SECONDARY CARE: EXPLORE THE OPTION OF KEEPING THEM IN-PATIENT/DAY-PATIENT/OUT-PATIENT THROUGH THEIR TREATMENT

Direct Veterinary Surgery
Surgical Solutions Direct to You

Veterinary medicine is constantly changing—more medicines, more diagnostics, more therapeutics, more sub-specialties, more diseases, more client variety (expectations, finances, abilities), more, more, more. As a surgeon watching all of this unfold over my career, I am thinking about ways to use my expertise and my business to further support the diversity-of-care needs we are facing in this profession. One size does not fit all in most ways; with regard to surgical care in the small animal profession, I see room for **expanding "secondary care" services for our patients** and clients.

History, in just my career timeline, has taken us from postoperative overnight/unsupervised care to ventilator support for days at a time. How we practice and what we offer – standards of care—are fluid things, shaped by honest, well-intentioned, thoughtful, practical veterinarians navigating patient care realities and client expectations. **Clients' ability to pay is a constant elephant in the room**, no matter how vehemently consultants and practice management gurus tell us it should not be. How then do we merge these disparate factors—standards of care and client finances—into a rational way forward? Our goal is optimal care and quality of life for our patients.

Surgery and anesthesia are classic categories with standards of care. If all we look at are medical factors when determining these standards, moving forward we will price the majority of pet owners out of veterinary care for their pets. If instead we rely on optimal care balanced atop medical and financial and communication and owner responsibility factors, we may be able to help many more. With personnel and facility costs driving the majority of veterinary fees, a logical place to start in defining "secondary care" is the outpatient model. Can we support animals perioperatively as outpatients, relying on top quality communication and owner participation in their own homes to navigate patient treatment and monitoring? **I think it is a road worth traveling.**

Big picture, what does this look like? What illnesses and injuries are amenable to this model? What communication pieces are needed to prepare clients sufficiently? What triage factors must be addressed to target the "right" patient and client? How do we characterize and quantify the risks and benefits to secondary care? Below are some thoughts to start the consideration and conversation. *See what you think and let me know if you'd like to travel down this road with me.*

Secondary care, outpatient, perioperative scenario

Patient comes in for illness or injury; you and your staff assess and diagnose and begin initial stabilization and communication about necessary care. Diagnosis warrants surgical treatment as part of care. As stabilization continues in-clinic, client discussions and

decision-making around **costs**, **patient needs**, and **avenues for surgical treatment** ensue.

Balancing these three variables, a decision is made to prepare patient for anesthesia/surgery (in-patient/out-patient as medical urgency dictates), perform anesthesia/surgery/recovery in-clinic, prepare patient for further recovery and support out-patient with periodic return visits during regular clinic hours as needed to support medical and client schedule parameters. **Patient supervision is down-graded through tiers** of in-patient (urgent care), day-patient (stabilizing care), out-patient (monitoring care), virtual (progress care).

Illnesses and injuries amenable to secondary care surgery

Trauma, neoplasia and tubular organ dysfunction (GI, bladder, uterus) are probably the most common variably-urgent conditions pets face these days. With many situations, the overall cardiovascular stability of the patient needs minor to moderate support to regain homeostasis; this is easily achieved with the level of knowledge, equipment and products available to most practices. Once stable enough for anesthesia, we are well versed with monitoring and maintaining them through a surgical episode. Thereafter, with the regional, parenteral and oral routes for analgesia and other essential medications, we can prepare them for an overnight at home and day-patient return for updated monitoring and medications. The following list easily springs to mind:

- Traumatic fracture / joint luxation
- Traumatic / neoplastic hemoabdomen
- GI obstruction
- Bladder stone/urethral obstruction
- Pyometra
- Dystocia

What other cases are you feeling confidence in managing through this framework?

Communications to optimize the secondary care surgery setting

A fully informed pet owner is essential to success with the secondary care case selection. Most of the conditions have some urgency, some seriousness, some higher morbidity/mortality considerations. All of these factors heighten the need for accurate, fully understood, and specifically acknowledged communications.

Stop, Look, and Listen...comes to mind when thinking about the client exchange with these cases and conditions.

> **Stop**—to slow things down, to allow emotional energy to settle out of decision-making, to focus attention on specific areas of personal responsibility.
>
> **Look**—utilize written and imaging materials to their fullest, diagram a timeline of care (who/where/when), prepare canned materials to improve efficiency.

Listen—repeat yourself, speak slowly and without urgent tone/body language, ask for owners to parrot back understanding and options.

Triage for the patient, triage for the client, triage for the veterinary team

Not every patient can be treated using this secondary care model; the next level of equipment (ex. ventilator), supplies (ex. blood products), staffing (ex. hourly care/monitoring) pushes some cases into the tertiary setting. **Triage with guidelines** allows for patient selection that fits the equipment/supply/staffing abilities of secondary care in your practice.

Not every client will want to or be able to participate at the more active/engaged level of pet care/monitoring this model demands. They may be squeamish, poorly practical, time-limited, physically challenged; and some may not be able to **assure us** of their understanding of the level of commitment this model requires. Secondary care requires solid owner participation in their pet's care and monitoring—introspection and self-awareness are essential!

Not every veterinary professional is cut out for the different risks associated with secondary care model; no shame it that! (I don't cut brains and backs for a reason these days!) The veterinary team choosing this model **needs to plan for *different* problems**—client interactions, patient morbidity/mortality, failures. I live by the Failure Model that *to fail is to learn* for next time; if I don't fail, I have not grown. (Don't get me wrong, I am obsessively resistant to the experience of failing! I work hard to prevent big failures by structuring life enough to only have a bunch of small failures instead. I try to learn frequently and non-catastrophically.)

Risks and benefits

I'll start with the risks and get the big one out of the way. I suspect that the number of patients you treat, who then die, will increase. I think that increase will be small, but real. Next on the list, the number of clients with whom you engage, who will be frustrated through the course of treatment, will increase. I think that increase will be small, but real. Both of these events are "learnable"—something from which to learn, get better and avoid. But, each one will challenge your decision to continue down this new road.

The benefits are more appealing. Saving more pets from the freezer; the harsh reality of full freezers at ERs is an unspoken, heart-wrenching, morally—I can't find the word…bad, wrong, no ones' fault, sad—fact. Can the niche of secondary care get at this problem? Expanding our professional expertise and fulfillment; finding "flow" in our professional lives (see Mihaly Csikszentmihalyi's work.) Can this new path bring some excitement and challenge to a tightly wound year?

These are but a few risks and benefits; there are more to unpack and study. Think about it and **let me know your ideas**. I will continue working through the canned trainings and

communications pieces that make this trip look more appealing (see emails and www.directvetsurg.com). **Stay tuned and drop me a line if you are interested in pursuing this model with DVS**.

****PLEASE NOTE:** If you are contacting us with a case, to optimize communications we ask that you **use email and title the subject "URGENT—patient name"**.

Include in the email:

1) full signalment,

2) problem list,

3) lab data/radiographs,

4) proposed/requested surgery, and

5) your preferred day/time.

The more information we have, tightly summarized, the quicker we can respond with pertinent advice and logistics. Let's do this!

Lara Marie Rasmussen, DVM, MS
Diplomate, American College of Veterinary Surgeons
Direct Veterinary Surgery, LLC
www.directvetsurg.com
directvetsurg@gmail.com
651 829-1111