eClinicalWorks

CASE STUDY

BLUESTONE PHYSICIAN SERVICES

DELIVERING QUALITY CARE WITH DIGNITY TO SENIORS
IN MINNESOTA, WISCONSIN, AND FLORIDA

improving healthcare together

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eClinicalWorks

CASE STUDY

Bluestone Physician Services

Dignity and Quality Care at the End of Life

The Challenge

For Bluestone Physician Services, quality healthcare means working with frail, elderly patients in nursing homes and assisted living facilities. The practice needed a partner with tools for Chronic Care Management, the ability to coordinate the efforts of hundreds of provider partners, and products to enable care delivery in mobile settings.

The Solution

During the last three years, Bluestone has built a true healthcare IT partnership with eClinicalWorks, relying upon the integrated EHR/PM solution, Chronic Care Management module, eClinicalMobile, and other tools to facilitate their rapid growth and focus on pre-acute and preventive care.

The Results

Bluestone, which has grown to more than 70 providers in Minnesota, Wisconsin, and Florida, provides quality care to thousands of patients near the end of life. With the support of eClinicalWorks, Bluestone has helped patients and caregivers meet the challenges of dementia and chronic illness with care and dignity.

How Bluestone Physician Services Began

Todd Stivland, MD

If you were to offer physicians a population in which the average patient is 87 years old, has dementia, suffers from multiple chronic health conditions, and is expected to live less than two more years, most would probably decline.

Not Minneapolis' Dr. Todd A. Stivland.

It was more than a decade ago, while still with his previous clinical practice, that Dr. Stivland began to change his approach to medicine, perceiving a growing need to provide additional services and care to some of society's frailest and most vulnerable citizens.

Rather than continue to ask families to bring their elderly relatives to the office — a process that could easily consume half a day — Dr. Stivland packed his medical bag, hit the road, and began paying house calls.

The response was so positive — and overwhelming — that Dr. Stivland quickly amassed 300 patients, and had to make a choice. In 2006, he left his practice to found a new endeavor, Bluestone Physician Services.

Largely Uncharted Territory

"We focus solely on assisted livings and group-home communities," Dr. Stivland said. "For the last 11 years, we've been doing on-site

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> — Todd Stivland, MD, Owner & CEO

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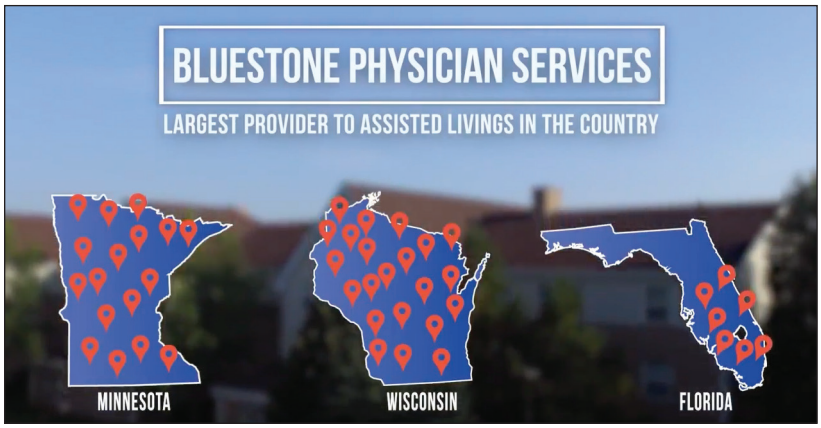
Given the steady aging of the U.S. population, developing a medical practice around the idea of serving the needs of elderly patients might seem obvious. But how to succeed at that — ensuring the delivery of quality care without facing financial losses — is far from obvious or easy.



Where others might have seen insurmountable obstacles, Dr. Todd Stivland saw an opportunity to provide better care to seniors near the end of life — and now leads the largest organization of its kind in the U.S.

While there is enormous growth in alternative care systems, Dr. Stivland said there “wasn’t really any mold to follow when we started doing this. A lot of what we’ve had to do, we’ve had to build out of necessity.”

Bluestone has had an EHR in place since their founding, and switched to eClinicalWorks three years ago. That decision was critical in helping them solve the challenges that come with trying to pull together the services of many physicians and other care providers for patients in hundreds of locations.

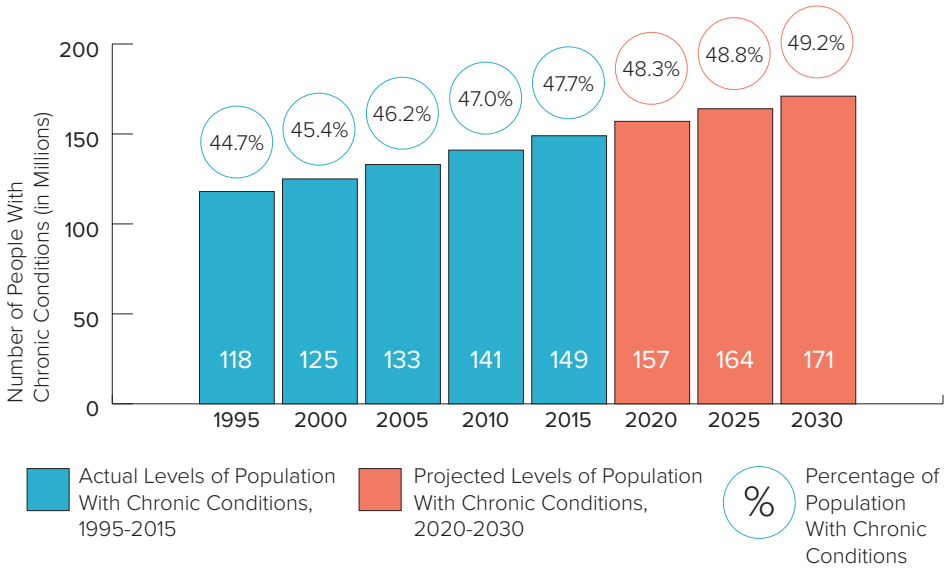
“One thing we’re very proud of the work we’ve done with eClinicalWorks is really intentionally integrating the work that our care coordinators or case managers are doing,” said Sarah Keenan, Bluestone’s Chief Clinical Officer and President of Innovative Care. “It’s not over to the side of what our providers are seeing with eClinicalWorks, but it really

Bluestone's Mission

Bring the highest-quality health care directly to residents in assisted living communities, memory care, and group home communities. By using the latest medical advances, technology, and collaboration with community/facility staff, patients, and their families, we have developed an unsurpassed care model for residential patients. We treat our patients with kindness and respect, recognizing their individuality, and working with them and all involved caregivers to provide optimal health care, supporting their independence.

http://www.bluestonemd.com/about-us/

Prevalence and Projected Growth of Chronic Conditions in the U.S. Population: 1995 – 2030 (in five-year increments)



Projected

SOURCES: Wu, Shin-Yi, and Anthony Green. *Projection of Chronic Illness and Cost Inflation.* Partnership To Fight Chronic Deseases; https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf

is an exchange of information that makes the work the care coordinators are doing and the work the providers are doing more meaningful and more efficient."

Applauding CCM — and Going Further

Nothing has illustrated the efficiency and coordination of the Bluestone/eClinicalWorks partnership like Chronic Care Management, which the Centers for Medicare & Medicaid Services launched on January 1, 2015, with the goal of rewarding providers for focusing their efforts on the needs of high-need patients with two or more chronic conditions.

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eClinicalWorks' CCM solution, along with eClinicalMobile and the comprehensive EHR itself, have provided Bluestone with the tools and data analytics they need to deliver quality care, as well as gauge their success.

But as Keenan notes, Bluestone saw the need for even more help — from lawmakers.

"When Chronic Care Management first came out, we were very excited because we looked at that as a paradigm shift on behalf of CMS," she said. "And, we didn't think it was quite enough. We identify only high-risk patients. We're a very high-touch, communicative practice. With many of our patients, we easily hit 20 minutes and beyond."

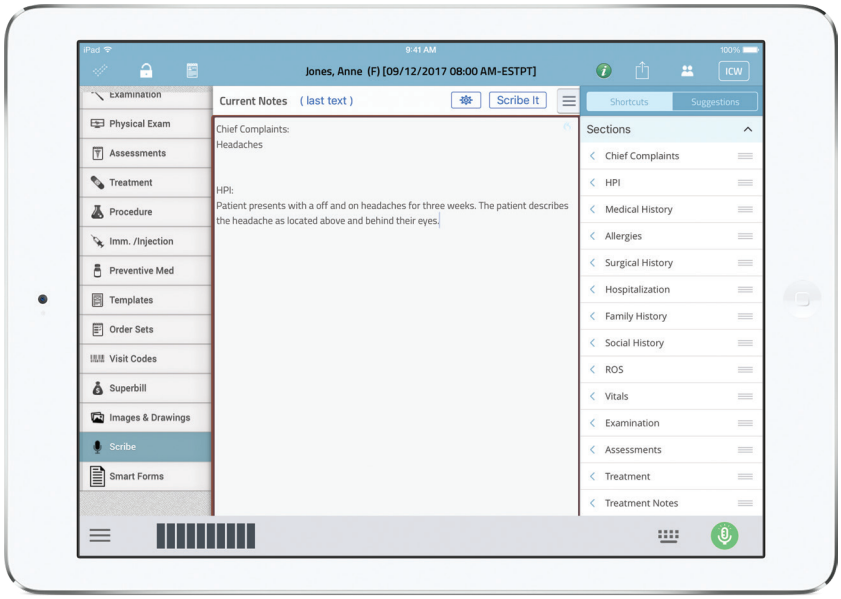
Bluestone's leadership worked closely with the Senate Finance Committee to advocate for additional flexibility in the CCM program. The original rules — providing for $42 per month, per patient for at least 20 minutes of non-face-to-face care — were revised and expanded. Beginning in 2017, providers can now earn additional reimbursements for additional time spent on the cases of patients with high needs.

Let's Flip Some Progress Notes!

With one legislative victory to their credit, Bluestone is now working on another.

“If you look at how medicine is taught, how medicine is built and coded and paid for, it’s on an acute basis,” Dr. Stivland said. “What’s that patient’s chief complaint? What’s the history of their present illness? And at the very bottom we say, well, what’s our plan? I learned a lot from our nurses. They say ‘Well, why are you ending with the plan? We always start with the plan.’”

For Dr. Stivland, that was a revelation. The vast majority of Bluestone’s patients don’t need a diagnosis, since 82% of them already have a diagnosis of dementia. So, the care coordination teams at Bluestone know what they’re up against.



eClinicalTouch providers at Bluestone Physicians Services the functionality and mobility they need for case documentation and connectivity wherever they go — including patients’ homes, nursing homes, and assisted living communities.

His latest idea then, Dr. Stivland said, is working with eClinicalWorks to transform the traditional physician’s Progress Note from a descriptive and reactive tool into a preventive one.

Dr. Stivland and his colleagues made a new case to CMS, that reimbursements for care provided to the frail elderly should be based upon providing good chronic care.

“Right now, the payment system is based on what your acute problem is today,” he said. “So you see a lot of programs and a lot of clinics, they’re set up to say ‘Well, we’ll wait until someone has a problem, then we’ll react to it, then we’ll do post-acute care.’ We’d rather do pre-acute care and have the documentation and the communication to follow that through.”

A New Definition of Team

While they have enjoyed legislative success, Bluestone’s leadership isn’t waiting on Washington. Their practice has experienced rapid growth and success, with more than 70 providers coordinating their efforts with those of more than 300 partner agencies to serve thousands of patients and families in Minnesota, Wisconsin, and Florida.

That success is driven by on-the-road care coordination teams that include the usual players — physicians, nurse practitioners, clinical support staff, and administrative staff — but add a critical new dimension, the staff at the nursing home and assisted living communities they serve.

"We work very intentionally to integrate them into the processes," Keenan said. "We always say, if you've seen one assisted living, you've seen one assisted living. It really is the patient's own home. And every assisted living is set up a little differently. There's different staffing models. So, it's on us to learn what that community is and how it functions."

> "We have created a pretty robust training program for all of our providers. We have a full-time training staff that spends two to three weeks side by side with our providers when they start. But beyond that, our trainers continually go out and rotate around with the different teams. We also do weekly learning labs. And then we've focused a lot on creating these really quick, little videos, like one to two minutes max, and then we'll send them out to the providers."
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"We have created a pretty robust training program for all of our providers," said Candice Levy, Senior Director of Clinical Operations. "We have a full-time training staff that spend two to three weeks side by side with our providers when they start. But beyond that, our trainers continually go out and rotate around with the different teams. We also do weekly learning labs. And then we've focused a lot on creating these really quick, little videos, like one to two minutes max, and then we'll send them out to the providers."

"Our chief clinical officer and I go out and meet with every provider face to face in every market, so across Minnesota, Wisconsin, and Florida, twice a year," Levy continued. "And we really use that time to talk to them about the things that they need to know, and why. So, why should you care about your MIPS score? And what are the upcoming quality measures that you should be paying attention to with your patients while you're taking care of them? And then I really beg them to complain about the EHR, so that I can take it back as a to-do list, and I've done everything I can fix to make their lives a little bit better!"

Three Challenges

Communication

Understanding how each community they serve functions is only the beginning of the process for Bluestone's providers. Because of the profile of their patient population, they face a challenge that is familiar to those who work in geriatrics — obtaining clear and effective communication with each patient and their families — except that the challenge is multiplied across the entire patient population.

"The common complaint around information exchange is patients are having to tell their stories over and over again," Keenan said. "With our patients, sometimes they can't tell their stories over and over again, particularly when they are going into the emergency department or into an acute stay. The stories are sad and all too common in our healthcare system of what happens to a dementia patient. We spend a lot of time trying to be proactive — a preventive model, as opposed to a reactive model — in helping folks kind of get off that treadmill."

Coordination

Bluestone's success in developing effective care models is a function of effectively coordinating their efforts with many partners.

"In the Minneapolis metro area we have 300 service partners who provide care to our patients," Dr. Stivland said, "whether that's wound care, nutritional care, physical therapy, or home care. That's a lot of people to keep track of, but they're doing the lion's share of the work, and if we don't, we miss a huge amount of information and opportunity."

And, as Levy notes, there are more assisted living facilities in the Tampa, Florida area alone than in all of Minnesota and Wisconsin combined. The coordination puzzle for Bluestone is enormous.

The key to that coordination, Dr. Stivland said, is accurately identifying every element and person in the patient's care network.

"The diagnosis code is this one little slice of that," he said. "How you document for a regulatory body is another. And someone who's

assigned by a health insurance program is yet another. But the whole program, the whole process, involves many, many people, and that could be the daughter that's doing most of the work, that could be a staff at the nursing facility that's doing most of that work. It could be a neighbor. You really have to dig into each patient and say, what are the structures around this person? What's their social structure? What's their integration? Who's the specialist that's doing their dialysis?"

Charting

Once clear communication channels are set up and all the relevant players looped in, how do Bluestone providers ensure that they can successfully draw in all the good work that is being done by everyone — from the home care nurse, to the care coordinator, to the case manager?

"Well, the first thing is getting devices that are portable," Dr. Stivland said, noting that in a practice such as Bluestone Physician Services that has no brick-and-mortar locations, they are constantly going room to room in the facilities they visit.

"So, we've kind of led the charge with iPad use. We're always pushing for how do we get more mobile?" he said. "You go into a large, concrete and metal building, it's pretty hard to pick up a signal from that building. A lot of the challenge is how do we just get an internet signal or a phone signal coming down to our devices so we can move throughout that building? So sometimes just the hardware and connectivity — issues which you don't have in the office space system — becomes a big challenge."

"I know that originally eClinicalMobile was more developed to be an extension of the core application," Levy added, "but we've really taken that and kind of flipped it around, where we use it exclusively in a lot of our teams."

Meeting MIPS Through Partnership

With such an innovative and challenging business model, Bluestone Physician Services could surely be forgiven for having some reservations about the latest changes in reimbursement models — the arrival of value-based care, including the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).

But given their general approach to healthcare, Bluestone can't wait to get started on this latest challenge.

"As with many clinics, our end goal would be APM," Keenan said, "but in the meantime, it's MIPS. We are very determined to be very successful with MIPS, which is saying something because we have a very unusual population. Quality measurement is not designed for an average age of 87. So, we spend a lot of time working creatively with the measures and working with our providers to say how can we make these measures best serve our patients?"

"We've got to make sure we get involved in this," Dr. Stivland said. "So that really takes that upfront evaluation and initial interview to put that team together. It can't be cookie cutter, where we say 'Oh, we're just here to get paid for a code, or this is just one program that the insurance company put in place, so we pop that person in.'"

"We're very excited," Keenan said. "We have two measures out of MIPS that we're able to implement this year, hopefully, around dementia care. We've never been able to do that before. It's a lot of effort, and it's one of the places that we're very excited. We've always had a partnership with eClinicalWorks, but it really feels like a partnership now around the development of MIPS dashboards and other tools we'll be using." ■

How the Doctor Visit May Be the Future of Medicine

The visiting physician may seem like something from America's Norman Rockwell past. But they never disappeared entirely, and there is new evidence that home visits can play an important role in providing healthcare to the aged and chronically ill — while saving taxpayers millions.

The Centers for Medicaid & Medicare Services (CMS) said in August 2016, that a demonstration project has shown that delivering comprehensive primary care services at home and to nursing facilities helped keep Medicare recipients with multiple chronic illnesses or disabilities out of hospitals and emergency rooms.

A growing body of literature on the impact of medical house call programs concludes that these programs are effective in reducing hospital and emergency room use, improving patient quality of life and well-being, and providing valuable benefits to patients.

POTENTIAL BENEFITS TO VULNERABLE PATIENTS:

- Improved access to medical care
- More timely diagnoses and treatment of injury or illness
- Evaluation of patient's home environment to improve safety and quality of life
- Improved care coordination and continuity of care
- More relaxed and intimate doctor/patient relationship
- Better ability for vulnerable residents to "age in place"
- Fewer hospital stays and emergency room visits

Source: The Pew Charitable Trusts; http://www.pewtrusts.org/. And Centers for Medicaid and Medicare Services (CMS); https://www.cms.gov