

Complex Care Program:

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

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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**

Complex Care Program

Blue Shield of California and Altais launched a Complex Care Program in May 2024.

Eligible members who have multiple, specific chronic illnesses and live in these Bay Area counties have access to comprehensive home-based care overseen by Altais.





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 Altais 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.

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).

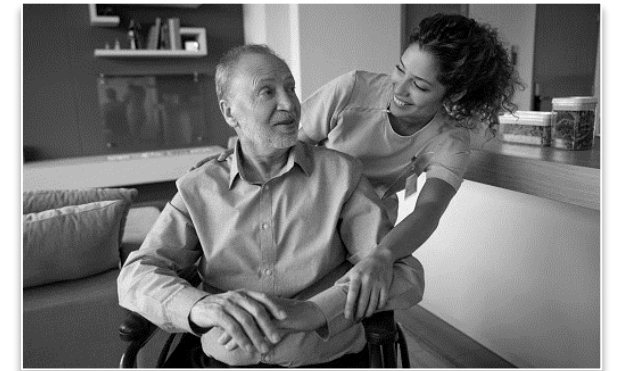
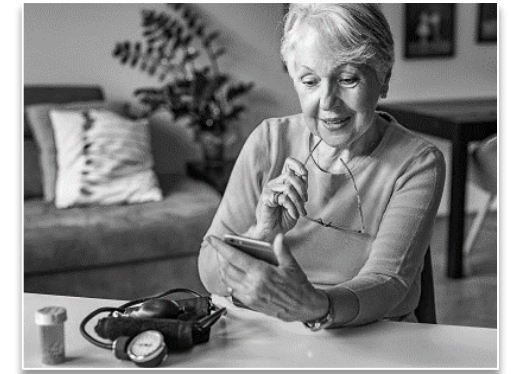
Exclusions:

- Lines of business: Blue Shield Promise Medi-Cal, BlueCard®, 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



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 Altais 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.

Comprehensive, multi-faceted approach to address medical cost



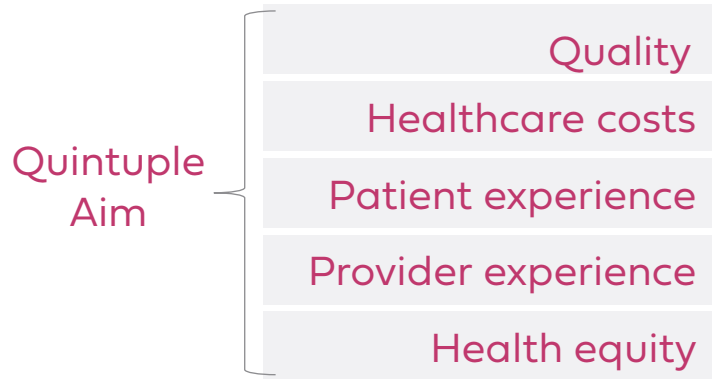
Minimizing Healthcare Cost Drivers

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.

Meeting patients where they are



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

Engaging patients in the Complex Care Program

Right
diagnosis,
right care,
best
outcomes

Enroll

- Health advocate outreach for patient enrollment

Access & engage

- Comprehensive assessment by ICT* and nurse practitioner
- Services deployed to address patient needs
- Frequency of outreach determined by risk level

Monitor

- Monitor triggers to reassess and re-stratify patient's risk level as needed
- Frequent ICT* rounds

Sustain

- Ongoing collaboration with patient and PCP


* ICT = Interdisciplinary care team

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 | <ul style="list-style-type: none"> • 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.

Patient risk levels drive level of engagement and support



| Status | Risk level | Frequency of visits |
|----------------------|---|-------------------------------------|
| Controlled | 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 |

Care delivery support to address the needs of patients and clinicians

Patient outreach and scheduling

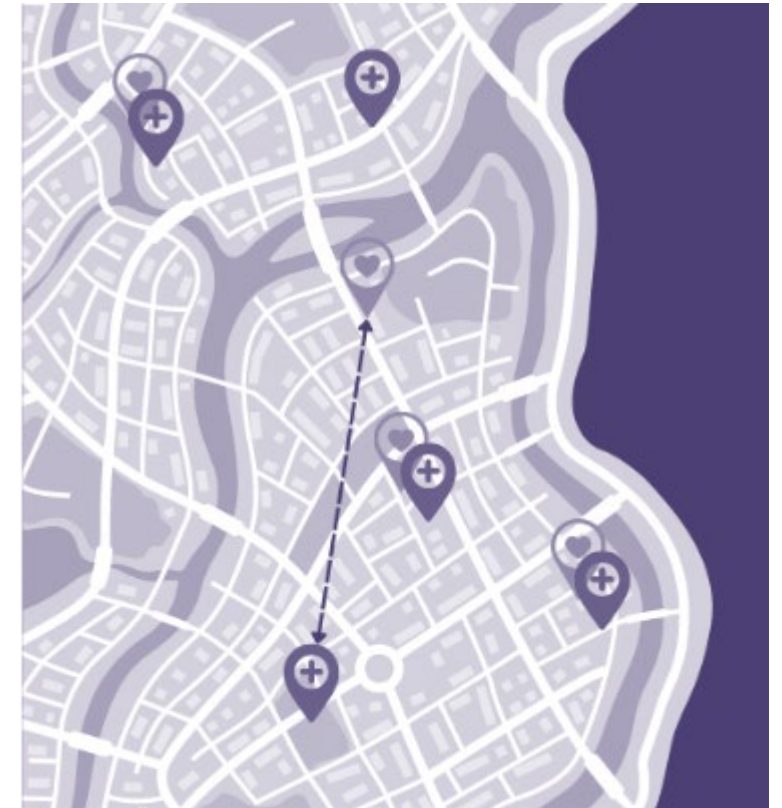
- Outreach by health advocate to schedule visits once member is enrolled.
- Daily clinician schedule development occurs centrally for field and virtual clinical teams.

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.

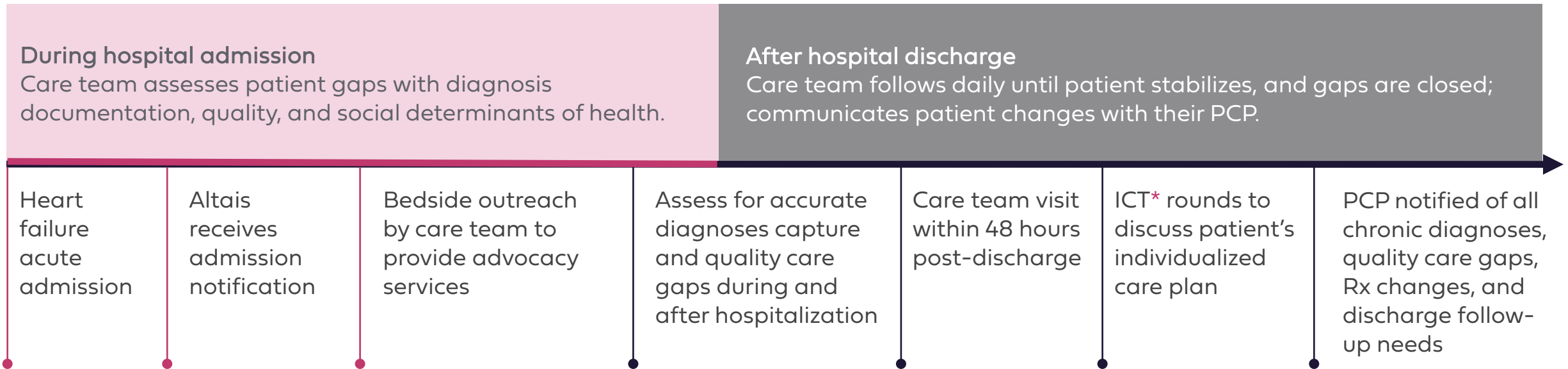


Matching patients to appropriate care and support

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

Engaging with Altais in support of complex patients

- Blue Shield notified IPA/medical groups and PCPs about the Program in April 2024 via written communication and hosted a webinar in May 2024.
- 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.

The screenshot displays a member's eligibility record on the Provider Connection website. The record is organized into several sections:

- Member Information:** Includes Member name (redacted), Status (Eligible), Subscriber ID (redacted), Date of birth (redacted), Gender (Male), Member address (redacted), Plan name (Platinum Full PPO 0/10 OffEx), Plan type (Commercial PPO (Fully Insured)), Coverage effective / start date (redacted), Coverage end / redetermination date (Present), Relationship to subscriber (Subscriber), Subscriber name (redacted), PCP name (redacted), and Office visit copay (In-network-\$10). There are also links for Print, ID Card, Benefits, and Claims.
- Network status:** Includes a link to Check status.
- Member information:** Includes Member phone (N/A), Language (English), and Subscriber dues paid to (N/A).
- Special Programs:** Includes Maven maternity status (Eligible) and Complex Care status (Aiais - Attributed But Not Engaged), which is circled in green.

Engaging with Altais in support of complex patients continued

Altais:

- 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 BSC-CCP@altais.com if they have questions about the program, member eligibility, and member care.
- 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.



Blue Shield of California is an independent member of the Blue Shield Association



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.