
blue of california

Blue Shield of California
An independent member of the Blue Shield Association

# Care Management Case Study

# Blue Shield of California's Innovative Care Model

*Blue Shield of California is a not-for-profit health insurance plan dedicated to providing Californians with access to high quality care at an affordable price.*

## Background

As an insurer, Blue Shield (BSCA) of California sees value in deepening provider partnerships. The biggest opportunity to impact quality, member experience, and affordability of care is through the "Integrated Care Model": "Extensivists" focusing on (1) advanced facility care, (2) home care, (3) high-risk clinics, and (4) care management and coordination across all settings. Top performing provider delivery systems have six essential elements of care—the Extensivists plus optimized primary and collaborative specialty care. BSCA seeks to consistently implement these components through its ACO partners across all lines of business.

## Program Description

When a patient requires medical care either at a hospital, a Skilled Nursing Facility (SNF), rehabilitation center, or the Emergency Department (ED), advanced facility care initiatives can help to decrease the length of time a patient spends in one of these facilities, make certain they receive optimal care delivery, coordinate their care, and further ensure they do not return to the inpatient setting again.

## Care Management Strategies

The following are the four key components of BCBA's innovative integrated care model.

***Advanced Facility Care***

Successful advanced facility care includes the following components:

- *Robust Hospitalist Program*: A physician dedicated to delivering comprehensive medical care exclusively in a hospital setting sees patients in the emergency room prior to their admission in order to assess if the admission is appropriate or can be handled at a lower level of care. In addition, hospitalists round daily with both an inpatient care manager specializing in care transition and intimate coordination with an outpatient care management team to coordinate the patients care while they remain in the hospital and to prepare for their discharge.
- *Readmission Prevention Program:* Evidence-based programs and daily review of readmissions are used to identify members who may be at a high risk for readmission and to determine cause and mitigate future risk of reoccurrence. These programs include comprehensive discharge planning and care transitions.
- *Inpatient Care Management Program:* Case managers, located in the hospital, are dedicated to managing a patient from pre-admission to discharge.
- *Skilled Nursing Facility (SNF) Program:* The SNF has full staffing and admits patients 24 hours per day and seven days per week. Together, a care manager and a SNF professional have significant family meetings and provide care coordination and palliative care as appropriate.

***Home Care***

Home care programs focus on patients who otherwise come to their usual place of care. Patient populations include the palliative care patient, home bound patients, patients in long term care, patients who require chronic dialysis, care transitions, chronically and persistently mentally ill, and short term acute stabilization. This patient population often includes socioeconomically disadvantaged, the elderly, frail, or those who are too sick to regularly tolerate travel to a physician's office or even a high risk clinic for services/care. These programs are most often led by a physician with the majority of care delivered by teams of nurse practitioners and social workers.

***High-Risk Clinics***

A health care delivery system designed to provide care to patients with comprehensive and complex needs. Components of successful high-risk clinics are:

- *High-risk discharge follow-up visits:* Appointments available and scheduled within 24 hours of discharge. When appropriate, a patient can be seen for multiple visits.
- *Care of complex patients:* Specialized team of physicians, nurses, pharmacists, and social workers dedicated to providing care to medically complex patients with chronic conditions or long term needs. This includes group visits (diabetes, COPD, CHF), oncology program, and pain management for seniors and commercial patients, though the clinical teams are different for both.
- *Services requiring medical oversight:* These include wound care and IV infusion therapy.
- *Coumadin and other medication management clinic:* Coumadin is a medication that requires very close monitoring to ensure the levels in the blood remain in a therapeutic window. A Coumadin clinic can prevent hospitalizations and ensure patients have a place to go for close monitoring.
- *Annual wellness exams:* Yearly exams for seniors ensure proactive identification of conditions and gaps in care.
- *Care for the chronically and persistently mentally ill*
- *Cardiovascular and other disease management coordinated care clinics*

***Care Management/Coordination***

Care management provides care to members while inpatient, outpatient, and as they transition in-between. Care management can be short term or longer term. The longer term often transitions into a high risk clinic or a home care program. Care management under the integrated care model includes:

- *Disease Management:* Patients are generally in a disease management program for 3-12 months with the goal of stabilizing/improving the patient's condition and teaching them to self-manage.
- *Complex Case Management:* A patient is typically considered complex when they have multiple conditions, are on medications that require close monitoring or they have a condition that needs to be tightly monitored or may cause a significant adjustment to their daily living.
- *Transitions of Care:* As members move throughout the care delivery system and transition from one level of care to another (hospital to home, hospital to long-term care, etc.), care management can help coordinate the care and facilitate smooth transitions. This includes screenings and preparations for patients who will be undergoing procedures or surgeries.

## Findings

BSCA's ACO partner organizations have achieved a $325 million cost savings over the initial five years of the program. This collaboration has also demonstrated a 13% reduction in admissions and 27% reduction in total hospital days during the same period. The patient population served by this program is about 325,000 people among approximately 20 ACO partner medical groups and IPA delivery systems.

Over the past year and over the next two years, BSCA is scaling this program to cover over 500,000 patients among 40 ACO medical groups and IPA's. BSCA anticipates that the new clinical design described will achieve an additional 25% reduction in hospital admissions and even great reduction in total hospital days. This will also result in even a larger proportion of total cost of care savings throughout the multiple geographies served by the ACO medical group/ IPA collaboration.