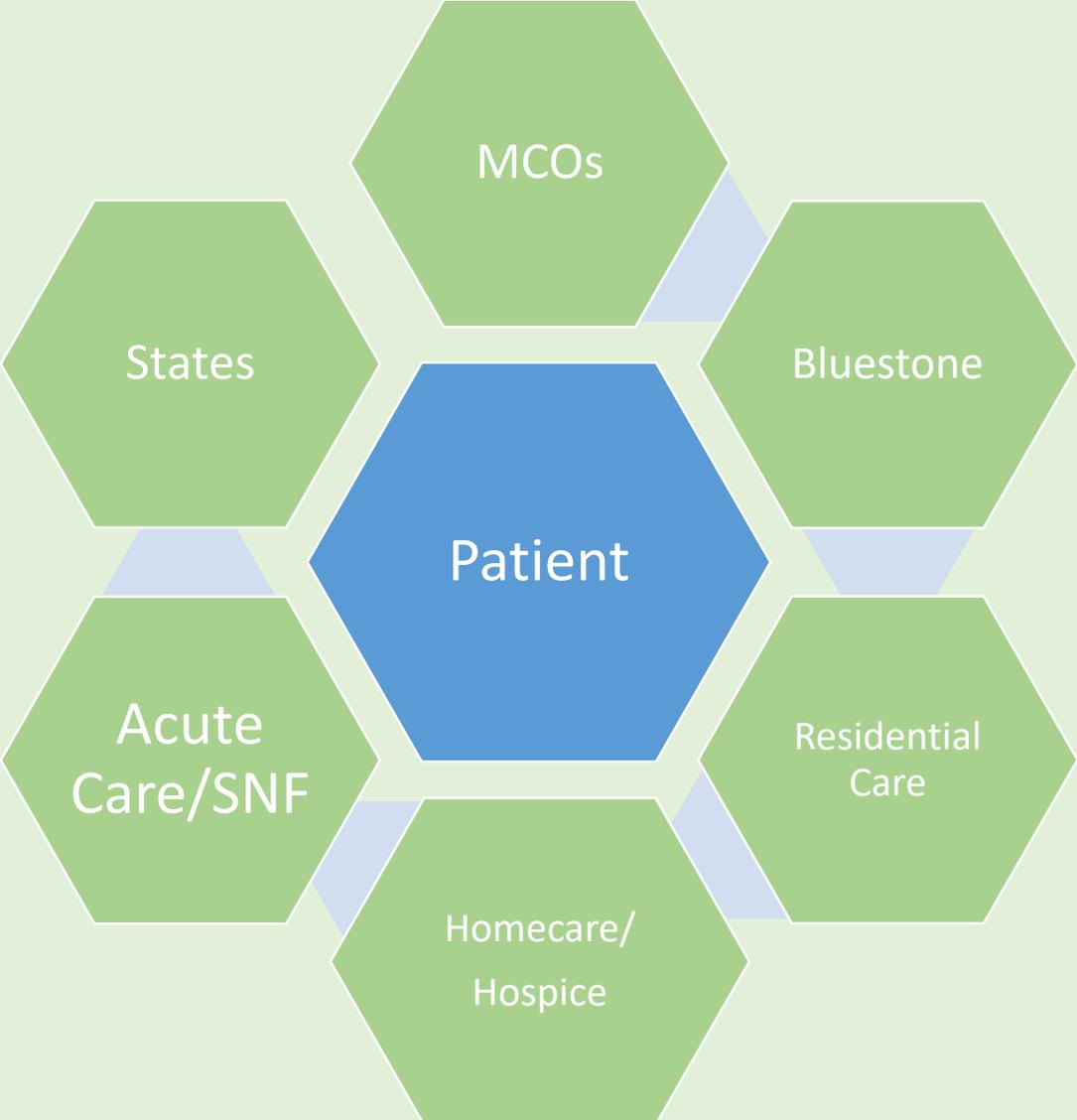
Bluestone Patients-Chronic Care

	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%
% DUALY ELIGIBLE	42%	81%	52%
% WITH FRAILTY FACTOR (VIA PAYER)	82.2%	—	14.86%

Bluestone Model of Care Pillars

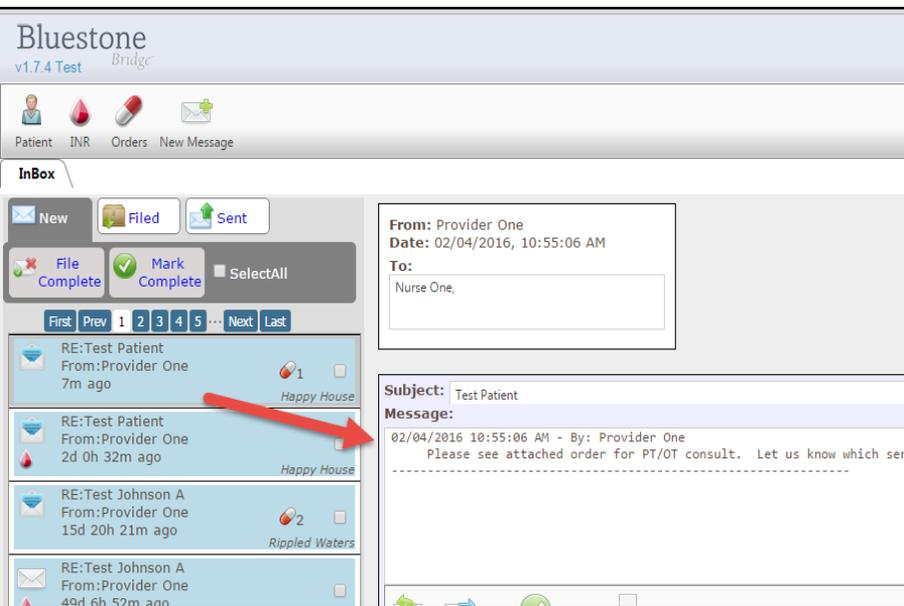
- Mission - To serve those not served well through traditional healthcare
- Preventative Chronic Care
- Community Based Care
 - Integration into residential care
- Patient Centered Education and Relationships
 - Advance Care Planning
 - Bluestone Bridge
 - Shared decision making
- Team-Based Care
- Sustainable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

Key Partners



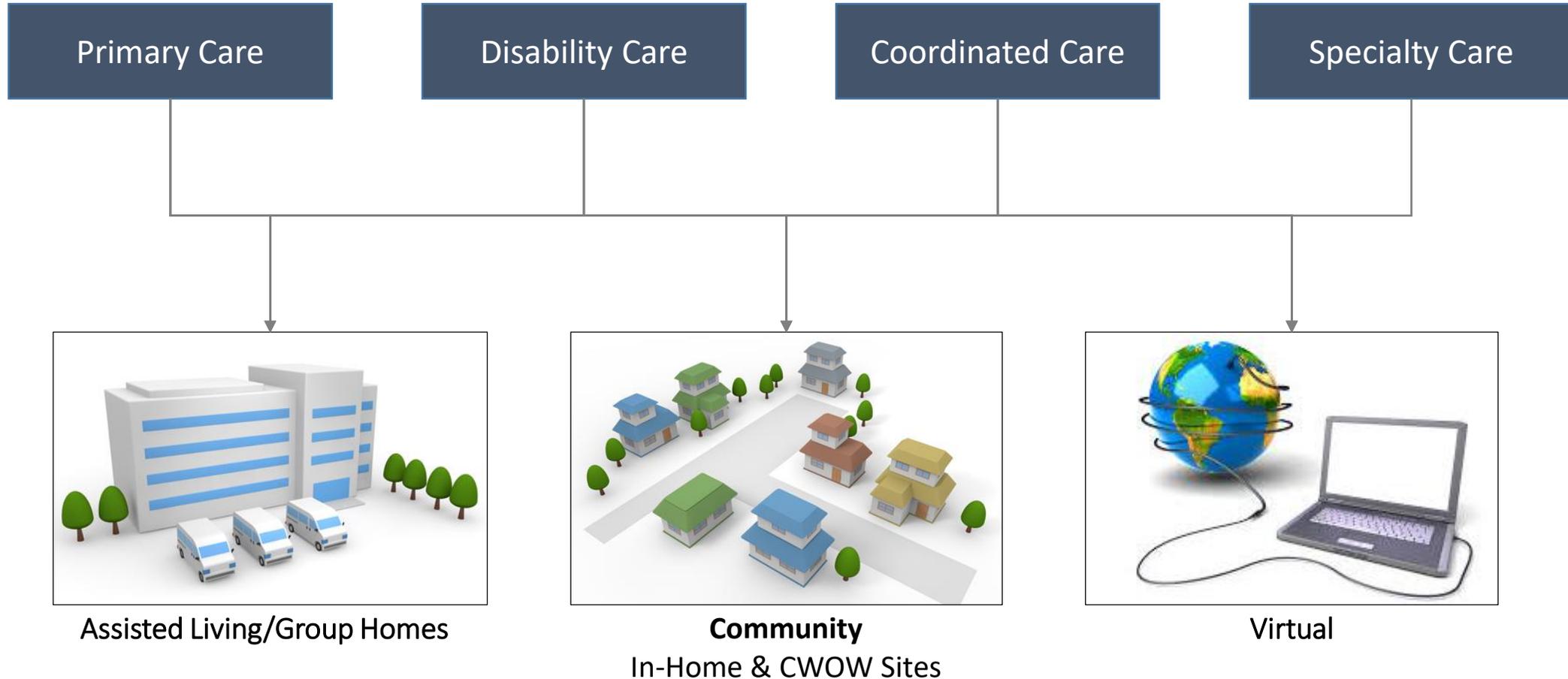
Technology Platform

- 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.

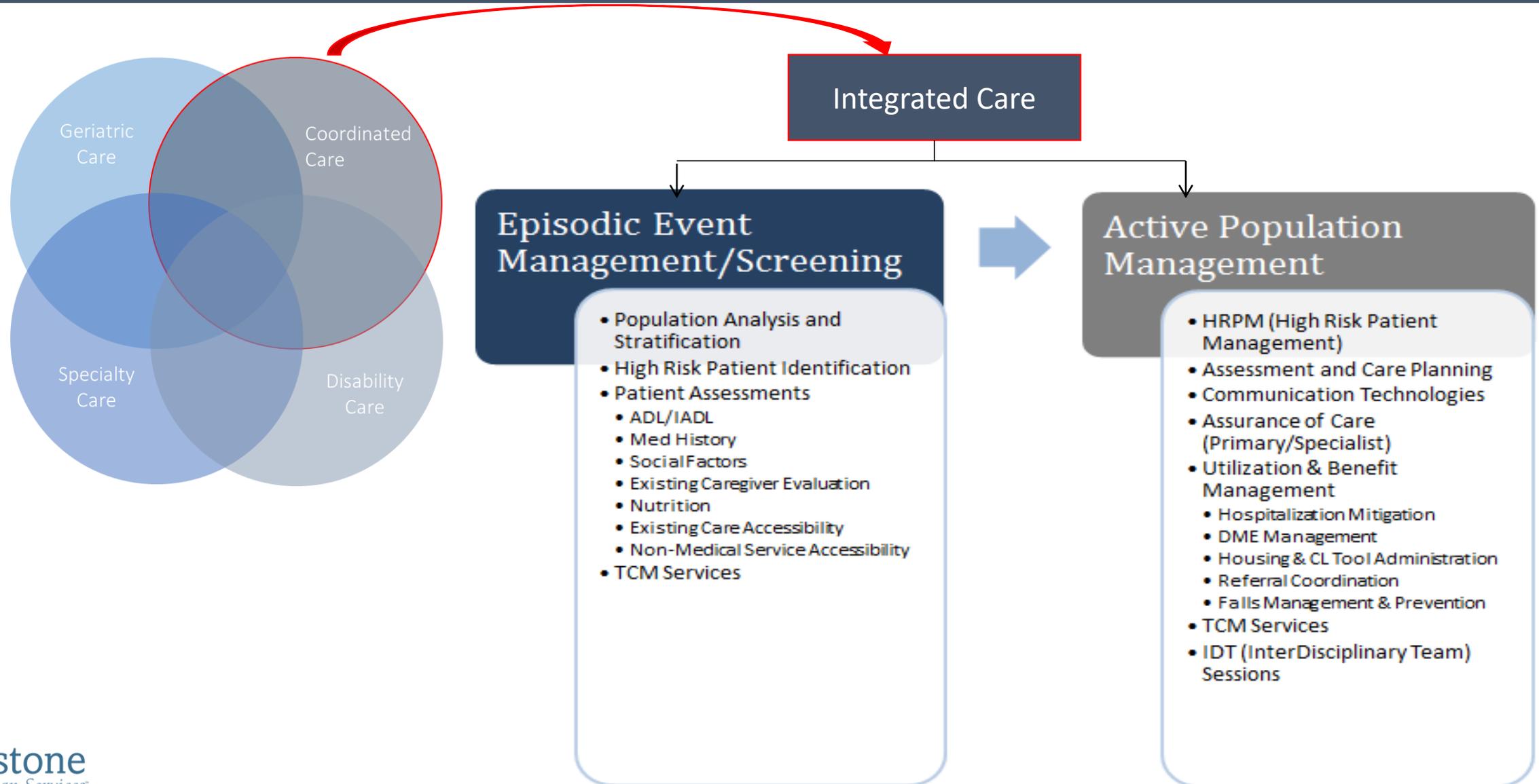


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High Risk Patient Management

- 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



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Determining Risk

High Hospitalization Risk (From Health Care Home ACG Data)

Recipientid	Care Coordinator	LocationName	Month of Month Year												
			June 2013	July 2013	August 2013	September 2013	October 2013	November 2013	December 2013	January 2014	March 2014	April 2014	May 2014		
	Michelle Heyer	ACR HealthCare Group											1	1	1
	Gina Myers	Shoreview Senior Living	1	1	2	2	2	2	2	2	2	2	2	2	2
	Gina Myers	Ecumen Prairie Lodge	1	1	1	0			2	2	0	0	0	0	1
	Angie Hemsworth	Mary T	3	1	1	1	1	1	1	1	1	1	1	1	0
	Gayle Uren	Rose Arbor & Wildflower Lodge												2	2
	Gayle Uren	Rose Arbor & Wildflower Lodge							0	0	1	2	2		
	Gayle Uren	*												2	
	Cynthia Stevens	Maplewood Gracewood Senior Living				1	1		1	1	1	1	1	1	1
	Gayle Uren	*	1	1	0	0	0	0	0	0	0	0	0	0	0
	Gayle Uren	Rose Arbor & Wildflower Lodge	1	2	3	4	4	4	4	4	4	3	3	3	3
	Gayle Uren	*	1	1	1	2	4	4	4	4	4	6	8	8	8
	Angie Hemsworth	Heathers Manor	1	1	1	1	1	1	2	2	2	2	2	1	
	Gina Myers	Lino Lakes Assisted Living	2	1	1	2	2	2	2	2	2	2	2	2	2
	Gayle Uren	Rose Arbor & Wildflower Lodge	0	0	1	1	1	1	1	1	1	1	1	1	1
	Gina Myers	Ecumen North Branch	0	0	0	0	0	0	0	0	0	0	0	0	0
	Michelle Heyer	ACR HealthCare Group			0	0			0	0	0	0	0	0	0
	Angie Hemsworth	Waterford Manor	0	0	0	0	0	0	0	0	0	0	0	0	0
	Gina Myers	The Landmark of Fridley			2	2	2	2	2	2	1	1	0	0	
	Michelle Heyer	White Bear Lake White Pine Senior Living											2	2	
	Angie Hemsworth	Whispering Pines Assisted Living	1	1	1	0	0	0	0	0	1	1	2	2	
	Alyssa Heighway	*	4	4	4	4	4	4	4	4	4	4	0	0	
	Angie Hemsworth	The Haven House													1
	Cynthia Stevens	The Friendship Home Community - Lydia ..	1	0	0	0	0	0	0	0	0	0	0	0	0
	Michelle Heyer	ACR HealthCare Group													1
	Cynthia Stevens	Oak Park Senior Living			1	2	2	2	1	1	1	1	0		
	Gayle Uren	Rose Arbor & Wildflower Lodge	0	0	0	0	0	0	0	0	0	0	0	0	0
	Gayle Uren	Rose Arbor & Wildflower Lodge	0	1	0	0	1	1	1	1	1	1	1	1	1
	Gina Myers	Ecumen Prairie Lodge			0										0
	Alyssa Heighway	*											24	16	16
	Gayle Uren	Rose Arbor & Wildflower Lodge	1	1	1	1	1	1	1	1	0	0	1	1	
	Gayle Uren	Arbor Lakes Senior Living	4	4	4	4	3	2	1	0	0	0	0	0	0
	Michelle Heyer	ACR HealthCare Group			1	1			1	1	1	1	0	0	
	Karen Hayes	Minnehaha Senior Living							1	1	1	1	1	1	1

Last Name
All

Prob. Hosp. Admission in 6 mos
From 0

Care Coordinator

- Alyssa Heighway
- Angie Hemsworth
- Cynthia Stevens
- Gayle Uren
- Gina Myers
- Jodi Westerham
- Karen Hayes
- Kim Mankey
- Melina Monson
- Michelle Heyer

LocationName

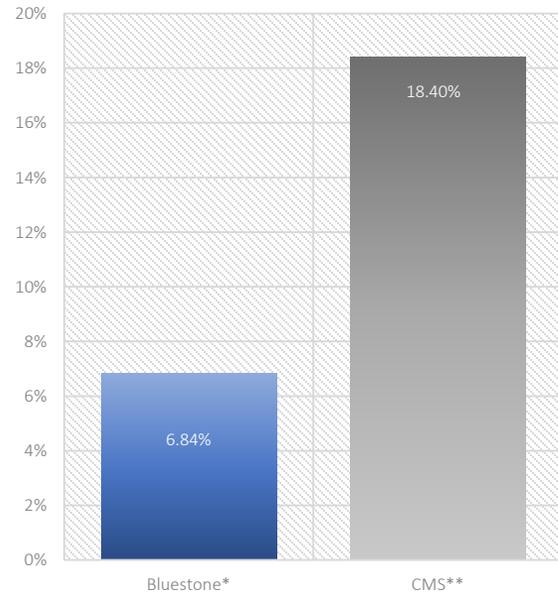
- ACR HealthCare Group
- Afton Care
- Arbor Lakes Senior Living
- Arbor Oaks of Andover
- Augustana Regent at Burnsville
- Blaine White Pine Senior Living
- Brookdale Senior Living: Clare Bri..
- Brookdale Senior Living: Clare Bri..
- Brookdale Senior Living: Clare Bri..
- Brookdale Senior Living: Freedom ..
- Carefree Living of Burnsville
- Carefree Living of Saint Cloud
- Catholic Eldercare MainStreet Lod..
- Catholic Eldercare RiverVillage Ea..
- Champlin Gracewood Senior Living
- Cherrywood Advanced Living: And..
- Cornerstone Assisted Living of Ply..
- Coventry Senior Living
- Earle Brown Terrace
- Ecumen Centennial House
- Ecumen North Branch
- Ecumen Parmlly LifePointes
- Ecumen Prairie Lodge
- Elder Homestead

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

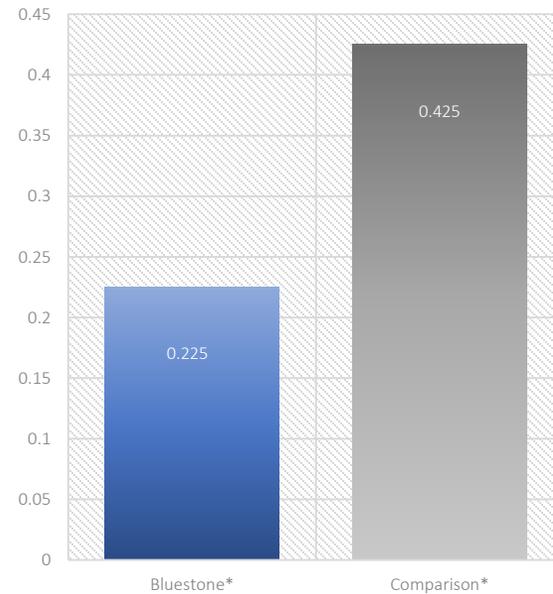
Bluestone Results

Lower Readmission Rates



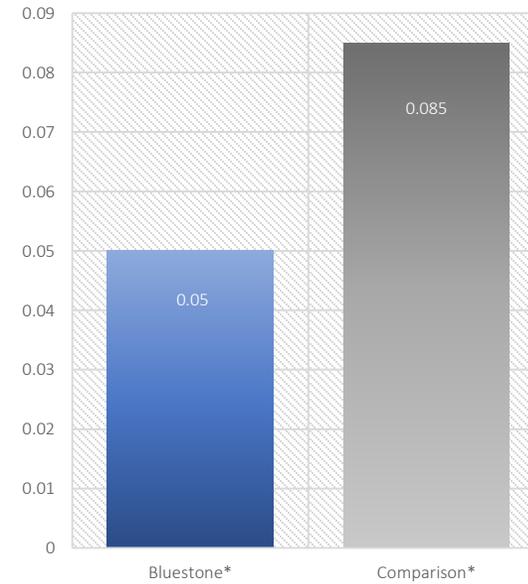
*Self-reported results based on 6 month measurement period in 2H 2013.
**Results based on CMS internal data from self reporting entities during 2012.

Reduced ER Visitation



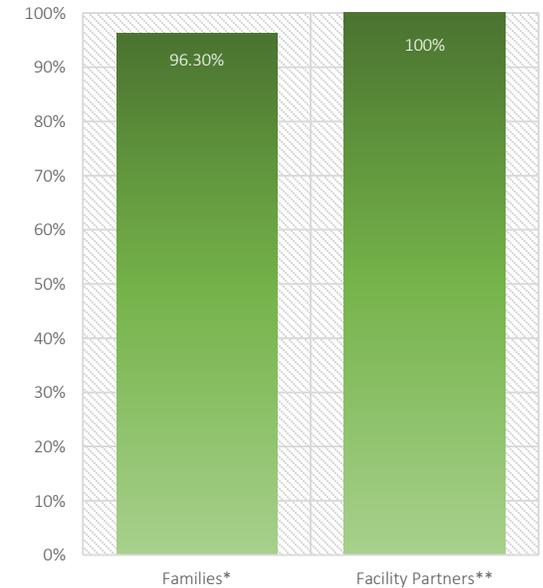
*Results from Medica© on per capita ER Visitation for Care Coordination patients over a 6 month period in 2012.

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.

Thank You

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CCO

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