

Service Design and Operational Issues

Specify services and processes, and expect to revisit. The clinical model and operational processes related to patient care impact care quality, patient and family satisfaction, and costs, so thoughtful attention to the details is essential. Even with careful planning, partners will need to solve problems and adjust along the way, so scheduled periods for reassessment and flexibility are key.

1 Align the clinical model with desired outcomes and patient needs.

- ▶ Payers and providers should clarify what outcomes they are looking for in writing, and should define the clinical services that are expected to produce those outcomes. Partners need to agree on the staffing model (who, what, where, how, how often) to appropriately consider costs and payment levels. Once a model is settled on, do a reality check — is it reasonable to expect that the specified interventions will lead to the desired outcomes?
- ▶ Services will vary based on the population and their unique needs (e.g., pediatric versus adult, rural versus urban, Medicaid versus commercial/Medicare, last year of life versus complex care). Partners should be realistic about how population characteristics impact potential outcomes; for example, length of service and use of health care services may

be higher for younger patients, patients with lower socioeconomic status, or those with behavioral health issues.

2 Clarify your expectations and your boundaries.

- ▶ Partners should be transparent about their expectations for clinical services to be delivered, and whether the contracted palliative care provider is equipped to deliver those services themselves or if other partners are needed. For example, clarify whether the palliative care team is expected to take over the care of the patient or only act as a consultant. Assess whether the provider has capacity for specific clinical interventions that patients may need (e.g., home-based IV infusion, physical therapy, occupational therapy) or if the payer can bring in other vendors to meet those needs.
- ▶ Providers should consider whether they are open to customizing their service model for different payers or whether they want to stick closely to a particular model. Customization may mean more potential payer contracts, but it is likely to be harder to sustain over time due to the need to assemble different provider teams and approaches for different payer sources.

3 Consider approaches that will increase efficiency.

- ▶ Investigate how telehealth and video visits could be used to improve efficiency and lower costs. This could include video visits with the physician to complement in-person visits from a nurse or social worker, or partnering with a local community health worker or health plan case manager who travels to the patient's home and facilitates the video connection to the palliative care team.
- ▶ Define opportunities for higher-intensity and lower-intensity service models for patients depending on their acuity and needs, with variation in which providers are involved, at what frequency, and in what settings.
- ▶ Primary care or specialty providers can be supported (and trained, as needed) to provide generalist palliative care (also called primary or frontline palliative care) to extend the capacity of the specialty palliative care team.

4 Identify pathways to prevent and resolve operational challenges.

- ▶ The payer and provider each have separate responsibilities in patient care, and coordinating these roles can be challenging. A common hurdle is securing health plan authorizations — for example, a palliative

care provider may identify a patient's need for in-home oxygen, wound care, or durable medical equipment but may have difficulties securing such services, as the palliative care provider is not the patient's primary provider or a health plan representative.

- ▶ With each new payer contract, payers and providers need to define administrative and operational processes and clarify roles for getting patients the services they need, when they need them. Processes to streamline or fast-track authorizations can reduce the burden on the palliative care team, which is at risk for spending a lot of time addressing these issues rather than providing their core services. Getting very clear on administrative processes and working to be as efficient as possible can go a long way toward assuring a positive payer-provider partnership and better outcomes. If a patient who needs a medication refill cannot get it, the odds of an emergency department visit go up, and patient satisfaction and quality of life go down.
- ▶ Some providers may want to take on the responsibility (and financial risk) for certain services — such as durable medical equipment, physical therapy, or home health — because they have well-established and highly functional relationships with vendors.

Key Questions for Service Design, by Desired Goal

Link services to needs and expectations	<ul style="list-style-type: none">▶ What support does the population need?▶ What problems are the partners looking to solve?▶ What are expectations for outcomes and impact?
Define roles and boundaries	<ul style="list-style-type: none">▶ What will the palliative care provider do?▶ What will the payer do?▶ What will other organizations do?
Revisit model and workflows regularly	<ul style="list-style-type: none">▶ Are there opportunities to increase efficiency?▶ Are any operational processes frustrating either party?▶ Are effort and outcomes satisfactory to both parties?

TOOLS AND RESOURCES

[23 Factors That Impact the Cost of Delivering Palliative Care](#), a resource published by the California Health Care Foundation, can help payers and providers appreciate the extent to which their policies, preferences, and practices impact the cost of delivering palliative care.

This paper is part of a series on payer-provider partnerships in palliative care. To read the rest of the lessons, visit www.chcf.org.