WISHIN
HIE SUMMIT 2020

January 29, 2020

Presented by:

WISCONSIN STATEWIDE HEALTH INFORMATION NETWORK

Preparing for Value-Based Care Using WISHIN and PatientPing

Presented by Bluestone Physicians Services:

Sarah Keenan, Chief Clinical Officer, President of Integrated Care

Nate Hunkins, Director of Population Health

Objectives

- Overview of the various value-based care models which impact primary care providers – focus on the Medicare population
- Define success in VBC payment arrangements
- Describe Bluestone’s value-based care strategies and the importance of leveraging real-time data from PatientPing and WISHIN

Bluestone
Physician Services℠

Bluestone is an innovative, primary care practice delivering on-site care to patients in senior living communities and to those with disabilities in both residential and community settings.

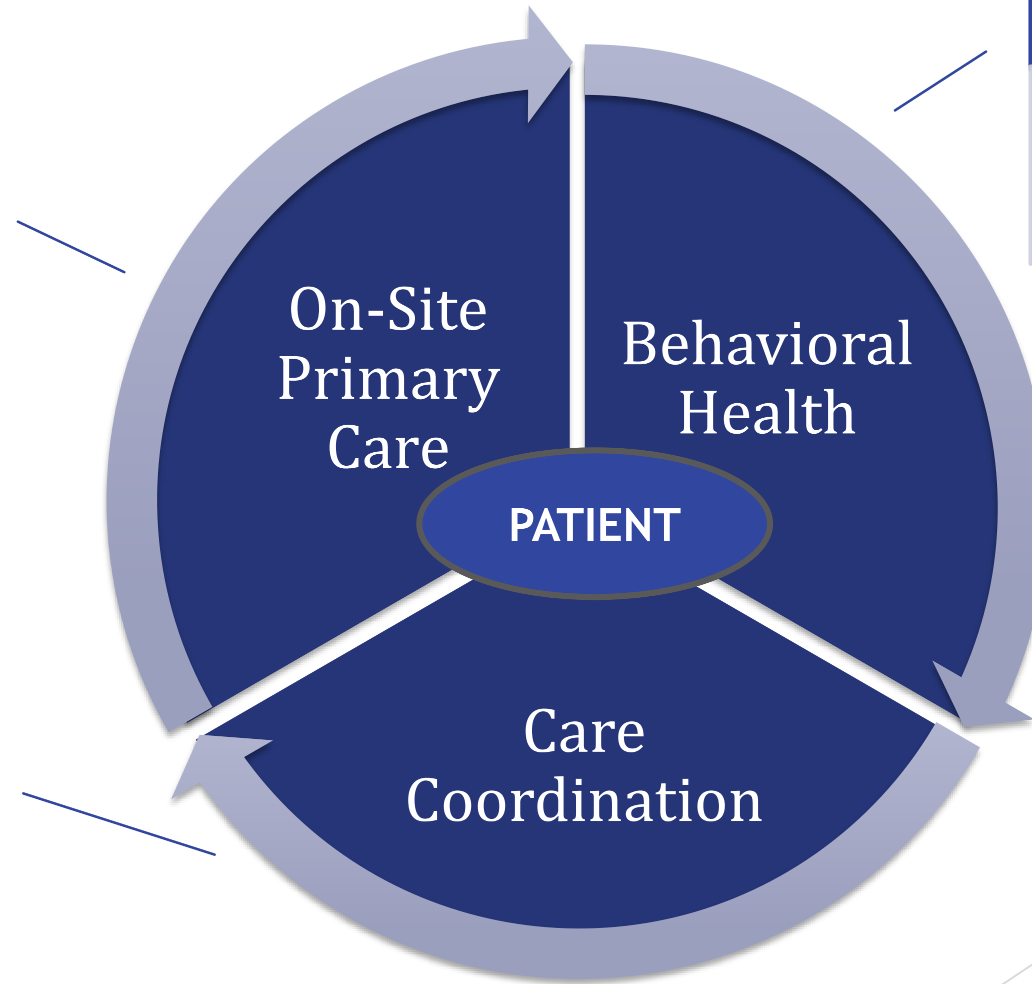
Our care model, which consists of a team approach, regular visits, and proactive care, reduces medical costs and patient stress. Providing care since 2006 for chronically ill, frail, elderly and disabled individuals, Bluestone has proven that personal engagement, quality of care and exceptional service results in high patient and staff satisfaction.

MISSION: We are dedicated to serving those who are not being well cared for in traditional care settings, as well as leading positive change in the general healthcare system.

Bluestone Services

On-Site Primary Care

- Founded in 2006 to serve chronic care patients in community settings
- 17,000 patients in MN, WI and FL
  - Average 8.25 Chronic Diagnosis



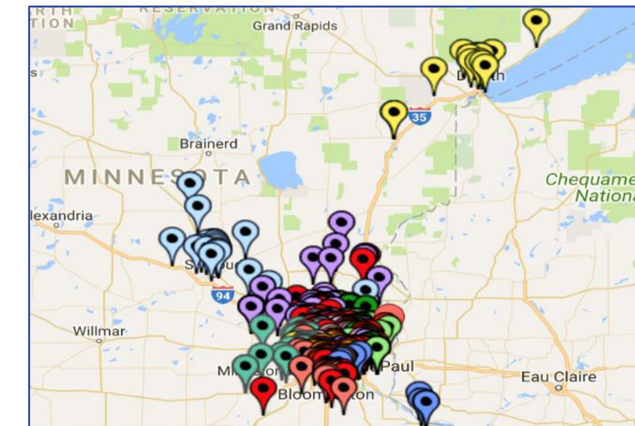
Psychiatry

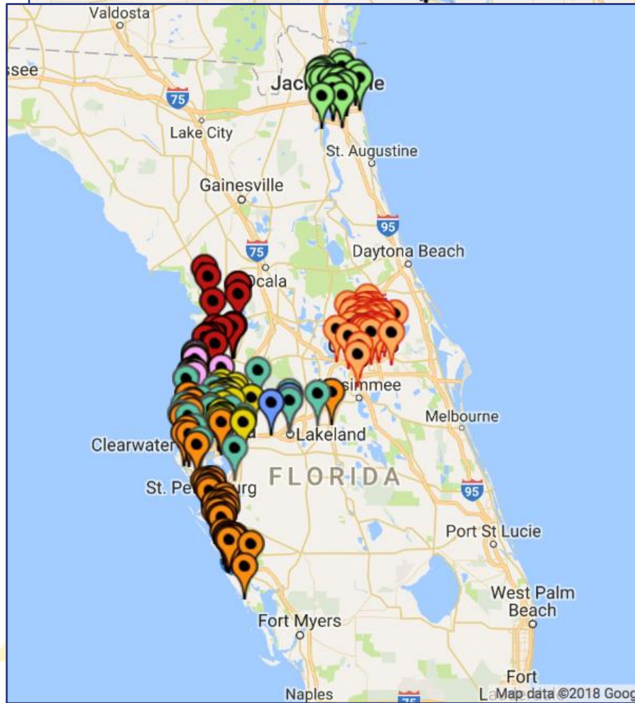
- Telehealth
- BHI

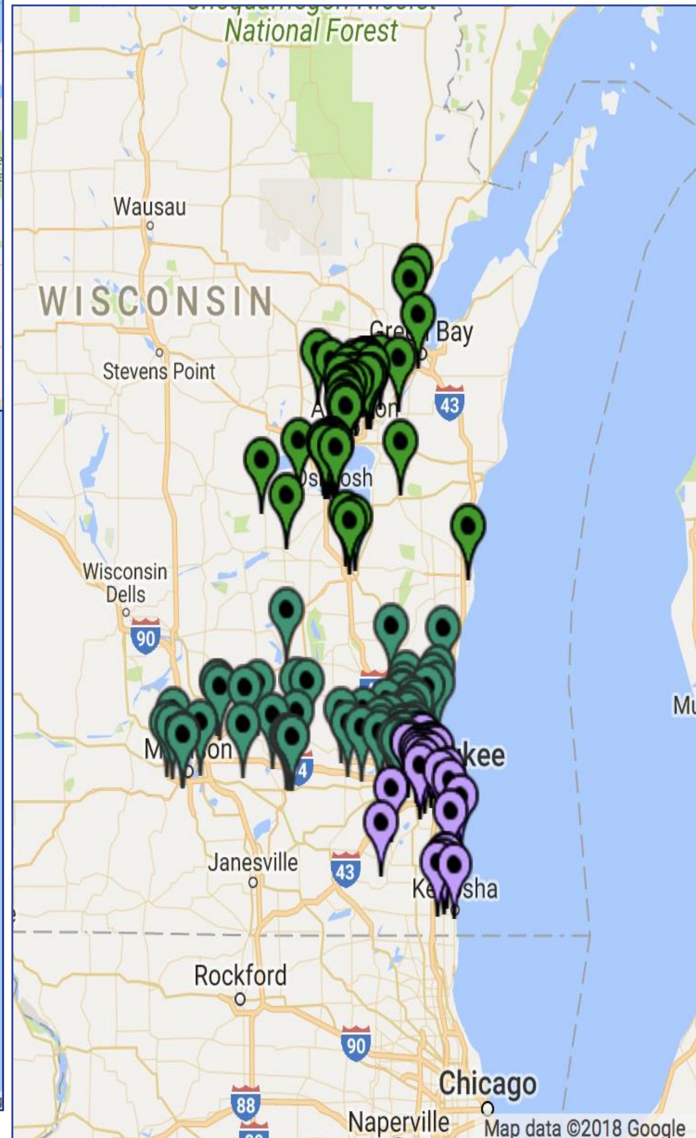
Care Coordination

- Preventative High Risk Patient Management
  - Duals
  - Medicaid ACO
  - Disability Care

Bluestone's Tristate Footprint



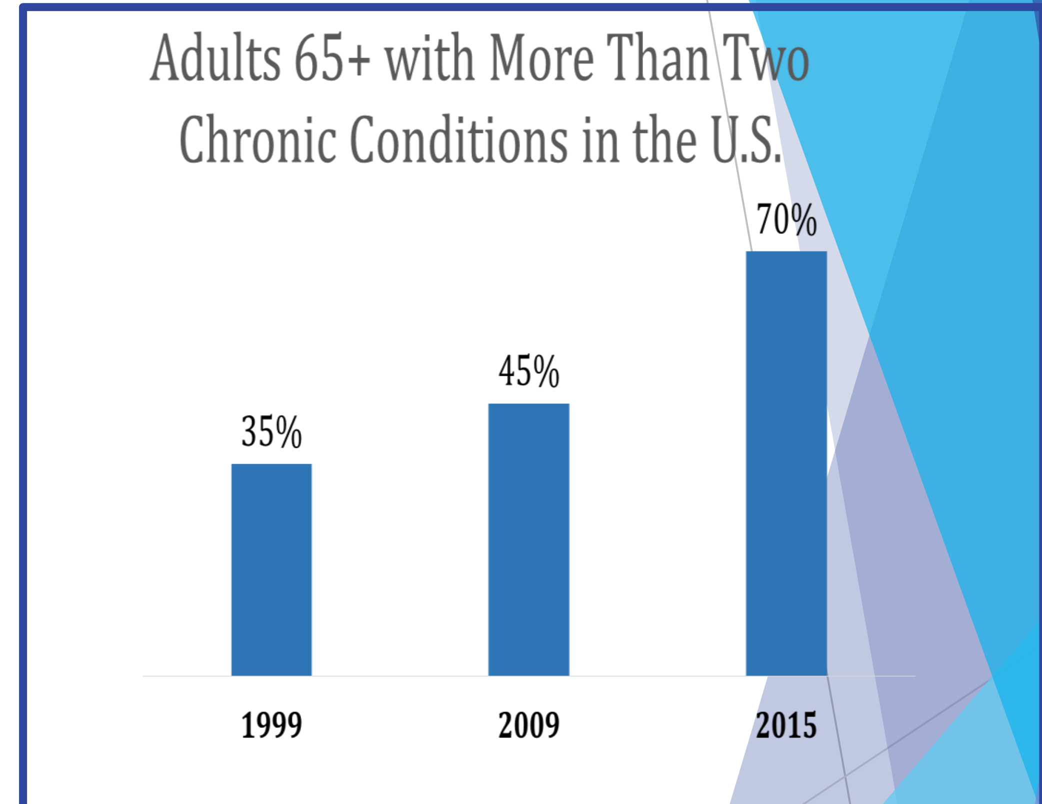




Market	Assisted Living Sites	Patients
Florida	300	5,500
Wisconsin	163	2,465
Minnesota	382	6,942
Current Total	*845*	*14,907*

Model of Care: Preventative Chronic Care

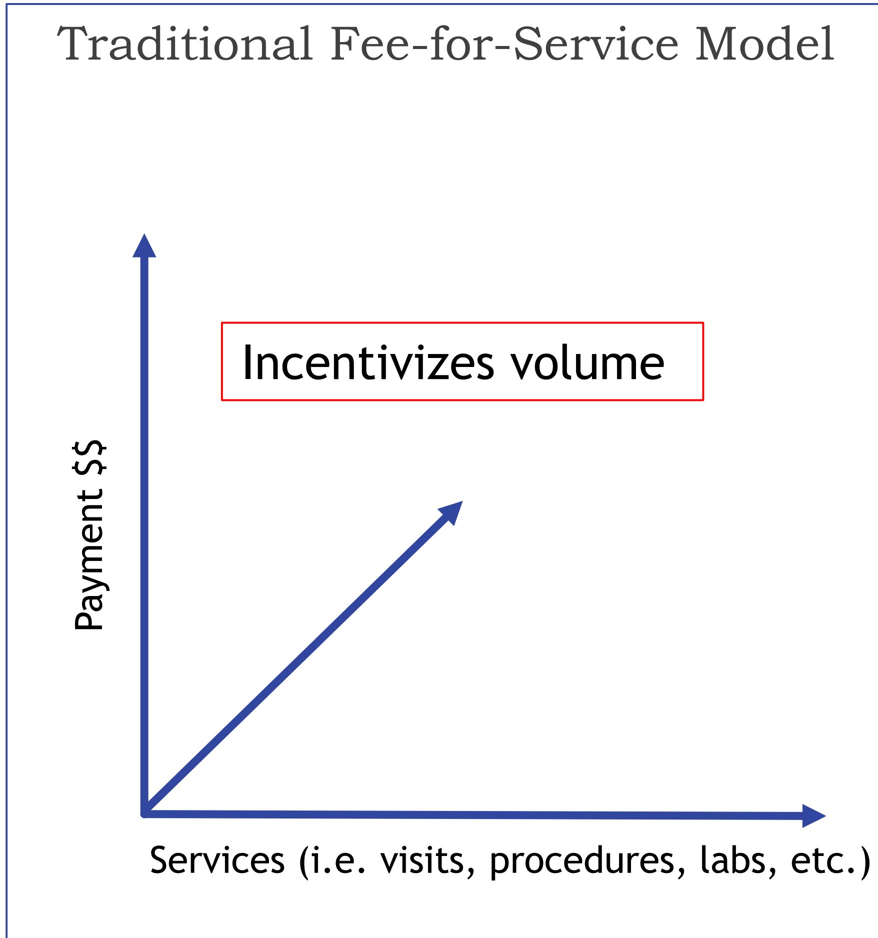
- Identification of high-risk patients and chronic condition management
  - Average 8.25 chronic conditions
  - 4+ ADL deficiency
- Medication Management
  - High-risk/High-cost programs
  - Emphasis on de-prescribing
- Advanced Care Planning/Goals of care
- Team based communication with community staff and family
- Avoiding unnecessary hospitalizations and ER visits
- Transitional Care Management

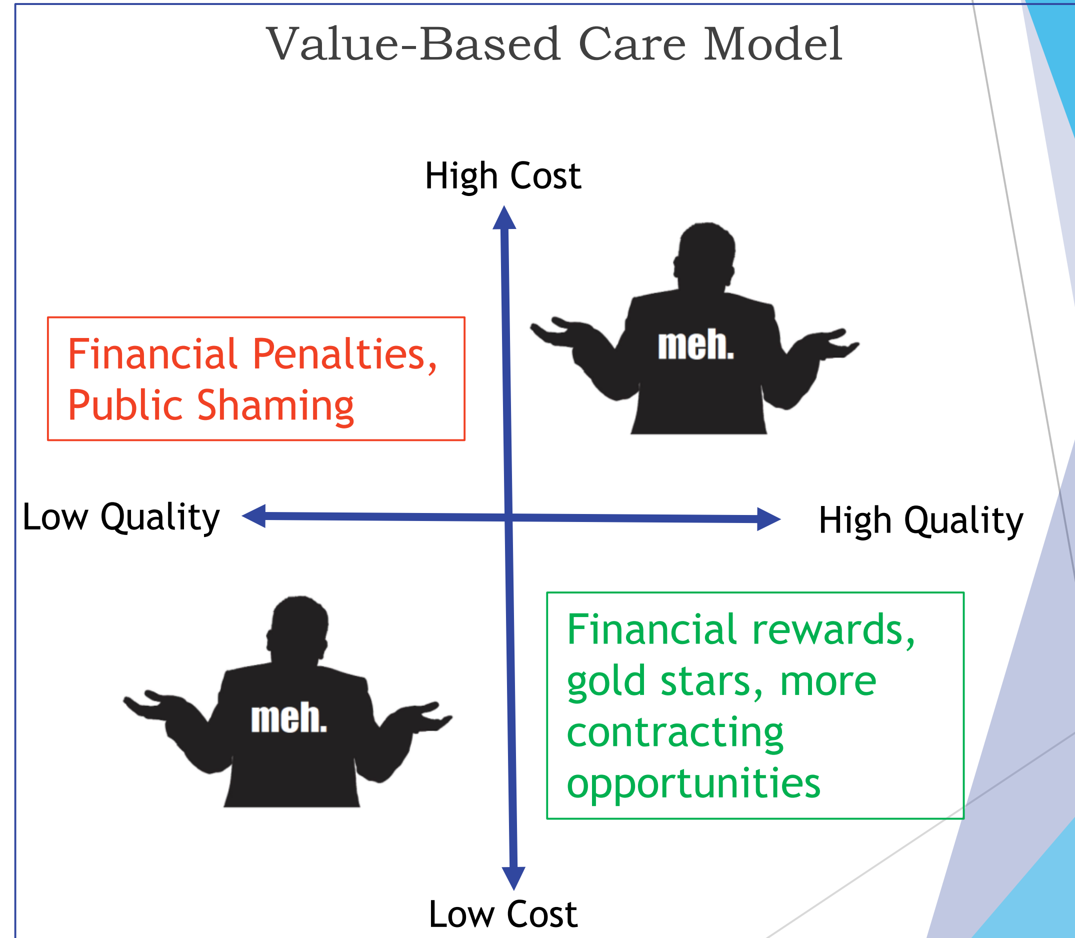


Bluestone Physician Services℠

Value-Based Care: The Formula for
Clinical and Financial Success is
Changing

Fee-for-Service vs. Value-Based Care





Why the shift to Value-Based Care?

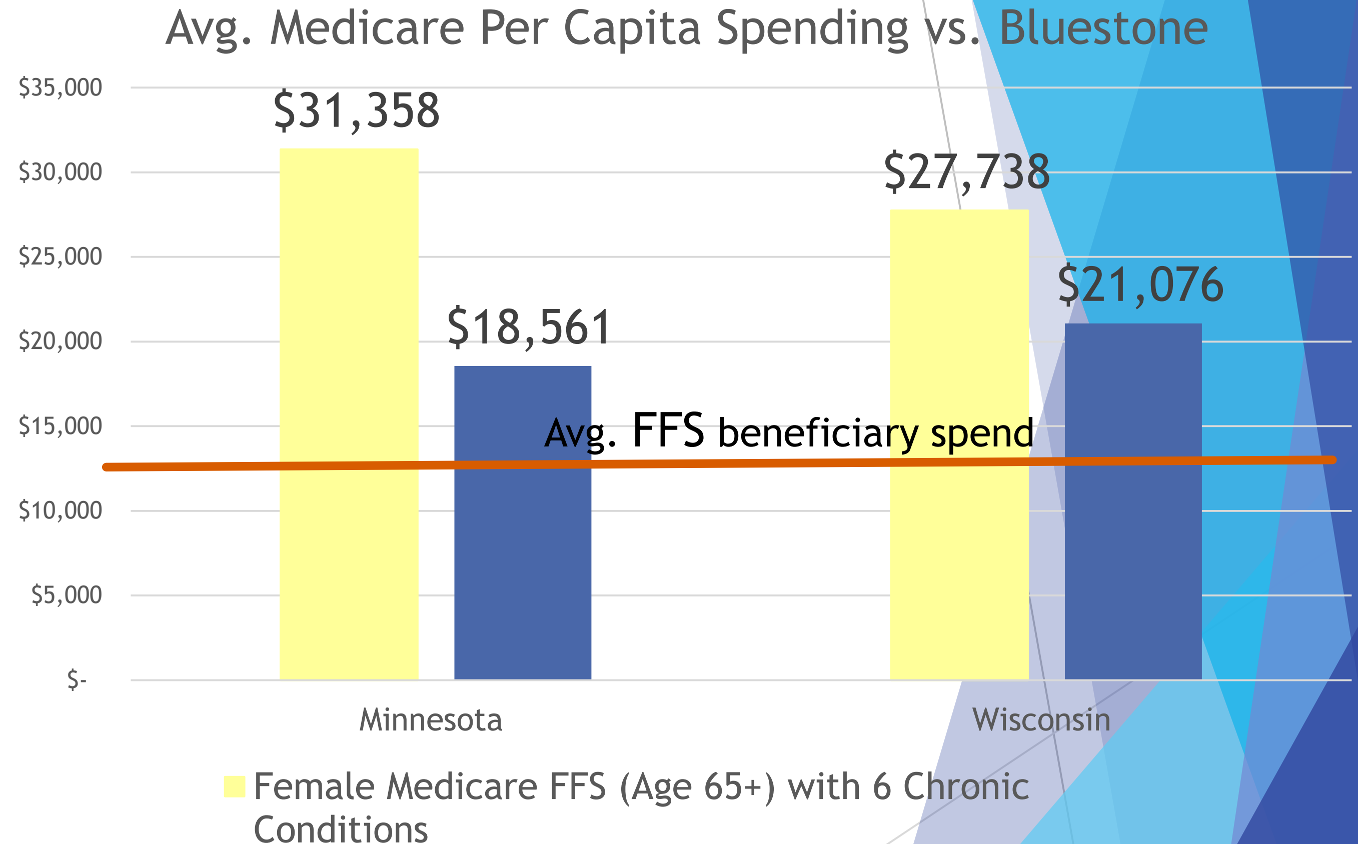
- Sky rocketing health care costs - current path is unsustainable
- Inconsistent quality outcomes
- Fragmentation in the healthcare system
- VBC supports patient-centered care models
- Aims to reduce burden on physicians and reward team-based approaches

Medicare Value-Based Care Payment Models

Pay For Performance	Medicare – MIPS: Incentive payments for meeting quality measure targets
Gain-Share	Medicare – MSSP ACO: Distribution of cost-savings, often including a quality component
Risk-Share	Medicare – MSSP ACO, Primary Care First: Distribution of cost savings and paying back losses
Capitation or Bundles	Medicare – Primary Care First, Direct Contracting, Special Needs Plans: Provider is responsible for services and receives a set monthly payment

Total Cost of Care & Assisted Living Patients

- The avg. Medicare beneficiary per capita spending is $13,500
- The avg. spending for female beneficiaries with 6 chronic conditions in WI is $27,738.
- Bluestone's ALF patients are 72% female with 8 chronic conditions



Data Source: Bluestone's 2018 MIPS Results & Medicare's Multiple Chronic Condition Data Set, 2017

VBC Strategies – Leveraging Real-time Data

Bluestone's VBC Strategies

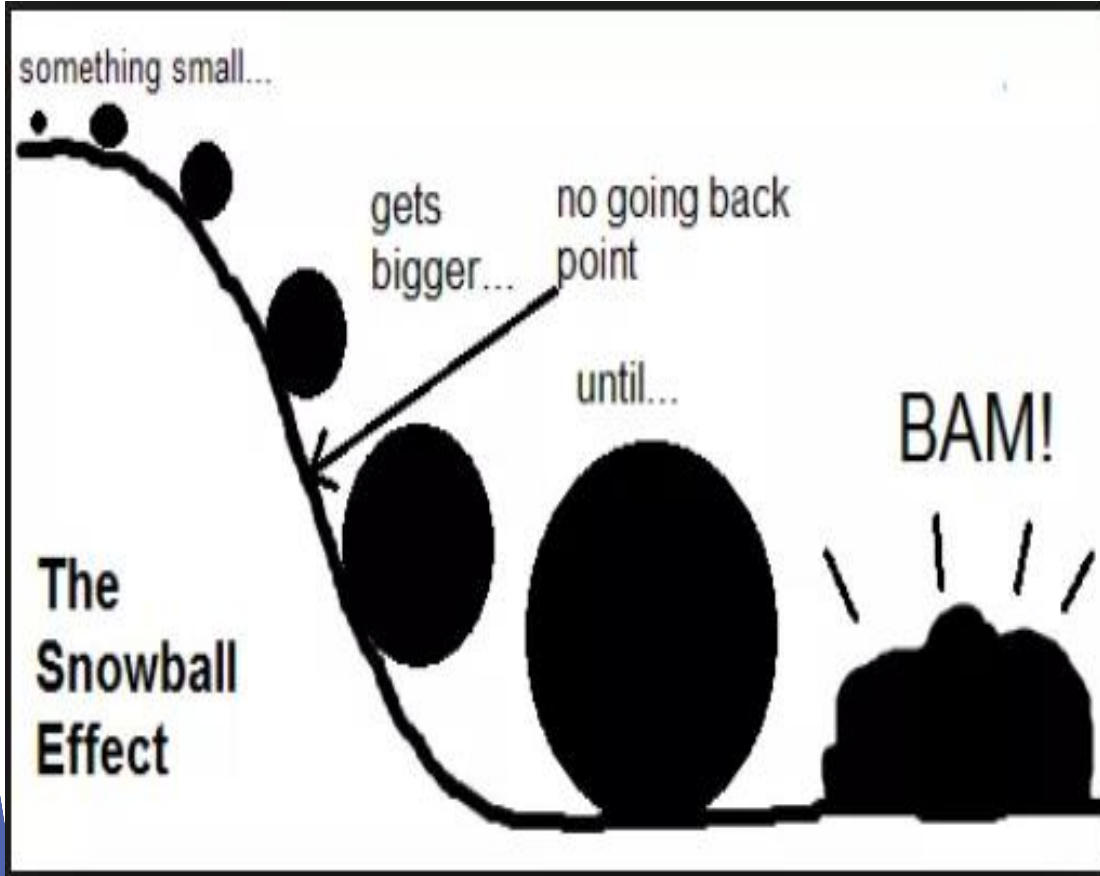
- **Transitions of Care**
  - Notification of pre-transfer or transfer
  - Care Management
  - ED Diversion
  - Pre-planning
  - PCP Identification and communication
  - Discharge planning and return to community

- **Medication Management**
  - Polypharmacy reduction
  - Medication Adherence
  - Appropriate use of anti-psychotics

- **Goals of Care Planning**
  - Advance Care Planning Discussions
  - Communication
  - Documentation
  - Care Conferences Hospice/End of Life discussions

- **Real-time Data / Communication**
  - Interoperability and medical record sharing
  - Reliable and quick turnaround on orders
  - Rounding forms and team huddles
  - Posts-visit care conference

VBC – *'it's a process not a flip of the switch'*



<u>PatientPing & WISHIN</u>

<u>Using Real-time data</u>

- HCC Coding
- Transitions
  - Event notifications
- PCMH Care Managers
- Post-acute care management

Admit-Transfer-Discharge-A Game Changer!

- ADT-
  - Event Notification Systems (ENS)
  - Three simple letters, a world of change
  - Cornerstone for managing value-based care patients

A Closer Look at the Data – Patient Ping 2019

Event Setting	Notification Count 2019
Emergency (presented)	3,925
Inpatient (admitted)	2,423 (avg. LOS 5.5)
Observation (discharged)	503
Skilled (admitted)	197
Home Health Agency (admitted)	270
Hospice (admitted)	29
Unique High Utilizers	868

3% of ED visits were on a holiday.

In 2018, our notifications relied on manual notifications from assisted living buildings or families.

Examining Potentially Preventable ED Visits

ED Primary Dx	Count
Unspecified fall, initial encounter	174
Weakness	94
Urinary tract infection, site not specified	93
Altered mental status, unspecified	65
Sepsis, unspecified organism	42
Pneumonia, unspecified organism	40
Unspecified injury of head, initial encounter	38
Syncope and collapse	38
Disorientation, unspecified	36
Shortness of breath	33
Cough	27
Encounter for examination and observation following other accident	26
Chest pain, unspecified	23

For Providers: Which diagnoses should/could have been addressed during a recent visit?

For Assisted Living: Educate on services we can perform on-site

Geographical Analysis & Resource Allocation and Intentional Partnerships

City of Discharge	Discharges
Milwaukee	573
Appleton	244
Racine	196
West Allis	174
Brookfield	165
Menomonee Falls	155

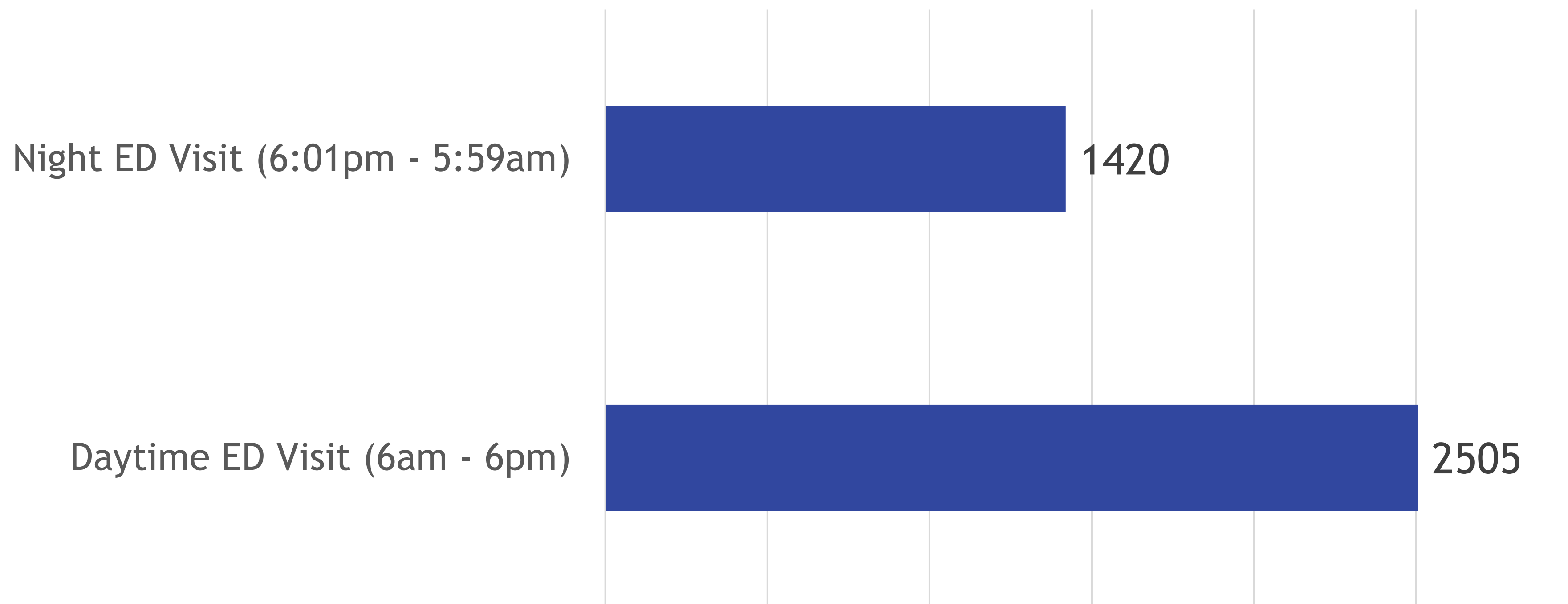
Discharge by hospital	Discharges
Aurora St. Luke's Medical Center	206
Wheaton Franciscan Healthcare - All Saints	195
Aurora West Allis Medical Center	174
Froedtert Hospital	170
St. Elizabeth Hospital	166
Wheaton Franciscan - Elmbrook Memorial Campus	165
Froedtert Health Community Memorial Hospital	155

Testing our Assumptions: "*Most patients get sent in on the weekend*"

2019 ED Visits by Day of the Week

Day	ED Visits
Sunday	520
Monday	551
Tuesday	591
Wednesday	552
Thursday	578
Friday	596
Saturday	537

Testing our Assumptions: "*Most patients get sent at night*"



The Impact of Patient-Ping and WISHIN on VBC

- Improved Care Transitions
  - Admit/Discharge/Transfer notifications
  - Transitional Care Management Visits
- Data-driven Resource Allocation
  - Geographical and facility level analysis to identify ‘hot-spots’
- Robust patient history – more effective visits and improved coding.

More Data, More Challenges – Uncovering Gaps in the Care Model

Gaps in Care
Lack of notification from ALF buildings prior to sending patients to the ED
Advance Care Plan and adherence to hospice protocol
Managing the increase in transitional care visit opportunities
Facilitator between hospital discharge teams and assisted living facilities - “Disagreements regarding readiness for discharge”
Tracking down discharge summaries is not always an efficient process
Families can be your best asset or your biggest barrier

Emma-A Before and After Case Study

Fragmented Communication

8.12-Emma is sent by facility staff to ED due to behaviors. ACP documents were not sent. MRI and labs ordered

-PCP/CC not notified of admission

8.12-admitted to acute stay for “decreased mental status” and “UTI”, add’l labs, Warfarin dose changed.

8.15-Transferred to TCU, additional labs. AL staff/PCP/CC not notified.

8.30-Transferred back to AL, staff notify PCP after arrival. No discharge summary available.

9.1-Updated med list not available, INR -4

Aligned Communication

8.12-Emma is sent by facility staff to ED due to behaviors. ACP documents were not sent.

- CC notified of transfer via ADT that day.
- CC contacts ED and facilitates record transfer and PCP-ED consult
- ED MD orders return to community with next day follow up by PCP.
- CC notifies family and staff.

Sarah Keenan (sarah.keenan@bluestonemd.com)
Nate Hunkins (nate.hunkins@bluestonemd.com