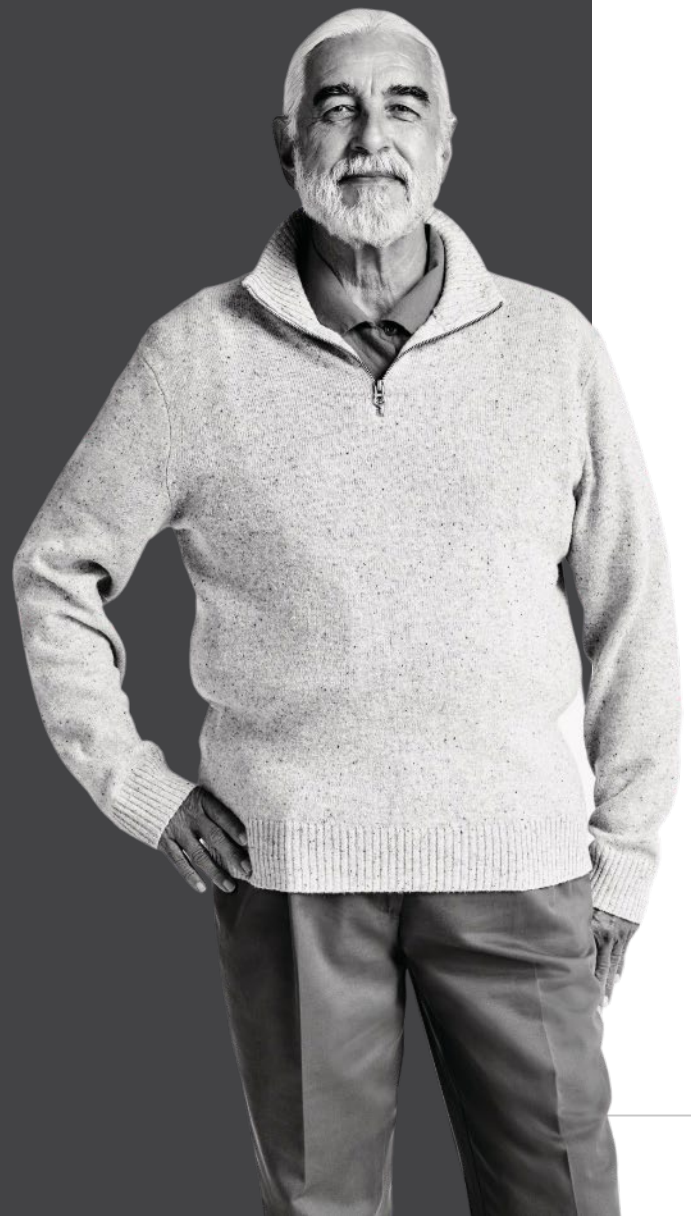


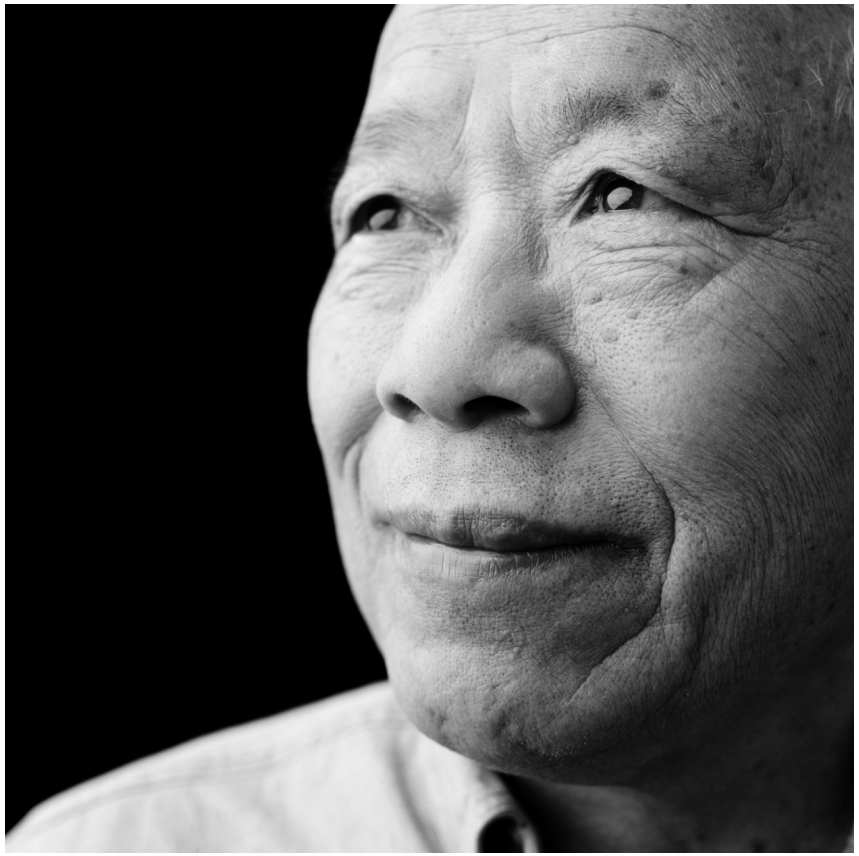
Complex Care Program:

In-home care for eligible San Francisco Bay Area Blue Shield members

May 2024

Y0118_24_213A_C 05092024

Agenda



- Complex Care Program overview
  - Service areas, member eligibility, member financial arrangement
- Complex Care Program model
  - Approach, member and PCP engagement, levels of engagement, care services, care team
- Member and provider outreach
- Q&A

Today’s presentation team

Nancy Wei
Senior Manager, Health Solutions
Blue Shield of California

Magda Lenartowicz, MD
Chief Medical Officer
Altais

Sondra Davis, MBA, BSHA, LVN, CPHQ, CCM
Vice President
Health Management Operations
Altais

New Complex Care Program

Blue Shield of California and Altais are administering a new Complex Care Program. Eligible members in select Bay Area counties who have multiple, specific chronic illnesses will have access to comprehensive home-based care provided by BT Health.

- **Blue Shield** contracted **Altais** to provide program administration services.
- My Health Medical Group DBA **BT Health** is managed by Altais to provide in-home and virtual care services.

Complex Care Program overview

1. Offers comprehensive home-based care including medical, behavioral and social services, plus 24/7 access to medical professionals and in-home urgent care.

2. Staffed by BT Health with nurse practitioners, registered nurses and a team of medical professionals who specialize in home-based care. Oversight is provided by licensed physicians.

3. Complements the care that PCPs are already providing to patients. The home-based care team collaborates with PCPs to ensure delivery and continuity of care.

Complex Care Program service area

A total of ten (10) Bay Area counties are in the Complex Care Program service area.

Live now	Live later in 2024
Alameda	Marin
Contra Costa	Napa
Santa Clara	Santa Cruz
San Francisco	Solano
San Mateo	Sonoma

Member eligibility

Blue Shield identifies members for inclusion in the Complex Care Program based on their health data and the following criteria.

- Member in a Medicare Advantage, Commercial, or IFP fully-insured plan, with Blue Shield plan as primary.
  - Exception: Eligible flex/self-funded plans: Blue Shield Employer Benefit Program and City and County of San Francisco (San Francisco Health Service System Fund).
- 18 years of age or older.
- Diagnosed with 4 or more specific chronic conditions in the previous 24 months **OR** at least 2 chronic conditions with recent history demonstrated need for complex care services (e.g., ER visits, SNF admission, hospitalization).

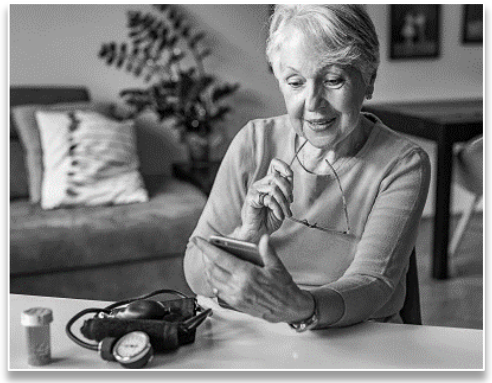
Exclusions:

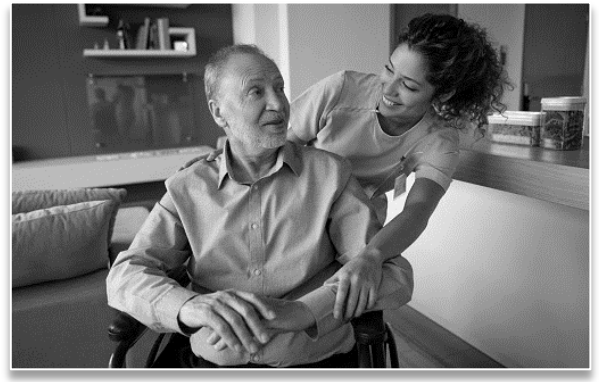
- Lines of business: Blue Shield Promise Medi-Cal, BlueCard®, CalPERS, FEP, Self-Funded (ASO), Shared Advantage, Specialty, and Tri-West
- Medicare Supplement plans
- Assignment to a full risk IPA/medical group
- Pregnancy within the last 12 months
- Hemophilia within the last 24 months
- Transplant acute stage
- Hospice, long-term acute care, or specialty-level palliative care

- See appendix for information re. other patient care programs offered to Blue Shield/Blue Shield Promise members.

Member financial arrangement

- Members opt into the Complex Care Program.
- Services are offered as an optional program to eligible members; participation does not impact members' benefits or how a provider bills.
- Program is available at **no additional cost** to those who meet the eligibility criteria.
- There is **no co-pay for services** provided by the program.
- Covered services provided by non-program providers through a referral from BT Health may be subject to co-pays, based on members' benefits and coverage.





Complex Care Program overview

Clinical care teams serve as an extension of the PCPs practice

Supporting the patient where they are In their healthcare journey

Collaborative care

Facilitate seamless transitions between care settings to ensure consistent, high-quality care.

Expanded access

Care teams provide expanded services and support to meet patients where they are in their health journey.

Proactive Communications

All visit notes and clinical summaries sent to the PCP via their preferred method of communication.

Patient Experience

Provide education and additional support to engage and empower patients to make informed decisions.

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Comprehensive, multi-faceted approach to address medical cost

Minimizing Healthcare Cost Drivers

Success is driven by the **ability to integrate** our care models and health solutions with **PCPs.**

- **High-risk and end-of-life care:** Chronic, complex and palliative care management. *
- **Inpatient care:** Clinical concierge care model.
- **ER utilization:** Behavioral health, focus on psychiatric diagnosis and substance use. Primary care access, technology, medical.
- **Specialist care:** E-consults and referral management.
- **Specialty medication management:** Rare disease management program. High-cost drug management.
- **Hospital outpatient vs. ambulatory surgery center:** Site-of-service redirection.
- **Health equity:** Community health advocates – Social determinants of health (SDoH).
- **Behavioral health:** Primary care collaborative care model.

* Patients are referred to Blue Shield's Home-Based Palliative Care Program when specialty-level palliative care is required.

Slide content provided by Altais®

Meeting patients where they are

Quintuple Aim

- Quality
- Healthcare costs
- Patient experience
- Provider experience
- Health equity

Complex Care Program

- Specialized in home concierge services for the most vulnerable patients
- Focused on 'what matters' to the patients and their families
- Empower patients to achieve their health goals
- Designed to defragment healthcare
- Work with patients to optimize their well-being

Differentiators

Concierge services

- Personalized services delivered where patients are located

Extended networks

- Clinical and community resource extension beyond PCP practice resources

Technology platform

- Interoperable, integrated tools that power data-driven and automated workflows

Patient engagement

- Elevate patient engagement and meet patients where they are with their knowledge and skills to manage their health

Patient experience

- Deliver high touch and high-tech whole person health services

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Engaging patients in the Complex Care Program

Right diagnosis, right care, best outcomes

Enroll	Access & engage	Monitor	Sustain
• Health advocate outreach for patient enrollment	• Comprehensive assessment by ICT* and nurse practitioner • Services deployed to address patient needs • Frequency of outreach determined by risk level	• Monitor triggers to reassess and re-stratify patient's risk level as needed • Frequent ICT* rounds	• Ongoing collaboration with patient and PCP

* ICT = Interdisciplinary care team

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Care team collaboration to ensure patients are supported by the most appropriate care pathway

Service pathways	Care services	Care team
Complex chronic care overseen by physician advisor	Caregiver support	• Registered nurse • Nurse practitioner • Health navigator • Community health advocate • Licensed clinical social worker • Pharmacist • Physical therapy • Occupational therapy • Speech language pathologist • Psychiatrist • Nurse practitioner
	Environmental assessment	
	Nutrition	
	Pharmacy	
	Rehabilitation and functional health	
	Remote patient monitoring	
Behavioral health	Behavioral health specialist	
Social determinants of health	Social determinants of health	
Palliative care	Palliative care (non-specialty) *	
Episodic care	24/7 and nurse triage	
	IV antibiotics	
	Transition of care	
	Wound care	

* Patients are referred to Blue Shield's Home-Based Palliative Care Program when specialty-level palliative care is required.

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Patient risk levels drive level of engagement and support

Status	Risk level	Frequency of visits
Stable	Multi-chronic that is controlled and stable	Monthly
Emerging risk	Uncontrolled chronic disease (uncontrolled blood glucose or blood pressure controlled)	Every two (2) weeks
High risk	Recent acute or post-acute discharge, appointment coordination, medication adherence	Weekly
Crisis	Uncontrolled symptoms (pain, shortness of breath), acute psycho-social needs, caregiver burnout	Daily until symptoms are controlled

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Care delivery support to address the needs of patients and clinicians

Patient outreach and scheduling

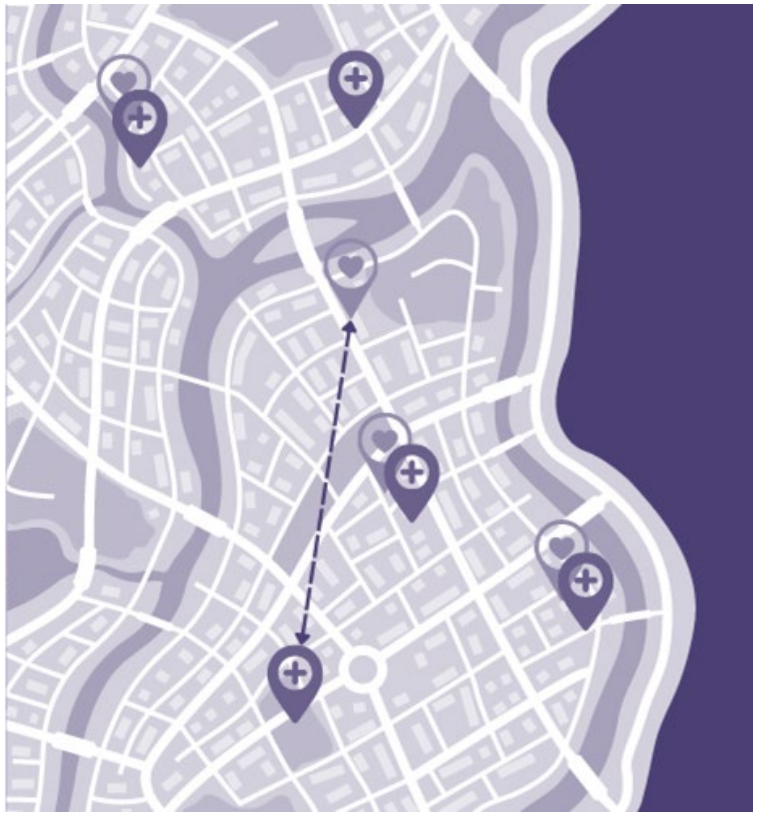
- Outreach by health advocate to schedule visits once member is enrolled.
- Daily clinician schedule development occurs centrally for field and virtual clinical teams.

Clinician field team management

- Daily huddles conducted with field team leaders to ensure clinician understanding of schedule, patients, and to identify any specific areas of concern.
- GPS location management tracks and manages field workforce, and supports real-time needs as they arise.

Patient and clinician support

- Clinician enablement team is available real-time to ensure all clinical, IT, or other questions and needs are met.
- Remote patient monitoring occurs within the support center to track diagnostics, where appropriate (along with alerting clinical team for follow up).
- Support teams operate both proactive outreach and reactive response when addressing patient and clinician needs.



Matching patients to appropriate care and support

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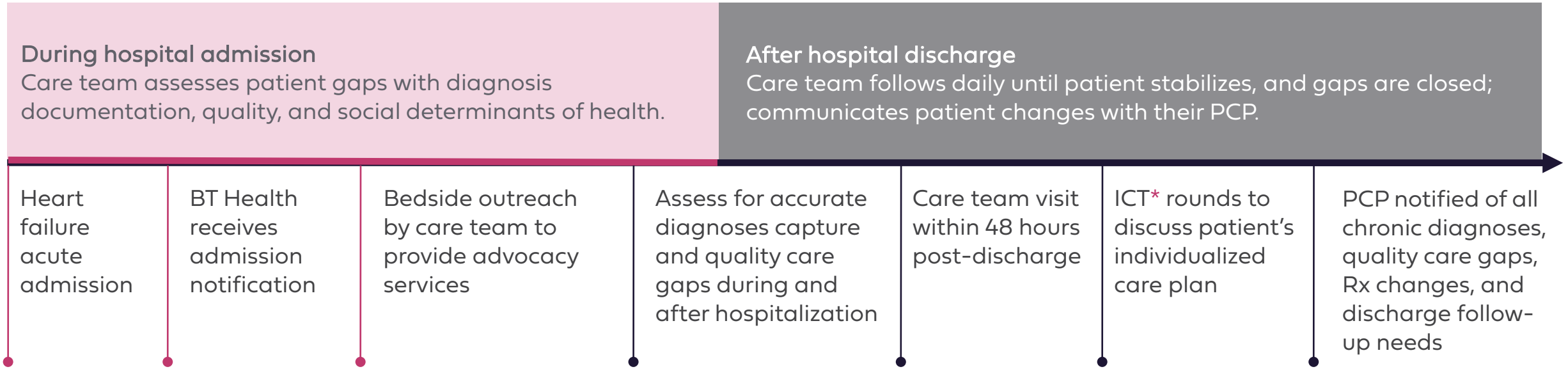
Whole person health management with every interaction = best outcomes

Episodic care pathway (acute hospital admission):
Care team comprehensively supports the patient across the care continuum to ensure we capture accurate diagnoses and drive high quality, evidence-based care.



* ICT = Interdisciplinary care team

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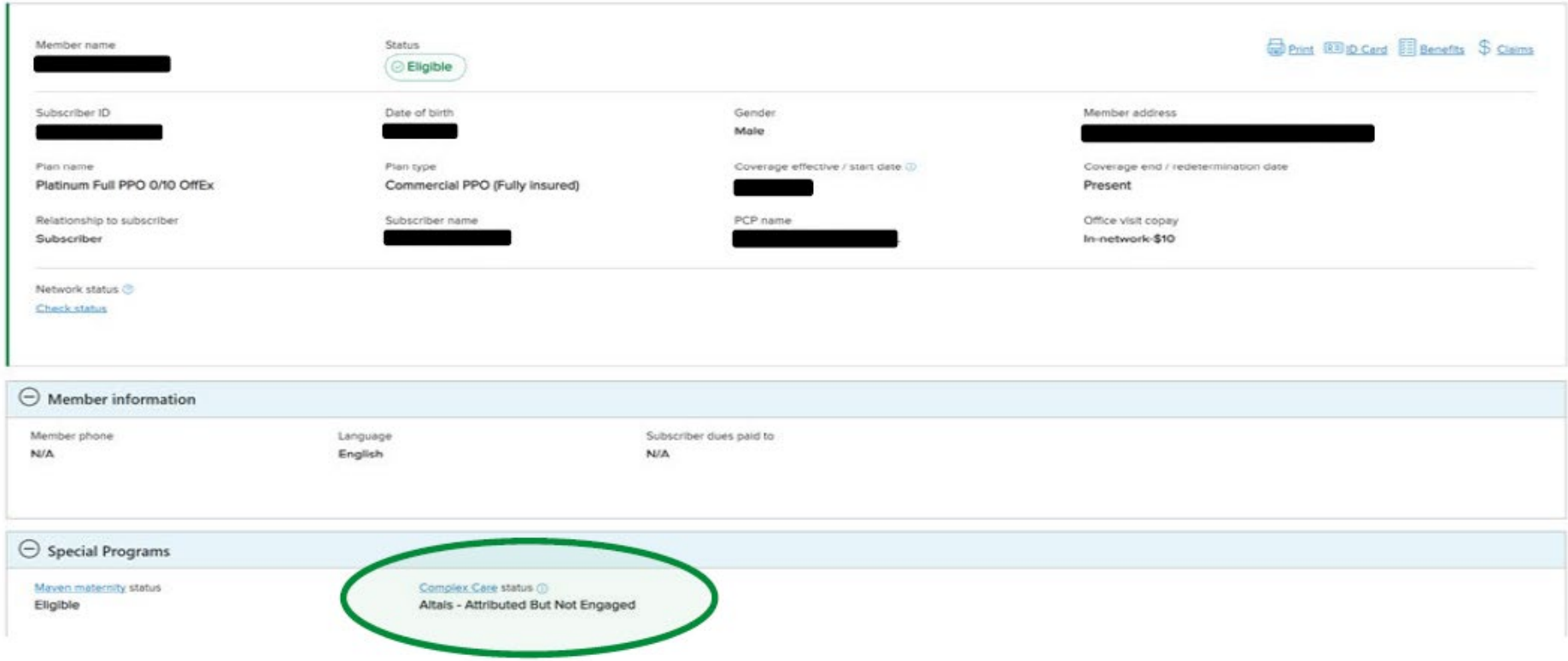
Engaging with Altais and BT Health in support of complex patients

- Blue Shield notified IPA/medical groups and PCPs about the Program in April via written communication with a link to register for this webinar.
- In early May, Altais:
  - Sent IPA/medical groups and PCPs a list of Program-eligible members attributed to the practice.
  - Began outreach to eligible members to explain the program and schedule an in-person assessment when a member opts in.
- After successful intake, Altais provides PCP an outline of the member's engagement and a contact list.

Complex care eligibility flag

- A *Complex Care Program* notation has been added in eligible members' eligibility record on the Provider Connection website (www.blueshieldca.com/provider). The notation indicates if a member is eligible as well as if the member opts in to the program.
    - To access, log in to Provider Connection and click *Verify Eligibility* from the home page or from the *Eligibility & benefits* section.



Engaging with Altais and BT Health in support of complex patients continued

BT Health:

- Sends initial assessment and all visit notes and clinical summaries to PCP after each visit, via the preferred method of communication.
- Provides a warm hand-off by clinical staff for urgent issues that need follow up by the PCP.
- Offers optimal co-management options including joint phone/ telehealth visits with the care team if requested.
- Presents PCP with discharge summary that includes a summary of active issues when a member disengages from the program.

Contacts

- Providers can contact Altais at **866-270-4514 or** complexcareprogram@altais.com if they have questions about the program, member eligibility, and member care. Altais will connect providers to BT Health representatives when needed.

- For general questions about the Complex Care Program, contact Blue Shield's Provider Customer Service at **800-541-6652** or log in to Provider Connection to start a chat.

- IPA/Medical Groups can also contact their Blue Shield Provider Relations Representative.

Appendix

Blue Shield patient care programs

Telephonic support

- On-demand services provided outside in-person support.
- Includes *Care Management, Teledoc,* and *NurseHelp 24/7.*
- Care Management: **877-455-6777** (TTY: 711) 8 a.m. to 5 p.m., Monday through Friday.
- Teledoc: **800-835-2362**
- NurseHelp: **877-304-0504** (TTY: 711)

Blue Shield Promise Complex Case Management Program

- Case managers work with high-risk members and their physicians to coordinate care and services.
- Goals are to help members regain optimum health or improved functional capability, educate members regarding their chronic condition, and reinforce the PCP-prescribed treatment plan.
- How to refer.

Blue Shield Home-Based Palliative Care Program (specialty-level)

- Specialized medical care focused on providing relief from pain and other symptoms of a serious illness such as cancer, heart disease, etc.
- Services are based on the needs of the patient, not on the patient's prognosis and can be provided along with curative treatment.
- How to refer: Download the Eligibility Screening Tool complete the form and email to BSCPalliativeCare@blueshieldca.com.

Blue Shield of California Complex Care Program

- Blue Shield identifies members for inclusion in this program based on age, health data, and plan type.
- Program offers comprehensive home-based care including medical, behavioral and social services, plus 24/7 access to medical professionals and in-home urgent care.
- The home-based care team collaborates with PCPs to ensure delivery and continuity of care.