California Health Care Foundation

23 Factors That Impact the Cost of Delivering Palliative Care

The cost of delivering palliative care (PC) is determined by many factors. Some of them, such as characteristics of the patient population or region, cannot be modified – you just need to account for these when designing the PC service and estimating costs. Other factors are modifiable and reflect policies, preferences, or practices of the payer and/or provider.

For example, neither the payer nor the provider can alter the fact that care is being delivered in a rural area; there is no way to shorten the physical distance, which could result in significant costs related to travel time for a home-based PC service, between patients' homes. To modify the cost in this example, the provider may propose a service delivery model that features video visits, which reduce travel time and lower the cost of care delivery in a rural area. The rurality of the region is a fixed factor, but choices about which types of contacts are allowable in the contract are modifiable.

Together, payers and providers can consider the extent to which their policies, preferences, and practices could be modified to bridge any gaps between the estimated cost of providing care and the amount of payment being offered for it. The table below details some factors that could be considered, and their implications for service delivery costs.

Factor		Possible implications for service delivery costs
Environment / region		
1	Rural area	Extensive travel time and costs for home-based services; may be very difficult for patients to use clinic or office-based services (which are less costly to offer); some rural regions have limited broadband or Wi-Fi capacity, which may limit feasibility of offering video visits.
2	Many households not within 50 miles of a hospice	Fewer hospice referrals; may result in longer enrollment in PC; in some cases, may need to offer more intensive PC support to meet patient needs in absence of hospice care.
3	Availability of health services generally	If area is underserved generally there may be fewer organizations to partner with to cover the full spectrum of patient needs; PC service may need to take on a larger role than would be the case in areas with more robust infrastructure.
Population characteristics / eligibility criteria		
4	Complex population with high prevalence of mental health issues, poverty, substance abuse	Social and practical needs will complicate delivery of core PC support; housing and food insecurity, safety, and other social needs may take priority; need for intensive case management; higher probability of no-shows/patients intermittently lost to follow-up; need to train staff in behavioral health and substance abuse care, or hire staff with existing expertise; enhanced need to coordinate with behavioral health providers and social service organizations; absence of transportation options and funds may prevent use of clinic-based services; poverty may make it difficult for some patients to agree to phone contacts (if they are rationing limited cell minutes) or video visits (may not have a smartphone or computer); lack of safe home environment or caregiver may prevent use of home hospice.

Factor		Possible implications for service delivery costs
5	Language diversity	Need to purchase interpreter services; extended time required to conduct Goals of Care conversations, family meetings, and to complete Advance Care Planning (ACP) documents if done with an interpreter.
6	Eligibility criteria limit services to individuals with very late stage illness	Patients may need very frequent visits if highly symptomatic; team may find that many referred patients do not meet criteria or that many are referred to hospice at the time of the initial assessment, creating a gap between number of patients assessed and number of enrolled (revenue-generating) patients; duration of enrollment may be very short, increasing effort related to screening, enrollment, and disenrollment.
7	Very specific and detailed eligibility criteria (e.g., ejection fraction <30%; MELD score >19; presence of specific comorbidities)	Team may find that many referred patients do not meet criteria, creating a gap between number of patients assessed and number of enrolled (revenue-generating) patients; difficulty of verifying eligibility may result in delay between referral and enrollment which may result in a lower proportion of referred patients who are ultimately enrolled; may discourage referrals, resulting in lower than expected volume.
8	Use of strict disenrollment criteria (e.g. as soon as patient stabilizes)	May result in significant effort to secure ongoing authorization for palliative care; reduces probability that some enrolled patients will experience periods of stability, meaning entire PC panel will be high-need patients; duration of enrollment may be very short, increasing effort related to screening, enrollment, and disenrollment.
Scope of service		
9	Which specific services the PC team is taking responsibility for providing	Disciplines needed on team and number and frequency of contacts needed to address specified scope areas.
10	Expected collaboration with other organizations	Could reduce effort investment for PC organization in some ways (if, for example, the payer partner provides case management services), but also introduces effort required to communicate and coordinate with external organization(s).
11	Strategy for ensuring 24/7 access, if this is part of the scope	Cost of engaging with an external organization to provide off-hour triage service, or cost of paying PC clinical team to share call duty, or cost of using existing internal triage service (for example, service already in place to triage calls from organization's hospice patients).

Care model		
12	Which disciplines are on the care team	Costs per patient will be higher if most or all services are covered by a physician or nurse practitioner; costs will be reduced and quality will be improved if services are provided by a team that includes multiple disciplines. It is often easier for organizations that have lots of PC business to realize the cost efficiencies created by using a robust interdisciplinary team (volume is needed to support the various FTE; 1 NP FTE could carry a panel of 30-40 patients, but 300 patients may be needed to support a team of 1 FTE physician, 1 FTE social worker, and 3 FTE RNs, for example).
13	Contractual mandates for minimum number of visits, by specific disciplines	May needlessly increase costs if some patients do not need services from a specific discipline at the designated frequency; may make it more difficult for the PC organization to increase visits to patients who are in crisis and need extra visits or support, without paying overtime or using per diem staff.
14	Allowable care settings and types of contacts	Costs could be reduced for some services and patients if phone and/or video visits are allowed.
Communication / coordination		
15	Frequency of Interdisciplinary Team (IDT) and other internal PC organization meetings	Cross-disciplinary communication is key to providing quality PC, promoting team unity, and preventing staff burnout, but may require significant time investments. Similarly, requiring field staff to participate in frequent organizational meetings can reduce time available for patient contacts, especially if providers are required to travel to a specific meeting site (vs. joining via phone or video).
16	Presence/frequency of meetings with external organizations (participate in clinic rounds, health plan case management meetings, etc.)	Cross-organizational communication is essential to promoting appropriate referrals and coordinating services, but may require considerable time investments. Requiring that field staff participate in many such meetings can reduce time available for patient contacts, especially if providers are required to travel to a specific meeting site (vs. joining via phone or video).
17	Processes for securing authorizations for DME, medication refills, etc.	PC teams can invest significant time in communicating with primary and specialty providers and payer representatives to secure authorizations for services, medications, and supplies, especially for patients who are pursuing disease-directed treatments. Such time investments can be excessive in the absence of processes that centralize knowledge and authority within payer organizations or referring medical groups (e.g. creating a single point of contact within a health plan for fielding requests from the PC organization).

Engaging patients / families and referring providers		
18	Strategies for promoting appropriate referrals	PC organizations may be required to invest considerable time in case-finding and promoting appropriate referrals if responsibility for this task is not shared by the payer partner or leadership of referring medical groups, clinics, or systems. This time investment by the PC organization may have lower than expected yield of referred patients if the PC organization is not affiliated with other providers and no effort is made to by the payer partner to create and nurture relationships between the PC organization and the organizations that are providing primary or disease-directed care.
19	Strategies used to orient/engage patients and families to the PC service	PC organizations may be required to invest significant time in orienting patients and families to the services a PC team can provide if responsibility for this task is not shared by the payer partner or leadership of referring medical groups, clinics, or health systems. This time investment by the PC organization may have lower than expected yield of patients accepting services if individuals who are already providing care or support (e.g., payer-employed nurse case managers, or primary and specialty providers) do not specifically endorse the referral and help educate patients and families about the kind of help a PC team can provide.
Operational effort		
20	Methods used to screen patients for eligibility	PC organizations may be required to invest significant time in gaining access to and reviewing medical records if responsibility for determining patient eligibility for PC services is not shared by the payer partner.
21	Processes mandated by payer related to case review/ongoing authorization for services/severity rating	Provider organization administrative and clinical staff may be required to invest significant time in gathering data and participating in reviews. Hours spent on the phone justifying service delivery or the appropriate rate of payment reduce the time clinical staff have for patient contacts. The burden of this work is tied to the amount and accessibility of required information (does the team have to collect additional data only for this purpose?) and the frequency of reviews (quarterly, or is rate paid for services assessed for every encounter with the PC team?).
22	Mechanisms used to bill for services	Some provider organizations may have to contract with a billing service to generate and process claims. Alternatively, maintaining manual records of service delivery (which are then submitted to the payer partner) can be labor intensive and error-prone.
23	Metrics required to report to payer and proportion that are not simple extractions from electronic health record (EHR)	PC organizations may be required to invest significant time in collecting and collating data required by a payer partner. Such investments can be especially burdensome if the required metrics cannot be generated with data that are already housed in an EHR.