Palliative Care Models

Clinic Based

Outpatient clinics operated under a hospital or health system structure generally fit into three broad types depending on who is organizing and paying for the clinical operations: #1 a stand-alone clinic; #2 a co-located clinic; and #3 an embedded clinic. There is considerable overlap between the co-located and embedded models in terms of clinic organization, payment and services.

Stand-Alone clinic

A palliative care “stand-alone” clinic may function like other specialty practices (e.g., cardiology or oncology clinics) with reserved office space and dedicated staff for palliative care services. These practices are administered separately from other outpatient practices; the palliative care program has oversight and responsibility for its own staffing, billing and scheduling.

Co-located clinic

These clinics operate using space and shared services from another clinic. They are often hosted by a high user of palliative care services, hence the clinic allows easy access to palliative care services by the referring clinicians. Examples include palliative care clinics co-located in an HIV/AIDS, oncology or CHF (congestive heart failure) clinic. Overhead and clinic operation staff (e.g., scheduling, medical assistant) may be provided entirely by the hosting clinic, or shared with the palliative care program. The patients seen in this palliative care practice may or may not share the diagnosis focus of the host clinic.

Embedded clinic

An embedded palliative care clinic is one in which there is a defined collaborative relationship between a host clinic (e.g., oncology) and the palliative care staff. Typically, all costs related to the clinic operations (e.g., scheduling, medical assistant, etc.) are borne by the host clinic. The palliative care team costs may or may not be borne by the host clinic, and billing oversight and revenue flow also may
vary. Patients will be predominantly, although not necessarily exclusively, referred from the host clinic staff. Clinical pathways or protocols may exist defining the relationships of patient flow between the host and palliative care staff. A fully embedded palliative care clinic may be marketed as one of the clinical services offered by the host clinic.

To improve care in the community, enhance patient/family satisfaction and reduce cost through reducing unnecessary acute-care hospital (re)admissions, hospitals and health systems are experimenting with new models of care whereby palliative care clinicians make visits to patients in their homes and/or their residence in health care facilities (e.g., long-term care, assisted living). Many large systems combine services to home and facilities into an integrated program to create operational efficiencies that also can be replicated in other markets.

**Community Based**

*Home visits*

A palliative care practice based around home visits is an example of community-focused care for patients with advanced illness. By offering specialty consultation in the home setting, some of the complex, time-consuming care coordination can be provided where it is needed most. Home-based care is suited for a) patients for whom an office-based visit is a major hardship; b) complex patients who require longer, intensive or more frequent visits than are realistic in a office setting; c) patients in areas without an available office-based palliative care practice. Home-visit programs may be offered as part of a comprehensive hospital-based palliative care program, or via home care or hospice agencies. These programs are often most suitable for patients who are not eligible for or interested in hospice services. There is wide variation in how these programs are funded, staffed and tailored and in the scope of services they provide.

A key consideration in service design and staffing choice is the relative importance of being able to have the home visit substitute for some office-based provider visits, and the balance of medical management needs vs. care coordination and psychosocial support. There are effective models that utilize nurses and social workers, and others that use advanced practice nurses or physicians; the APN or MD
model is consistent with more medical management needs, in particular medication management and care coordination.

A special population in which home-based palliative care can provide an excellent opportunity to coordinate care is children with serious chronic illness(es) in need of chronic disease management, such as children at home on mechanical ventilators and those with frequent and often long hospital stays. A pediatric palliative care home-visit team may become primary care providers or may co-manage care with other providers; longer patient involvement than with adults is common in this population.

Facility visits

Palliative care services can be provided within long-term care and assisted-living facilities or long-term acute care hospitals, often through external consultants. These consultants will come to visit patients in their “home” environment and bill for consultation services while ongoing continuous care is provided by the facility providers. Note: a hospice providing nonhospice palliative care consultation services in nursing facilities represents a distinct program that is separate and apart from traditional hospice services provided to long-term care residents via the Medicare Hospice Benefit.

Independent Practice

Although uncommon, there are palliative care practitioners who have established independent office-based practices and/or practices geared around home or other facility visits, and/or hospital consulting activities. These practices operate under contractual arrangements with hospitals, hospices and long-term care and assisted-living facilities to provide services. Doing this successfully requires a business model that generates higher volumes of visits per day and/or a favorable reimbursement package with insurers or from health systems.