Dialogue Summary

Taking a Step Towards Achieving Worry-free Surgery in Ontario

30 October 2017

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The McMaster Health Forum's goal is to generate action on the pressing health-system issues of our time, based on the best available research evidence and systematically elicited citizen values and stakeholder insights. We aim to strengthen health systems – locally, nationally, and internationally – and get the right programs, services and drugs to the people who need them.

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the dialogue summary. The funders reviewed a draft dialogue summary but the authors had final decision-making authority about what appeared in the dialogue summary.

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Dialogue

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SUMMARY OF THE DIALOGUE

The deliberation about the problem initially focused on the concept of 'worry-free surgery.' There were mixed views about the concept, with some dialogue participants expressing concern that it implied that there would no longer be surgery-related complications, and others seeing its value as a call to action that health-system leaders and stakeholders should respond to. Deliberations then turned to the shortfalls in peri-operative risk assessment and management in Ontario. In addition to the features of the problem articulated in the evidence brief, participants highlighted four additional challenges: 1) lack of timely access to surgical care; 2) lack of patient information and education about peri-operative risk assessment and management; 3) lack of integrated post-surgical care approaches (including care pathways and shared decision-making); and 4) limited availability and contextualization of peri-operative data.

In deliberating about the elements of a potentially comprehensive approach to taking a step towards achieving worry-free surgery in Ontario, dialogue participants generally agreed about the need for system-wide interventions to strengthen the continuum of peri-operative care. In discussing element 1 (strategies to support the implementation of optimal peri-operative risk assessment and management), participants highlighted the need for combining robust research evidence, concrete examples of optimal practices and patient stories, and peer pressure to bring about the needed behavioural changes among professionals and hospital managers. In addition, participants emphasized the need to more effectively leverage existing infrastructure and programs to support quality-improvement initiatives. For element 2 (financial arrangements that support the implementation of optimal peri-operative risk assessment and management), participants highlighted the need for more flexibility in hospital budgets, and the right financial incentives for professionals and hospital managers to support the uptake of clinical-practice guidelines. Lastly, for element 3 (broader system arrangements that support the implementation of optimal peri-operative risk assessment and management), participants focused on the need to better align accountability and authority within the system, streamline care pathways, enhance technological infrastructure, and adjust public reporting to ensure professionals and organizations are treated fairly.

Participants prioritized seven actions as part of a first step towards achieving worry-free surgery in Ontario: 1) spreading awareness among health-system leaders of the importance of streamlining peri-operative risk assessment and management; 2) supporting existing communities of practice to build quality-improvement capacity among health-system stakeholders; 3) supporting the development of training opportunities for professionals to support optimal peri-operative risk assessment and management; 4) working with partners across the health system to establish a consensus on what peri-operative data should be collected, and to make data more easily available; 5) exploring the types of small-scale innovation projects that could be designed to optimize peri-operative care and to help build the case for the uptake of clinical-practice guideline recommendations; 6) developing a research agenda to strengthen peri-operative risk assessment and management; and 7) pursuing stakeholder-engagement initiatives to advance an agenda towards achieving worry-free surgery.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

The deliberation about the problem initially focused on the concept of 'worry-free surgery' proposed in the evidence brief. In the brief, worry-free surgery was defined as:

- engaging the patient and the care team in the decision-making process about whether to proceed with surgery in light of the patient's needs, conditions, values and preferences;
- minimizing risk for peri-operative complications by proactively identifying and addressing risk factors; and
- using care pathways that are informed by the best available clinical-practice guidelines.

Dialogue participants' reactions were mixed regarding the proposed concept. Some expressed concern that the concept may imply that the goal is to eliminate risk of surgical complications. As one participant noted: "The only worry-free surgery is no surgery." Others raised questions about who is worrying. They pointed out that not only patients and families worried, but also professionals, managers and policymakers, with one of the surgeons in the room stating that "we are paid to worry for our patients." Others also indicated the need to explicitly define what is a 'surgery,' given new and emerging medical procedures (e.g., percutaneous interventions), as well as who is at risk. One participant emphasized that the field of surgery is constantly evolving, stating: "It's all shifting. It's a moving target. Who we consider at risk is also shifting."

Other participants recognized that 'worry-free surgery' was a "catchy phrase" that could spark a discourse about the importance of optimizing peri-operative risk assessment and management. As one participant remarked: "Less worrisome surgery doesn't sell as well." Several participants saw the value of worry-free surgery as a call to action, a "horizon objective" or an "aspirational goal" that could create buy-in among health-system leaders and stakeholders to achieve evidence-informed peri-operative risk assessment and management. These participants emphasized the need for peri-operative risk assessment and management to be informed by the best-available research evidence, and not just the best available clinical-practice guidelines.

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

1) it addressed an issue currently being faced in Ontario;
2) it focused on different features of the problem, including (where possible) how it affects particular groups;
3) it focused on three elements (among many) of a potentially comprehensive approach for addressing the policy issue;
4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three elements of a potentially comprehensive approach for addressing the problem, and key implementation considerations;
5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;
6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
7) it ensured fair representation among policymakers, stakeholders and researchers;
8) it engaged a facilitator to assist with the deliberations;
9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
10) it did not aim for consensus.

We did not aim for consensus because coming to agreement about commitments to a particular way forward can preclude identifying broad areas of agreement and understanding the reasons for and implications of specific points of disagreement, as well as because even senior health-system leaders typically need to engage elected officials, boards of directors and others on detailed commitments.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

Participants then deliberated about the different facets of the problem. Many participants echoed the challenges that were presented in the brief, including that:

- the growing scope and volume of surgeries create challenges for the health system, with one participant quoting a recent large retrospective cohort study revealing that 1.4% of adults die in the post-operative period;
- peri-operative complications create ripple effects for patients, caregivers, health professionals and the health system, with several participants emphasizing the impact of complications on health professionals' stress levels and workloads, which may affect their decision-making capacity, lead to burnout, and contribute to a culture of defensive medicine;
- many patients do not receive optimal peri-operative risk assessment and management, with several participants drawing attention to regional variations in surgical outcomes, failures to recognize some of the major complications, and behaviours like failing to inform patients about their risk, and discharging them more rapidly and without proper patient preparation);
- peri-operative risk assessment and management is not consistently being optimized based on the best-available data, evidence and guidelines, with participants highlighting the use of unnecessary peri-operative tests and variability in the uptake of clinical-practice guidelines); and
- system-level factors make it difficult to support the widespread uptake of optimal peri-operative risk assessment and management, with participants emphasizing how fragmentation in the health system results in reduced ability to detect complications early, as well as how organization-funding models and the dominant physician-remuneration model do not incentivize the uptake of optimal models of care (e.g., they create incentives to routinely order unnecessary pre-operative tests, and create disincentives to conduct remote monitoring after hospital discharge).

In addition to the features of the problem articulated in the evidence brief, participants highlighted four additional challenges, which build on those listed above: 1) lack of timely access to surgical care; 2) lack of patient information and education about peri-operative risk assessment and management; 3) lack of integrated post-surgical care approaches (including care pathways and shared decision-making); and 4) limited availability and contextualization of peri-operative data. We discuss each of these in detail below.

Lack of timely access to surgical care

Lack of timely access to surgical care emerged as one of the biggest challenges to achieving worry-free surgery. Several dialogue participants highlighted that wait times exacerbated the anxiety experienced by patients, families and caregivers. Participants also noted that extended delays in surgery can result in a deterioration of a patient's health status and, as a result, increased peri-operative risks. As some participants pointed out, in some instances deterioration in health while waiting for surgery can result in surgery no longer being possible. One participant referred to a patient-engagement initiative led by an organization which revealed that patients are generally more concerned about wait times than by the safety-related aspects of surgery: "It's not so much the wait, but it's the uncertainty around the wait."

Several participants expressed concerns about access to surgical care for specific populations, including people of low socio-economic status, the frail elderly, people in rural and remote areas, and Indigenous peoples. One participant indicated that readmission rates are high for surgery patients in rural and remote areas, particularly among those who are also of low socio-economic status. Participants also noted additional concerns in relation to these specific populations: they may lack timely access to primary and specialized care before surgery and to post-operative support systems; and they may be less likely to seek care to manage peri-operative complications. Referring specifically to Indigenous populations, one participant indicated that some may not seek care because "they may not feel safe in our system."

Lack of patient information and education about peri-operative risk assessment and management

Dialogue participants generally agreed that health professionals typically do not adequately inform and educate patients, families and caregivers about peri-operative risk assessment and management. As one participant said, this is generally due to time pressures: "I suspect a lot of our educational strategies are time-crunched."

Several participants pointed out that patients (and even medical residents) were increasingly turning to 'Dr. Google' to answer their health-related questions. These participants were concerned that using Google led many to use unreliable sources of information and information that is not adapted to the unique circumstances of each patient. As one participant shared: "Patients never check Google for comorbidity. (They) increasingly check YouTube for the surgery they think they will have, which creates a lot of anxiety." This resonated with a second participant who stated that in their experience "more and more chronic-care patients are downloading info from God knows where."

On the other hand, some participants suggested that the upside of 'Dr. Google' is that patients are increasingly taking ownership of their illness, such as in the self-management of chronic diseases. Several participants suggested the need to move away from paternalistic approaches, such as pre-operative and discharge classes during which instructions are provided, and towards new technologies, such as apps on tablets and interactive websites, to better prepare patients and families before surgery, and to proactively engage them in peri-operative risk assessment and management. However, as some participants pointed out, the challenge will be ensuring that these digital platforms are trusted by patients, families and caregivers, and that they have the digital literacy to use such platforms to their full potential.

Lack of integrated post-surgical care approaches

One dialogue participant stressed that while great advances have been made in delivering safe intra-operative care, most surgery-related complications happen in the post-operative period. Referring to the mortality rates in surgery patients, this participant indicated that "when you look at the data, few will die in the OR [operating room]. Most die after the OR or after being discharged." Generally agreeing with this statement, other participants emphasized that a key contributor to surgery-related complications is the lack of integrated post-surgical care approaches, both within the hospital setting and after discharge from hospital.

Some participants pointed out that the lack of communication among health professionals and the high number of patient handovers also contribute to the 'in-hospital' dimension of the problem. However, most participants emphasized the lack of integration with primary and community care in the post-operative period as the bigger challenge. Some highlighted this lack of integration as a missed opportunity given that primary- and community-care professionals can play a significant role in engaging patients in risk assessment and management, as well as closely monitoring patients after they are discharged from hospital following surgery. One participant offered the example of the high readmission rates after hip and knee replacement surgeries as a sign that patients often worry about what to expect after being discharged, and return to hospital due to lack of integrated follow-up to help them understand what is normal and what is not. This resonated with a second participant who indicated that "unless you have appropriate follow-up, it should be expected that you'll have frequent readmissions."

Participants emphasized that three of the most important underlying causes of the challenges outlined above are: 1) limited opportunities to engage in shared decision-making (where patients, families, caregivers and their health professionals develop clear expectations and a detailed care plan); 2) care pathways that are patient-centred and integrated with the full range of sectors and health professionals involved in surgical care; and 3) limited uptake of (and little financial support for) new and emerging smart technologies that could support care integration and help to monitor patients more closely in the post-operative period, both in hospital and at home.

Limited availability and contextualization of peri-operative data

The lack of availability and contextualization of peri-operative data was identified as a key challenge by dialogue participants. Some participants pointed out that in recent years, most data-related efforts in Canada have been focused on collecting and reporting data on wait times for priority procedures (e.g., cataract surgeries, hip and knee replacements, and hip fracture repairs). Similar investments have not been made in peri-operative data, with the result that such data are often lacking, do not address the right issues (e.g., potential causes of, not just rates of, readmission and 30-day mortality), are not presented in an easy-to-use format, and frequently cannot be linked to data available on other data platforms. As one participant said: "Death is real and concrete, but we're failing in identifying the causes." Moreover, several participants emphasized that "patients' voices" are often not included, despite calls for greater use of patient-reported outcome measures.

Without robust peri-operative data, some participants suggested that it is hard for health-system leaders to assess performance and understand gaps in the quality of care. However, it was also acknowledged that it is often difficult to move from data to change, with one participant stating that "once you have the information, that alone isn't enough to make meaningful change." Regardless, participants generally agreed that having robust peri-operative data is needed to build a business case from a macro perspective, with one participant indicating that "(there can't be) a lot of movement without a burning platform."

Some participants were optimistic about the progress being made by the Ontario Surgical Quality Improvement Network and the National Surgical Quality Improvement Program (NSQIP-ON), which tracks a series of indicators allowing surgeons and hospitals to compare themselves with their peers. However, as some participants highlighted, the initiative is currently limited to 31 Ontario hospitals, although efforts are currently being made to increase the number of participating hospitals. And while a public reporting phase is expected, the collected data is not yet being made publicly available.

DELIBERATION ABOUT ELEMENTS OF A POTENTIALLY COMPREHENSIVE APPROACH TO ADDRESS THE PROBLEM

Dialogue participants generally supported the three elements of the potentially comprehensive approach described in the evidence brief. These included strategies to support the implementation of optimal peri-operative risk assessment and management (element 1); financial arrangements that support the implementation of optimal peri-operative risk assessment and management (element 2); and broader system arrangements that support the implementation of optimal peri-operative risk assessment and management (element 3).

Element 1 – Strategies to support the implementation of optimal peri-operative risk assessment and management

The deliberation about the first element focused on using professional-targeted strategies to support the implementation of the best-available clinical-practice guidelines. Two key themes emerged during these deliberations: 1) research evidence, concrete examples (including patient stories and examples of ineffective or harmful practices), and peer pressure are needed to bring about the needed behavioural changes among health professionals and hospital managers; and 2) existing infrastructure and programs must be leveraged more effectively to support quality-improvement initiatives.

Dialogue participants first discussed what is needed to bring about the needed behavioural changes among health professionals and hospital managers to support the use of clinical-practice guidelines. A few participants indicated that one way to facilitate and trigger the use of clinical-practice guidelines could be to emphasize that they are informed by the best-available research evidence. To achieve this, they emphasized the need to be more systematic and transparent in how we grade the quality of evidence and strength of recommendations contained in guidelines (e.g., using approaches such as those proposed by the GRADE working group). Other participants highlighted the need for powerful and concrete examples such as patient stories and illustrative cases of ineffective or harmful practices, to illustrate the opportunity costs and the consequences of poor-quality peri-operative risk assessment and management. Two concrete examples were proposed:

- measuring brain natriuretic peptide (BNP) or N-terminal fragment of proBNP (NT-proBNP) before surgery to enhance peri-operative cardiac risk estimation (which is recommended in the recently published national guideline) as opposed to expensive and ineffective cardiac testing (which is not recommended yet continues to be frequently used); and
- point-of-care ultrasound to guide vascular access procedures (which is recommended in the same guideline because it can reduce the risk of catheterization failure and complications, while improving patient comfort and satisfaction) as opposed to the traditional technique of relying on the use of anatomical landmarks (which is not recommended).

Participants suggested that the combination of research evidence and concrete examples could be used to encourage positive "peer pressure" to improve the uptake of clinical-practice guidelines.

Participants also noted the need to more effectively leverage existing quality-improvement infrastructure and programs. Several participants began this discussion by questioning the capacity of individual health professionals and hospital managers across the province to lead quality-improvement initiatives, or even to respond meaningfully to performance data that highlight gaps in their care as compared to the best-available guidelines. To overcome this, these participants emphasized the need for regional and provincial initiatives that engaged all key stakeholders, including patients and families, in identifying key metrics (including patient-reported outcome measures) and developing an integrated quality/safety monitoring and improvement system.

Element 2 – Financial arrangements that support the implementation of optimal peri-operative risk assessment and management

The deliberation about the second element focused on two approaches to better aligning financial arrangements (including health professional remuneration and hospital funding) with clinical-practice guideline recommendations. First, several dialogue participants argued for more flexibility in budgets. Participants generally agreed that in general budgets need to be made "more nimble" because achieving system-level changes requires coordination among many players in the system and moving money between silos. Participants also pointed out that hospital budgets need to be more accommodating, given alterations to care pathways typically need to be paid for through inflexible departmental budgets, even if they would yield hospital- or system-wide savings. Emphasizing the importance of flexible funding arrangements that can accommodate new and more effective ways of doing things, one participant said: "It's hard to be innovative when the Health-Based Allocation Model penalizes you for doing that. The savings on one side are costs on the other part of the silo."

Second, participants highlighted the need to properly incentivize health professionals and hospital managers to support the uptake of peri-operative risk assessment and management guidelines. One participant offered an example of why this is so important: "Guidelines suggest that certain cardiac tests don't improve care. The problem is that hospitals make money from these (cardiac) tests. The system would be better served with biomarker tests, but the system is not set up this way.… The financial incentives are not organized in a way to support optimal risk assessment and management."

Element 3 – Broader system arrangements that support the implementation of optimal peri-operative risk assessment and management

The deliberation about the third element focused on broader (non-financial) system arrangements required to take a step towards achieving worry-free surgery. Three key themes emerged during these deliberations: 1) using governance arrangements to better align accountability and authority within the system; 2) strengthening the delivery of care by changing how care is designed to meet the needs of patients, families and caregivers, and enhancing the supports that are needed to deliver such care; and 3) public reporting must be risk adjusted.

Starting with the first theme, several dialogue participants made the case for better aligning accountability and authority within the health system. While one participant noted that "we have decentralization in Ontario but all health service agreements are still mandated by Queen's Park," and others suggested that there needed to be more focus on leadership at the local level to optimize peri-operative risk assessment and management, many participants recognized that accountability and authority needed to be clarified. A few participants cited the cancer-care system as exemplary on this front, with one participant stating that "we have a system in place to align funding with reporting, audit and feedback, engaging patients and families.… All the pieces are integrated within the cancer-care system."

Turning to the second theme, participants discussed both changing how care is designed to meet the needs of patients, families and caregivers, and enhancing the supports that are needed to deliver care. For the former, participants emphasized the need to streamline peri-operative care pathways. Doing so could include a number of activities, including efforts to foster greater collaboration in care delivery (e.g., through team-based approaches that support optimal transitions across primary/community care, surgical care and back to primary/community care), and greater patient and family engagement in the delivery of peri-operative care. For the latter, participants emphasized the need to ensure access to a robust technology infrastructure, including a mature digital infrastructure to collect peri-operative data and the technology to support continuous non-invasive monitoring in home settings.

Regarding the last theme, while one participant expressed optimism about the potential for public reporting to support behavioural changes, stating that "if you know you're an outlier, you'll make adjustments," most participants called for caution and specifically for risk-adjusted public reporting. In particular, concerns were expressed that some surgeons and hospitals that deliver peri-operative care to high-risk patients may score poorly compared to those that deliver care to low-risk patients. Risk adjustment was perceived as essential to having fair and balanced reporting of performance indicators, given that some surgeons and organizations are more likely to deliver complex surgeries to high-risk patients than others. As one participant stressed, "when providing feedback and reporting outcomes, we have to be clear [they are] being assessed across institutions in an equitable way." Other participants went further, stating that without risk adjustment, there will be no incentive for surgeons and organizations dealing with the most complex cases to report their data. In addition, participants suggested that in the absence of risk adjustment, performance indicators may provide misleading information about the quality of peri-operative care delivered. As one participant noted, "if a specific outcome measure or report makes a system look bad, where is the incentive to report? Care may be superior in a place that chooses to report ugly statistics."

Considering the full array of elements

In considering the full array of elements, there was a general agreement about the need for interventions addressing the continuum of peri-operative care (including primary care, community care and specialized care). While dialogue participants generally agreed that it was essential to use behaviour-change strategies targeting professionals to support the implementation of the best-available clinical-practice guidelines (element 1), they generally focused on the need for system-wide interventions such as proper financial incentives and flexibles budgets (element 2), as well as governance and delivery arrangements that support the uptake of new models of care (element 3).

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Dialogue participants identified three implementation barriers during deliberations. First, participants identified system inertia as a key factor impeding the scale-up and spread of innovations, such as those proposed to take a step towards achieving worry-free surgery. Some suggested that this inertia appears to be driven by the aversion of health-system leaders to change how they do things, and their tendency to rely on calling for more research evidence before moving forward (e.g., needing more peri-operative data to examine how Canada fares in comparison with other countries). Some participants reflected on this barrier, saying that "we turn ourselves into the kings of analysis" and that "we often wait until we have the evidence" before trying things. Second, participants emphasized the challenge facing health-system leaders who must pay attention to a myriad of pressing issues, and in a context of "health-spending reforms that are changing all the time." Lastly, several participants indicated that balancing competing demands is particularly difficult when considered in combination with challenging health-system features such as siloed budgets that make it difficult to incorporate innovations in care that may ultimately improve the patient experience, improve health outcomes and keep system-level costs manageable.

Having discussed barriers, participants identified five features of the current landscape that could collectively create a window of opportunity to take a step towards achieving worry-free surgery:

1) the synergy between a potential call to action towards achieving 'worry-free surgery' and several issues currently on the government's agenda, such as enhanced accountability, quality and patient safety;
2) new and emerging technologies (e.g., apps for engaging patients and technologies allowing automated remote monitoring outside the hospital environment) that could support peri-operative risk assessment and management;
3) ongoing initiatives to enhance coordination across professional groups that could improve peri-operative risk assessment and management (e.g., the Canadian Institute for Health Information is coordinating a

consultation with professional groups to identify missing data in various sectors, as well as to develop national standards and indicators that could help propel analyses to the next level);
4) ongoing efforts to standardize peri-operative data and integrate such data from different sources (e.g., efforts by the Canadian Institute for Health Information, Health Quality Ontario, Institute for Clinical Evaluation Sciences and National Surgery Quality Improvement Program-Ontario); and
5) the Ontario Technology Advisory Committee, which could provide needed supports to enhance the uptake of optimal peri-operative care models.

Dialogue participants were particularly engaged by the idea of issuing a call to action for taking a step towards achieving worry-free surgery that would resonate with the current government priorities of enhanced accountability, quality and patient safety. Some participants noted that the Excellent Care for All Act, which aims to strengthen accountability in Ontario's health system to deliver high-quality patient care, could be leveraged to raise the profile of the 'worry-free surgery' agenda and to mobilize health-system policymakers and stakeholders. Other participants noted their optimism about, and the synergy with, the possibility of scaling up the work of the National Surgical Quality Improvement Program - Ontario (NSQIP-Ontario).

Several participants emphasized that new and emerging technologies could be 'game changers' in taking a step towards achieving worry-free surgery. Several examples shared include: technologies for measuring brain natriuretic peptide or N-terminal fragment of proBNP before surgery to enhance peri-operative cardiac risk estimation; technologies that allow for automated, non-invasive and continuous monitoring of surgery patients in hospital and at home; and/or tablet-based technologies that can be used to inform and engage patients in peri-operative risk assessment and management.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

In the deliberations about next steps, participants outlined what they would bring back to their respective constituencies and how their suggestions could work to advance the proposed solutions. Together, participants prioritized seven actions towards achieving worry-free surgery in Ontario:

1) spreading awareness among health-system leaders of the importance of streamlining peri-operative risk assessment and management, with a particular emphasis on ensuring that standards of care are consistent across the province, while being sensitive to the province's most vulnerable populations;
2) supporting existing communities of practice to build quality-improvement capacity among health-system stakeholders (e.g., NSQIP-Ontario), and provide these communities of practice with the tools to streamline and optimize peri-operative risk assessment and management;
3) supporting the development of training opportunities for professionals to support optimal peri-operative risk assessment and management (e.g., developing training opportunities based on the 'competence by design' approach promoted by the Royal College of Physicians and Surgeons of Canada, in order to foster a culture change towards evidence-informed and value-based practices);
4) working with partners across the health system to establish a consensus on what peri-operative data should be collected, and to make such data more easily available;
5) exploring the types of small-scale innovation projects that could be designed to optimize peri-operative care and to help build the case for the uptake of clinical-practice guideline recommendations (e.g., measuring brain natriuretic peptide or N-terminal fragment of proBNP before surgery to enhance peri-operative cardiac risk estimation, and using point-of-care ultrasound to guide vascular access procedures);
6) developing a research agenda to strengthen peri-operative risk assessment and management, which could include topics such as:
    a) empirically examining how the lack of timely access to surgical care can affect 'worry-free surgery,' and how timely access to care may relate to the different dimensions of 'worry-free surgery',
    b) pilot-testing new and emerging technologies to support remote monitoring,
    c) developing and assessing patient-specific risk calculators,

d) assessing the effectiveness of interventions to engage patients and caregivers in risk assessment and management,
e) examining the cost-effectiveness of new financial incentives to improve peri-operative risk assessment and management, such as 'bundled care' (a form of case-mix funding in which hospital and home-care dollars are combined and 'tied' to individual patients), and
f) examining the most cost-effective ways to support the uptake of clinical-practice guidelines by various stakeholders; and

7) pursuing stakeholder-engagement initiatives that include patients, caregivers, health professionals, hospital managers, and regional and provincial policymakers to advance an agenda towards achieving worry-free surgery, as well as engaging industry to leverage new and emerging technologies to achieve this.

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