BACKGROUND

Mayo Clinic has developed tools and processes that embed basic palliative care principles into the day-to-day practice of primary care. The initiative is one of 10 programs identified by Mayo’s Office of Population Health Management as key components of the “Mayo Model of Community Care” (MMOCC). Launched in 2013, the MMOCC strategy was designed to prepare the health system to transition from fee-for-service to value-based payment. Today, Mayo participates in multiple value-based payment models accepting varying degrees of risk.

Palliative care meets the complex care needs of frail and seriously ill patients with proactive pain and symptom management and by aligning treatments with the patient’s goals of care, often helping patients to avoid unwanted ED visits and hospital stays. Mayo’s integration of palliative care principles into primary care workflows generates value by identifying patients with unmet palliative care needs and by meeting those needs more efficiently. The new tools and processes were designed by an enterprise-wide think tank dubbed “Co-PAL” (Community Palliative Care) that brought together primary and palliative care professionals from Mayo’s different regions. Launched in 2017, the initiative is being implemented in over 80 primary care practices in the Mayo network, with ongoing data monitoring for quality improvement.

APPROACH

Mayo’s community palliative care initiative is designed to support three key goals: 1) successfully identify patients with palliative care needs; 2) assess and manage both physical and non-physical symptoms for identified patients; and 3) document patients’ wishes for their future medical care.

Under this initiative, PCPs identify patients with palliative care needs by using the “surprise question,” which asks whether the clinician would be surprised if the patient died within the next 12 months. Although Co-PAL considered the option of using a data-driven algorithm to identify patients, PCPs preferred the surprise question approach because it was a better cultural and practical fit within existing workflows. Since the program’s inception in early 2017, primary care practices report using the surprise question to identify patients with palliative care needs within 60% of their team huddles (versus a target of 80%). Mayo recently asked PCPs to also consider other indicators of palliative care need as defined by the Center to Advance Palliative Care (CAPC): cognitive or functional limitation, symptom distress, caregiver exhaustion and/or residential placement.

Once patients are identified, PCPs schedule a longer visit during which they conduct an initial discussion about patients’ goals and wishes for future medical care. During a second visit, patients complete short assessments of physical and non-physical symptoms and conclude the advance care planning (ACP) conversation, which is documented in a special note in the medical record.

The short assessment tools were designed by Co-PAL. The physical assessment measures pain, fatigue, nausea, and shortness of breath, while the non-physical assessment measures quality of life and physical, emotional and spiritual well-being. Patients are also screened for depression with the widely-used PHQ-9 tool. The assessments align with the National Consensus Project for Quality Palliative Care as well as the measures recommended by the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association, released shortly after the Co-PAL tools were finalized.¹

PCPs are expected to manage their patients more proactively after the assessment. To this end, Mayo has developed and is testing an opioid prescribing tool which may be embedded in the EHR to provide PCPs with decision support when managing pain. If the primary care team cannot fully meet the care needs of the patient, PCPs are encouraged to refer to specialty palliative care, but there are no automatic alerts to prompt a referral.

Physicians use an ACP template embedded in the medical record to document the patient’s capacity to make decisions, wishes for future medical care, and health care proxy. This allows the PCP to bill under the Medicare advance care planning codes. To support this element of
the process, Mayo developed an e-learning module on advance care planning that guides physicians through the required components and how to bill for the planning process. PCPs also have access to a suite of online resources from CAPC, where they can take courses in needed conversation skills and pain and symptom management.

To help disseminate and promote the changes to primary care practices, Mayo uses data to provide feedback to regional Co-PAL leadership on a quarterly basis.

**RESULTS TO DATE**

Results from the Community Palliative Care initiative have been encouraging, showing that PCPs are successfully integrating the new palliative care principles into existing workflows. Since the new processes were rolled out in early 2017, the surprise question method has helped PCPs to identify target patients. For example, among patients identified in the Upper Mid-West region, Mayo found that 88% had at least one uncontrolled symptom, and more than 60% had depression.

The initiative has also driven a steady increase in the number of patients with an advance care plan noted in their medical record. In a study across the Mayo system, Mayo found a 99.1% concordance between care received and the wishes documented in the ACP note. For patients with an ACP note who died during the study period, Mayo found that ED use, hospital days, and hospital admissions were lower than rates suggested by the literature.

**TOOLS & VENDOR PARTNERS**

Mayo became a member of CAPC to provide its PCPs with access to online courses and expertise to support these clinicians in navigating conversation and in developing new pain and symptom management skills. Although Mayo holds a small-group conversation skills training program quarterly, CAPC’s resources are valuable because they can be used at scale and at any time.

**CHALLENGES WITH IMPLEMENTATION**

Mayo’s roll out of the Community Palliative Care initiative coincided with a system-wide transition to a new EHR platform, Epic. This meant that primary care practices were adapting to multiple new requirements and process improvements at the same time, and it also delayed measures for some elements of the initiative, such as the impact on billing for ACP conversations.

**KEY LEARNINGS**

- **Design processes that fit within existing workflows** – New requirements will face resistance if they disrupt existing workflows. Invite key stakeholders to act as design partners in the development of tools and metrics.
- **Look for financial incentives** – Mayo uses advance care planning codes to make its Co-PAL initiative generate revenue.
- **Measure everything** – A data-driven quality improvement framework is the key to understanding what to do more of and what to change.

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