Thank you for joining us!

VCU Palliative Care ECHO will start shortly.

*ECHO: Extension of Community Healthcare Outcomes

VCU Palliative Care ECHO*

October 10, 2019

Outpatient Palliative Care

*ECHO: Extension of Community Healthcare Outcomes

Continuing Medical Education

October 10, 2019| 12:00 PM | teleECHO Conference

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Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continuing Nursing Education: 1.5 CE Contact Hours

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Disclosures

October 10, 2019| 12:00 PM | teleECHO Conference

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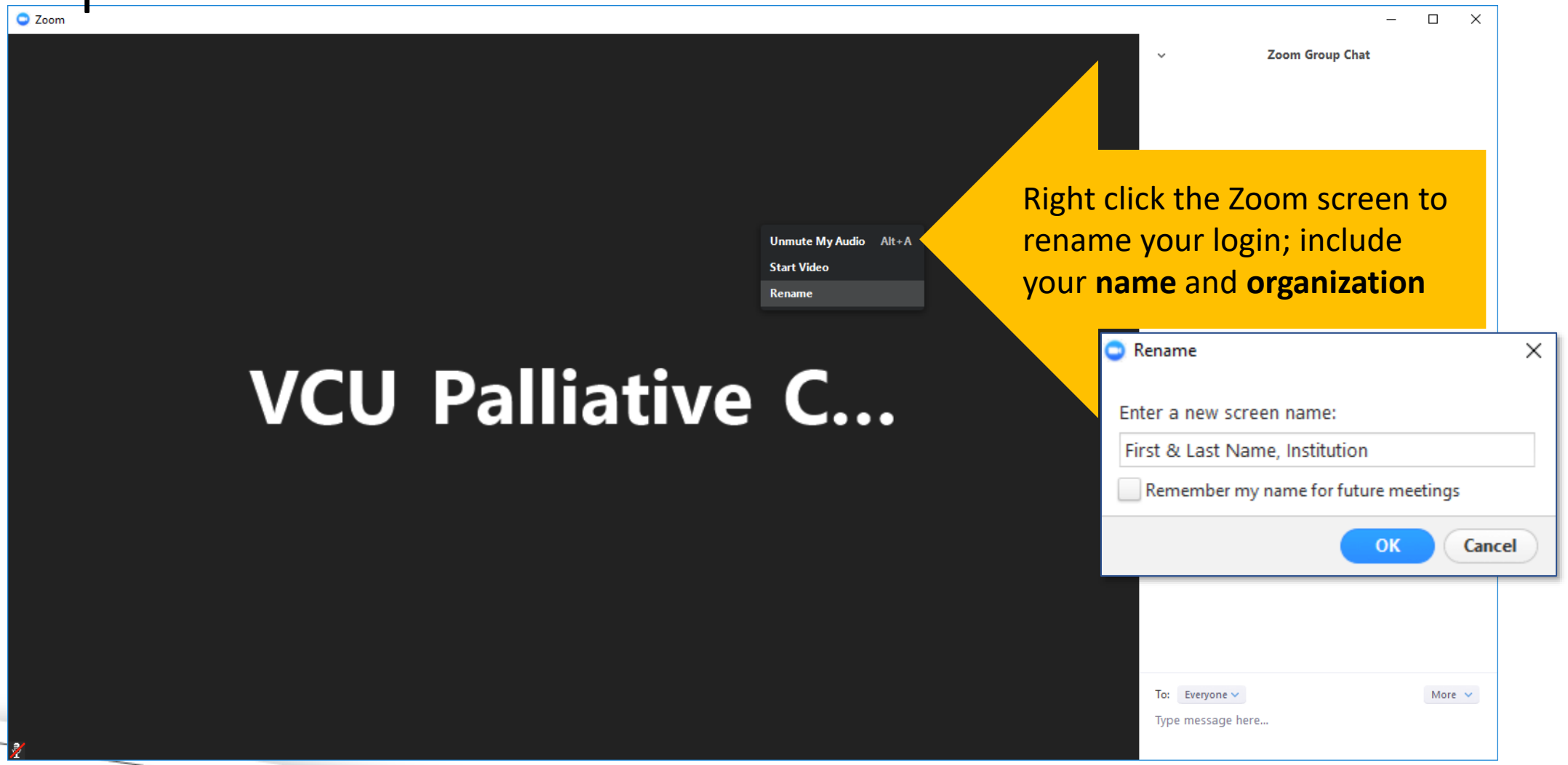
The following Planning Committee and Presenting Faculty Members report relevant financial relationships to disclose:

The following Planning Committee and Presenting Faculty Members report having no relevant financial relationships:

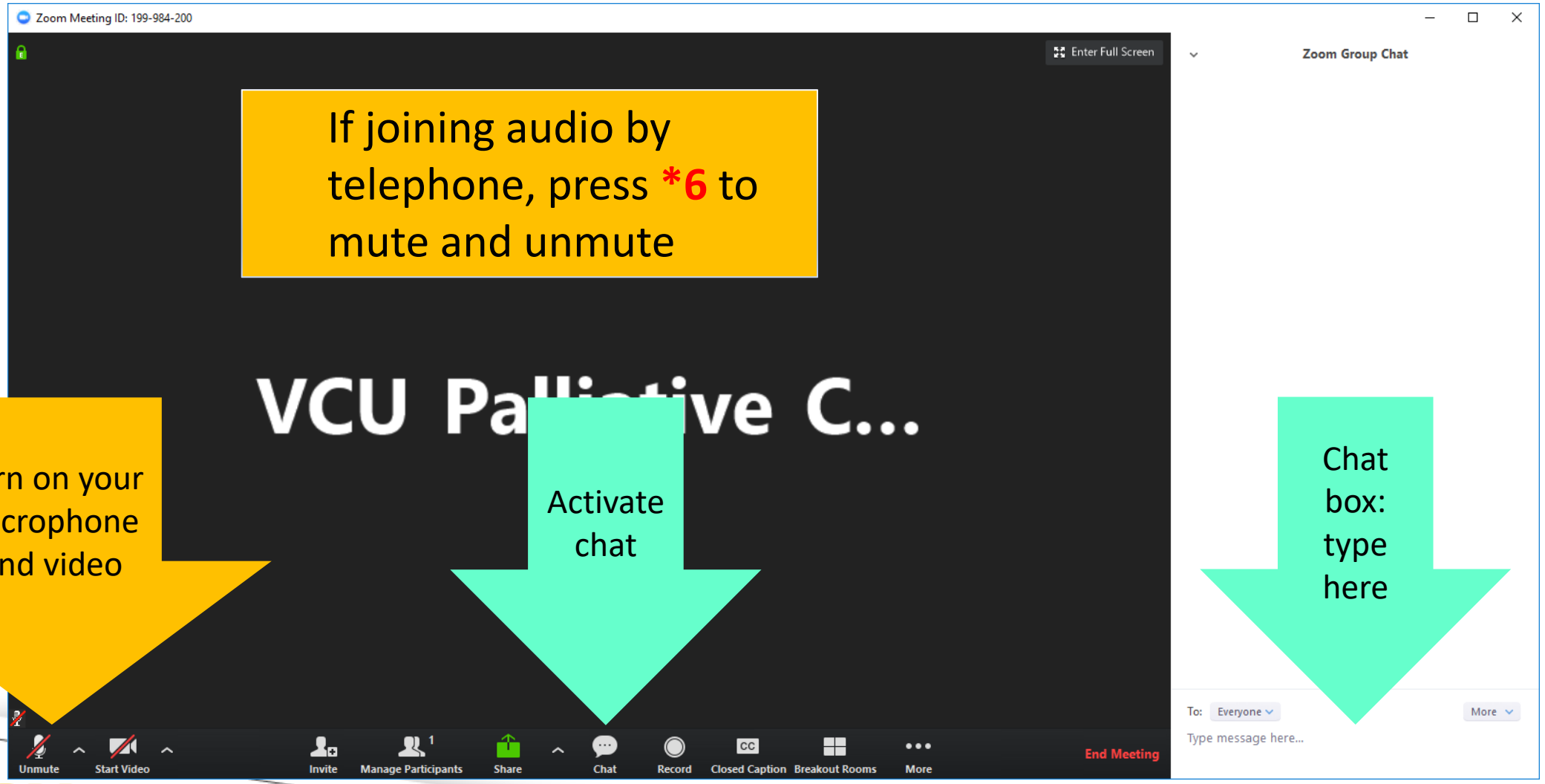
Emily B. Rivet, MD MBA FACS FASCRS
Danielle Noreika, MD

No commercial or in-kind support was provided for this activity

Helpful Reminders



Helpful Reminders



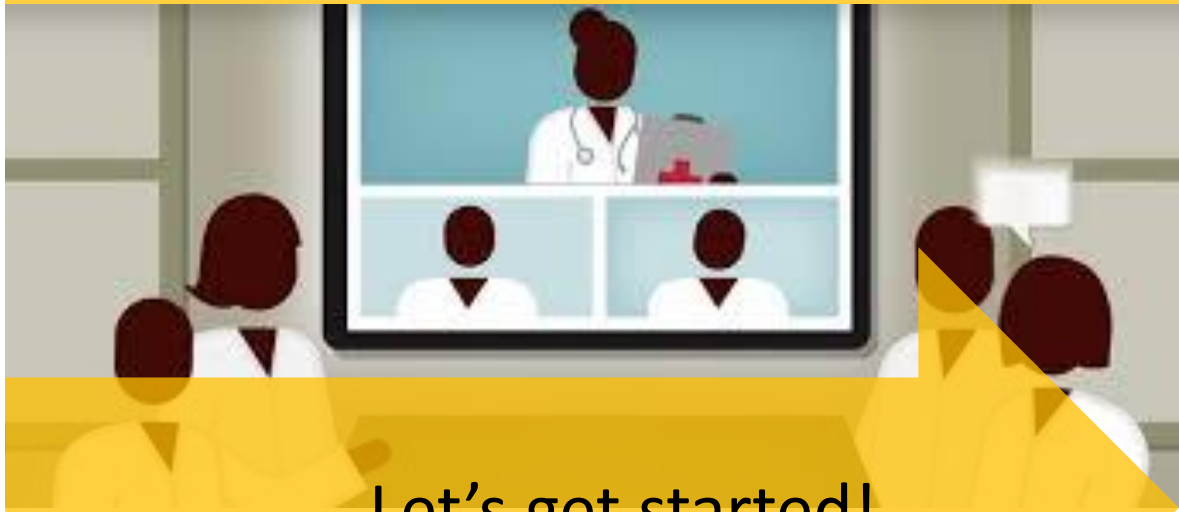
What to Expect

I. Didactic Presentation
   20 minutes + Q&A

II. Case Discussions
   - Case Presentation
     5 min.
   - Clarifying questions from spokes, then hub
     2 min. each
   - Recommendations from spokes, then hub
     2 min. each
   - Summary (hub)
     5 min.

III. Closing and Questions

- Bi-weekly tele-ECHO sessions (1.5 hours)
- Didactic presentations developed by inter-professional experts in palliative care
- Website: www.vcuhealth.org/pcecho
- Email: pcecho@vcuhealth.org



Let's get started!

Hub Introductions

VCU Team	
Clinical Directors	Egidio Del Fabbro, MD VCU Palliative Care Chair and Program Director Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Researcher Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff Program Manager Telemedicine Practice Administrator IT Support	 Teri Dulong-Rae & Bhakti Dave, MPH David Collins, MHA Frank Green

Spoke Participant Introductions

Name and Institution

Case Presentation

Emily Rivet MD MBA FACS FASCRS

- CC: Patient is a 69 year old female initially presented to ED via EMS transfer from OSH for “scalp mass”
- HPI: The growth has been present for ~ 40 years or possibly her entire life but for most of that time, small, “thumb-sized.” Has grown rapidly over the last several months
  - + Discharge
  - Denies any fevers, chills, nausea, vomiting, unintentional weight loss, or night sweats
- PMH: Arthritis, super-morbid obesity, has not seen a physician in 40 years
- PSH: Denies
- SH: negative for alcohol, tobacco, + marijuana
- FH: reports sister and daughter with similar birth marks

- ROS: negative
- Meds:
- Allergies: none

- Physical exam:

  VS: 37.1 169/65 94 17 99

  Height 170 cm, weight 218 kg, BMI 75

  General: comfortable, no acute distress

  Eye: no scleral icterus

  HEENT: Palpable firm lymphadenopathy to the R neck. None detected to L neck or supraclavicular space b/l, exam limited by patient habitus. Large fungating head mass on the R posterior aspect of the head, approximately 9 cm wide. Open and draining brown and purulent fluid.

  Respiratory: Normal effort of breathing. Symmetric chest wall expansion

  Cardiovascular: regular rate rhythm

  Gastrointestinal: nontender, nondistended

  Neurologic: awake alert and orient to person, place and time

  Extremities: moving all extremities spontaneously

- Labs

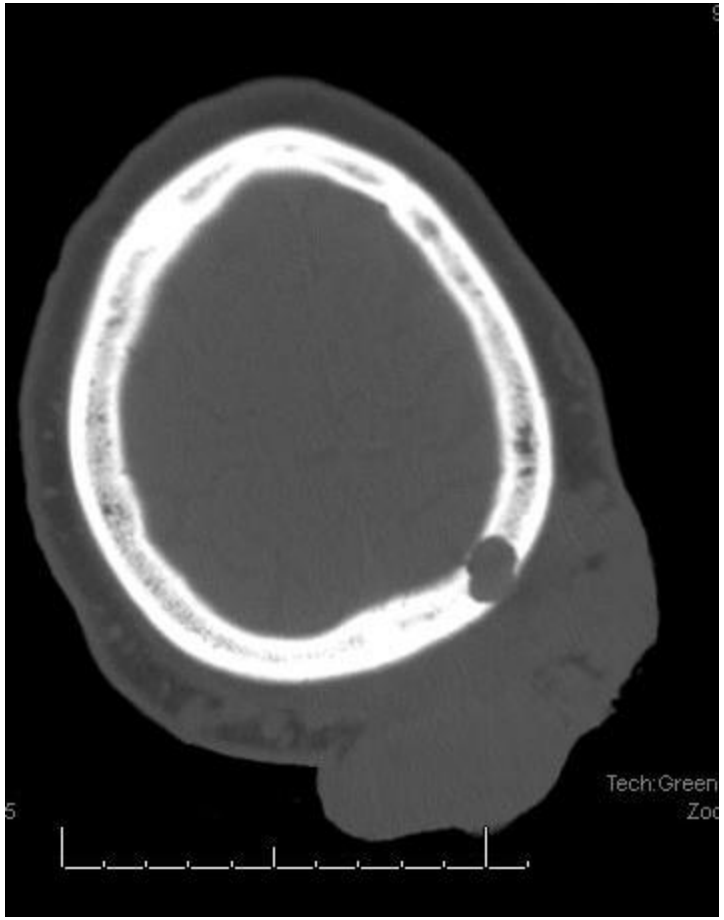
BMP (09/16 20:22) Na 131 K 4.5 Cl 100 CO2 26 AG 5 BUN 7 Cr 0.88 Glu 151 Ca 12.8

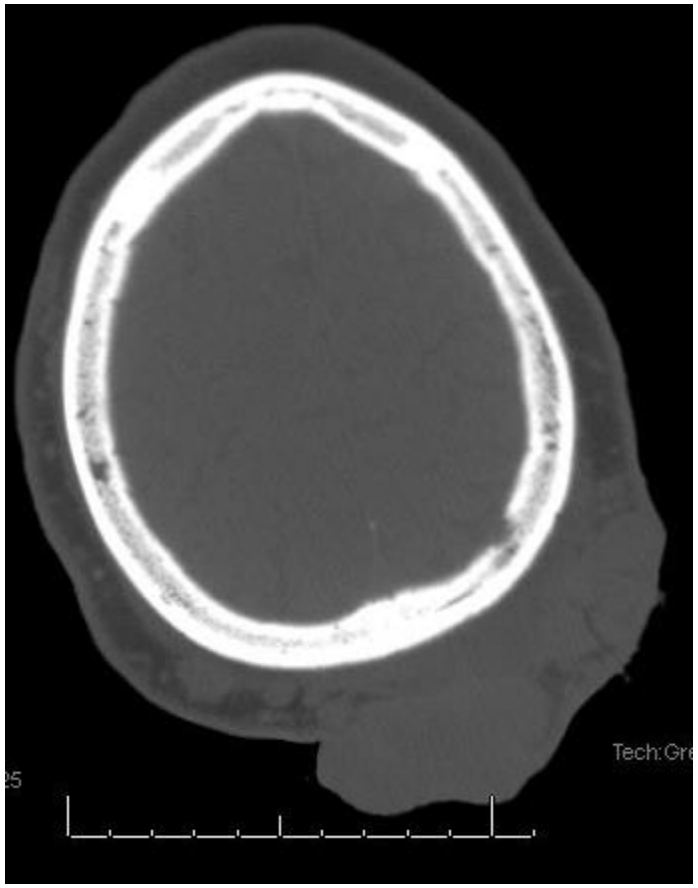
CBC (09/16 20:22) Hgb 12.1 HCT 38.2 WBC 12.4 MCV 92.3 PLT 359

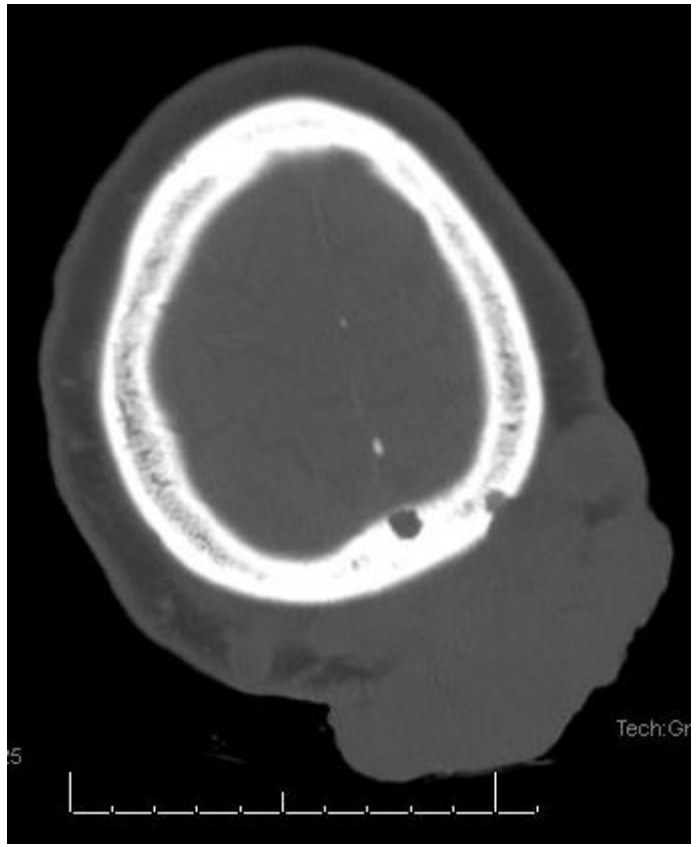
DIF (09/16 20:22) Neu 77.6% Lym 13.4% Mono 7.7% Eos 0.9% Baso 0.4%

COAG (09/16 20:22) PTT 31 PT 15.3 INR 1.2

- Imaging



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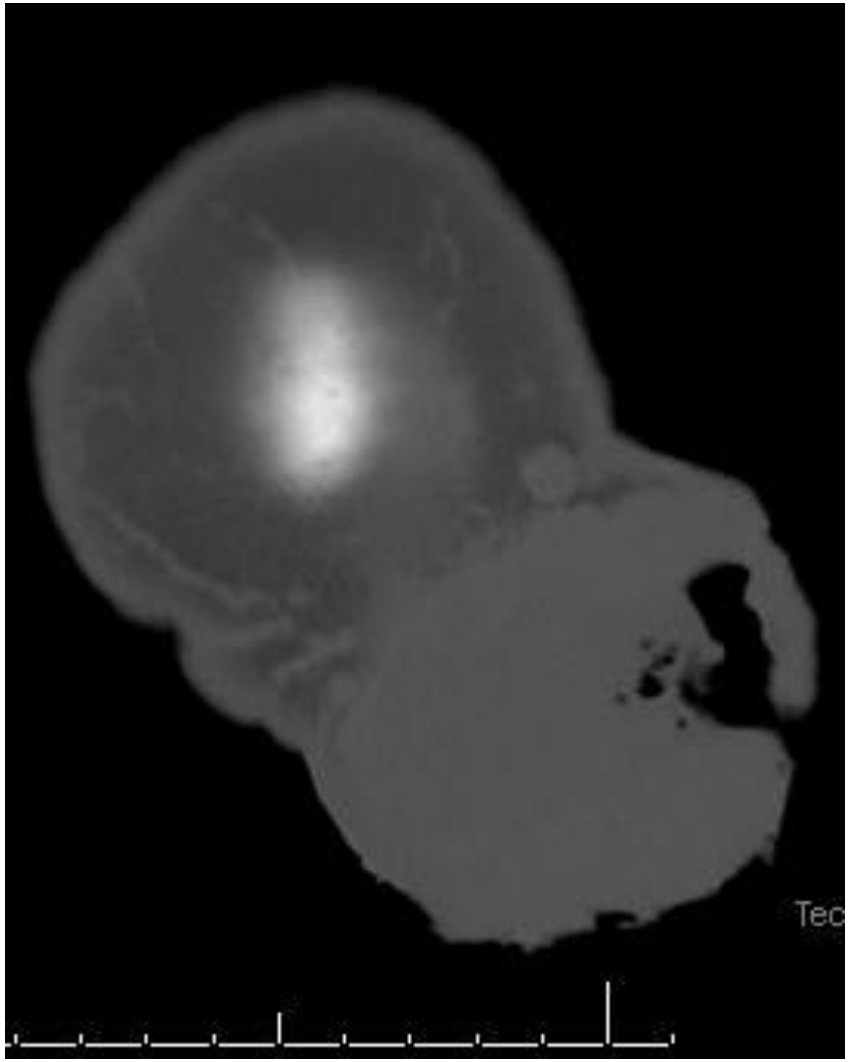


Further evaluation

- **Surgical Pathology Comment (Verified)**
- Sections demonstrate a complex, infiltrative proliferation of atypical epithelial cells with squamous differentiation. The histopathologic findings are consistent with an invasive carcinoma with squamous differentiation. The differential diagnosis includes an invasive squamous cell carcinoma, or an adnexal carcinoma with extensive squamous differentiation. Given the lack of ductal differentiation, as supported by the immunohistochemical stain EMA, an invasive squamous cell carcinoma is favored. The lesion extends to both the deep and peripheral margins in the sections examined.

Further path

- **UN Micro Interp**
- **Mass, left neck, level IIIB; ultrasound guided fine needle aspiration biopsy (smears and cell block):**
- - Malignant cells present
- - Metastatic squamous cell carcinoma.

Social Work

The patient has three adult children. Her youngest son resides in California, however, manages the household finances for the patient and her husband. Her oldest son resides in Richmond, VA. and her daughter in Pennsylvania. SNF placement is being recommended for the patient, however, she adamantly refuses this, stating "I'm going home!" PT and OT also talked with the patient about this to no avail. She is requesting assistance with transportation back home (Will need to use Alternative Funds for this purpose). Tendercare is not able to assist, stating that the patient, who weighs 505 lbs, is too wide for their wheelchair and stretcher. Richmond Ambulance is able to assist with transportation for a charge of $912.00 one way. The patient said that she may be able to pay a portion of this (She has placed a call to her son who manages the household finances; will follow up). The patient is Medicaid pending (Per Financial Counseling) and does not have Medicare. When asked about this, she stated that she has applied for Medicare on numerous occasions, however, was always turned down. The reason she was given is that she does not have enough quarters in the systen to qualify.

Hem Onc

- 69 yo female with large invasive fungal SCC of scalp with local cervical LAD, possible metastatic lesions in bones and ?lung.

#Invasive SCC of the scalp - with likely metastatic disease in the neck (awaiting FNA result from L cervical node) and possible metastasis in bone and lung

- f/u LN biopsy.. Anticipate it will be positive for metastatic SCC.
- if LN biopsy negative, would biopsy lung lesion in the RLL to r/o primary lung cancer vs. met
- pt would be a candidate for systemic therapy with cemiplimab to help shrink the primary tumor. Depending on response, could then perform surgery and even XRT after immune therapy.
- in a phase I/II trial (Migdin NEJM 2018) cemiplimab induced durable response in about 50% of patients with locally advanced/unresectable or metastatic SCC of the skin. It is now FDA approved for this indication.
- will set up with medical oncology in clinic on 9/30/19 with Dr. Rasheed to discuss regarding neoadjuvant immunotherapy
- would recommend port placement in anticipation of starting immunotherapy

#Hypercalcemia likely related to malignancy, now resolved -

- agree with zolendronic acid given per geriatrics
- check PTHrP as PTH was low

- Patient discharged with plan for out patient follow up
- Readmitted 4 days later

Pre Op Evaluation

She is largely bed bound at home, is able to independently transfer from bed to wheelchair and toilet. She has not walked in 5 years. She gets around with a wheelchair, manual, she is able to push what sounds like 20 ft before stopping The patient denies shortness of breath or chest pain when she stops. She states it is mostly due to discomfort in her legs due to the position that she sits in a wheelchair when she has to stop. She takes no medications at home besides Tylenol. She has no other known chronic medical conditions.

Geriatrics consulted for pre op risk stratification .

RCRI score 0. Patients METS <4 due to morbid obesity and being wheelchair bound. TTE with normal EF and no focal wall motion abnormalities.

No further cardiac workup recommended, proceed to OR.

October 10, 2019

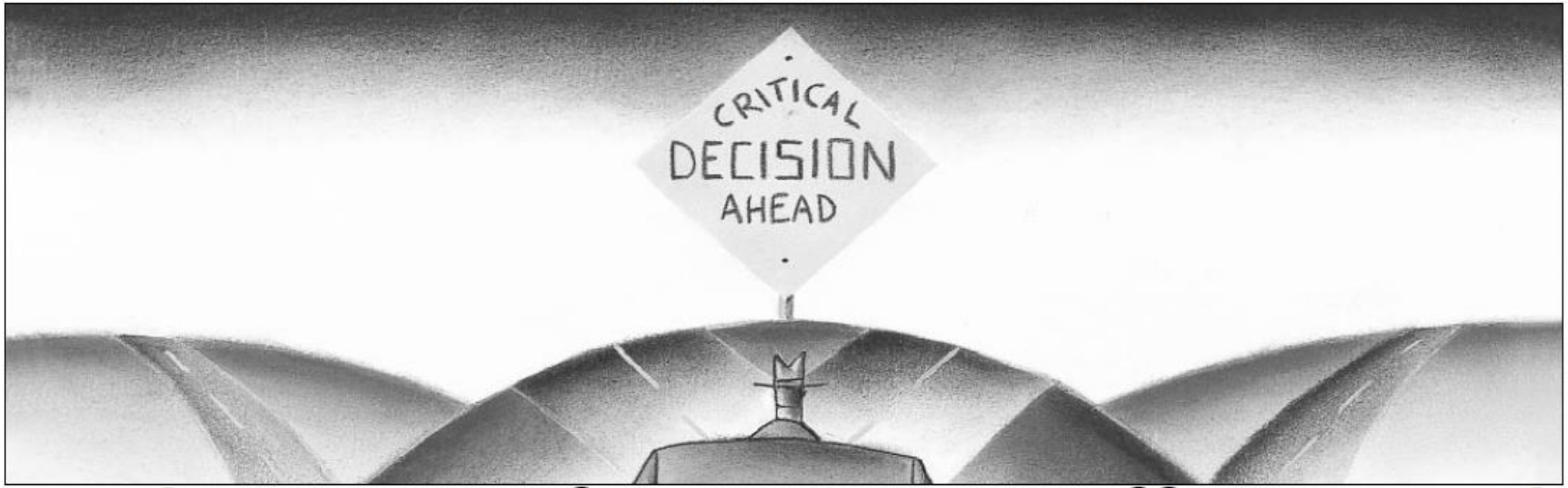
Getting Through to Physicians Resistant to Consulting Palliative Care

Emily B. Rivet, MD MBA FACS FASCRS

Objectives

- Assess gaps in current volumes from palliative- relevant procedures
- Discuss evidence on barriers to consulting palliative
- Describe rapport-building approaches for multiple disciplines

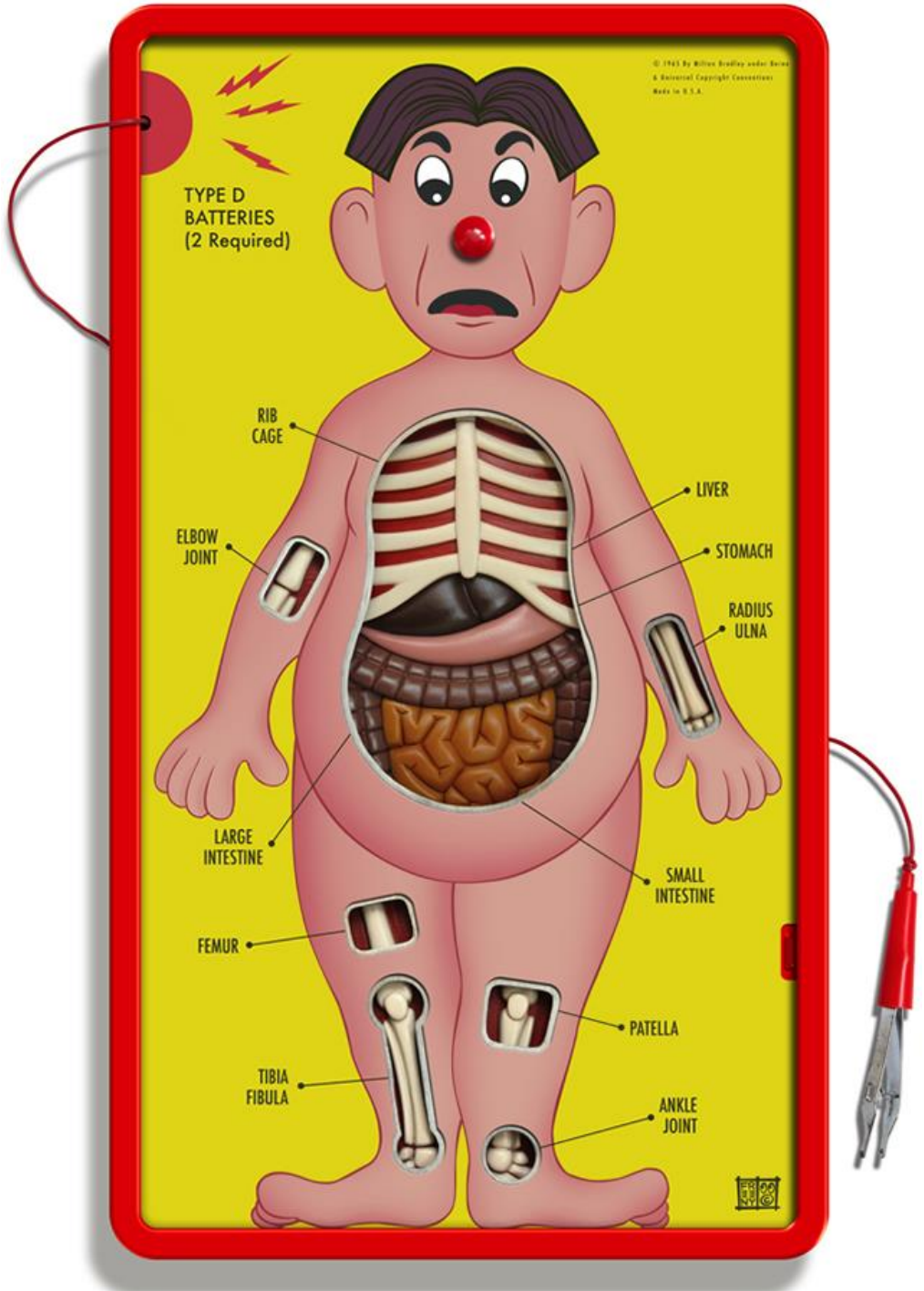
Leading Change:



Why Transformation Efforts Fail

by John P. Kotter

Kotter, John P. "Leading change: Why transformation efforts fail." (1995): 59-67.


TYPE D
BATTERIES
(2 Required)
RIB
CAGE
LIVER
ELBOW
JOINT
STOMACH
RADIUS
ULNA
LARGE
INTESTINE
SMALL
INTESTINE
FEMUR
PATELLA
TIBIA
FIBULA
ANKLE
JOINT

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The stories we tell, the stories that happen in real life …

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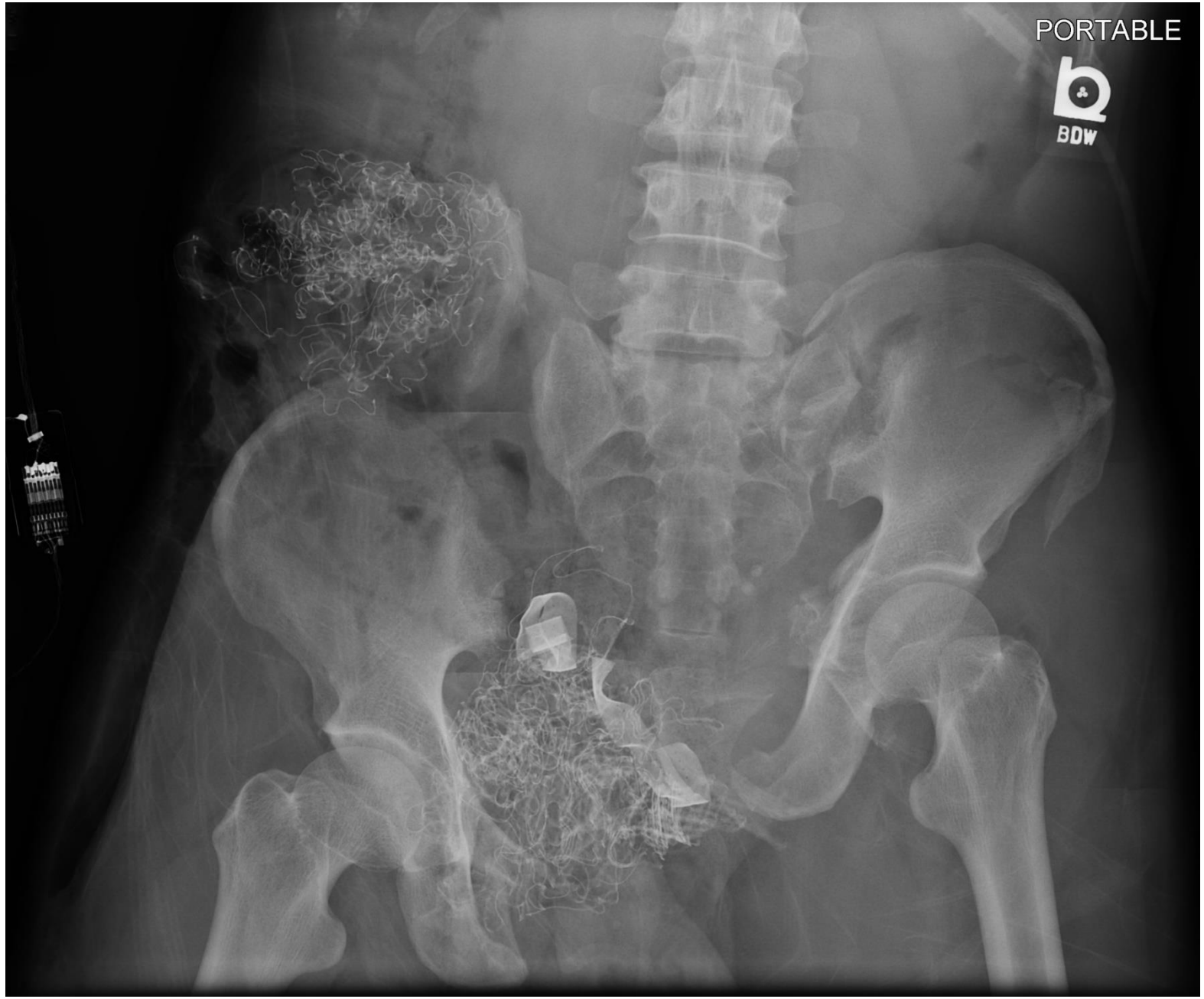
1. Establish a Sense of Urgency

- Crisis or opportunity
- “Without motivation, people won’t help and the effort goes nowhere.”
- “… a frank discussion of potentially unpleasant facts…”

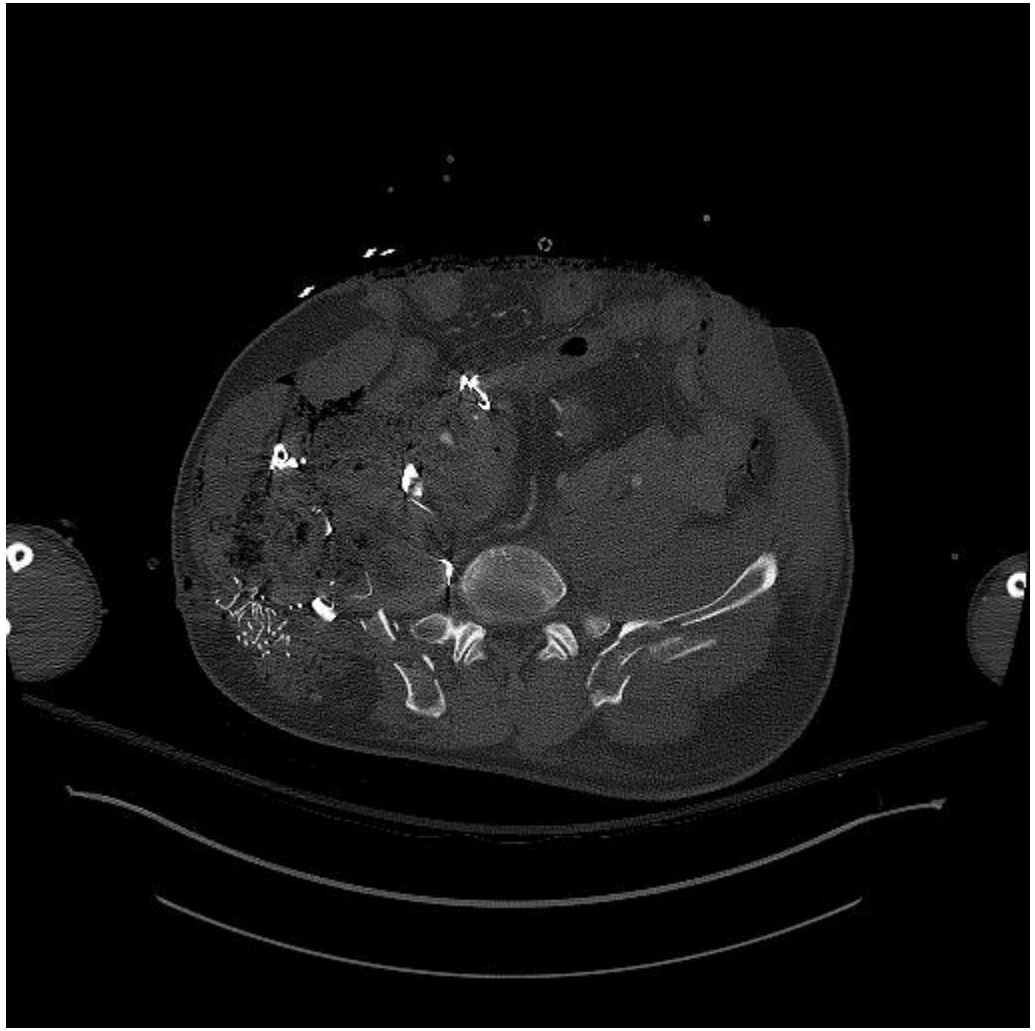
Patient DK

- Healthy 47 year old man with severe pelvic crush injury
- On arrival: BP 67/54, “weak, thready pulse” unable to move lower legs, able to answer questions
- Extensive open pelvic fracture dislocation
- Massive transfusion protocol (> 100 units, most in 1st 36 hours)
- 7 surgeries/ procedures in 4 days


PORTABLE
BDW

Patient DK

- IR
- Rectosigmoid resection
- Ligation ureters, cystectomy
- Attempted arterial shunt REIA to RCFA then ligation
- Calf fasciotomies
- Anterior external pelvic fixator
- Bilateral guillotine AKAs
- AKA washout and revisions
- Abdominal washout and closure, end colostomy



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Patient DK

- Plan to allow soft tissue to demarcate and then determine extent of resection and potential for reconstruction
- Two days after final surgery, wife began to express concern about patient's future impairments and quality of life
- Made DNR
- Patient with persistent delirium and pain
- Lack of alignment between family, physician and nursing teams]
- PC consult, ethics consult
- Multiple meetings with patient's family and friends as well as multiple members of care team
- Patient transferred to palliative care unit and received palliative sedation, died about 24 hours later

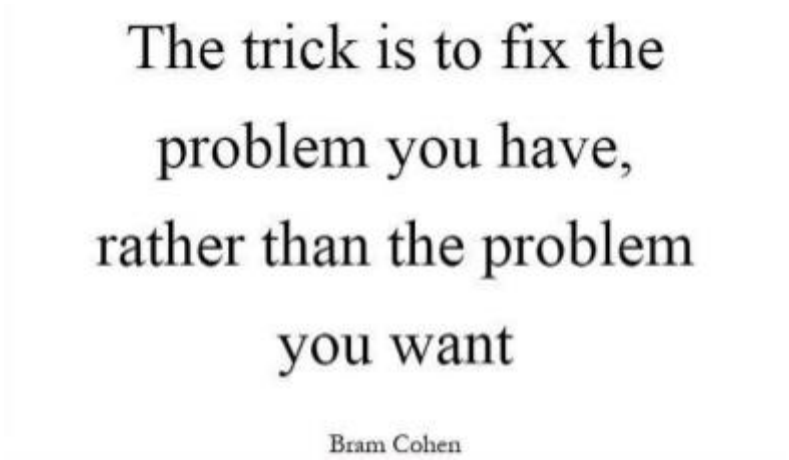
2. Form a Powerful Guiding Coalition

- By definition operates outside the normal hierarchy
- Someone needs to get people together, help them develop a shared assessment of problems and create trust and communication

Patient DK

- Schwartz rounds presentation with trauma attending
- Two nursing staff members, trauma attending and myself presented
- Trauma attending also medical director of STICU and fellowship director Surgical Critical Care fellowship

The “in real life” piece



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3. Create a vision

- Communicate in < 5 minutes and get a reaction that signifies understanding and interest

Integrate Palliative Care into the STICU

- Incorporate into FASTHUGS

Table 1. Components of "FAST HUGS BID"

FAST HUGS BID	
F	Feeding
A	Analgesia
S	Sedation
T	Thromboembolic prophylaxis
H	Head of bed elevation
U	Ulcer (stress) prophylaxis
G	Glycemic control
S	Spontaneous breathing trial
B	Bowel regimen
I	Indwelling catheter removal
D	De-escalation of antibiotics

4. Communicate the vision

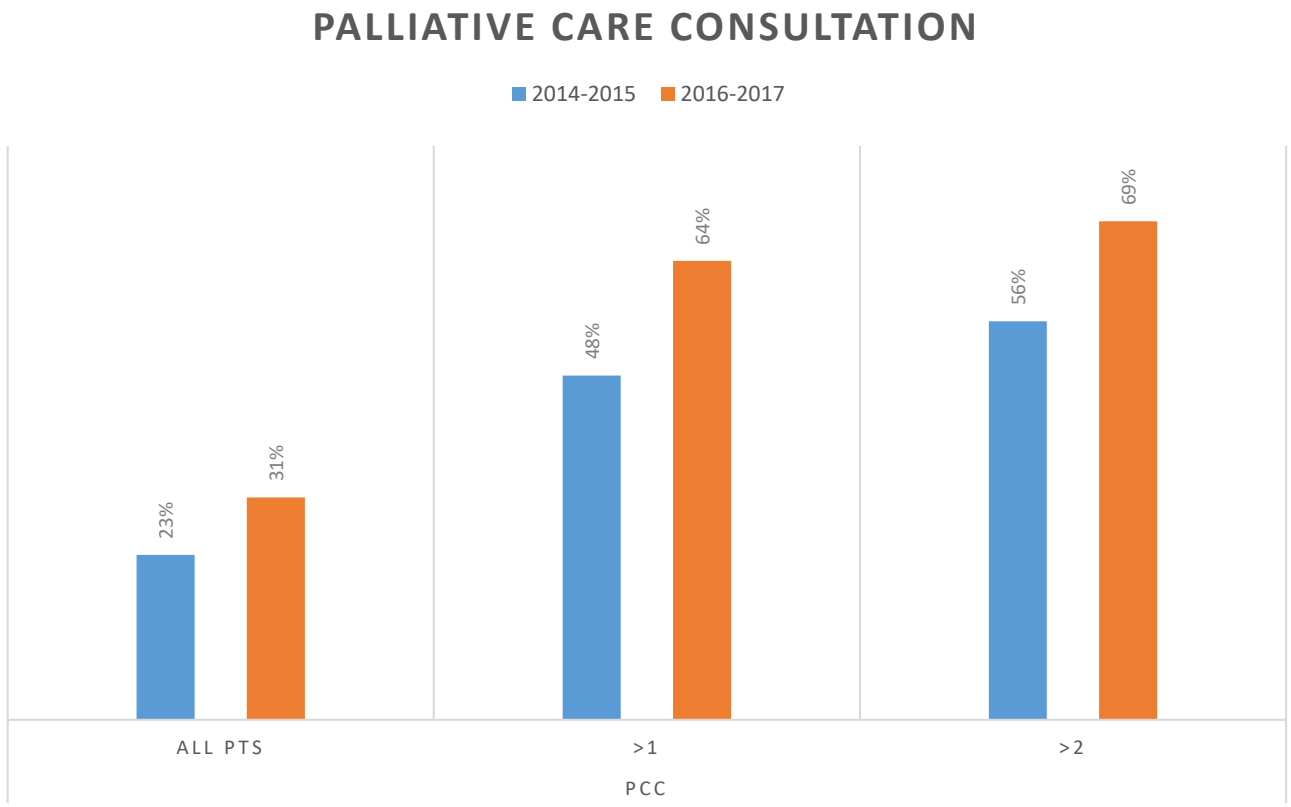
- Use all existing communication channels to broadcast the vision
- Become a living symbol of the transformation- “walk the walk”

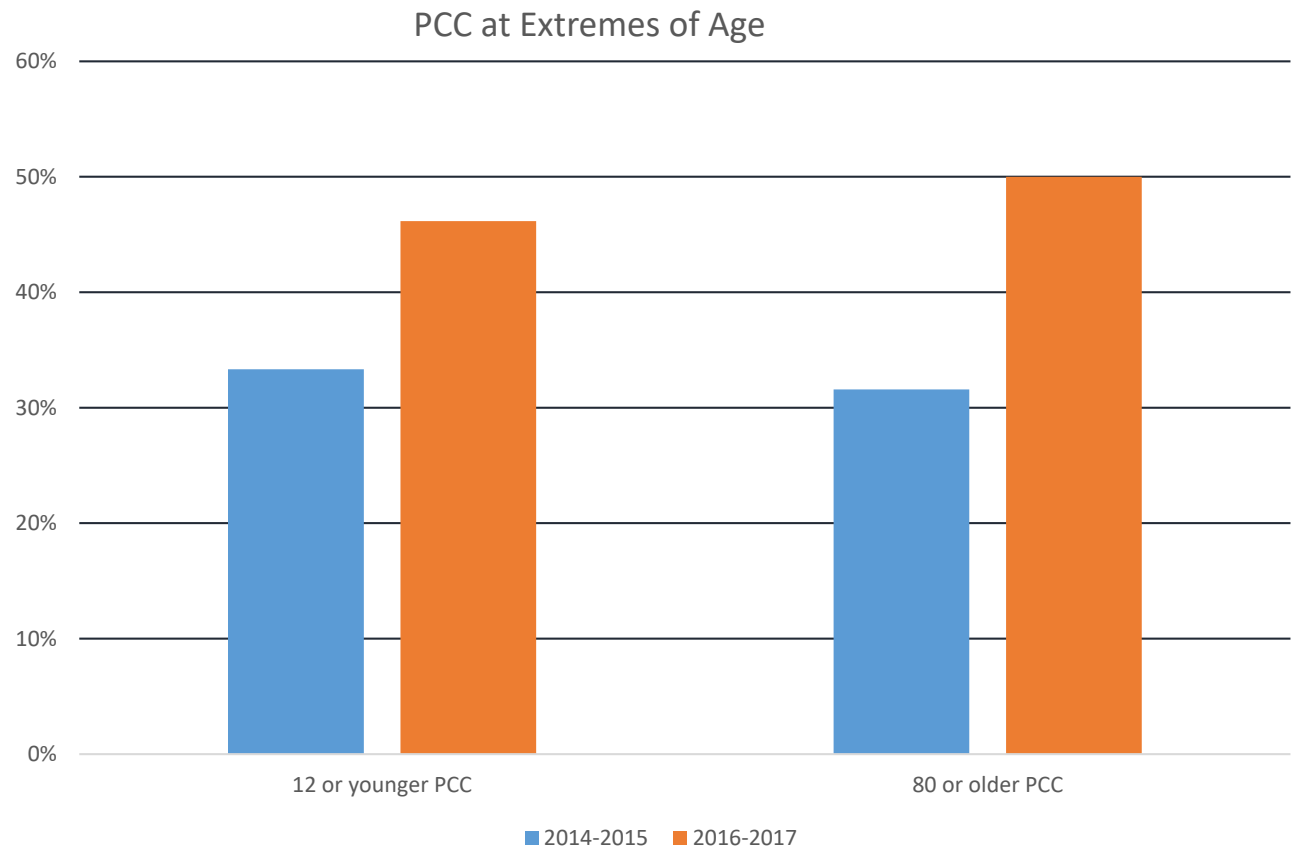
5. Empower others to act

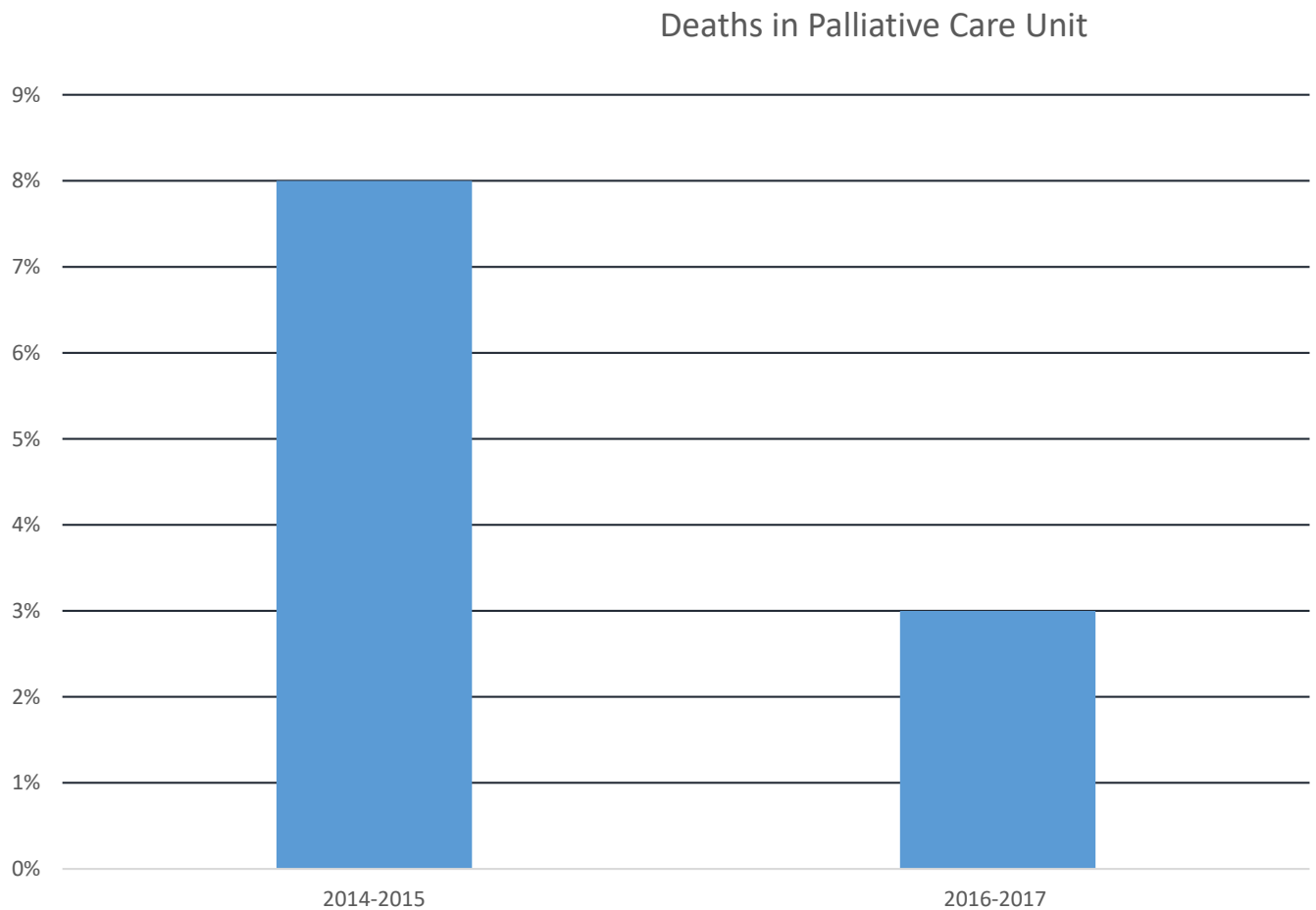
- Remove barriers
- Consider incentives
- Encourage risk taking

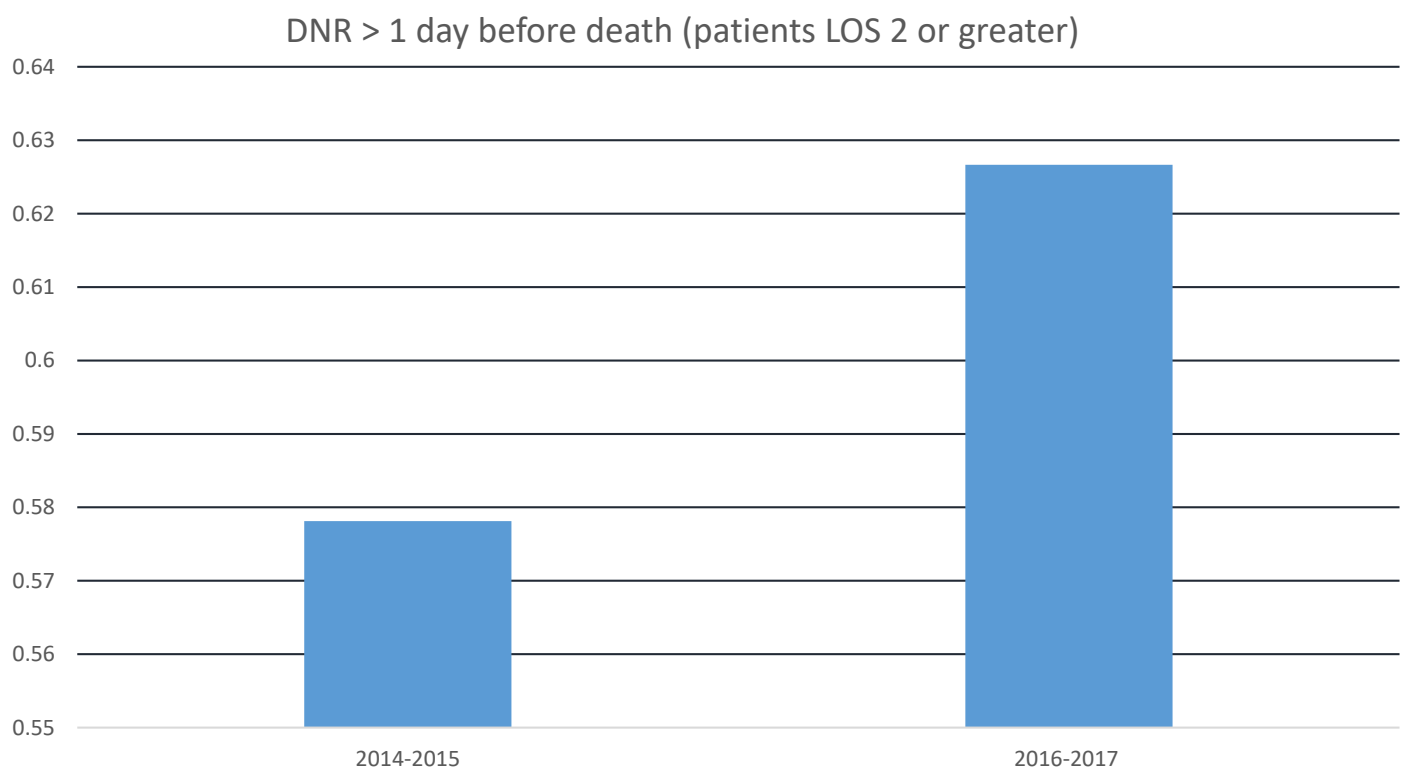
Pilot cohort study examining impact of Palliative Surgeon Intervention

- Population is patients dying from trauma, one year period pre and post intervention (Rivet rotation in trauma ICU September 2016)
- Total 332 patients
- October 2014 to September 2015
- October 2016 to September 2017
- Preliminary data


PALLIATIVE CARE CONSULTATION
2014-2015
2016-2017
23%
31%
48%
64%
56%
69%
ALL PTS
>1
>2
PCC


PCC at Extremes of Age
60%
50%
40%
30%
20%
10%
0%
12 or younger PCC
80 or older PCC
2014-2015
2016-2017


Deaths in Palliative Care Unit
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
2014-2015
2016-2017


DNR > 1 day before death (patients LOS 2 or greater)
0.64
0.63
0.62
0.61
0.6
0.59
0.58
0.57
0.56
0.55
2014-2015
2016-2017

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In real life

- Other professional priorities of guiding coalition
- Protocols that structure involvement of other care teams
- The intervention changed access to palliative care consultation and impacted some outcome measures such as timeliness of DNR and more upstream focus of palliative care consultation.
- Other measures such as location of death may be affected by other factors such as palliative care unit availability, patient condition/ survival and did not show improvement from the intervention. Prognosis is uncertain so CPR is appropriate in some patients.
- The most meaningful outcomes are those we do not routinely measure such as experience of family members and caregivers and staff member distress, burnout and resilience.

6. Plan for and create short term wins

- Identify achievable objectives and provide rewards

Surgical Innovation

Palliative Care Assessment in the Surgical and Trauma Intensive Care Unit

Emily B. Rivet, MD, MBA; Egidio Del Fabbro, MD; Paula Ferrada, MD

What Is the Innovation?

How can we prioritize the fundamental needs of patients in the increasingly technical and data-driven environment of modern health care, especially in the intensive care unit? Palliative care is a relatively new specialty that focuses on the most basic and human elements of medicine, including

- treatment of the symptoms associated with serious illness;
- attention to the social, spiritual, and psychological needs of the individual;
- collaboration among clinicians to optimize care; and
- communication with patients and families regarding prognosis, treatment plans, and care goals.

The innovation is incorporating a palliative care assessment into the daily rounding metrics in the surgical and trauma intensive care unit (STICU). The palliative care assessment is a simple question—does this patient have any palliative care needs?—that the team understands to include symptom management challenges, issues of psychosocial support, and disparities in perception of treatment plan and prognosis. Incorporating this question into the daily rounds allows these aspects of patient care to be given equal priority as issues such as hemodynamics and infection in the daily rounding discussion.

What Are the Key Advantages Over Existing Approaches?

The STICU is a complex, high-volume system whose focus on recovery from critical illness may sometimes prioritize clinical over personal needs. After the innovation was adopted, we observed an increase in specialist palliative care referrals from the STICU. Perhaps more important is that we also noted heightened attention to pain and other symptoms, discussions of clinical trajectories and prognosis, and awareness of psychosocial and spiritual aspects of care during rounds. Given the shortage of palliative care specialists in the United States, increasing the STICU team's attentiveness and responsiveness to these issues may be of greatest value. Implementation was facilitated by a surgeon with specialty training in palliative care who provided education about the role of palliative care and rounded with the STICU team for 1 month. The presence of such dual-trained physicians is not essential, but it may expedite changes in practice and has done so in other fields, such as oncology.[1] Furthermore, data from our program demonstrate that palliative care consultation can improve recognition of conditions such as delirium and increase the comprehensiveness of discussions regarding end-of-life care.[2] This integrated approach that combines primary and specialist palliative care as well as the role of each in treating patients will need to be defined by additional research and will depend on the resources of specific health systems.

How Will This Affect Clinical Care?

The emerging concept of "sudden advanced illness" provides a useful framework for appreciating why surgical and trauma patients may have particularly intense palliative care needs as a result of sudden onset of illness, uncertain prognosis, and frequent lack of existing advance directives.[3] A different but equally needy population in this setting is the subset of patients with decline due to age or chronic illness. In these cases, injury from ground-level falls is a presentation of frailty rather than a result of the mechanism in isolation. Patients facing complex decisions about the potential benefit and risk of surgery for issues other than traumatic injury are another group in the STICU with particularly robust palliative care needs. Benefits of palliative care for these patients can include improved management of symptoms such as pain and delirium, more effective communication about prognosis, improved family and patient satisfaction, and increased alignment among care team members.

Is There Evidence Supporting the Benefits of the Innovation?

Mosenthal et al[4] show that a structured palliative care intervention integrated into standard care increases discussions of pain, other symptoms, and goals of care on rounds in the trauma ICU. This study and others also demonstrate that early palliative care intervention can move upstream the timing of do-not-resuscitate orders and withdrawal-of-life-support consent without affecting mortality rates. However, although a recent single-institution study of a prospectively maintained database found that 20% of specialty palliative care consultations from surgical services were for symptom management, limited data are available regarding the outcomes of such consultations in this population.[5] Palliative care specialists improve recognition and treatment of conditions, such as delirium, that increase morbidity, mortality, and health care costs in the critical care setting.[6] A recent systematic review showed positive findings associated with palliative care in surgical patients but also noted significant limitations in evidence.[7]

What Are the Barriers to Implementing This Innovation More Broadly?

National organizations, such as the American College of Surgeons, have endorsed the value of palliative care for surgical patients since 2005, but acceptance is not yet universal. A major factor remains the "rescue culture" of surgery and the pervasive sense that recovery and palliation are sequential rather than parallel elements of an individual's medical trajectory. Other important factors are the national shortage of specialist palliative care clinicians and the current lack of education and training of surgeons to deliver primary palliative care. Furthermore, outcome measures prioritize survival over other metrics, such as quality of life or time spent out of the hospital. Last, the financial incentive structure of the American health care system does not always effectively align the values of patients, insurance providers, surgeons, and hospitals. All of these factors may

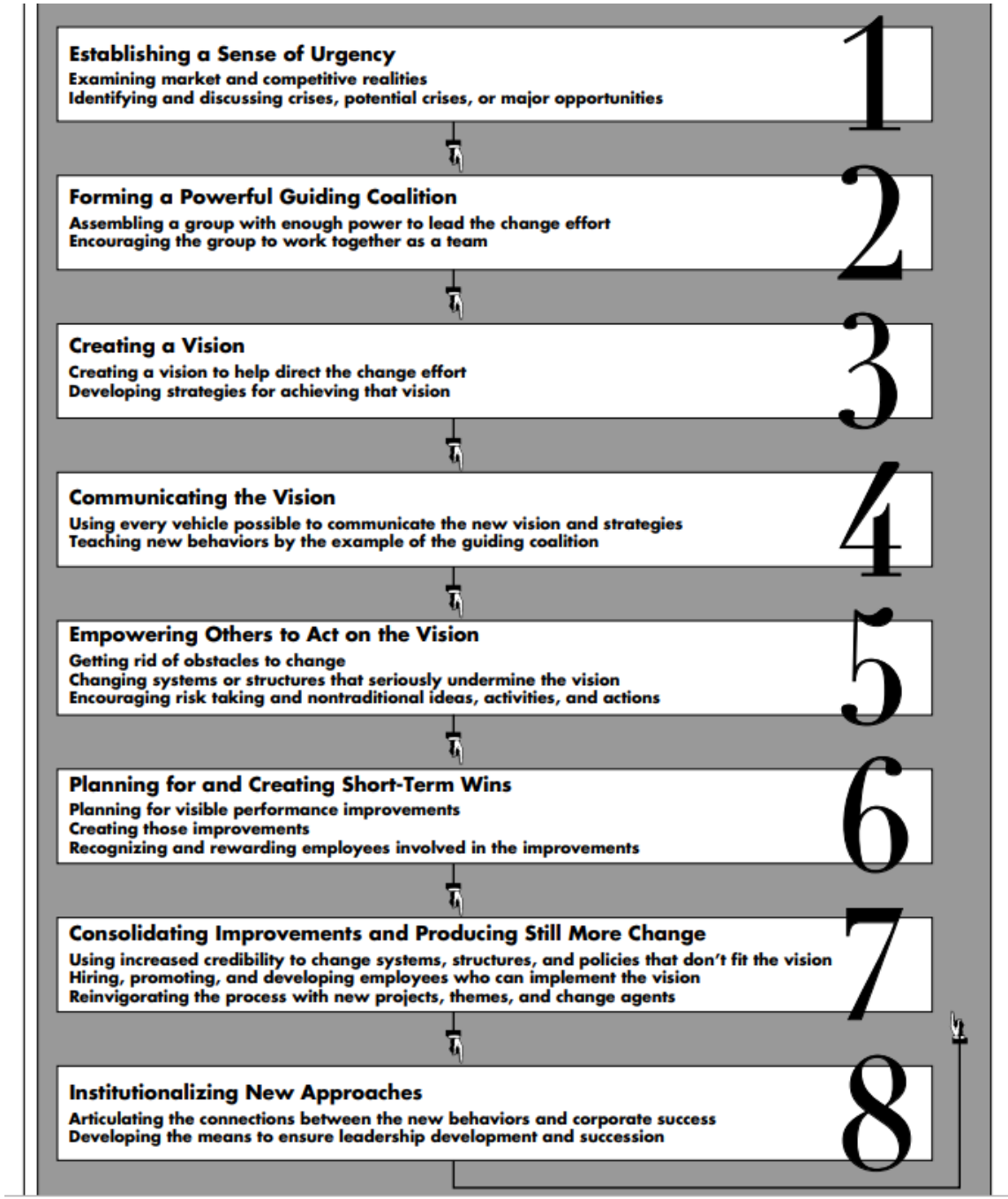
7. Consolidate and produce more change

- Don’t declare victory too soon
- Changes take 5-10 years to “sink into” organizational culture
- Use the credibility from short term wins to tackle even bigger projects
- In one successful transformation peak change in year 5, 36 months after first set of visible “wins”
- New projects
- Right people

Table 1: Characteristics of cancer patients who died during same hospitalization as major surgery		
	Median	Range
Age	61	39-94
Length of Stay	23	3-183
ICU Days	4	0-86
Days before Death DNR	2.5	0-33
	N	%
Gender		
Male	19	54
Female	16	46
Race		
Caucasian	19	54
African/African American	12	34
Hispanic	1	3
Other	3	9
Insurance Status		
Medicare	13	37
Medicaid	0	0
Private	18	51
No insurance	4	11
Distance from VCU		
< 30 miles	11	31
> 30 miles	24	68
Acuity of surgery		
Emergency	20	43
Elective	15	57
Palliative surgery	21	60
Palliative care consultation	24	68
Hospice Candidate	30	86
Location of death		
Intensive care unit	19	54
Palliative care unit	8	23
General care unit	9	26
DNR	30	86
Malignant bowel obstruction	14	40
Received CPR	7	20

8. Anchor changes in culture

- It becomes “the way we do things around here”
- Reinforce the correct connections between actions and outcomes


Establishing a Sense of Urgency
Examining market and competitive realities
Identifying and discussing crises, potential crises, or major opportunities
1
Forming a Powerful Guiding Coalition
Assembling a group with enough power to lead the change effort
Encouraging the group to work together as a team
2
Creating a Vision
Creating a vision to help direct the change effort
Developing strategies for achieving that vision
3
Communicating the Vision
Using every vehicle possible to communicate the new vision and strategies
Teaching new behaviors by the example of the guiding coalition
4
Empowering Others to Act on the Vision
Getting rid of obstacles to change
Changing systems or structures that seriously undermine the vision
Encouraging risk taking and nontraditional ideas, activities, and actions
5
Planning for and Creating Short-Term Wins
Planning for visible performance improvements
Creating those improvements
Recognizing and rewarding employees involved in the improvements
6
Consolidating Improvements and Producing Still More Change
Using increased credibility to change systems, structures, and policies that don't fit the vision
Hiring, promoting, and developing employees who can implement the vision
Reinvigorating the process with new projects, themes, and change agents
7
Institutionalizing New Approaches
Articulating the connections between the new behaviors and corporate success
Developing the means to ensure leadership development and succession
8

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Real life lessons

- Honor the perspective of others
- Low hanging fruit
- Allies
- Easy victories
- Provide a product
- Keep smiling and keep talking
- Persistence
- Emphasize the similarities
- Always keep options open and there’s always a chance for change

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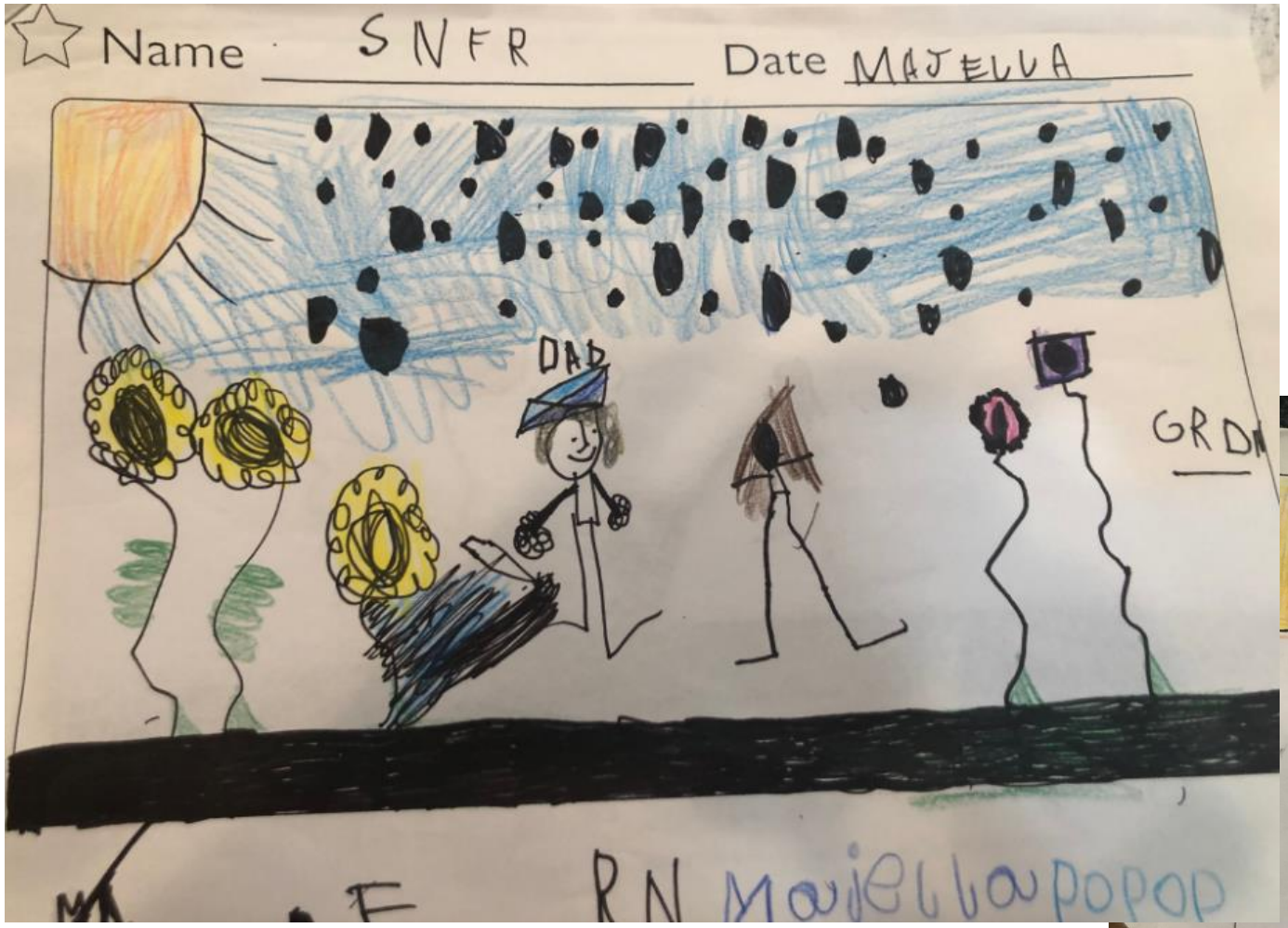
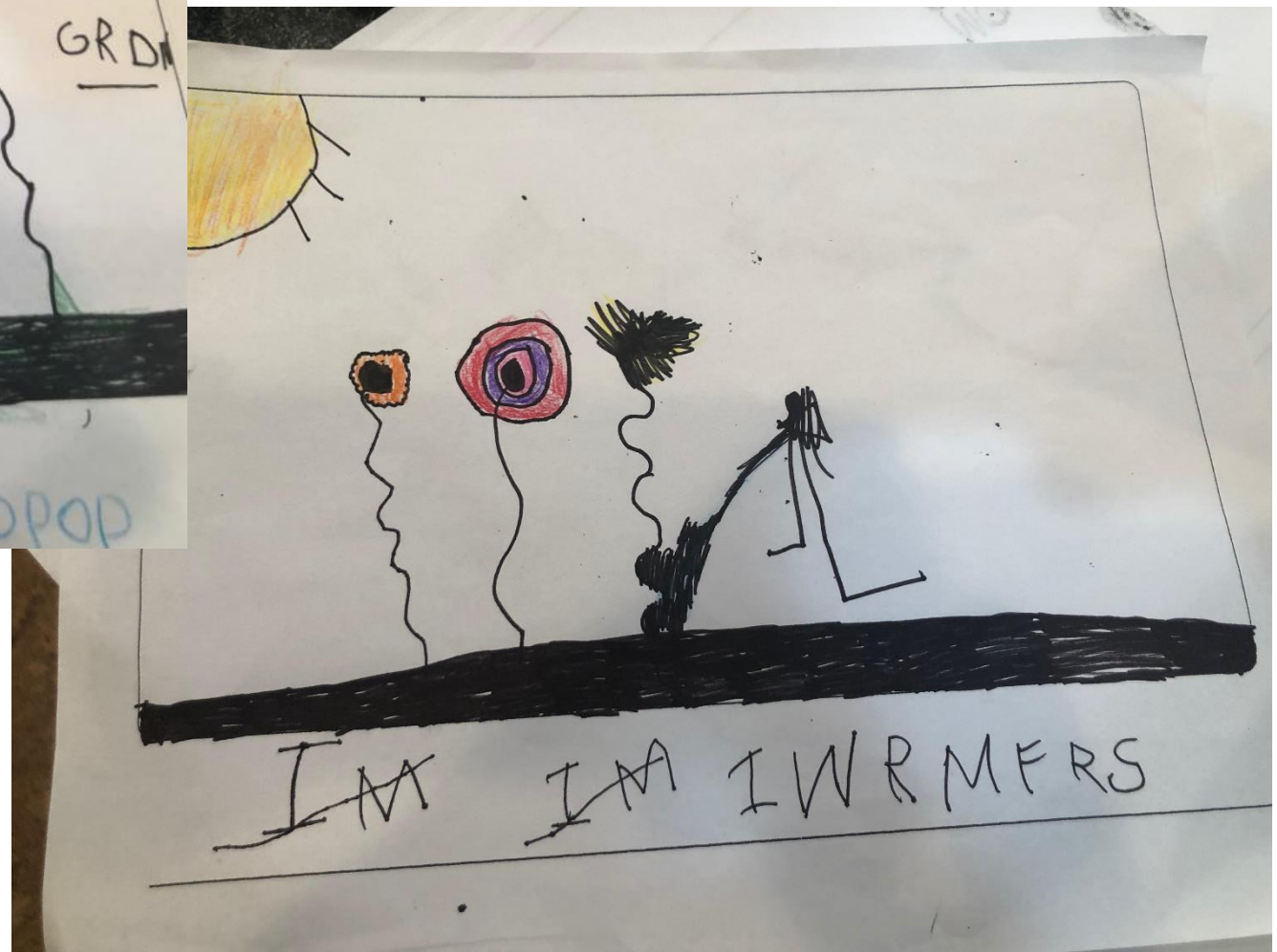
Name SNFR Date MAJELLA



RN Majellapopop



Questions and Discussion

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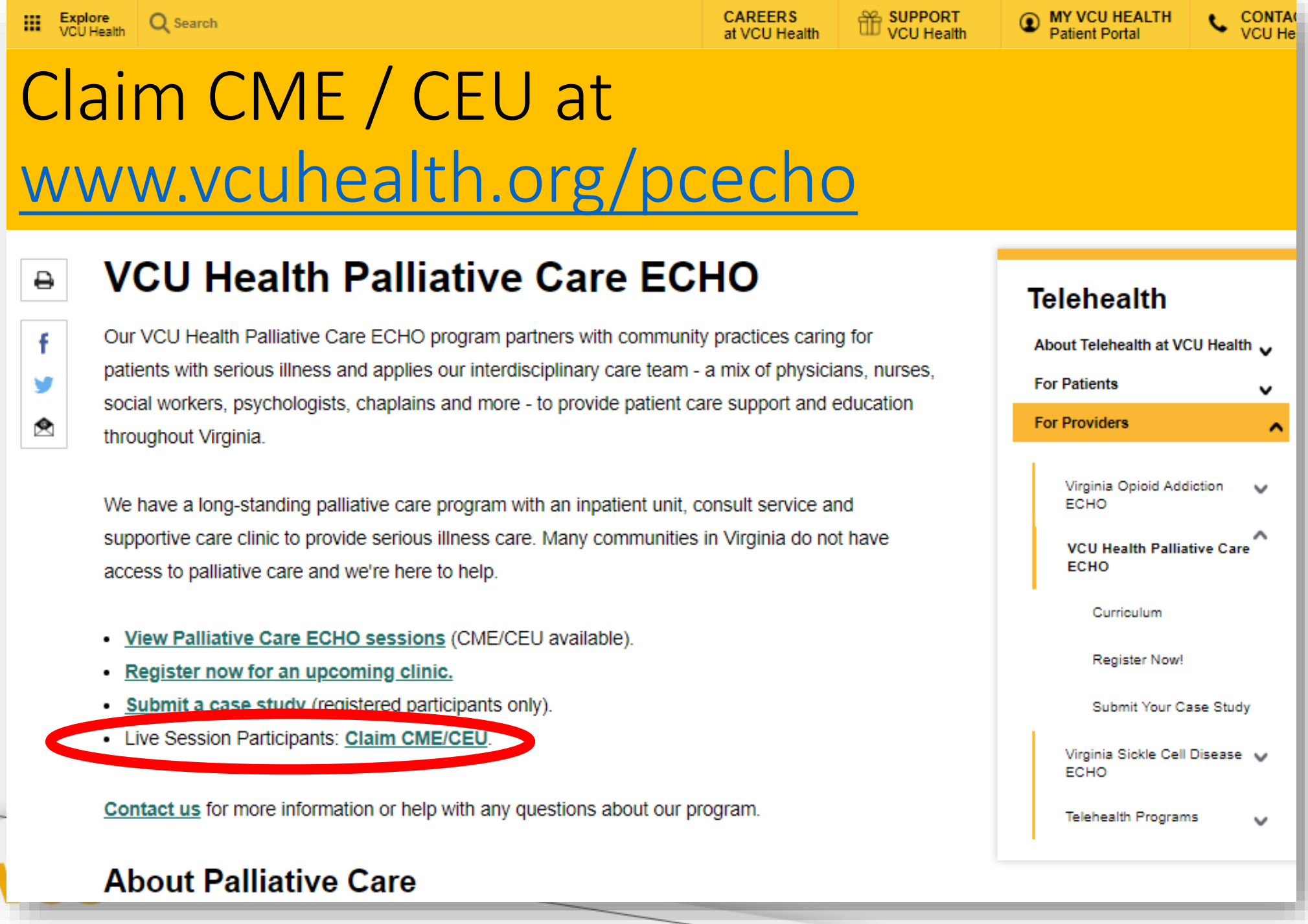

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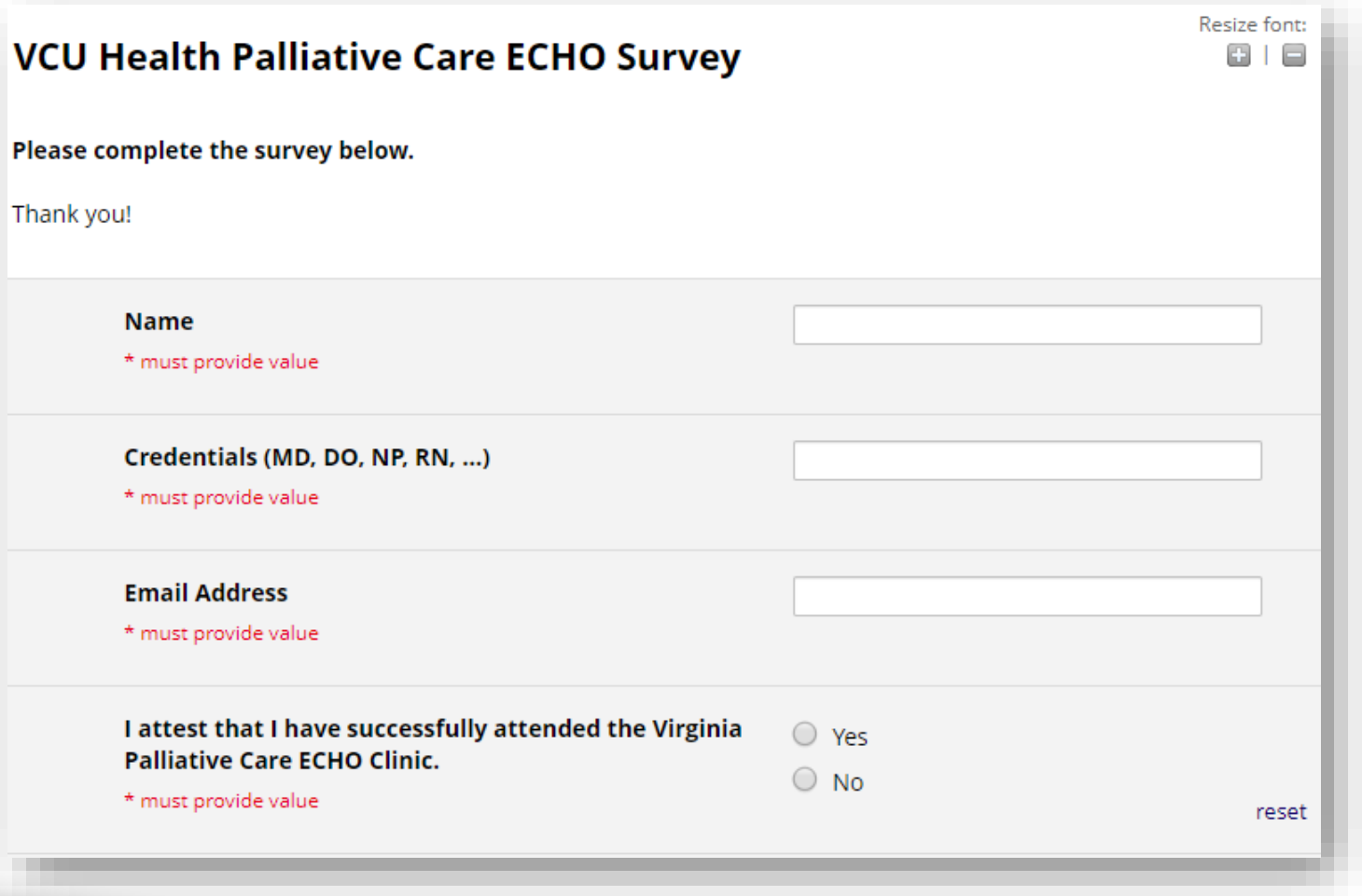

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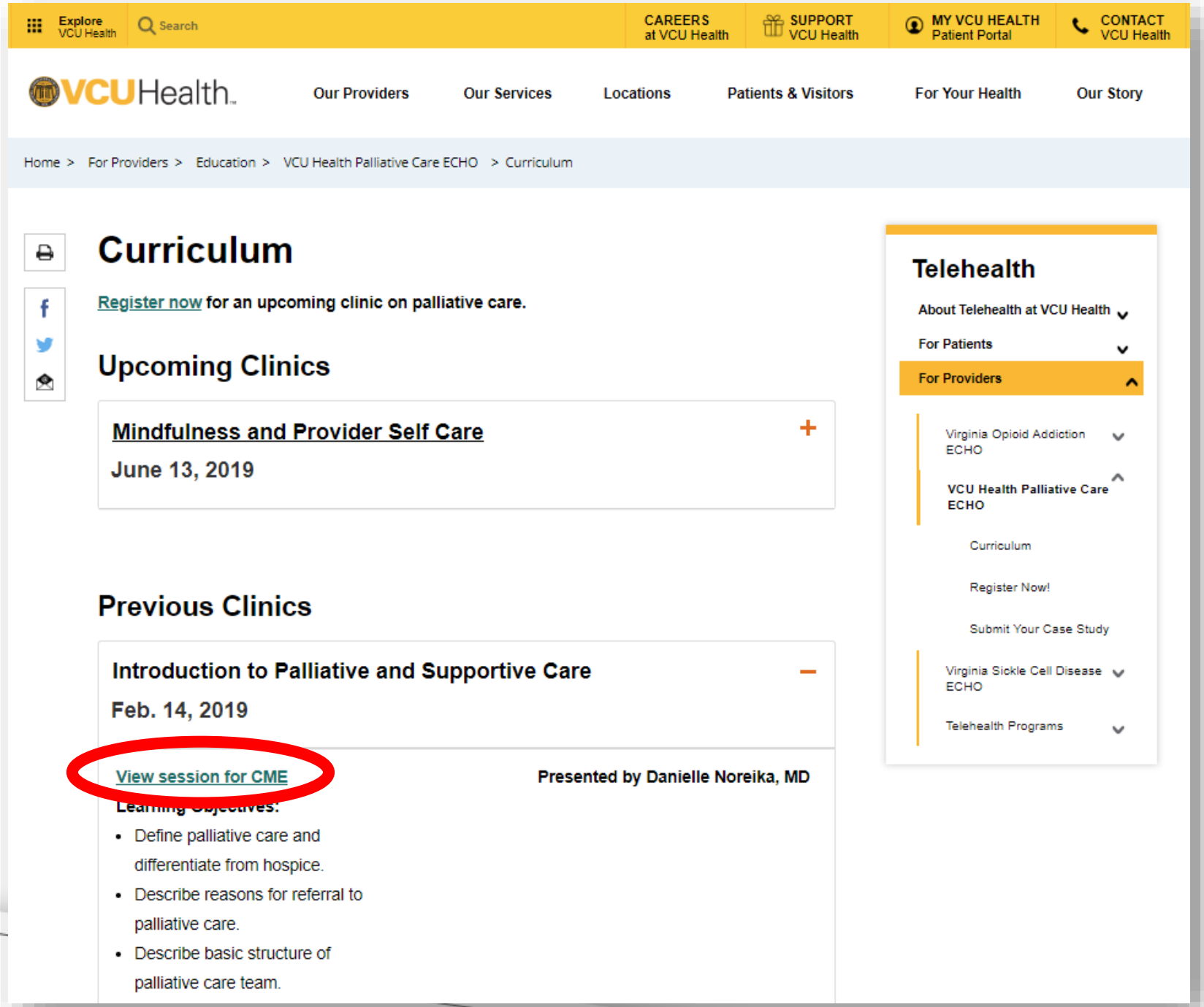

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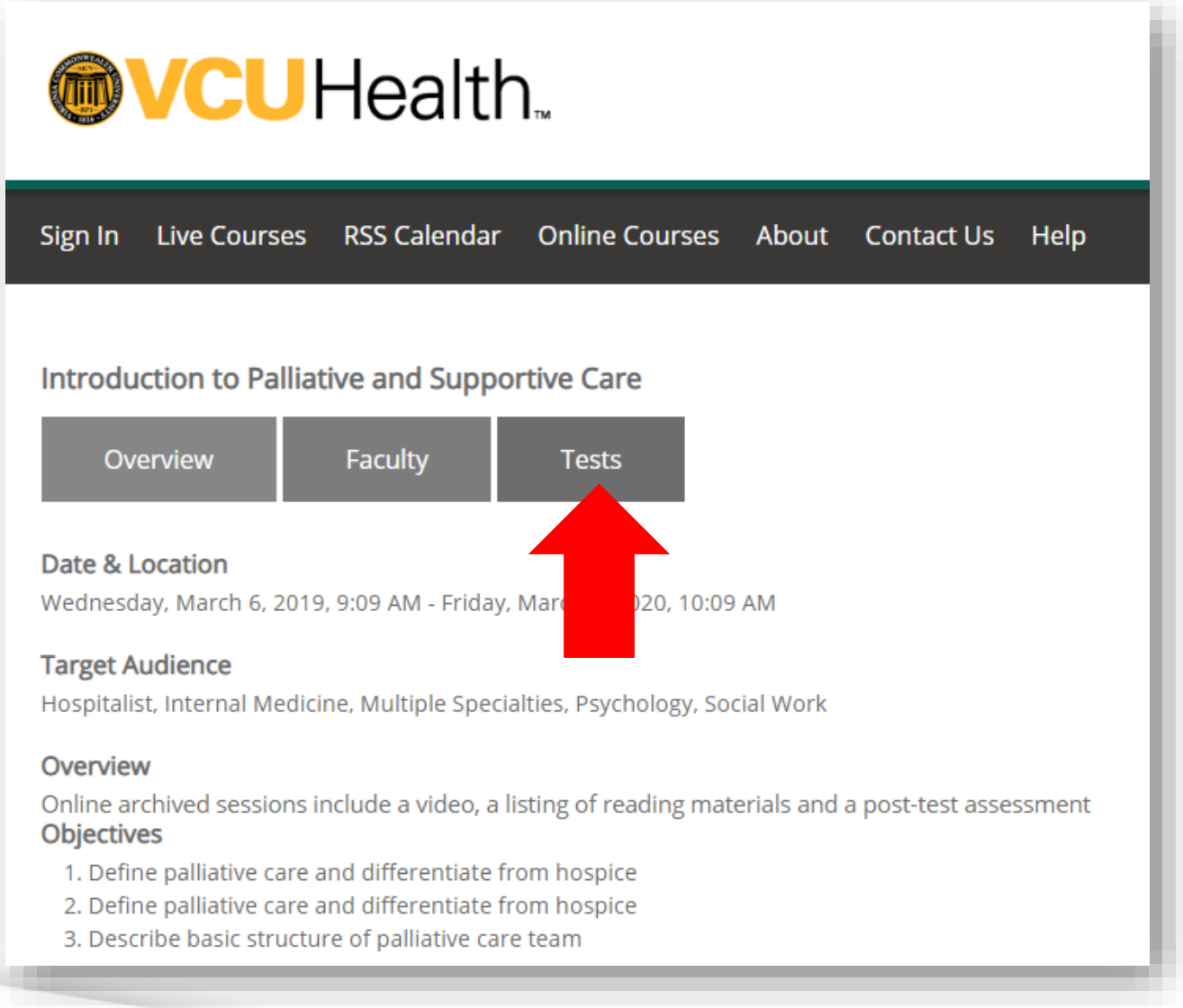

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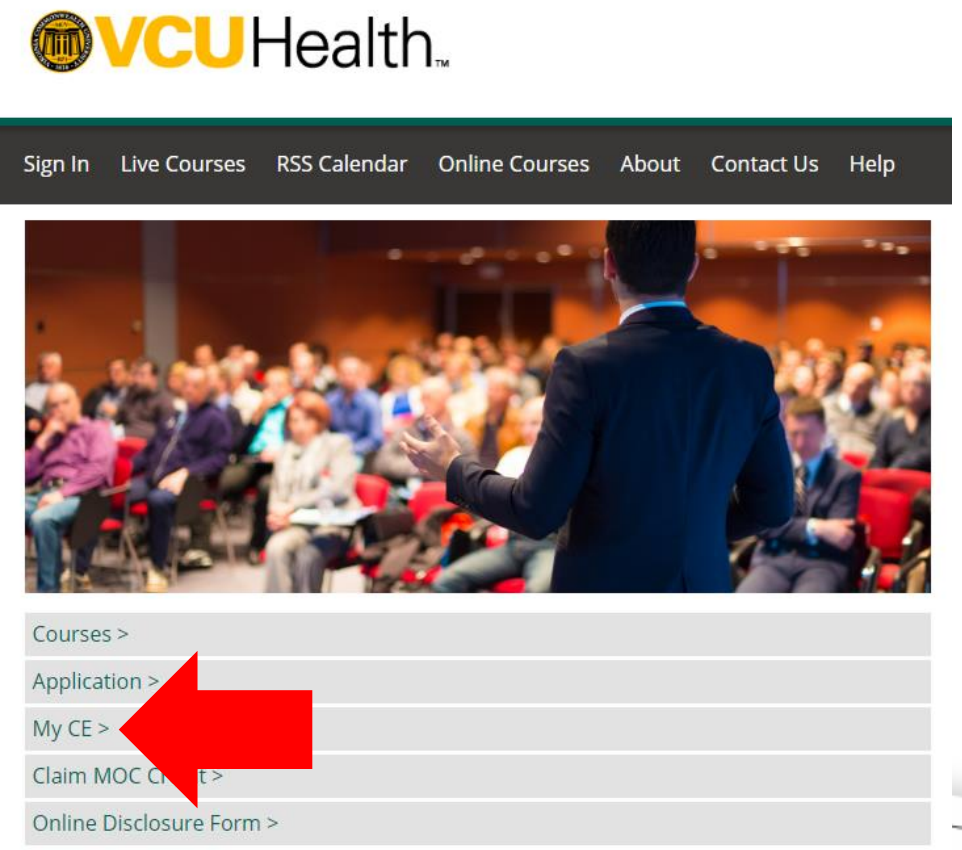

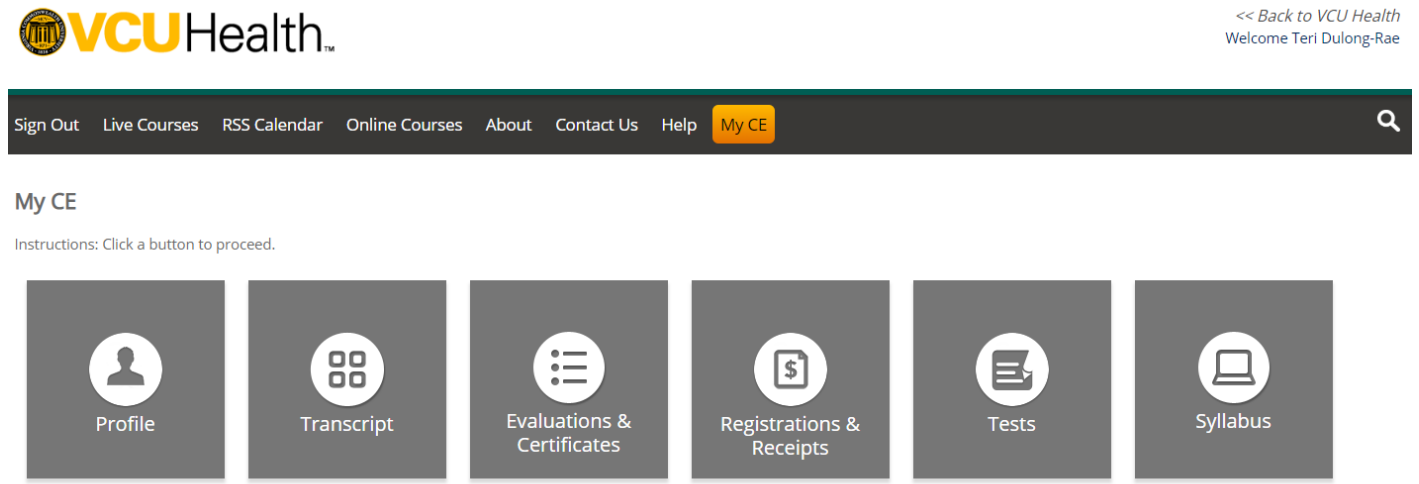

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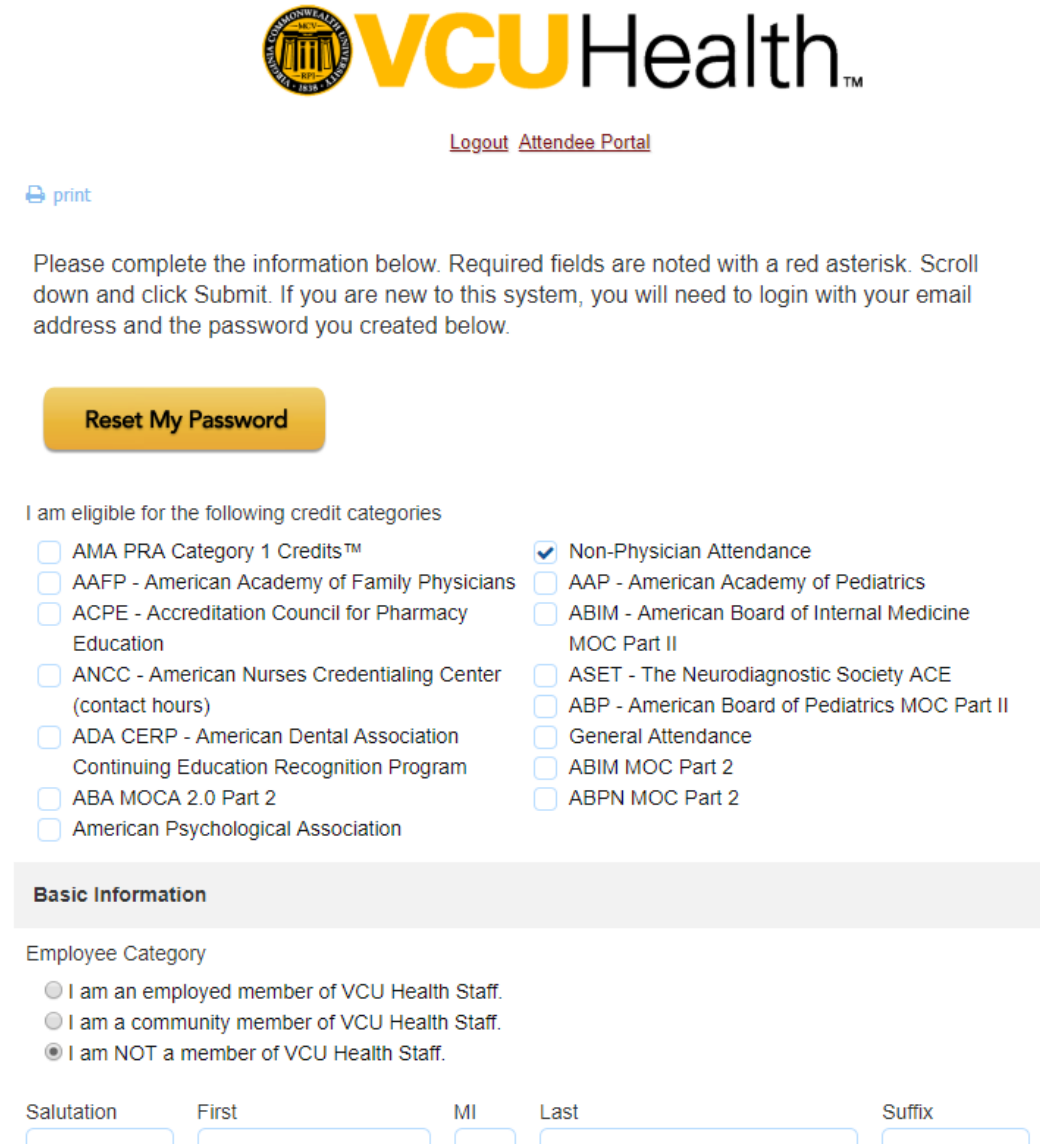

THANK YOU!

We hope to see you at our next ECHO

October 10, 2019 Getting through to physicians resistant to consulting palliative care
Emily Rivet, MD MBA FACS FASCRS

Further Reading

Rivet EB, Del Fabbro E, Ferrada P. Palliative Care Assessment in the Surgical and Trauma Intensive Care Unit. JAMA Surg. 2018 Mar 1;153(3):280-281. doi: 10.1001/jamasurg.2017.5077. PMID: 29322172

Kotter, John P. "Leading change: Why transformation efforts fail." (1995): 59-67. (See below)

COMPETITIVE STRATEGY

Leading Change: Why Transformation Efforts Fail

by John P. Kotter

FROM THE MAY–JUNE 1995 ISSUE

Over the past decade, I have watched more than 100 companies try to remake themselves into significantly better competitors. They have included large organizations (Ford) and small ones (Landmark Communications), companies based in the United States (General Motors) and elsewhere (British Airways), corporations that were on their knees (Eastern Airlines), and companies that were earning good money (Bristol-Myers Squibb). These efforts have gone under many banners: total quality management, reengineering, right sizing, restructuring, cultural change, and turnaround. But, in almost every case, the basic goal has been the same: to make fundamental changes in how business is conducted in order to help cope with a new, more challenging market environment.

A few of these corporate change efforts have been very successful. A few have been utter failures. Most fall somewhere in between, with a distinct tilt toward the lower end of the scale. The lessons that can be drawn are interesting and will probably be relevant to even more organizations in the increasingly competitive business environment of the coming decade.

The most general lesson to be learned from the more successful cases is that the change process goes through a series of phases that, in total, usually require a considerable length of time. Skipping steps creates only the illusion of speed and never produces a satisfying result. A second very general lesson is that critical mistakes in any of the phases can have a devastating impact, slowing momentum and negating hard-won gains. Perhaps because we have relatively little experience in renewing organizations, even very capable people often make at least one big error.

Error #1: Not Establishing a Great Enough Sense of Urgency

Most successful change efforts begin when some individuals or some groups start to look hard at a company's competitive situation, market position, technological trends, and financial performance. They focus on the potential revenue drop when an important patent expires, the five-year trend in declining margins in a core business, or an emerging market that everyone seems to be ignoring. They then find ways to communicate this information broadly and dramatically, especially with respect to crises, potential crises, or great opportunities that are very timely. This first step is essential because just getting a transformation program started requires the aggressive cooperation of many individuals. Without motivation, people won't help and the effort goes nowhere.

Compared with other steps in the change process, phase one can sound easy. It is not. Well over 50% of the companies I have watched fail in this first phase. What are the reasons for that failure? Sometimes executives underestimate how hard it can be to drive people out of their comfort zones. Sometimes they grossly overestimate how successful they have already been in increasing urgency. Sometimes they lack patience: "Enough with the preliminaries; let's get on with it." In many cases, executives become paralyzed by the downside possibilities. They worry that employees with seniority will become defensive, that morale will drop, that events will spin out of control, that short-term business results will be jeopardized, that the stock will sink, and that they will be blamed for creating a crisis.

A paralyzed senior management often comes from having too many managers and not enough leaders. Management's mandate is to minimize risk and to keep the current system operating. Change, by definition, requires creating a new system, which in turn always demands leadership. Phase one in a renewal process typically goes nowhere until enough real leaders are promoted or hired into senior-level jobs.

Transformations often begin, and begin well, when an organization has a new head who is a good leader and who sees the need for a major change. If the renewal target is the entire company, the CEO is key. If change is needed in a division, the division general manager is key. When these individuals are not new leaders, great leaders, or change champions, phase one can be a huge challenge.

Bad business results are both a blessing and a curse in the first phase. On the positive side, losing money does catch people's attention. But it also gives less maneuvering room. With good business results, the opposite is true: convincing people of the need for change is much harder, but you have more resources to help make changes.

But whether the starting point is good performance or bad, in the more successful cases I have witnessed, an individual or a group always facilitates a frank discussion of potentially unpleasant facts: about new competition, shrinking margins, decreasing market share, flat earnings, a lack of revenue growth, or other relevant indices of a declining competitive position. Because there seems to be an almost universal human tendency to shoot the bearer of bad news, especially if the head of the organization is not a change champion, executives in these companies often rely on outsiders to bring unwanted information. Wall Street analysts, customers, and consultants can all be helpful in this regard. The purpose of all this activity, in the words of one former CEO of a large European company, is "to make the status quo seem more dangerous than launching into the unknown."

In a few of the most successful cases, a group has manufactured a crisis. One CEO deliberately engineered the largest accounting loss in the company's history, creating huge pressures from Wall Street in the process. One division president commissioned first-ever customer-satisfaction surveys, knowing full well that the results would be terrible. He then made these findings public. On the surface, such moves can look unduly risky. But there is also risk in playing it too safe: when the urgency rate is not pumped up enough, the transformation process cannot succeed and the long-term future of the organization is put in jeopardy.

> One chief executive officer deliberately engineered the largest accounting loss in the history of the company.

When is the urgency rate high enough? From what I have seen, the answer is when about 75% of a company's management is honestly convinced that business-as-usual is totally unacceptable. Anything less can produce very serious problems later on in the process.

Error #2: Not Creating a Powerful Enough Guiding Coalition

Major renewal programs often start with just one or two people. In cases of successful transformation efforts, the leadership coalition grows and grows over time. But whenever some minimum mass is not achieved early in the effort, nothing much worthwhile happens.

It is often said that major change is impossible unless the head of the organization is an active supporter. What I am talking about goes far beyond that. In successful transformations, the chairman or president or division general manager, plus another 5 or 15 or 50 people, come together and develop a shared commitment to excellent performance through renewal. In my experience, this group never includes all of the company's most senior executives because some people just won't buy in, at least not at first. But in the most successful cases, the coalition is always pretty powerful—in terms of titles, information and expertise, reputations and relationships.

In both small and large organizations, a successful guiding team may consist of only three to five people during the first year of a renewal effort. But in big companies, the coalition needs to grow to the 20 to 50 range before much progress can be made in phase three and beyond. Senior managers always form the core of the group. But sometimes you find board members, a representative from a key customer, or even a powerful union leader.

Because the guiding coalition includes members who are not part of senior management, it tends to operate outside of the normal hierarchy by definition. This can be awkward, but it is clearly necessary. If the existing hierarchy were working well, there would be no need for a major transformation. But since the current system is not working, reform generally demands activity outside of formal boundaries, expectations, and protocol.

A high sense of urgency within the managerial ranks helps enormously in putting a guiding coalition together. But more is usually required. Someone needs to get these people together, help them develop a shared assessment of their company's problems and opportunities, and create a minimum level of trust and communication. Off-site retreats, for two or three days, are one popular vehicle for accomplishing this task. I have seen many groups of 5 to 35 executives attend a series of these retreats over a period of months.

Companies that fail in phase two usually underestimate the difficulties of producing change and thus the importance of a powerful guiding coalition. Sometimes they have no history of teamwork at the top and therefore undervalue the importance of this type of coalition. Sometimes they expect the team to be led by a staff executive from human resources, quality, or strategic planning instead of a key line manager. No matter how capable or dedicated the staff head, groups without strong line leadership never achieve the power that is required.

Efforts that don't have a powerful enough guiding coalition can make apparent progress for a while. But, sooner or later, the opposition gathers itself together and stops the change.

Error #3: Lacking a Vision

In every successful transformation effort that I have seen, the guiding coalition develops a picture of the future that is relatively easy to communicate and appeals to customers, stockholders, and employees. A vision always goes beyond the numbers that are typically found in five-year plans. A vision says something that helps clarify the direction in which an organization needs to move. Sometimes the first draft comes mostly from a single individual. It is usually a bit blurry, at least initially. But after the coalition works at it for 3 or 5 or even 12 months, something much better emerges through their tough analytical thinking and a little dreaming. Eventually, a strategy for achieving that vision is also developed.

> A vision says something that clarifies the direction in which an organization needs to move.

In one midsize European company, the first pass at a vision contained two-thirds of the basic ideas that were in the final product. The concept of global reach was in the initial version from the beginning. So was the idea of becoming preeminent in certain businesses. But one central idea in the final version—getting out of low value-added activities—came only after a series of discussions over a period of several months.

Without a sensible vision, a transformation effort can easily dissolve into a list of confusing and incompatible projects that can take the organization in the wrong direction or nowhere at all. Without a sound vision, the reengineering project in the accounting department, the new 360-degree performance appraisal from the human resources department, the plant's quality program, the cultural change project in the sales force will not add up in a meaningful way.

In failed transformations, you often find plenty of plans and directives and programs, but no vision. In one case, a company gave out four-inch-thick notebooks describing its change effort. In mind-numbing detail, the books spelled out procedures, goals, methods, and deadlines. But nowhere was there a clear and compelling statement of where all this was leading. Not surprisingly, most of the employees with whom I talked were either confused or alienated. The big, thick books did not rally them together or inspire change. In fact, they probably had just the opposite effect.

In a few of the less successful cases that I have seen, management had a sense of direction, but it was too complicated or blurry to be useful. Recently, I asked an executive in a midsize company to describe his vision and received in return a barely comprehensible 30-minute lecture. Buried in his answer were the basic elements of a sound vision. But they were buried—deeply.

A useful rule of thumb: if you can't communicate the vision to someone in five minutes or less and get a reaction that signifies both understanding and interest, you are not yet done with this phase of the transformation process.

Error #4: Undercommunicating the Vision by a Factor of Ten

I've seen three patterns with respect to communication, all very common. In the first, a group actually does develop a pretty good transformation vision and then proceeds to communicate it by holding a single meeting or sending out a single communication. Having used about .0001% of the yearly intracompany communication, the group is startled that few people seem to understand the new approach. In the second pattern, the head of the organization spends a considerable amount of time making speeches to employee groups, but most people still don't get it (not surprising, since vision captures only .0005% of the total yearly communication). In the third pattern, much more effort goes into newsletters and speeches, but some very visible senior executives still behave in ways that are antithetical to the vision. The net result is that cynicism among the troops goes up, while belief in the communication goes down.

Transformation is impossible unless hundreds or thousands of people are willing to help, often to the point of making short-term sacrifices. Employees will not make sacrifices, even if they are unhappy with the status quo, unless they believe that useful change is possible. Without credible communication, and a lot of it, the hearts and minds of the troops are never captured.

This fourth phase is particularly challenging if the short-term sacrifices include job losses. Gaining understanding and support is tough when downsizing is a part of the vision. For this reason, successful visions usually include new growth possibilities and the commitment to treat fairly anyone who is laid off.

Executives who communicate well incorporate messages into their hour-by-hour activities. In a routine discussion about a business problem, they talk about how proposed solutions fit (or don't fit) into the bigger picture. In a regular performance appraisal, they talk about how the employee's behavior helps or undermines the vision. In a review of a division's quarterly performance, they talk not only about the numbers but also about how the division's executives are contributing to the transformation. In a routine Q&A with employees at a company facility, they tie their answers back to renewal goals.

In more successful transformation efforts, executives use all existing communication channels to broadcast the vision. They turn boring and unread company newsletters into lively articles about the vision. They take ritualistic and tedious quarterly management meetings and turn them into exciting discussions of the transformation. They throw out much of the company's generic management education and replace it with courses that focus on business problems and the new vision. The guiding principle is simple: use every possible channel, especially those that are being wasted on nonessential information.

Perhaps even more important, most of the executives I have known in successful cases of major change learn to "walk the talk." They consciously attempt to become a living symbol of the new corporate culture. This is often not easy. A 60-year-old plant manager who has spent precious little time over 40 years thinking about customers will not suddenly behave in a customer-oriented way. But I have witnessed just such a person change, and change a great deal. In that case, a high level of urgency helped. The fact that the man was a part of the guiding coalition and the vision-creation

team also helped. So did all the communication, which kept reminding him of the desired behavior, and all the feedback from his peers and subordinates, which helped him see when he was not engaging in that behavior.

Communication comes in both words and deeds, and the latter are often the most powerful form. Nothing undermines change more than behavior by important individuals that is inconsistent with their words.

Error #5: Not Removing Obstacles to the New Vision

Successful transformations begin to involve large numbers of people as the process progresses. Employees are emboldened to try new approaches, to develop new ideas, and to provide leadership. The only constraint is that the actions fit within the broad parameters of the overall vision. The more people involved, the better the outcome.

To some degree, a guiding coalition empowers others to take action simply by successfully communicating the new direction. But communication is never sufficient by itself. Renewal also requires the removal of obstacles. Too often, an employee understands the new vision and wants to help make it happen. But an elephant appears to be blocking the path. In some cases, the elephant is in the person's head, and the challenge is to convince the individual that no external obstacle exists. But in most cases, the blockers are very real.

Sometimes the obstacle is the organizational structure: narrow job categories can seriously undermine efforts to increase productivity or make it very difficult even to think about customers. Sometimes compensation or performance-appraisal systems make people choose between the new vision and their own self-interest. Perhaps worst of all are bosses who refuse to change and who make demands that are inconsistent with the overall effort.

> Worst of all are bosses who refuse to change and who make demands that are inconsistent with the overall effort.

One company began its transformation process with much publicity and actually made good progress through the fourth phase. Then the change effort ground to a halt because the officer in charge of the company's largest division was allowed to undermine most of the new initiatives. He paid lip service to the process but did not change his behavior or encourage his managers to change. He did not reward the unconventional ideas called for in the vision. He allowed human resource systems to remain intact even when they were clearly inconsistent with the new ideals. I think the officer's motives were complex. To some degree, he did not believe the company needed major change. To some degree, he felt personally threatened by all the change. To some degree, he was afraid that he could not produce both change and the expected operating profit. But despite the fact that they backed the renewal effort, the other officers did virtually nothing to stop the one blocker. Again, the reasons were complex. The company had no history of confronting problems like this. Some people were afraid of the officer. The CEO was concerned that he might lose a talented executive. The net result was disastrous. Lower level managers concluded that senior management had lied to them about their commitment to renewal, cynicism grew, and the whole effort collapsed.

In the first half of a transformation, no organization has the momentum, power, or time to get rid of all obstacles. But the big ones must be confronted and removed. If the blocker is a person, it is important that he or she be treated fairly and in a way that is consistent with the new vision. But action is essential, both to empower others and to maintain the credibility of the change effort as a whole.

Error #6: Not Systematically Planning For and Creating Short-Term Wins

Real transformation takes time, and a renewal effort risks losing momentum if there are no short-term goals to meet and celebrate. Most people won't go on the long march unless they see compelling evidence within 12 to 24 months that the journey is producing expected results. Without short-term wins, too many people give up or actively join the ranks of those people who have been resisting change.

One to two years into a successful transformation effort, you find quality beginning to go up on certain indices or the decline in net income stopping. You find some successful new product introductions or an upward shift in market share. You find an impressive productivity improvement

or a statistically higher customer-satisfaction rating. But whatever the case, the win is unambiguous. The result is not just a judgment call that can be discounted by those opposing change.

Creating short-term wins is different from hoping for short-term wins. The latter is passive, the former active. In a successful transformation, managers actively look for ways to obtain clear performance improvements, establish goals in the yearly planning system, achieve the objectives, and reward the people involved with recognition, promotions, and even money. For example, the guiding coalition at a U.S. manufacturing company produced a highly visible and successful new product introduction about 20 months after the start of its renewal effort. The new product was selected about six months into the effort because it met multiple criteria: it could be designed and launched in a relatively short period; it could be handled by a small team of people who were devoted to the new vision; it had upside potential; and the new product-development team could operate outside the established departmental structure without practical problems. Little was left to chance, and the win boosted the credibility of the renewal process.

Managers often complain about being forced to produce short-term wins, but I've found that pressure can be a useful element in a change effort. When it becomes clear to people that major change will take a long time, urgency levels can drop. Commitments to produce short-term wins help keep the urgency level up and force detailed analytical thinking that can clarify or revise visions.

Error #7: Declaring Victory Too Soon

After a few years of hard work, managers may be tempted to declare victory with the first clear performance improvement. While celebrating a win is fine, declaring the war won can be catastrophic. Until changes sink deeply into a company's culture, a process that can take five to ten years, new approaches are fragile and subject to regression.

In the recent past, I have watched a dozen change efforts operate under the reengineering theme. In all but two cases, victory was declared and the expensive consultants were paid and thanked when the first major project was completed after two to three years. Within two more years, the useful changes that had been introduced slowly disappeared. In two of the ten cases, it's hard to find any trace of the reengineering work today.

Over the past 20 years, I've seen the same sort of thing happen to huge quality projects, organizational development efforts, and more. Typically, the problems start early in the process: the urgency level is not intense enough, the guiding coalition is not powerful enough, and the vision is not clear enough. But it is the premature victory celebration that kills momentum. And then the powerful forces associated with tradition take over.

Ironically, it is often a combination of change initiators and change resistors that creates the premature victory celebration. In their enthusiasm over a clear sign of progress, the initiators go overboard. They are then joined by resistors, who are quick to spot any opportunity to stop change. After the celebration is over, the resistors point to the victory as a sign that the war has been won and the troops should be sent home. Weary troops allow themselves to be convinced that they won. Once home, the foot soldiers are reluctant to climb back on the ships. Soon thereafter, change comes to a halt, and tradition creeps back in.

Instead of declaring victory, leaders of successful efforts use the credibility afforded by short-term wins to tackle even bigger problems. They go after systems and structures that are not consistent with the transformation vision and have not been confronted before. They pay great attention to who is promoted, who is hired, and how people are developed. They include new reengineering projects that are even bigger in scope than the initial ones. They understand that renewal efforts take not months but years. In fact, in one of the most successful transformations that I have ever seen, we quantified the amount of change that occurred each year over a seven-year period. On a scale of one (low) to ten (high), year one received a two, year two a four, year three a three, year four a seven, year five an eight, year six a four, and year seven a two. The peak came in year five, fully 36 months after the first set of visible wins.

Error #8: Not Anchoring Changes in the Corporation's Culture

In the final analysis, change sticks when it becomes “the way we do things around here,” when it seeps into the bloodstream of the corporate body. Until new behaviors are rooted in social norms and shared values, they are subject to degradation as soon as the pressure for change is removed.

Two factors are particularly important in institutionalizing change in corporate culture. The first is a conscious attempt to show people how the new approaches, behaviors, and attitudes have helped improve performance. When people are left on their own to make the connections, they sometimes create very inaccurate links. For example, because results improved while charismatic Harry was boss, the troops link his mostly idiosyncratic style with those results instead of seeing how their own improved customer service and productivity were instrumental. Helping people see the right connections requires communication. Indeed, one company was relentless, and it paid off enormously. Time was spent at every major management meeting to discuss why performance was increasing. The company newspaper ran article after article showing how changes had boosted earnings.

The second factor is taking sufficient time to make sure that the next generation of top management really does personify the new approach. If the requirements for promotion don’t change, renewal rarely lasts. One bad succession decision at the top of an organization can undermine a decade of hard work. Poor succession decisions are possible when boards of directors are not an integral part of the renewal effort. In at least three instances I have seen, the champion for change was the retiring executive, and although his successor was not a resistor, he was not a change champion. Because the boards did not understand the transformations in any detail, they could not see that their choices were not good fits. The retiring executive in one case tried unsuccessfully to talk his board into a less seasoned candidate who better personified the transformation. In the other two cases, the CEOs did not resist the boards’ choices, because they felt the transformation could not be undone by their successors. They were wrong. Within two years, signs of renewal began to disappear at both companies. • • •

There are still more mistakes that people make, but these eight are the big ones. I realize that in a short article everything is made to sound a bit too simplistic. In reality, even successful change efforts are messy and full of surprises. But just as a relatively simple vision is needed to guide people through a major change, so a vision of the change process can reduce the error rate. And fewer errors can spell the difference between success and failure.

A version of this article appeared in the May–June 1995 issue of *Harvard Business Review*.

John P. Kotter is a best-selling author, award winning business and management thought leader, business entrepreneur and the Konosuke Matsushita Professor of Leadership, Emeritus at Harvard Business School. His ideas, books, and company, Kotter, help people lead organizations in an era of increasingly rapid change.

This article is about COMPETITIVE STRATEGY

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TOBY LUCICH a year ago

These core tenets remain at the heart of all client discussions of effective change management. Not just for transformational efforts, but for initiatives that require engagement of both hearts and minds.

As often as not, we see errors #4 (under communicating) and #5 (absentee sponsorship) as the most common shortcomings of project leadership. Not just a frequency challenge, but communicating and advocating with visible frequency, and on a face-to-face, personal level. So incredibly powerful when we monitor delivery and watch for these errors!

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POSTING GUIDELINES

Surgical Innovation

Palliative Care Assessment in the Surgical and Trauma Intensive Care Unit

Emily B. Rivet, MD, MBA; Egidio Del Fabbro, MD; Paula Ferrada, MD

What Is the Innovation?

How can we prioritize the fundamental needs of patients in the increasingly technical and data-driven environment of modern health care, especially in the intensive care unit? Palliative care is a relatively new specialty that focuses on the most basic and human elements of medicine, including

- treatment of the symptoms associated with serious illness;
- attention to the social, spiritual, and psychological needs of the individual;
- collaboration among clinicians to optimize care; and
- communication with patients and families regarding prognosis, treatment plans, and care goals.

The innovation is incorporating a palliative care assessment into the daily rounding metrics in the surgical and trauma intensive care unit (STICU). The palliative care assessment is a simple question—does this patient have any palliative care needs?—that the team understands to include symptom management challenges, issues of psychosocial support, and disparities in perception of treatment plan and prognosis. Incorporating this question into the daily rounds allows these aspects of patient care to be given equal priority as issues such as hemodynamics and infection in the daily rounding discussion.

What Are the Key Advantages Over Existing Approaches?

The STICU is a complex, high-volume system whose focus on recovery from critical illness may sometimes prioritize clinical over personal needs. After the innovation was adopted, we observed an increase in specialist palliative care referrals from the STICU. Perhaps more important is that we also noted heightened attention to pain and other symptoms, discussions of clinical trajectories and prognosis, and awareness of psychosocial and spiritual aspects of care during rounds. Given the shortage of palliative care specialists in the United States, increasing the STICU team's attentiveness and responsiveness to these issues may be of greatest value. Implementation was facilitated by a surgeon with specialty training in palliative care who provided education about the role of palliative care and rounded with the STICU team for 1 month. The presence of such dual-trained physicians is not essential, but it may expedite changes in practice and has done so in other fields, such as oncology.[1] Furthermore, data from our program demonstrate that palliative care consultation can improve recognition of conditions such as delirium and increase the comprehensiveness of discussions regarding end-of-life care.[2] This integrated approach that combines primary and specialist palliative care as well as the role of each in treating patients will need to be defined by additional research and will depend on the resources of specific health systems.

How Will This Affect Clinical Care?

The emerging concept of "sudden advanced illness" provides a useful framework for appreciating why surgical and trauma patients may have particularly intense palliative care needs as a result of sudden onset of illness, uncertain prognosis, and frequent lack of existing advance directives.[3] A different but equally needy population in this setting is the subset of patients with decline due to age or chronic illness. In these cases, injury from ground-level falls is a presentation of frailty rather than a result of the mechanism in isolation. Patients facing complex decisions about the potential benefit and risk of surgery for issues other than traumatic injury are another group in the STICU with particularly robust palliative care needs. Benefits of palliative care for these patients can include improved management of symptoms such as pain and delirium, more effective communication about prognosis, improved family and patient satisfaction, and increased alignment among care team members.

Is There Evidence Supporting the Benefits of the Innovation?

Mosenthal et al[4] show that a structured palliative care intervention integrated into standard care increases discussions of pain, other symptoms, and goals of care on rounds in the trauma ICU. This study and others also demonstrate that early palliative care intervention can move upstream the timing of do-not-resuscitate orders and withdrawal-of-life-support consent without affecting mortality rates. However, although a recent single-institution study of a prospectively maintained database found that 20% of specialty palliative care consultations from surgical services were for symptom management, limited data are available regarding the outcomes of such consultations in this population.[5] Palliative care specialists improve recognition and treatment of conditions, such as delirium, that increase morbidity, mortality, and health care costs in the critical care setting.[6] A recent systematic review showed positive findings associated with palliative care in surgical patients but also noted significant limitations in evidence.[7]

What Are the Barriers to Implementing This Innovation More Broadly?

National organizations, such as the American College of Surgeons, have endorsed the value of palliative care for surgical patients since 2005, but acceptance is not yet universal. A major factor remains the "rescue culture" of surgery and the pervasive sense that recovery and palliation are sequential rather than parallel elements of an individual's medical trajectory. Other important factors are the national shortage of specialist palliative care clinicians and the current lack of education and training of surgeons to deliver primary palliative care. Furthermore, outcome measures prioritize survival over other metrics, such as quality of life or time spent out of the hospital. Last, the financial incentive structure of the American health care system does not always effectively align the values of patients, insurance providers, surgeons, and hospitals. All of these factors may

present challenges for the widespread adoption of the palliative care assessment into the daily rounding work of STICU teams. However, we believe the low burden and high effect of this innovation present an opportunity for its wide acceptance.

In What Time Frame Will This Innovation Likely Be Applied Routinely?

A critical momentum has been reached to radically change how surgeons think about outcomes, benefits, and care. Indications of the changing paradigm include surgeons undertaking specialty training in palliative care, recent literature proposing that acute care general surgeons could provide palliative care consultation, and national surgical organizations advocating for palliative care.[8] The balance between primary and specialist palliative care may vary in particular health systems, in geographic areas, and on the basis of needs of individual patients, but the core innovation of the palliative care assessment in every STICU remains the objective.

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REFERENCES

1. Hui D, Bruera E. Integrating palliative care into the trajectory of cancer care. *Nat Rev Clin Oncol*. 2016;13(3):159-171.

2. Rivet EB, Ferrada P, Albrecht T, et al. Characteristics of palliative care consultation at an academic level one trauma center. *Am J Surg*. 2017;214(4):657-660.

3. Barnett MD, Williams BR, Tucker RO. Sudden advanced illness: an emerging concept among palliative care and surgical critical care physicians. *Am J Hosp Palliat Care*. 2016;33(4):321-326.

4. Mosenthal AC, Murphy PA, Barker LK, Lavery R, Retano A, Livingston DH. Changing the culture around end-of-life care in the trauma intensive care unit. *J Trauma*. 2008;64(6):1587-1593.

5. Rodriguez R, Marr L, Rajput A, Fahy BN. Utilization of palliative care consultation service by surgical services. *Ann Palliat Med*. 2015;4(4):194-199.

6. de la Cruz M, Fan J, Yennu S, et al. The frequency of missed delirium in patients referred to palliative care in a comprehensive cancer center. *Support Care Cancer*. 2015;23(8):2427-2433.

7. Lilley EJ, Khan KT, Johnston FM, et al. Palliative care interventions for surgical patients: a systematic review. *JAMA Surg*. 2016;151(2):172-183.

8. O'Connell K, Maier R. Palliative care in the trauma ICU. *Curr Opin Crit Care*. 2016;22(6):584-590.