TOOLS & SUPPORT

Building Capacity in a Provider Network for Palliative Care: Blue Shield of California

In pursuit of opportunities to improve care for members across its entire population, the California Public Employees' Retirement System (CalPERS) approached its contracted health plan, Blue Shield of California (Blue Shield), to develop a creative approach to providing care for seriously ill members. This case study illustrates how a large purchaser's inquiry led the market to change.

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Case Study

Ensuring a network of providers can meet the need for palliative care

Introduction

Health care purchaser customers, particularly self-insured customers, often direct their contracted health insurance plans to design and implement specific strategies or programs to meet the needs of their populations. Such was the case when the California Public Employees' Retirement System (CalPERS) asked its contracted plan, Blue Shield of California (Blue Shield), to build a palliative care strategy for CalPERS members. This case study represents the power of a large purchaser to move the market to action, and the ingenuity on the part of a health plan partner to bring the purchaser's request to life.

Catalyst for Payment Reform interviewed representatives from Blue Shield to learn how it designed and implemented its program on behalf of CalPERS. Interviewees included Torrie Fields, MPH, Senior Manager, Advanced Illness & Palliative Care and Annette Graham, Senior Director of Utilization Management and Case Review from Blue Shield.

The Problem & Background

A unique opportunity

Only a few years ago, the greater medical community and insurance industry in California began looking to palliative care as a new frontier for improving the quality of health care and containing health care costs. In the midst of this trend, in 2014 CalPERS also began seeing palliative care as potentially adding significant value and decided to pursue opportunities to improve care for members living with cancer and other serious illnesses. CalPERS approached Blue Shield to come up with a creative solution, asking about opportunities in "palliative care" across the CalPERS population, without specifying how it wished Blue Shield to structure the program. The health plan was unsure of how to proceed, but it welcomed the opportunity to lead the design and implementation of a unique program that met the purchaser's needs.

The Design of the Program

Looking to the future and building a statewide network

Once CalPERS made its request to create a palliative care solution, Blue Shield of California realized it needed to build a statewide solution, as CalPERS has members across the entire state. It would also need to assess what providers it currently had in its network that could meet the need for palliative care and what services they provide.

> The provider network is the foundation of effective case management
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> For case managers to be effective, the providers to whom they refer patients must be equipped to handle patient needs and deliver specialty palliative care services.

The program designed by Blue Shield began with an isolated, home-based palliative care pilot in the San Francisco area to meet the needs of CalPERS' members living with serious illness in that community. As Blue Shield started thinking about how to scale the effort statewide, the California Health Care Foundation (CHCF) was working on a database of palliative care programs and mapping them to community palliative care providers in all counties across the state.[1] Using CHCF's database, Blue Shield was able to see what community-based programs existed, where the providers were, and what services they offered. Blue Shield then ran its current provider contracts against the CHCF data to construct a strategy for its provider network to build out its community-based palliative care service program. Specifically, the health plan looked at its accountable care organizations (ACOs) where there were network contracting relationships already in place to serve the CalPERS population.

Ensuring provider capabilities

While case management is an essential component of the program, Blue Shield felt that to scale the program, it needed first to prepare its network providers to deliver palliative care. Thus, Blue Shield started by helping its contracted ACOs build out their capabilities and began including palliative care and quality of care components in its agreements with ACOs. Once Blue Shield laid this groundwork with providers, its case managers could begin directing patients to these provider systems. This helped to ensure that assessments and referrals made by case managers lined up with the services patients could actually receive.

Implementation

Phase 1: pre-pilot efforts

[1] https://www.chcf.org/wp-content/uploads/2018/05/NarrowingGap.pdf

Prior to implementing the pilot in the San Francisco area, Blue Shield of California realized it needed to develop criteria and tools to enable case managers to identify those members who could benefit from palliative care. This included a data analytics tool that looked at the CalPERS population specifically and identified potential needs based on claims. All previous claims (inpatient, outpatient, and facility) within the last 12 months that a patient incurred, diagnosis, past utilization, and authorization records for inpatient stays, pharmacy, and durable medical equipment are considered when identifying patients. Case managers then conducted outreach calls to talk with potential patients and assess whether they had needs for palliative care. To determine if palliative care will help, case managers assess patients based on their need to control pain and the severity of their symptoms.

Blue Shield also found that a successful approach to case management helps case managers distinguish between palliative care, which can help patients with serious illness at any stage of life, and hospice, which is limited to end-of-life care. Through in-person trainings and email communications, the health plan worked to break down myths and emphasize to case managers that palliative care could be the first step in treating a member with a serious illness instead of waiting to change how they are cared for until they are eligible for hospice. Once case managers determined that a patient could benefit from palliative care, the Blue Shield case manager would develop a care plan and have advance care planning conversations with that patient. The Blue Shield case manager would ensure the patient's goals for their medical care were met and their treatment preferences were documented.

Case manager training and effective patient identification is an ongoing process

Since the program's initial implementation, Blue Shield of California has strengthened the training it provides for case managers to help them better identify patients in need of palliative care. Blue Shield found the initial identification of patients to be adequate, but not good enough to meet members' needs fully – they need to reach people regardless of the stage of their condition to reduce delays to care as well as unnecessary treatments and admissions. Blue Shield has also taken steps to educate health systems about the availability of the program, so providers can refer patients to it as well.

Phase 2: the pilot goes live

By the end of 2015, Blue Shield began looking at what other services were needed by members with serious illness, beyond or in addition to the telephonic support provided by case managers. As a result, Blue Shield started a payer-provider initiative with support from the California Health Care Foundation for the planning and pilot implementation of home-based palliative care and with a provider partner. Blue Shield selected the University of California, San Francisco (UCSF) as the provider partner, along with Hospice by the Bay, forming a joint partnership to support specialty-level palliative care in the home. At the same time, Hill Physicians Medical Group, including the physicians providing care at UCSF, requested funding from the Blue Shield ACO team to support the development of training for primary care providers in advance care planning and related communication skills as well as funding to build a case management team for its HMO population, which includes some of the CalPERS population. With UCSF and Hill Physicians Medical Group on board, the pilot went live in 2016, creating a home-based palliative care program.

The pilot presented learning opportunities for Blue Shield. The health plan engaged external palliative care specialists, including Sharp Healthcare in San Diego, to review the patient identification criteria Blue Shield developed in Phase 1. These criteria followed evidence-based guidelines developed to identify palliative care patients for Sharp Healthcare's electronic medical record and then adapted to identify patients through administrative claims data. Simultaneously, Blue Shield began the process of identifying palliative care programs, mapping them to community palliative care providers in all counties across the state, and constructing a strategy to develop its provider network.

Building the strongest care team possible

During the launch of the pilot, Blue Shield worked with UCSF to identify the services that a home-based palliative care team should provide, and which professionals should comprise the interdisciplinary team. Blue Shield and UCSF conducted a literature review as well as informational interviews with other health plans and programs. As a result of their research, Blue Shield and UCSF decided to model the pilot after Kaiser Permanente's in-home palliative care program, which brings together a physician, nurse, social worker, home health aide, and a chaplain[2] on an interdisciplinary team. Members of the interdisciplinary team are available to patients 24 hours a day, seven days a week. In addition, a nurse case manager is also part of each team who is available to providers and patients, and who can coordinate additional care that the patient needs. All palliative care team members must obtain credentialing through the Joint Commission or the American College of Health Care and receive a designation in community-based palliative care. By January 1, 2020, all team members must receive this certification. Until then, the Blue Shield team assesses team members prior to issuing a contract and reassesses the teams and individuals annually. In addition to the services a home-based palliative care team provides, Blue Shield also changed their internal authorization processes to expedite access to services that patients with serious illness need, including things like access to prescriptions and durable medical equipment.

In scaling the program, Blue Shield had to build some flexibility into its requirements for palliative care teams. It noticed that some care teams had trouble directly integrating certain members of the team, such as a home health aide or a chaplain, due to the lack of availability or scarcity of those professionals in some regions. Thus, Blue Shield has allowed some flexibility in what type of clinician provides which services or how that care is delivered, but will not waver on its clinical criteria or on who counts as a contracted palliative care provider – what is important is the ability of providers to build teams and help scale the program, while maintaining clinical integrity. For instance, some teams have community health workers instead of home health aides, and some make use of telemedicine.

Payment to providers

Blue Shield of California consulted with researchers and program managers who developed Kaiser Permanente's program to gain a better understanding of the average duration of patient visits by provider

[2] In this case, "chaplains" are board certified to talk with patients about existential pain or suffering, do not subscribe to any particular religion or belief, and can coordinate with community spiritual leaders if needed.

type to know what to expect for its own contracted providers. Blue Shield's actuarial team used this information to develop a per enrolled member per month (PMPM) case rate that reflects payments for all providers on the team and used averages for the patient population. The payment model is essentially a capitated rate based on the services the health plan expects the team to provide. Purchasers, including CalPERS, would pay for this as a professional service, rather than as a facility service. In creating this payment model, the health plan ensured it could layer it into an ACO arrangement where it could help reduce the total cost of care.

In presenting this payment model to its ACO providers, Blue Shield needed to cross-walk ACO agreements with the PMPM amount and convince the ACOs that this palliative care program was a worthy quality improvement initiative that supported the triple aim–to improve quality, enhance patient satisfaction and reduce costs–and would produce strong outcomes for both the ACOs and purchasers.

Blue Shield found that a provider's familiarity with palliative care greatly affected the contracting conversation. If the provider was well informed about the evidence base for palliative care, they typically understood the benefit right away and wanted to work with the health plan to roll out the program. Conversely, if the provider was unfamiliar with the evidence, the program often sounded too good to be true. In these cases, the health plan needed to identify the right provider champions who could help build support for the business case internally.

Results

Blue Shield of California has served 1,600 patients across all lines of business with its palliative care program in the last year. The program began with a small number of patients so reaching a greater number is a key performance indicator for the health plan. The palliative care program continued to expand from one program in San Francisco in March 2016 to a total of 27 home-based palliative care providers and growing. Other metrics by which the health plan measures success include whether the number of patients who have gotten an assessment or enrolled in the program increases utilization of hospice and/or length of stay in hospice. To date, there has been a 50% increase in hospice utilization, and a 55% increase in average length of stay on hospice. Additionally, 90% of Blue Shield of California members enrolled in palliative care who have passed away did so at home, according to their wishes. Blue Shield of California's palliative care program has a 96% patient satisfaction rate, a 4- or 5-star patient satisfaction rating, has demonstrated improved quality of life, and reduced the use of unnecessary health care services.

Key Insights

Blue Shield of California saw CalPERS' request as an opportunity to design and implement a unique solution that met the purchaser's needs. But it also recognizes that a partnership between the purchaser and plan on any initiative helps both parties define and achieve the end goal sooner. It's helpful for the health plan to understand the purchaser's expectations at the outset, including the outcomes the purchaser hopes to achieve and the measures by which it will evaluate the program and the plan.

Blue Shield also emphasizes the importance of palliative care and its potential to deliver value to purchasers. Employers and other health care purchasers looking to implement a palliative care program who are unsure where to start can always begin by asking their health plan for help, as CalPERS did. CalPERS now has a statewide home-based palliative care program that provides value to its covered population. Any large purchaser has the power to move the market to action and can sometimes rely on the ingenuity of a health plan partner to bring a request to life.