An Innovative Model for Ethical Engagement in Healthcare

Presented by
Memorial University Medical Center
April 4, 2014
Presentation Team

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  Chair, Bioethics Nurse Liaisons
- Frank Davis, MD
  - Chair, Bioethics Services Committee
  - Trauma Surgeon
  - Chief Medical Informatics Officer
- Bill Bromberg, MD
  - Co-chair, Bioethics Services Committee
    - Resource Allocation and Policy
    - Interim Director Trauma Services
- Mary Ann Bowman Beil, MTS
  - VP, Ethics Officer
  - Ethical Pilgrim
The Mission

1. Cure disease / Heal the wounded
2. Relieve pain and suffering
3. Know the difference between #1 and #2

However, society does very little to align expectations with reality.

Providers and hospitals are ill equipped to resolve this conflict of unrealistic expectations.
“Insurance rates are higher because of the uninsured. Uncompensated care in 2008 was $27 billion in the United States. Three quarters of that was picked up by the taxpayers.”

Ezekiel Emanuel, MD
Chair, Dept. of Medical Ethics and Public Policy
University of Pennsylvania
The Margin
Complex Cases
Significant Operational Challenges

- Improving outcomes
  - System errors >> operator errors
- Right-size utilization
  - Delivery of evidence-based care ensures
    - Patients receive only the most appropriate care
    - Reducing unnecessary utilization
- Reducing costs
  - Standardization
- Improve effective capacity
  - Must reduce length of stay
The Ethical Dilemma

- “How do we approach the question of the basic minimum levels of care?
- Do we provide equal care?
  - We don’t know.
- Will it become a multi-tiered society regarding healthcare, we do that already.”
- “What ethical principals could be used to decide the allocations of these scarce resources?”

- Melvin Polchow, MD
- Chair, Biomedical Ethics Committee
- Hackensack University Medical Center
- Sixteenth Annual Biomedical Ethics Symposium
All Too Common

- Society often refuses to consider “advanced care planning”
  - Death / severe illness are “uncomfortable” subjects
  - Time consuming / no real incentives for physicians
- Families often request: “Do everything”
  - No matter how futile
  - No matter the degree of pain and suffering
  - No idea of what they are really asking
- Physicians make treatment decisions based on disease severity
  - Regardless of a patient’s ability to pay
- When there is no cure......
  - Health systems poorly equipped to compassionately communicate and deliver alternative options
The Ethical Dilemma

- The “need” to resolve ever increasingly complex clinical cases
  - Available assets: 1.5 FTE to solve
- Financial challenges
  - Improving outcomes
  - Right-size utilization
  - Reducing costs
  - Improve effective capacity
- Market Forces in a Performance-Based Environment

Overwhelming “opportunities”
Limited resources

What’s it’s gonna take?
Bioethics: The Need
Ms. R.H.

- 57 y/o AA female / Now Day 12
- Problem list
  - Massive cerebrovascular hemorrhage with tonsilar herniation
  - Prolonged down time
  - Hypertension
  - Previous CVA 10 years ago
- Current status
  - Ventilator dependent
  - GCS 3
    - Slight gag reflex / No corneals / Last sedation > 5 days ago
- Pre-admission function
  - Mild deficits from previous CVA
  - Able to perform basic ADL’s
- Medical decision / prognosis
  - Neurosurgeon #1
    - Prognosis - 0
  - Neurosurgeon #2 (2nd opinion)
    - Prognosis for meaningful recovery is nil
  - Pulmonary / Critical Care: Futile care

Futile: < 1% chance of survival / meaningful recovery

Consensus among medical team

Lack family consensus
Ms. R. H.

- **Advanced directive**
  - No

- **Family**
  - Lives with husband: Age 88 / in wheelchair
    - Listened to discussion but did not ask any questions
  - 7 children
    - 3 live Locally
      - Don’t want to make any decision
    - 1 sister has Hx of schizophrenia
      - Escorted off campus / asked not to return
  - One daughter lives in Virginia
    - Significant pushback to DNR / withdrawal
• **Summary:**
  - Severe hemorrhagic stroke
  - GCS slightly above brain death
    - Medical consensus: No chance of meaningful recovery
  - Family: Various degrees pushback / inability to make EOL decisions

• **Bioethics rec:**
  - Unilateral DNR / withdrawal
  - Allow family 24 hours to find another physician / hospital

• **Met with 2 daughters**
  - Informed of decision
  - Agreeable / no pushback
  - Offered 24 h to move
    - They withdrew the same afternoon
How Do We Get There From Here?
Here--Starting Point: Ground 0

- Bioethics Committees Historically
  - Average 1-2 cases (15 cases total/year)
  - Cases surfaced only after:
    - All resolution efforts failed
    - Emotions escalated
    - Lines drawn in the sand
  - Minimal enthusiasm among committee members
  - Viewed more as a “responsibility” than passion
  - Thoughtful, non-binding ruminations
There: Radical Redesign and Integration

It’s not just bioethics as the ethical landscape crosses all boundaries.
Redesign Step #1
Expand Engagement

• Expand integrated manpower
  • Nurse liaisons (30)
    • Larger net for case identifications
    • Real time assessment of surrogate, advance directive, documentation concerns
    • Enhancement of MD-Nursing communication

• Fully engage case management for initial background

Good first step
Bioethics now on the map
Redesign Step #2
Ethics Consult Team Structures

System Ethics Committee

- Adult BioPIT
- Pediatric/Neonatal BioPIT
- Behavioral Services BioPIT
- Cancer Tumor Boards
Redesign Step #3
Consultation Services- Model

Advice Request → Clarification
Consult Request → Standing Biopit
Urgent Consult Request → Called Consult Team
Redesign Step #4
Consult Acuity and Response

- Stat
- Urgent
- Standard
Redesign Step #5
The process flow

Case Consult

- Rounds
- Consult
- BioPITS
Part II  Clinical Integration and Physician Engagement

- “If we build it, will you come?”
- Changing the language with clinical benchmarks
- Following in the footsteps of Quality and Patient Safety
- Clinical triggers for bioethics consultation in a world of data mining

- Preparing for the new ethical landscape:
  - Throughput
  - Transitions of care
  - Readmissions data
  - Mortality indexing
## Redesign Step #6 Detail

### Evidence-Based Ethics Protocol

#### Institute for Ethics

**Evidence-Based Ethics Protocol**

<table>
<thead>
<tr>
<th>Identify an opportunity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Best practice literature/interviews</td>
<td></td>
</tr>
<tr>
<td>Vet with MD leadership/RN</td>
<td></td>
</tr>
<tr>
<td>Take to BioPIT for OK</td>
<td></td>
</tr>
<tr>
<td>Assign task force (MD lead/RN lead)</td>
<td></td>
</tr>
<tr>
<td>Relevant policy review/emendation</td>
<td></td>
</tr>
<tr>
<td>Process review, flow w/ PS&amp;Q</td>
<td></td>
</tr>
<tr>
<td>PS&amp;Q (Angela Long) production</td>
<td></td>
</tr>
<tr>
<td>Work&gt;BioPit (FYI)</td>
<td></td>
</tr>
<tr>
<td>Final product to MD section of MS</td>
<td></td>
</tr>
<tr>
<td>Approved product &gt;MEC</td>
<td></td>
</tr>
<tr>
<td>Schedule for Change Day</td>
<td></td>
</tr>
<tr>
<td>Education Council</td>
<td></td>
</tr>
<tr>
<td>Additional Communication: newsletters, e-mails, meeting agendas</td>
<td></td>
</tr>
</tbody>
</table>
Redesign Step #7
Percutaneous Endoscopic Gastrostomy (PEG)

- Problem: National concern regarding appropriateness of PEGS in chronically ill patients
  - Perceived poor quality of life
  - Poor short-term survival
- End-stage (advanced) dementia
  - Progressive, ultimately fatal neurologic disease.
- Placement of feeding tubes
  - Does not improve survival
  - Does not prevent aspiration
  - Does not heal /prevent decubitus ulcers

**PEG Decision Tree**

- **Advanced Dementia**
  - **Medical Eval / Tx**
  - **Inadequate PO Nutrition**
    - Determine Benefits / Burdens Classification?
    - **End of Life Discussion**
      - Advanced Directive?
      - **Swallow Eval**
        - Determine Benefits / Burdens Classification
        - (If unable to maintain nutritional needs, PEG education with family)
        - **Consider Ethics Consult**
        - **PEG Consult**
        - **Home vs Nursing Home**
  - **Stroke**
    - **Neurology Evaluation**
      - **Poor prognosis (Nonreversible)**
      - **Good prognosis (Reversible)**
        - **Inadequate PO Nutrition**
          - **Swallow Eval**
          - **Hospice / Palliative Care Consult**
          - **Trial Feeding Tube Or PEG**
            - Unable to maintain nutritional needs
            - Continue swallow treatment as appropriate
  - **Primary Trigger**
<table>
<thead>
<tr>
<th>Benefits and Burdens of PEG Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed Head Injury or Head / Neck Cancer</td>
</tr>
<tr>
<td>Dysphagic Stroke (Patients with previous good quality of life, high functional status(^1) and minimal comorbidities)</td>
</tr>
<tr>
<td>Dysphagic Stroke (Patients with decreased level of consciousness, multiple comorbidities, poor functional status(^1) prior to CVA)</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)</td>
</tr>
<tr>
<td>Persistent Vegetative State (PVS)</td>
</tr>
<tr>
<td>General Frailty (Patients with multiple comorbidities, poor functional status, failure to thrive)</td>
</tr>
<tr>
<td>Advanced Dementia (Patients needing help with daily care, having trouble communicating, and/or incontinent)</td>
</tr>
<tr>
<td>Advanced Cancer (Excludes patients with early stage esophageal &amp; oral cancer)</td>
</tr>
<tr>
<td>Advanced Organ Failure (Patients with CHF, renal or liver failure, COPD, anorexia-cachexia syndrome)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prolongs Life</th>
<th>Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely</td>
<td>Likely</td>
</tr>
<tr>
<td>Likelihood in the short term</td>
<td>Likely</td>
</tr>
<tr>
<td>Not likely in the long term</td>
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</table>

<table>
<thead>
<tr>
<th>Improves Quality of Life and/or Functional Status</th>
<th>Likely</th>
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</thead>
<tbody>
<tr>
<td>Likely</td>
<td>Likely</td>
</tr>
<tr>
<td>up to 25% regain swallowing capabilities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enables Potentially Curative Therapy/Reverses the Disease Process</th>
<th>Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likely</td>
<td>Not Likely</td>
</tr>
</tbody>
</table>

> 2 points: PEG likely beneficial
= 2 points: Consider PEG
< 2 points: Discourage PEG

Likely = 2 points
Uncertain = 1 point
Not likely = 0 points
## Benefits and Burdens of PEG Placement

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Dysphagic Stroke</th>
<th>Dysphagic Stroke</th>
<th>Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig’s Disease)</th>
<th>Persistent Vegetative State (PVS)</th>
<th>General Frailty</th>
<th>Advanced Dementia</th>
<th>Advanced Cancer</th>
<th>Advanced Organ Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolongs Life</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Likely</td>
<td>Not Likely</td>
<td>Not Likely²</td>
<td>Not Likely</td>
<td>Not Likely</td>
</tr>
<tr>
<td>Improves Quality of Life and/or Functional Status</td>
<td>Up to 25% regain swallowing capabilities</td>
<td>Not Likely</td>
<td>Uncertain</td>
<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
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<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
<td>Not Likely</td>
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</table>
# Redesign Step #8

## Data and Crude Metrics

<table>
<thead>
<tr>
<th>Description/Definition</th>
<th>Mandatory/Optional</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Attending MD</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Date initiated</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Consult Case # (1/L)</td>
<td>O</td>
<td>Crosswalk w/ Tier 3 cases only</td>
</tr>
<tr>
<td>Problem List</td>
<td>M (Tier 3) O (Tier 1-2)</td>
<td>Free text annotations</td>
</tr>
<tr>
<td>Reason for Consult</td>
<td>M</td>
<td>Free text annotations</td>
</tr>
<tr>
<td>Initial Case Tier</td>
<td>M</td>
<td>1-discussed, 2-NR doc, 3-full consult, 4-systemic issue identified</td>
</tr>
<tr>
<td>Closing Case Tier</td>
<td>M</td>
<td>To capture case level migration</td>
</tr>
<tr>
<td>Case status</td>
<td>M</td>
<td>Open, closed, archived, discussed</td>
</tr>
<tr>
<td>Consult Team Assignment</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>Adult BioPit</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Pediatric BioPit</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Behavioral Services BioPIT</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Oncology BioPit</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td># Team Involved</td>
<td>M</td>
<td>Calculate ROI of time/engagement</td>
</tr>
<tr>
<td><strong>Reason Codes/Fields</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EOL/DNR Needed</td>
<td>O</td>
<td>DNR</td>
</tr>
<tr>
<td>EOL/Withdrawal</td>
<td>O</td>
<td>Non-escalation of treatment</td>
</tr>
<tr>
<td>EOL/Withdrawal</td>
<td>O</td>
<td>Withdrawal of life support</td>
</tr>
<tr>
<td>EOL/LOC</td>
<td>O</td>
<td>Lack of EOL Plan/General</td>
</tr>
<tr>
<td>EOL/Utility of Care</td>
<td>O</td>
<td>&lt;1% meaningful outcome;</td>
</tr>
<tr>
<td>Capacity Determination</td>
<td>O</td>
<td>Patient requires competency/capacity eval</td>
</tr>
<tr>
<td>Clarification of surrogate</td>
<td>O</td>
<td>Designate surrogate for medical decisions</td>
</tr>
<tr>
<td>No surrogate</td>
<td>O</td>
<td>Consult team as rights protection</td>
</tr>
<tr>
<td>Lack of consensus</td>
<td>O</td>
<td>Mediate conflict&gt; consensus</td>
</tr>
<tr>
<td>Resource allocation concerns</td>
<td>O</td>
<td>Marginally effective resource utilization</td>
</tr>
<tr>
<td>Communications issues</td>
<td>O</td>
<td>MD/Team lack of clear communication</td>
</tr>
<tr>
<td>Discharge planning concerns</td>
<td>O</td>
<td>Barriers to appropriate placement</td>
</tr>
<tr>
<td>Unfunded treatment</td>
<td>O</td>
<td>Tubal ligations, highSSS transfers, etc</td>
</tr>
<tr>
<td>OP Dialysis/UIP Unit</td>
<td>O</td>
<td>Unfunded</td>
</tr>
<tr>
<td>Cultural/Religious Request</td>
<td>O</td>
<td>Waiving of effective tx</td>
</tr>
<tr>
<td>Patient safety concern</td>
<td>O</td>
<td>Discharge to unsafe environment</td>
</tr>
<tr>
<td><strong>Recommendation Codes/Fields</strong></td>
<td>M</td>
<td>Free text annotations</td>
</tr>
<tr>
<td>DNR Order</td>
<td>O</td>
<td>DNR order in place</td>
</tr>
<tr>
<td>DNR w/ 2 signatures</td>
<td>O</td>
<td>Assessment and validation required</td>
</tr>
<tr>
<td>Non-escalation of care (W/D)</td>
<td>O</td>
<td>NEC: Comfort Care Measures</td>
</tr>
<tr>
<td>PC Consult</td>
<td>O</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Hospice Consult</td>
<td>O</td>
<td>Hospice</td>
</tr>
<tr>
<td>Transfer to another institution</td>
<td>O</td>
<td>Per GA law: relocate consistent w/ wishes</td>
</tr>
<tr>
<td>Psych Consult/Capacity</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>APS Referral</td>
<td>O</td>
<td>Patient requiring guardian assignment</td>
</tr>
<tr>
<td>DFACS Referral</td>
<td>O</td>
<td>Patient requiring investigation of home</td>
</tr>
<tr>
<td>Unfunded procedure --Yes</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>
Intraprofessional Opinion

The active Ethics committee and process at Memorial has greatly assisted with addressing through-put barriers related to futility of care and lack of surrogate decision makers. It has also greatly assisted with complex cases through resolution of challenging family dynamics/differing opinions on care direction, and given support to physicians having to make difficult care decisions.

Bridget Schmidt, Case Management
Physician’s Perspective

- Communicate / communicate / communicate
  - Not only with patient / family but with consultants
    - Make sure all physicians are on same page
- When a patient consents to a surgical procedure
  - They are also “committing” themselves to the care and potential complications “after” the operation
  - Difficult to engage in a “tour de force” and then just walk away

Karen Brasel, MD / Professor surgery / Bioethics at Medical College of Wisconsin
Paradigm Shift: Physician’s Perspective

- **10 years ago:**
  - Bioethics consult
    - Felt equivalent to getting “called out on the carpet”
  - After redesign / education
    - Most physicians welcome Bioethics consults
    - Someone else is helping “me” with the tough decisions
Physician’s Perspective
Lessons Learned

• Is there a conflict?

• Functional status of patient prior to admission?

• Who is the decision maker?
  • Patient vs surrogate
    • Relationship of surrogate to patient

• Is there a terminal condition?
  • Cancer with metz
  • Alzheimer’s
  • Failure to thrive
  • High quadriplegia with advanced age

• What is the “climb out” from current condition?
Physician’s Perspective
Market Forces in a Performance-Based Environment

- Upholding of majority of the Affordable Care Act
- Continued growth of health care expenditures at 150% - 175% the GDP
- Silver tsunami
  - Significant increase in Medicare patients with > 4 chronic conditions
- Future payments tied to performance
- Forces shaping future hospital margins
  - Deteriorating case mix
    - Medical demand from aging populating crowding out profitable procedures
  - Decelerating reimbursement growth
  - Shifting payer mix
  - Continuing cost pressure
“...waste in U.S health care, defined more broadly as spending on interventions that do not benefit patients, actually amounts to a much larger sum—at least 30% of the budget—and that this waste is a major driver of cost increases.”