Palliative Care and the Perioperative Surgical Home

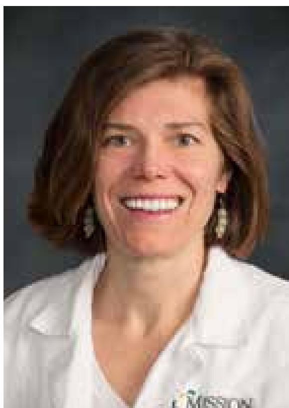
Kristin Forner, M.D.
ASA Subcommittee on Palliative Care
Perioperative Forum, American Academy of Hospice

The potential for creative cross-over, stimulating overlap of expertise, and ground-breaking collaboration between palliative care and anesthesiology within the Perioperative Surgical Home (PSH) environment is enormous.

Palliative care has been defined as patient- and family-centered care that attempts to optimize quality of life while minimizing the burden of disease. Palliative care is provided by a team of interdisciplinary specialists who address the physical, emotional, psychosocial and spiritual domains that make up a whole person. Unlike hospice care, palliative care is not constrained to an expected prognosis, so patients may receive palliative care at any stage in the course of their serious illness and they may receive curative treatment alongside palliative treatment. For patients with serious illness, palliative care provides better quality care at a lower cost.[1]

The PSH has been defined as "a patient-centered and physician-led multidisciplinary and team-based system of coordinated care that guides the patient through the entire surgical experience," from decision for the need for surgery until 30 days post-discharge from a medical facility. The goal is to create a better patient experience and make surgical care safer; thus, promoting a better medical outcome at a lower cost.[2]

Leaders of the PSH movement view it as "an innovative, patient-centered, surgical continuity of care model that fully incorporates shared decision-making."[3] Shared decision-making, in which the patient and provider make health care decisions together, is at the heart of patient-centered care. Patient-centered care improves clinical outcomes, quality of life and patient satisfaction, and is associated with a decrease in inappropriate health care utilization and expenditure.[4]



Kristin Forner, M.D., is Assistant Professor, University of North Carolina, Mission Palliative Care, Mission Hospital, Asheville, North Carolina.

From its inception, the field of palliative care has focused on the importance of patient-centered care and shared decision-making, and multiple studies have demonstrated that palliative care provides better quality care at lower cost.[5-8]

The focus preoperatively in the PSH is on determining if the surgery itself is medically appropriate and in line with the patients' goals of care as well as optimizing their preoperative symptom management and medication regimen. Intraoperatively, the goal becomes guiding the patient through the surgery as safely as possible. Postoperatively, then, the focus shifts to optimizing pain and symptom management, and getting the patients home as quickly and safely as possible, while minimizing readmission and complication rates. Palliative care practitioners are experts in symptom management and goals-of-care conversations and could be extraordinarily helpful in guiding the care of these patients.

The health care system in the U.S. is moving from a fee-for-service model ("pay for volume") to a bundled payment model ("pay for value"), incentivizing organizations to improve quality and service while lowering the costs. The Institute for Healthcare Improvement (IHI) came up with the "Triple Aim" as a framework of three interdependent goals to guide this necessary health care reform. The goals are 1) to improve the individual patient's experience of care (prioritizing shared decision-making and patient-centered care), 2) to improve the health of populations (educating and empowering patients to take a leadership role in their own as well as their family's and

	IHI	PSH	PC
Goal #1	Improve patient experience	Improve patient experience	Improve patient experience
Goal #2	Improve population health	Minimize surgical complications	Minimize burden of disease
Goal #3	Reduce per-capita cost	Reduce per-capita cost	Result is reduction in per-capita cost

IHI = Institute for Healthcare Improvement PSH = Perioperative Surgical Home PC = Palliative Care

their community's health) and 3) to decrease the per-capital costs of care. The Patient-Centered Medical Home (a primary care model) already exists, and recent data suggest it meets the triple aim. The PSH would be the surgical equivalent.[9] Palliative care's entire philosophy incorporates the goals of the triple aim.

There are 30 million major inpatient surgeries and 50 million ambulatory outpatient surgeries in this country every year. More than half of hospital admission expenses are related to surgical care, and almost a third of patients 65 years and older undergo surgery the year before they die. The number of surgical patients 65 years and older is expected to reach 55 million by 2020 and 72 million by 2030.[3,9]

"Who better to provide these patients expert palliative care than a palliative-trained anesthesiologist? One who understands both sides of the coin (the perioperative side and the specialized palliative care side) and can help patients and their families get where they want to be."

A study done at Brigham and Women's in 2012 showed that nearly 5 percent of preoperative outpatients died within one year of their procedure. Among all preoperative patients there, half of those expected to require a postoperative ICU admission did not know this risk, and many reported feeling conflicted about having surgery at all.[12]

How many of these surgeries are necessary? How many are happening simply because the train is moving forward and no one has thought to apply the brakes? We need more focused patient-centeredness, shared decision-making and preoperative goals-of-care conversations. We need more palliative care in the perioperative environment.

Patients with serious illness and poor prognoses often receive care that does not help them achieve their goals. Who are these patients most commonly, and where can palliative care involvement be most helpful? While not an exhaustive list, below are a few examples where palliative care would significantly improve standard perioperative care.

- The elderly – especially those with dementia – and their families could benefit from thorough preoperative goal-of-care conversations. These patients are also at highest risk for postoperative delirium. Are the procedures we providers recommend going to give these patients what they want and need?
- Patients with cancer who have chronic cancer-related pain, and who are on opiates preoperatively, may require a more complicated pain management regimen perioperatively. These patients may also benefit from goals-of-care conversations.
- End-stage heart failure patients who are being evaluated for mechanical assist devices need more thorough preparedness planning than a simple advance directive or living will provides. The Joint Commission now requires a palliative care provider to be a part of the core interdisciplinary ventricular assist device team for programs to receive advanced certification.
- Patients with multiple comorbidities are often symptomatic preoperatively and could use palliative care involvement to optimize their symptom management throughout the perioperative period.
- All patients receiving a tracheostomy and/or a feeding tube deserve a goals-of-care conversation to ensure these procedures are in line with patients' and family members' expectations.
- And patients, and families of patients, who have suffered neurologic or orthopedic trauma may need the kind of emotional support or goals-of-care guidance palliative care teams are trained to provide.

These patients and their families deserve better care than they are receiving in our current health care system. The PSH is one way of getting them that care. Physician anesthesiologists are skilled in providing much of this perioperative care. Even

Continued on page 30

Continued from page 29

though most anesthesiologists are not trained in palliative care, all are capable of providing primary palliative care. Primary palliative care is defined as the basic communication and management "skills and competencies required of all physicians and other healthcare professionals" who care for patients with serious illness.[13]

Specialty palliative care becomes appropriate when patients require more complicated symptom management or goals-of-care conversations. Anesthesiologists are not trained in how to conduct complicated goals-of-care conversations. Most are not

"The perioperative patient population is an untouched frontier for palliative care. As the PSH movement continues to gain momentum, the possibilities for collaboration between the fields of anesthesiology and palliative care are wide open. And the need and opportunities for palliative-trained anesthesiologists, especially, have never been higher. Now is the time to join forces and get involved."

experts in delirium management or "total pain" when patients' psychosocial suffering is causing them physical pain. These patients need and deserve expert palliative care.

Who better to provide these patients expert palliative care than a palliative-trained anesthesiologist? One who understands both sides of the coin (the perioperative side and the specialized palliative care side) and can help patients and their families get where they want to be.

In 2006, the American Board of Anesthesiology acknowledged certification in Hospice and Palliative Medicine, formally designating it a medical specialty open to anesthesiologists. As of 2014, there were 78 ACGME-accredited fellowships and 111 certified anesthesiologists. But the number of fellowship-trained and board-certified anesthesiologists practicing palliative care is a much smaller number, probably on the order of 20.[14]

The perioperative patient population is an untouched frontier for palliative care. As the PSH movement continues to gain momentum, the possibilities for collaboration between the fields of anesthesiology and palliative care are wide open. And the need and opportunities for palliative-trained anesthesiologists, especially, have never been higher. Now is the time to join forces and get involved.

References:

1. National Hospice and Palliative Care Organization website. http://www.nhpco.org/. Accessed August 17, 2015.
2. Garson L, Schwarzkopf R, Vakharia S, et al. Implementation of a total joint replacement-focused perioperative surgical home: a management case report. *Anesth Analg*. 2014;118(5):1081-1089.
3. Vetter TR, Ivankova NV, Goeddel LA, McGwin G, Pittet J; UAB Perioperative Surgical Home Group. An analysis of methodologies that can be used to validate if a perioperative surgical home improves patient-centeredness, evidence-based practice, quality, safety, and value of patient care. *Anesthesiology*. 2013;119(6): 1261-1274.
4. Vetter TR, Goeddel LA, Boudreaux AM, Hunt TR, Jones KA, Pittet JF. The perioperative surgical home: how can it make the case so everyone wins? *BMC Anesthesiol*. 2013;13:6. doi:10.1186/1471-2253-13-6.
5. Braiteh F, El Osta B, Palmer JL, Reddy SK, Bruera E. Characteristics, findings, and outcomes of palliative care consultations at a comprehensive cancer center. *J Palliat Med*. 2007;10(4):948-955.
6. Temel JS, Greer JA, Muzikansky M, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEMJ*. 2010;363(8):733-742.
7. Morrison RS, Penrod JD, Cassel JB, et al. Palliative Care Leadership Centers' Outcomes Group . Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168(16):1783-1790.
8. Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Aff (Millwood)*. 2011;30(3):454-462.
9. Vetter TR, Boudreaux AM, Jones KA, Hunter JM Jr, Pittet JF. The perioperative surgical home: how anesthesiology can collaboratively achieve and leverage the triple aim in healthcare. *Anesth Analg*. 2014;118(5):1131-1136.
10. Ankuda CK, Block SD, Cooper Z, et al. Measuring quality of decision-making for advance care planning and surgery. *J Surg Res*. 2012;172(2):189.
11. von Gunten CF. Secondary and tertiary palliative care in US hospitals. *JAMA*. 2002;287(7):875-881.
12. American Board of Anesthesiology website. www.theaba.org. Accessed August 27, 2015.