How Might We Improve Quality and Patient Experience for Seriously Ill Patients Facing Surgery

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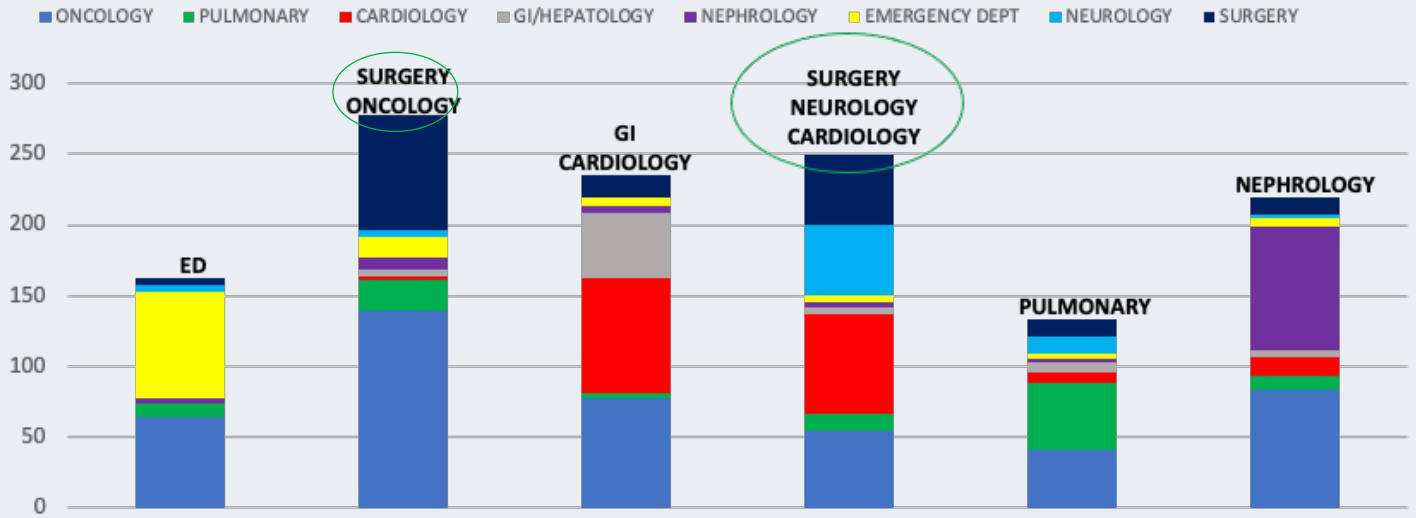
Driving Question:

How might we improve quality and patient experience for seriously ill patients facing surgery?

Image Generated by DALL-E-2, “Scared patient in operation theater vector illustration.”

Leaders in Outpatient Consults to VA Palliative Care



Problem

Palliative Care (PC) interventions for seriously ill surgical patients are associated with improved quality outcomes.

Palliative care consults from surgeons were occurring late among surgical patients, within days of the patient’s death.

Why?

Why Implementation Science?

Implementation science seeks to systematically close the gap between what we ***know*** and what we ***do?***

Objectives

1) To understand surgeon and palliative care perspectives on improving quality of care for seriously ill patients in the perioperative period

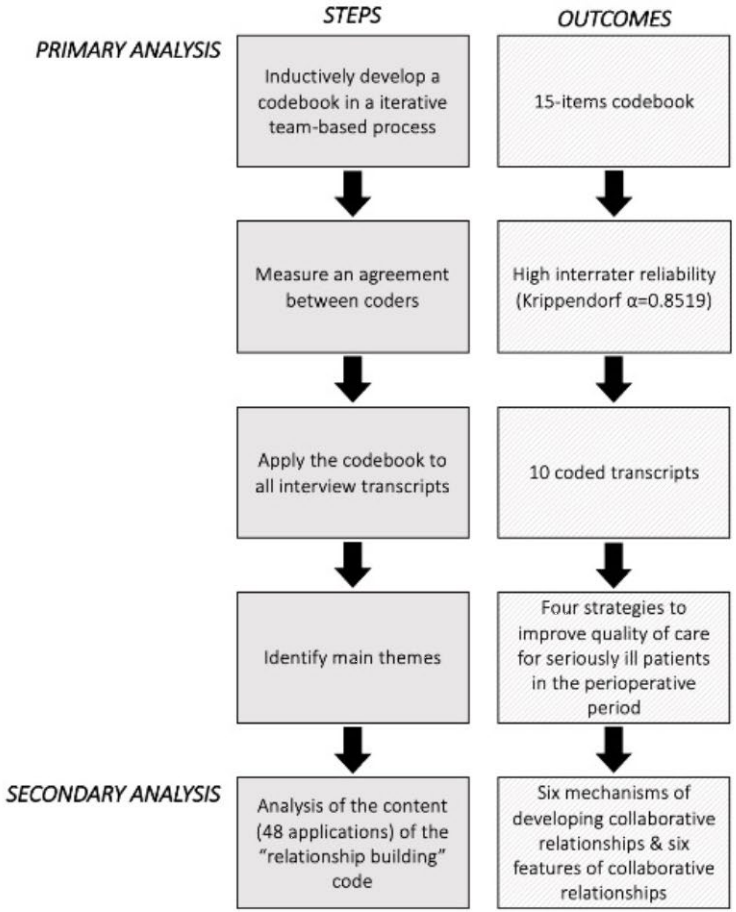
2) To identify factors that influence developing collaborative relationships between palliative care teams and surgeons/surgical teams

3) To develop and test interventions to improve quality through inclusion of palliative care approaches in the perioperative period

Respondents and Sites

	Sites (n=9)	Participants (n=35)				
		PC physicians (n=12)	nurse practitioners (n=4)	social workers (n=3)	psychologists (n=1)	surgeons (n=15)
High PC consult sites	5 (56%)	6 (30%)	0 (0%)	2 (10%)	1 (5%)	12 (100%)
Low PC consult sites	4 (44%)	6 (30%)	4 (20%)	1 (5%)	0 (0%)	3 (0%)

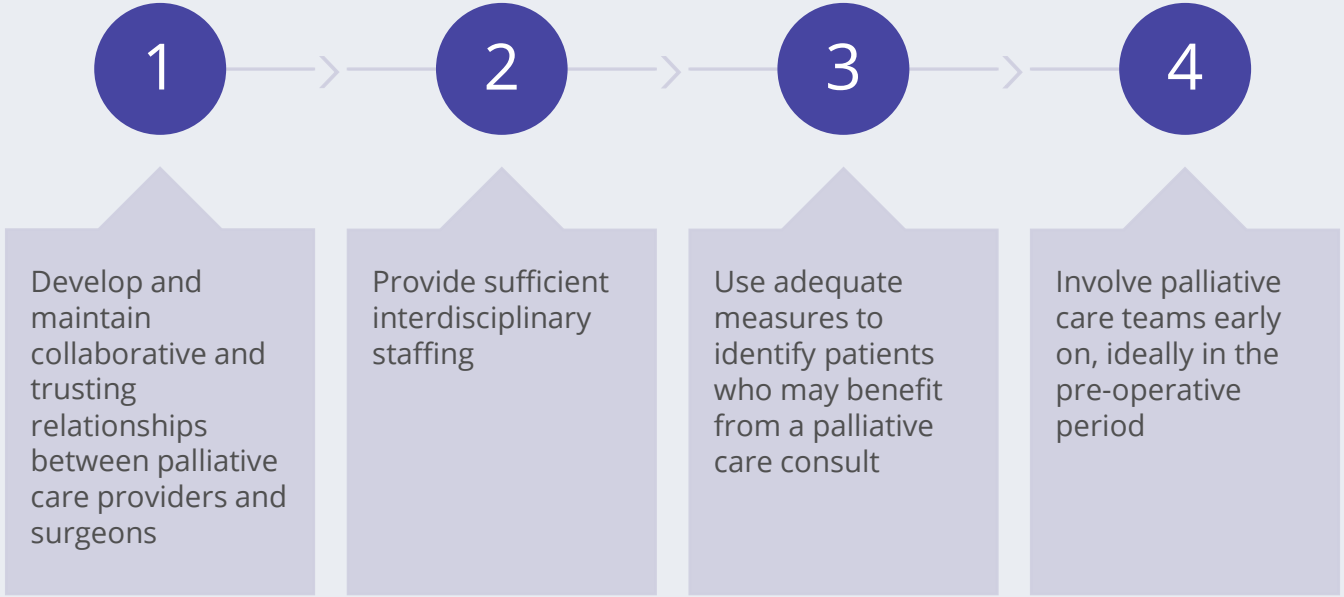
Analytic steps



Paper 1

Paper 2

Intervention Version #1

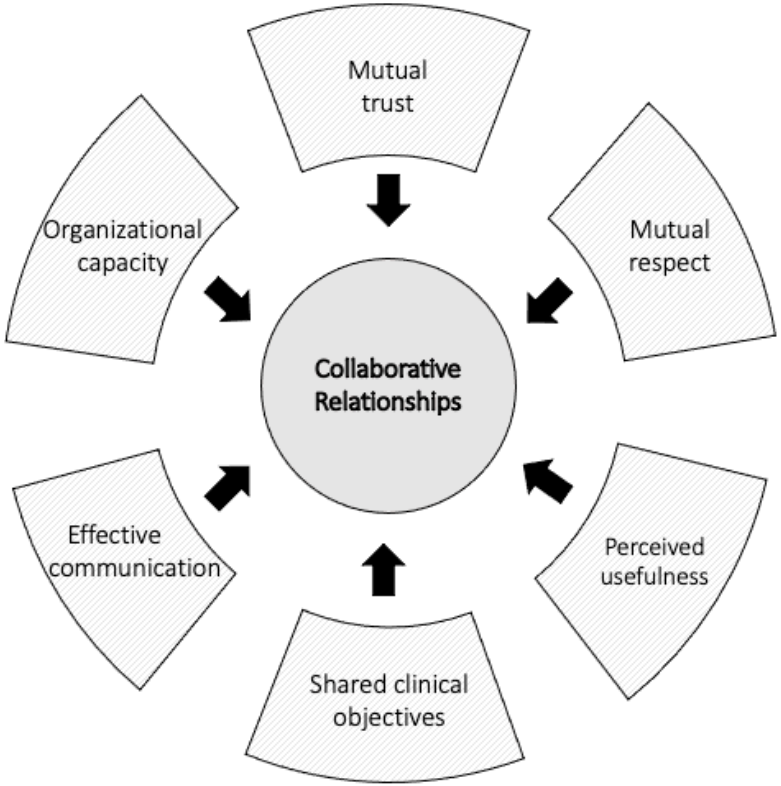


Strategy 1: Relationships

Develop and maintain collaborative and trusting relationships between PC providers and surgeons

Palliative Care Provider Quote	VA Surgeon Quote
*"I think that that **speaking directly to surgeons** was important by **showing that you actually have value** in their management that can be with symptom management, that can be with helping to determine the goals of care."*	*"Having that **trust that palliative care providers are not going to provide inaccurate information** to patients or lead them to make decisions that the surgeons might want to weigh-in more on or have further discussions."*

Features of successful collaborative relationships between palliative care and surgeons



Factors that influence developing collaborative relationships between palliative care teams and surgeons/surgical teams

Factor 1: Being present, available, and responsive

- *"When people are exposed to your presence, they remember to utilize your services…"*
- *"What helps is we're all on one campus at this VA; our nursing home, our outpatient clinics, and our hospital are all in one building… our team [is consistently present] at leadership meetings, on QI projects, on committees, and just…walking through the hallways, we're here… I think that goes far in building trust and collaborations."*

Factor 2: Understanding roles

- *"It's not just a relationship with the patient and the family, it's a relationship with these different providers… They don't have to love us or even like us, but they have to see that we will benefit the patient and the family dynamic… Part of it is getting the doctor's buy-in that we can be of assistance, of support, and that we're not going to overstep. Especially when it involves surgeons."*
- *"[Surgical residents]… conflate palliative care with hospice, with giving up, with throwing in the towel…"*

Factor 3: Establishing communication

- *"Surgery is one of the services that when I interface with, I have to remember that I need to talk to the upper-level people involved, so the chiefs and the attendings… I have found that if I don't reach out to the chief, then I'm not sure what they want, and that doesn't go well for a palliative care consultation."*

Factor 4: Recognizing a connecting role of supporting staff

- *"To me, that goes back to relationship building. If you can build relationships with your staff, be it nursing, PT… It's not just doctors. I think we get so focused on medical providers, but if a PT or speech therapist knows that you're helpful, they're going to stop you in the hallway and say—Hey, have you seen Mr. X in the ICU? And if we haven't, then maybe we're going to… look and see what's going on with Mr. X. To me, relationship building is just key."*

Factor 5: Working as a team

- *"…It's like—Oh, thank you for your input, and that's it. There's not this continued dialogue on a daily basis…They want limited discussion with us. This is not a like, let's all get together."*

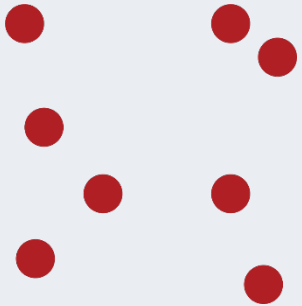
- *"…We nurses are in the frontlines so we depend on what is in the note because not very many physicians talk to us face to face or inform us of certain changes… That usually causes a lot of confusion. And sometimes they talk to the patients without talking to us… I wish that could be bridged. I wish there was a way of really communicating more closely with physicians or trusting the nurses with information that we really need to know to help the patient."*

Factor 6: Building on previous experiences

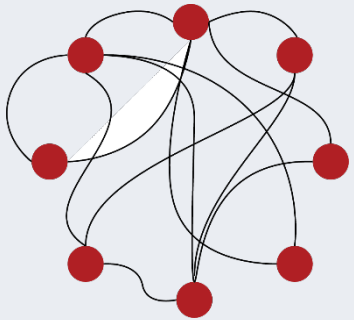
- *"Most of our physicians stay here, so they get to know us as a team… It's really about building consult to consult because if they realize that you can be of benefit and you are not going to get in their way or overstep…, it just builds trust and then… they're more likely to consult again… This has waxed and waned over the years."*
- *"I asked if I could see another patient, and they said… 'We're not referring to palliative care anymore, ever since Mr. So-And-So, because… the thought among us is that you guys kind of killed him'… We haven't had another consult from them and I think it could take years to come back."*

To Improve Quality – Build the Team

What is a team?

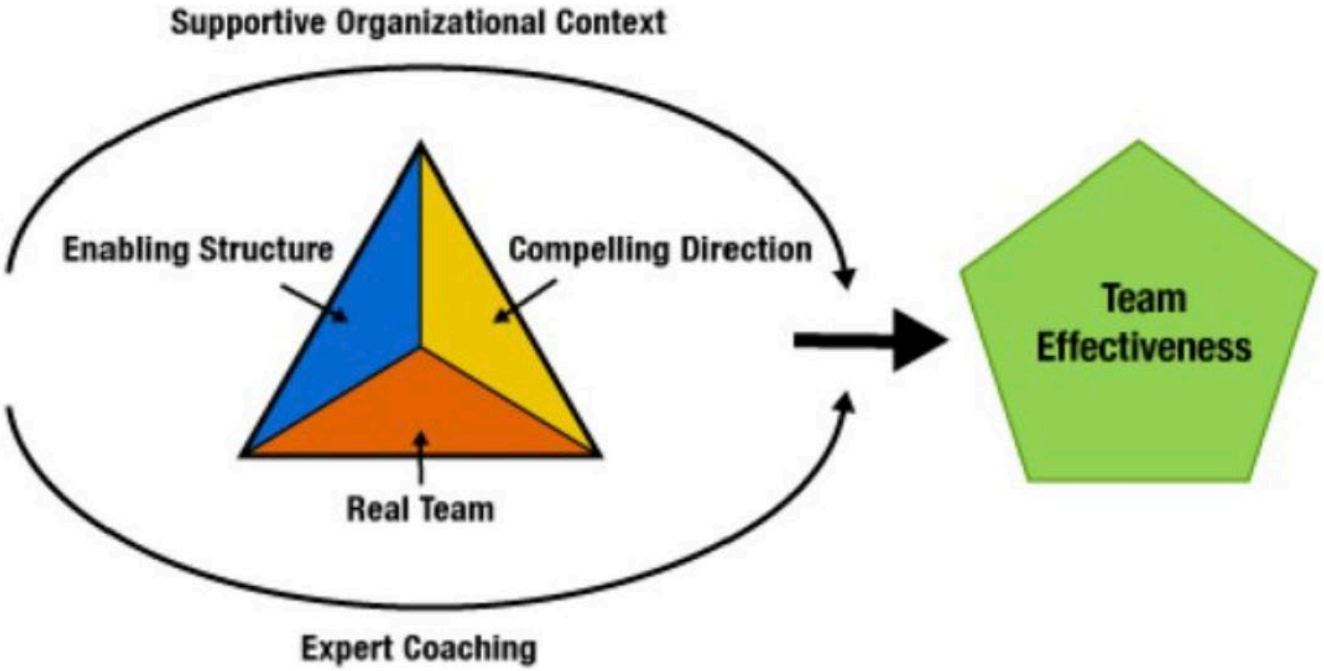


A group It can have individuals with varied interests, attitude as well as thought processes who are not necessarily coordinating towards a common objective.



A team is a group of individuals who work together for a common purpose who can coordinate their work amongst themselves**.**

Conditions of Team Effectiveness



Hackman, 2002

Strategy 2: Timing

Clarify the team process to occur in advance of the surgical procedure

Palliative Care Provider Quote

*"If something can be done **before an event**, in this case surgery, that is going to be much better. And by better I mean that they will be able to work through whatever their goals are in that particular instance."*

VA Surgeon Quote

*"…**when we do not get patients earlier,** and now in the disease course to have these discussions where they show up to this kind of more in an emergent surgical situation and do not have family support then **we cannot really clarify their goals of care** in a good way as far as where the structure breaks up."*

Strategy 3: FTE

Communicating about Goals takes dedicated provider time

Palliative Care Provider Quote

"You cannot do dedicated palliative care unless you have, I think at least one full time dedicated staff member, but even that, ***how can you sustain doing this work if you're the only one. I know this because I was the only one."***

VA Surgeon Quote

*"****Gap right off the bat is manpower****. I think that's an easy one. I think—I'll give an example that we run into here. We have—we for sure do not have enough manpower. And those that are here, they're—part of the individuals who are involved with this (GoCC) process do telework."*

Strategy 4: Risk Screening

Connect screening to a process that follows screening

Palliative Care Provider Quote

*"…**they are using one of the VA's surgical mortality scores. When this triggers it, that when** they'll start to get involved. **But that falls apart sometimes when they have a sick person,** but they're just looking at this is a very straightforward fracture that needs to be repaired… they don't necessarily recognize that they may need a more in-depth discussion."*

VA Surgeon Quote

*"… if the overall surgical risk reaches a threshold of, you know, 20% mortality, 5% mortality, whatever it is that that might possibly trigger something. But we already use those things quite a bit and **oftentimes those don't necessarily line up with completely all the different risk factors."***

Strategy 5: Empower Surgeons to communicate about goals

Facilitate surgical culture change towards willingness to have goals of care conversations

Palliative Care Provider Quote

*"…**do the surgeons need to be having some of these conversations, and I think that they really do**. I wish that there would be a way that I could get the surgeon's buy-in to say, if I'm personally worried that this surgery may not get what the patient wants done, I need to back off for a minute and see how this is going to play out."*

VA Surgeon Quote

*"**Every surgeon worth their salt should be able to have these discussions with their patients**. Palliative care (service) is not a crutch. They are a resource just like anyone else."*

Implications

- PC providers and surgeons at diverse sites identified strategies for improving palliative care use and goals of care conversations in the perioperative period.
- Several of the identified strategies are feasible to implement widely.

3 Site Pilot of Intervention Version #2

Pilot includes:

- Screening for surgical mortality pre-operatively (using RAI)
- Document Goal of Surgery
- Have and document pre-operative tailored goals of care conversation
- Employ Interdisciplinary provider training for combined PC and surgical teams
  - Workflow (with provider swim-lanes)
  - Timing of PC consult
  - Shared mechanism for accountability

New Barriers and Challenges Emerging

- Training barriers
- Interdisciplinary leadership support
- Agreement around what surgical risk screening tool to use
- Documentation burden
- The iterative nature of goals of care conversations
- Surgeon readiness to have these conversations
- Aligning conversations about goals of surgery with patient goals of care


Co-Design is iterative

Next round of questions

How does this need to be tailored or adapted for special populations?

Or how do workflows need to be optimized for specific surgical disciplines (e.g. urology)?

How do we build communication interventions to align goals of surgery with more global patient goals of care?

Thank you!

- Please reach out!
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