

## Initial Engagement

**Invest in the beginning.** Payers and providers that wish to partner to offer palliative care services should take the time to communicate openly and share information about organizational characteristics, goals, and priorities. This helps partners assess if their match will be successful and lays the groundwork for trusting relationships built on flexibility and collaboration.

### 1 Take the time to create a strong foundation.

- ▶ The planning period requires an investment of time — and is best accomplished with as much face-to-face interaction as possible to develop relationships and avoid misunderstandings. Phone meetings, especially when many individuals will be participating, may not be the ideal forum for voicing concerns; conversely, in-person design sessions allow participants to pick up on others' cues and to develop trust. However, phone meetings are often the most feasible, and frequent contact is better than infrequent contact.
- ▶ The initial planning process is typically overseen by a core group that has primary responsibility for exploring the potential partnership. This group then collaborates with colleagues from key operational units (e.g., contracting, finance, informatics, clinical, and operational stakeholders) who can anticipate

and address problems early on. Involving individuals from multiple areas of each organization also creates internal champions and experts — individuals who are familiar with the proposed palliative care service who can step in to address issues that arise after contracts are implemented.

### 2 Start at the beginning — ask questions and don't assume.

- ▶ Make sure there is a common understanding of what palliative care is, why each organization wants to pursue this type of partnership, what each partner wants to achieve, what success would look like, what outcomes the partners are looking for, and what priorities and pressures are guiding their choices.
- ▶ Explore the nature of the relationships that the health plan and the palliative care provider have with community physicians and other providers who will provide referrals to the program. Do trusting relationships already exist, or will education and relationship building need to be an early core focus? Have these groups collaborated successfully in the past on quality improvement efforts, or have past efforts created reluctance to engage? Suspicious or burned-out primary care or specialty providers could present a referral barrier that will have to be addressed as part of the partnership.

### 3 Be prepared to gather and share information to assess the viability and scope of a partnership.

- ▶ **Geographic service area.** Where will patients come from, and where is the provider willing to go to deliver home-based services? What are the characteristics of the environment (e.g., rural, urban, mixed) and how might that affect service provision (e.g., travel time, general availability of health care services, etc.)?
- ▶ **Targeted health plan product lines.** Which specific health plan product lines will be included in the agreement? Who holds financial risk for patients covered by these products?
- ▶ **Patient population profile and volume.** Given the targeted health plan products and likely referral sources, what are the expected population characteristics (e.g., average age, socioeconomic status, clinical complexity)? What are realistic estimates of volume? How many patients would qualify for services, how many will likely be referred, and how many would actually accept services? What are current costs and health care service use of these patients?
- ▶ **Palliative care experience and capacity.** What experience does the provider have delivering community-based palliative care (CBPC) services? What is its capacity to take on new patients? Would new staff be

needed? If so, what is the recruitment or training plan? Does the health plan have experience with specialty palliative care contracting?

- ▶ **Care model.** How is the provider’s program currently staffed, what is the care model, and what services are provided? Does the provider have existing relationships with referring providers? How will each partner work to maximize referrals and patient acceptance of referrals? What are the payer’s expectations regarding service levels (e.g., visit frequency by provider type) or modality (e.g., in person or televisit)?
- ▶ **Infrastructure and resources.** What resources can the health plan provide both behind the scenes (e.g., data mining to identify potential patients, expedited service authorizations, streamlined payment processing) and in direct patient care (e.g., case managers)? If the provider needs to increase staffing to accommodate expected volume, is the payer willing to offer start-up support to help cover losses in the period before referral volumes catch up to staffing costs? Are there existing programs within the health plan that will be improved, challenged, or duplicated by the proposed palliative care program? How will the services be billed for and paid for?

### Gathering and Sharing Information

#### Information that providers should collect from payer partners:

- ▶ Geographic catchment area
- ▶ Number and characteristics of target population
- ▶ Expected number of visits and types of services
- ▶ Administrative and care management resources available to support CBPC
- ▶ Who holds financial risk for target population
- ▶ Cost and health care service use patterns of eligible patients
- ▶ Experience contracting for CBPC

#### Information that payers should collect from provider partners:

- ▶ Geographic catchment area
- ▶ Status of relationships with current and potential referring providers
- ▶ Experience providing CBPC
- ▶ Current CBPC staffing and care model
- ▶ Information on program processes and outcomes
- ▶ Capacity to take on new patients

### TOOLS AND RESOURCES

*Improving Care for People with Serious Illness Through Innovative Payer-Provider Partnerships* is a free resource developed by the Center to Advance Palliative Care and the National Business Group on Health. The document includes a review of palliative care delivery models, essential features of successful palliative care programs, and a “Getting Started” checklist.

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/payer-provider-lessons](http://www.chcf.org/payer-provider-lessons).

## 4 Anticipate complexity and create capacity to modify agreements over time.

- ▶ The planning period needs to address clinical, financial, and operational issues, including defining workflows, billing and payment processes, and how problems will be addressed in real time. This complexity is amplified by the number of people at the payer and provider organizations that need to be involved — for example, to develop a contract that spans multiple health plan product lines. Clear communication is key. It will almost certainly take longer than expected to go from concept/intention to implemented contract.
- ▶ During the planning period, payers and providers should get specific about program parameters (e.g., eligible patient population) and workflow processes and operational issues (e.g., the exact steps for approving patient eligibility, the process for paying providers). Still, there’s no such thing as a perfect contract — changes will be needed, so flexibility to revise (or end) the contract needs to be built in up front. Rather than thinking of this as an occasional contract renegotiation, it may be more helpful to go into the agreement anticipating ongoing negotiation and adaptation.