September 12, 2024

Update on Advanced Primary Care work on behalf of SFHSS

Purchaser Business Group on Health

PBGH Care Excellence Award

Our mission is simple yet transformative: to make it easy for employers and purchasers to identify and partner with the highest quality primary care clinics in any region.

First awardees were announced last week

SFHSS challenged us to improve the primary care experience

A stressed primary care system:

20.6 Days

Average family medicine wait time[1]

$3,300

Additional cost of employee when they don't have PCP[2]

altais PBGH blue california

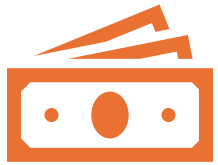
Non-traditional partners coming together to innovate and deliver advanced primary care

Advanced Primary Care attributes:

1. **Timely access the way a patient prefers,** expanded hours, various forms of communication E.g. virtual visits, asynchronous messaging
2. **Relationship-based person and family centered care**
3. **Interdisciplinary teams including integrated mental health**
4. **Comprehensive care** that considers SDOH, family and community relationships, lifestyle and health equity.
5. **Integrated and coordinated with rest of health care system,** particularly by referring to highest quality specialists
6. **Equitable** by tracking and addressing disparities

1. Medical Economics: https://www.medicaleconomics.com/view/appointment-wait-times-drop-for-family-physicians-indicating-shift-in-care
2. Chartbook on Care Coordination: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html ; The High Cost of Avoidable Hospital Emergency Department Visits: https://www.unitedhealthgroup.com/newsroom/posts/2019-07-22-high-cost-emergency-department-visits.html

Blue Shield is working through multiple channels to support primary care transformation



Primary Care Payment models

Advanced Primary Care Hybrid Model

Primary Care Hybrid Model

Fee for Service Plus

Accountable Care Alliance

Multi-Payer Primary Care

IHA Advanced Primary Care

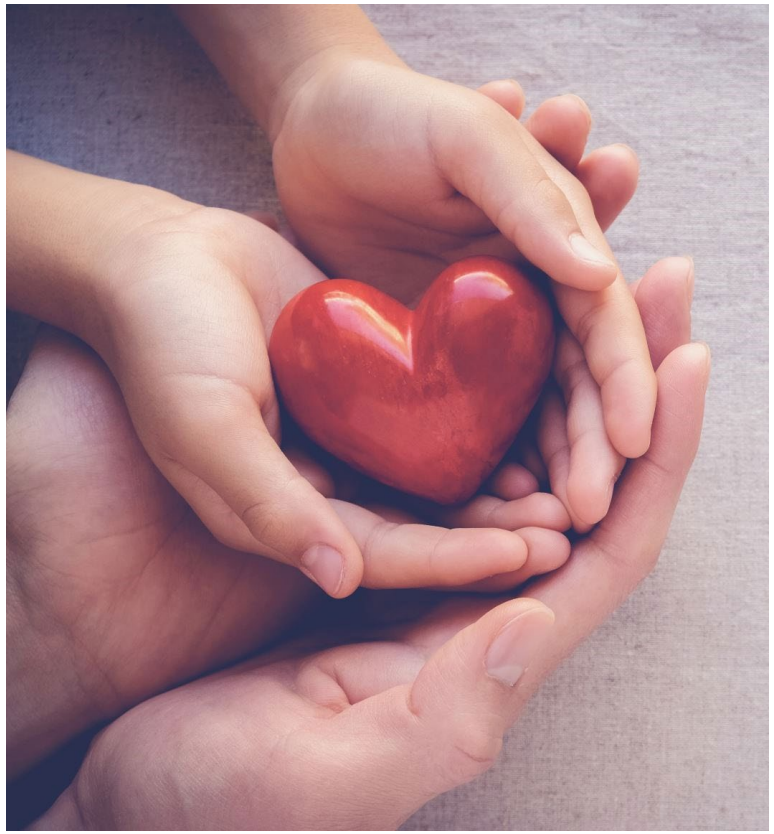
Advanced Primary Care Designation with PBGH Care Excellence Program

PBGH Care Excellence Program

Provider Enablement

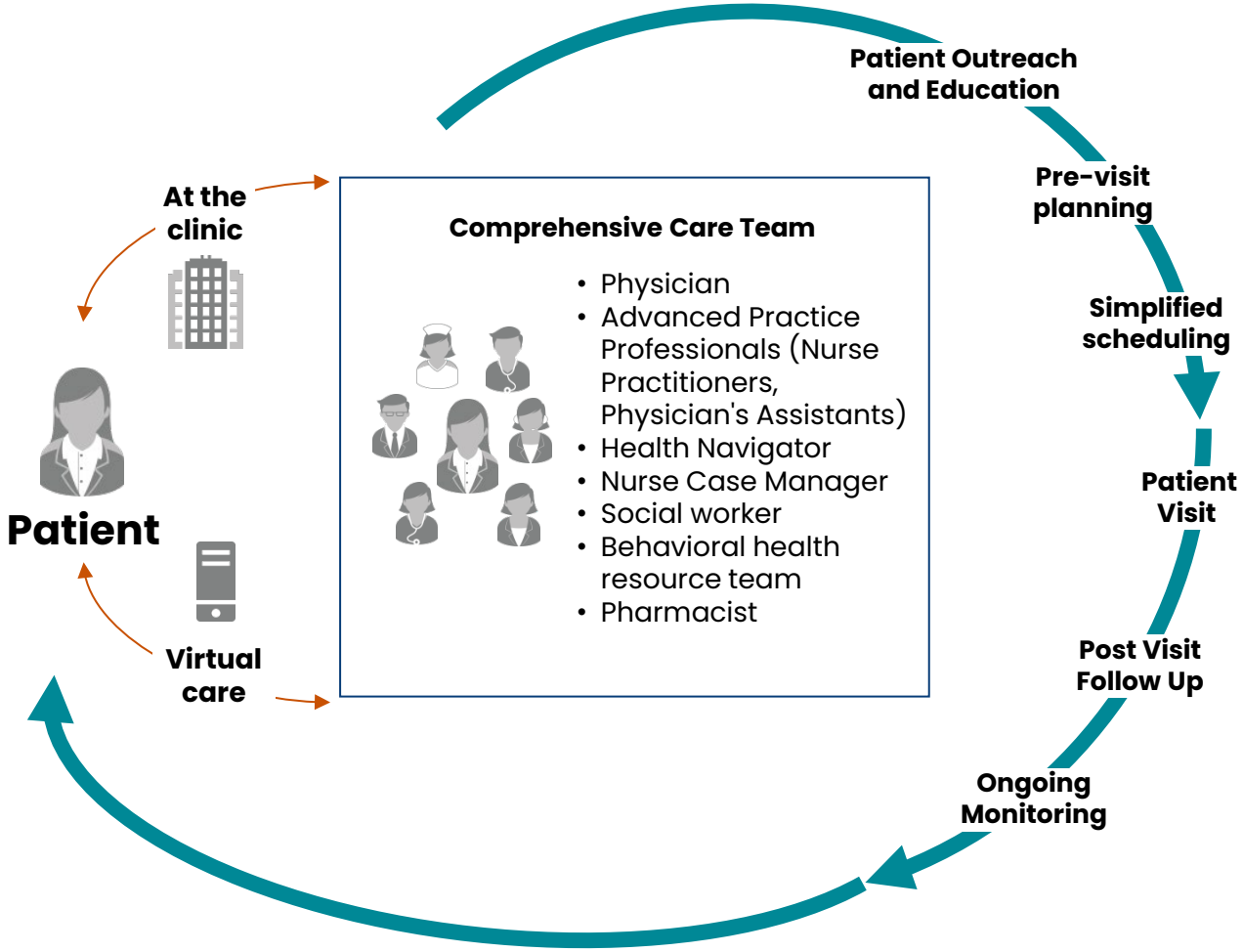
Teams and tools to support practices in value-based care success

Goals of Advanced Primary Care

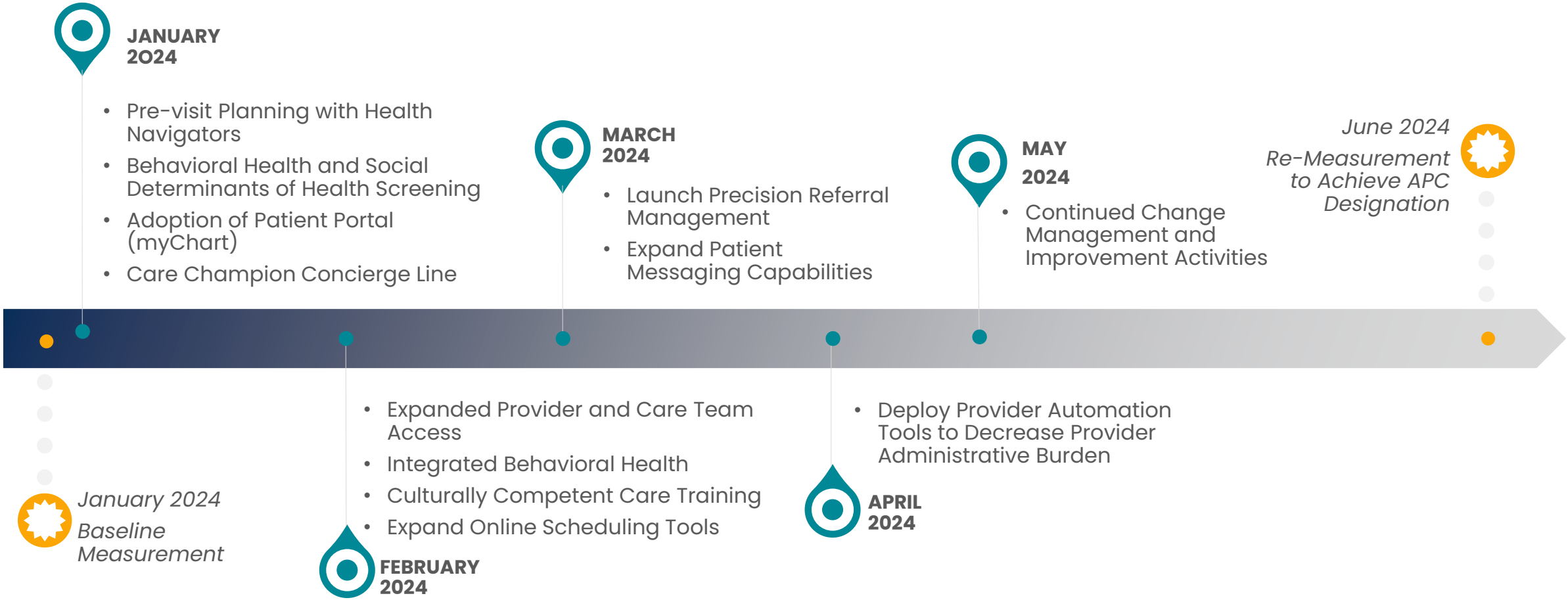


- Pilot and **scale the Advance Primary Care model** through suitable provider groups
- **Increase primary care spending** while managing total costs
- Innovate using the Advanced Primary Care designation model to boost healthcare **access, equity, and quality**
- Empower and improve health care **workforce experience** to provide high quality whole person care including **shared decision making**
- Enroll more patients into Advanced Primary Care practices, enhancing **access** and quality
- Transform **payment models** for better care and outcomes
- Enable best **patient experience** and quality through the specialty referral process
- Deliver transparent **performance reporting to purchasers**

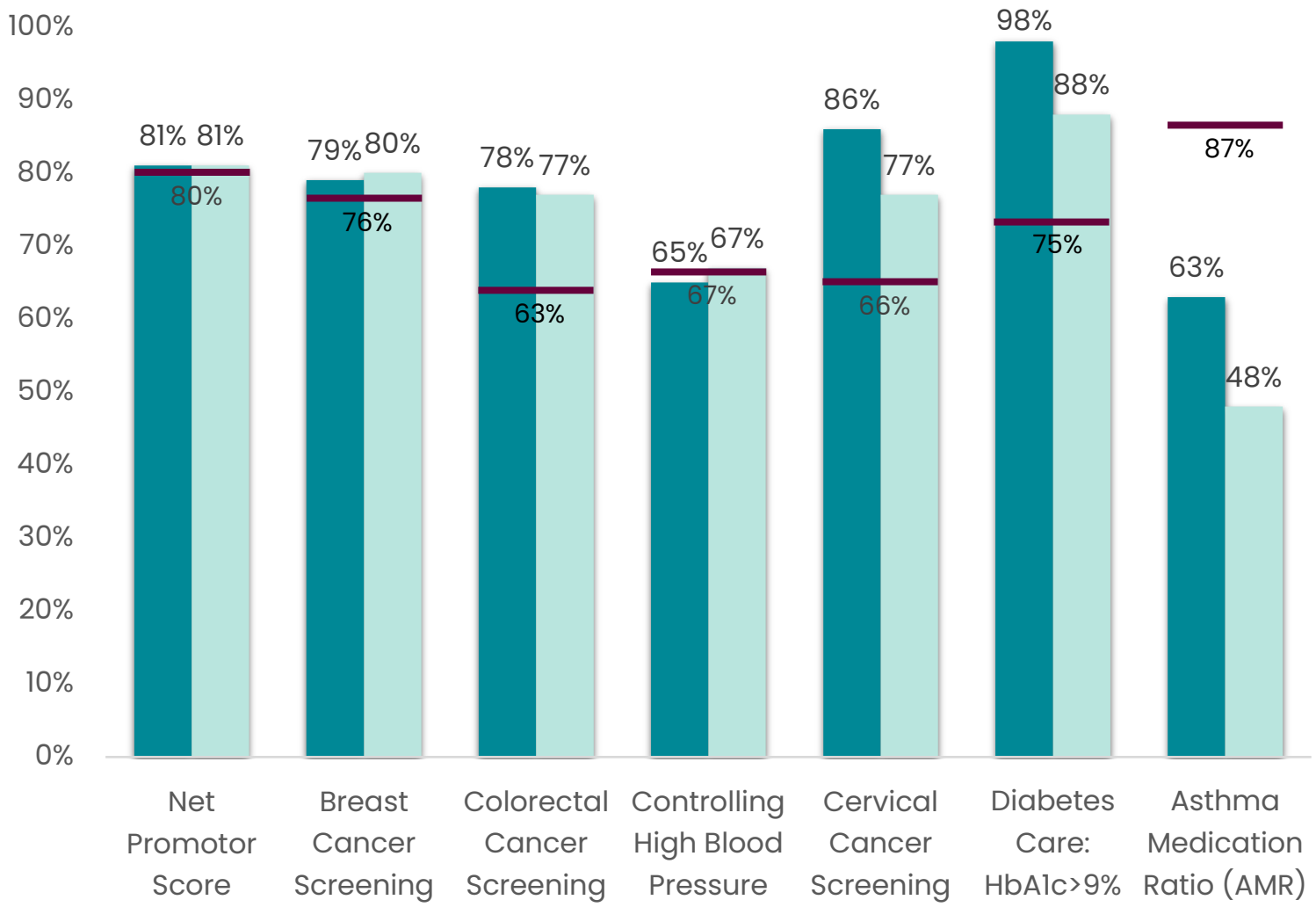
Patient Journey Supported by Comprehensive Care Team



Advanced Primary Care 2024 Implementation Timeline



Most Performance Measures for Advanced Primary Care Perform Above Target



- ✓ Target is 66th percentile of National Average Performance
- ✓ Reporting period 05-31-2023 to 06-01-2024
- ✓ Population: HMO, PPO and Fee For Service
- ✓ Net Promoter score is for all BTH patients

Increasing Access to Care and Ease of Communication

Goal

Provide patients with tools to access timely care increase the ease of patient and provider communications.

Accomplishments

- Expanded online scheduling, registration, and check in.
- Enhanced patient and provider messaging
- Increased MyChart enrollment and sent 8500 patient communications.
- Launched Care Champion Concierge Line.

Key Results

- 3rd next available appointment is 3 days.
- 79% of patients are enrolled in MyChart messaging.

Engaging Patients and Providers in Quality Care

Goal

Ensure completion of referrals, labs and screenings while providing pro-active care to patients and transparency of patient needs to providers.

Accomplishments

- Launched Health Navigators to support patients before & after PCP visit to address quality care gaps and assist with follow up.
- Created provider dashboard with the ability to stratify quality measures by patient demographic to enable a focus on health equity.

Key Results

- 1042 Pre and post visit meetings have been completed with a Health Navigator.
- Over 4800 behavioral health screenings and 1163 Social Determinants of Health screenings have been performed with appropriate referrals to behavioral health and community health programs

Integrating Behavioral Health into Primary Care

Goal

Improve access to behavioral health treatment and support for our patients.

Accomplishments

- Launched a new integrated behavioral health program that focuses on treating patients in the primary care setting using a psychiatrist consultation.
- 487 Referrals to the program have been made since March 2024.

Key Results

- 93 Patients are active in the program
- 100 Patients declined participate and are monitored for changes to their condition
- 294 patients in ongoing outreach and monitoring
- Positive feedback from patients – *"I am so thankful that someone reached out to me!"*

Guided Referrals to High Quality Specialists

Goal

Support patients to navigate the referral process and ensure timely care to high quality specialists.

Accomplishments

- Analyzed quality data to form a high value specialist network.
- Implemented outreach to patients to assist them in scheduling specialist visits.
- Pilot of virtual specialty options, including virtual specialist visits, and PCP-to-specialist formalized “curbside” consults.

Key Results

- 73% of referrals are to a high value specialist.
- Successful pilot of patient cases through formalized curbside consults - 1 case resulted in avoidance of a 6 month wait for a specialist visit.

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Thank You