IntegratedEthics in Action
Issue 14

Spreading Promising Practices that Improve Ethics Quality: IntegratedEthics Competitive Enhancement Grants

In an ongoing effort to support facilities in expanding promising ethics practices, the National Center for Ethics in Health Care (NCEHC) awarded competitive funding to a total of 14 field-based IntegratedEthics (IE) programs during fiscal years 2010 and 2011. (See sidebar for a complete listing.) The grantees, which were both VISN offices and facilities, were chosen from among numerous proposals that were submitted to NCEHC by the field. In separate articles, this issue of IntegratedEthics in Action details the accomplishments of two 2010 grantees, the ***VISN 10 office*** *and the* ***New Mexico VA Health Care System****.* ***Mary Davidson*** *and* ***Laura Ruzick*** *describe how VISN 10's IE Advisory Council teamed up with the network's new Palliative Care Coordinator to develop innovative educational programming related to ethical and other perspectives surrounding artificial nutrition and hydration at the end of life.* ***Dr. Cynthia Geppert*** *discusses how her IE program used the grant to spread ethics consultation and preventive ethics resources and services to the 11 rural clinics affiliated with the New Mexico facility.* ❖

Artificial Nutrition and Hydration at the End of Life

Contributors:
Mary E. Davidson, MSN, RN, CHPN, Palliative Care Program Manager and Member of IE Advisory Council for VISN 10
Laura E. Ruzick, BS, BSN, MBA, IE Program Officer (IEPO) for VISN 10 and Co-chair of the IE Advisory Council, VISN 10

How did you select this joint project between the IntegratedEthics (IE) and Palliative Care (PC) councils for further development under the competitive enhancement grant?

The topic of artificial nutrition and hydration (ANH) at the end of life was originally raised in an ISSUES cycle completed by our Cleveland facility. Mary Davidson then checked VISN-level data, and found that a lot of patients in the Intensive Care Unit (ICU) were dying without receiving a palliative care consult, which meant that these patients might have been receiving more aggressive and curative (rather than comfort-oriented) care at the end of their lives than they desired. Early palliative care consultation helps ensure that the patient's preferences regarding their goals of care are clarified.

How was the lecture program developed and presented?

To involve as many facilities and community partners as possible, the IE and PC councils decided to host four one-hour teleconferences instead of on-site presentations. Each would be devoted to a separate perspective associated with ANH at the end of life: ethical, medical and physical, psychosocial, and spiritual. We then located an interdisciplinary group of national speakers who had all contributed research and presentations in the field of hydration and nutrition. (See sidebar for a list and description of the presenters.)

The discussion on spiritual issues proved especially illuminating. From earlier surveys, we learned that the majority of people we serve in this VISN were either Christian or Jewish. Accordingly, we hired speakers that represented these faiths. Our Jewish speaker, Jonathan Cohen, Ph.D., an associate professor at Hebrew Union College, described Jewish perspectives on end-of-life issues. The psychosocial lecture discussed unique ethics issues that can arise with Veterans who survived combat, such as the dilemma of withholding nutrition from a Veteran who had been subjected to the Korean War death marches. Our lecturers' remarks helped open our minds on how we're all different, and they reminded us to think of our patient's perspective when considering end-of-life options. Without patient and family input, we cannot assume we know what is right.

What impact have the lectures had?

Our PC clinicians had previously tried to partner with ICU clinicians around issues relating to end-of-life care, but they encountered difficulties in discussing PC in acute-care environments. These lectures, which were widely attended and favorably received by ICU clinical staff, provided the entrée that PC was looking for.

In fact, the content inspired "aha" moments among ICU clinical staff because PC is not taught in medical or nursing school and is not part of the ICU environment.

Artificial Nutrition and Hydration at the End of Life Speakers

Ethical Issues. . .

- Mark Aulisio, Ph.D., Associate Professor of Bioethics, Department of Bioethics at Case Western Reserve University, Cleveland, OH

Medical Issues. . .

- Thomas E. Finucane, M.D., Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, MD

Psychosocial Issues. . .

- F. Amos Bailey, M.D., Director of Palliative Care, Birmingham (AL) VAMC
- Elizabeth R. Goy, Ph.D., Director of Psychology Postdoctoral Fellowship in Palliative Care, Portland (OR) VAMC

Spiritual Issues. . .

- Bonnie Meyer, D.Min., Director of Spiritual Care, Hospice of the Bluegrass, Lexington, KY
- Jonathan Cohen, Ph.D., Director, Hebrew Union College-University of Cincinnati Center for the Study of Ethics and Contemporary Moral Problems, Cincinnati, OH.

The lectures provided new opportunities for communication and collaboration between the PC and ICU services. The takeaway of many participants was that ANH is part of medical goal planning; conversations about ANH should happen when Veterans first arrive in the ICU so that they and their families can make the decisions that are right for them. The PC team still talks about how the lectures provided an opportunity not only to hear knowledgeable speakers but also to reach out to their ICU colleagues.

We also looked at some data on how many patients were dying in ICUs across the VISN. In fiscal year 2009, 30% of the patients who died in the hospital did so in the ICU. In fiscal year 2010, this has dropped to 25%. In addition, in the first quarter of fiscal year 2011, VISN 10 led VHA in proportion of deaths that occur in hospice settings (56%). These numbers indicate that the trend is definitely moving in the right direction; the ICU and PC teams are more frequently identifying the impact of medical interventions and helping Veterans and families make choices that best honor the life they have lived.

Moreover, between fiscal years 2009 and 2010, referrals to PC teams increased by over 26%, from 1709 to 2161 referrals. This increase can be directly attributed to an increase

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in the floor staff's expertise with handling end-of-life concerns. Anecdotal observations also indicate that PC is receiving more referrals from attending physicians. In fiscal year 2011, as inpatient staff members become increasingly knowledgeable and comfortable with routine end-of-life care, the referrals to PC are reflecting new challenges, which are being addressed earlier in the Veterans' hospital stay.

Finally, in the quarter following the lecture series, ethics consults increased VISN-wide by 40%.

Did you use grant funding for any other activities?

With money left over from the grant, we purchased portable DVD players and DVDs on advance care planning for each facility. We are distributing these materials to social workers and home care teams so that they can do bedside education on advance care planning with Veterans and their families in inpatient or outpatient settings. With IE's support, we are escaping the silos that exist in clinical care.

How has this collaboration between IntegratedEthics and Palliative Care impacted VISN 10 facilities' policies and practices surrounding artificial nutrition and hydration?

While we have always had good policies in place, we found that clinicians can be challenged to fit ANH decisions into the clinical picture. Through these educational efforts, we have been able to show how policy supports clinical practice. Now clinicians are aware that a broader discussion involving the Veteran and family needs to happen around ANH and other decisions relating to end-of-life care. In this way, goals for hospice and PC this year have been supported and nurtured.

What overarching lessons have you learned from participating in this collaboration?

Programming four lectures was challenging; next time we might want to simplify the format. Our overarching takeaway was that everybody's opinion is based on their individual backgrounds and upbringing. Our goals as clinicians are not necessarily the goals of patients or family members. Ultimately, we believe our ANH programming helped spread the idea that it's important for the clinical team to collaborate with all those involved in the patient's care, and that they understand where the patient and family are coming from. ❖

New Mexico VA Health Care System (HCS)

Expansion of the IntegratedEthics Program for Rural Stakeholders

Contributor: Cynthia M. A. Geppert, M.D., Ph.D., M.P.H., IntegratedEthics Program Officer (IEPO) and Ethics Consultation Coordinator (ECC), New Mexico VA Health Care System (HCS)

How did you select the promising practice for further development under the competitive enhancement grant?

The New Mexico population is mostly rural. Rural environments introduce unique aspects of health care ethics that are not applicable in large urban medical centers. Because our system includes 11 VA and contract community clinics, we experience clinical challenges in providing care for patients without many of the resources and support services we have at the main facility.

When the competitive enhancement grants were announced, we had just begun collaborating with ethics consultant Elizabeth Eutsler, LISW, to reach out to our community clinics. The grant mechanism enabled us to further develop a promising practice.

What activities did you accomplish under the grant?

Our objective was to sustain and spread the IntegratedEthics (IE) program into the rural health care environment by further developing the Ethics Consultation (EC) service and initiating a Preventive Ethics (PE) function at our community-based and contract clinics.

Phase 1 of the project involved conducting a needs assessment with the assistance of Dr. William Nelson, an external expert and former member of the National Center for Ethics in Health Care (NCEHC) staff. Eight clinics completed the needs assessment, from which we learned that rural clinicians face a variety of ethical dilemmas every day. The most commonly encountered issues were related to resource allocation and boundaries, requests for inappropriate treatments or refusals of appropriate treatments, and confidentiality and privacy.

For Phase 2, two members of our facility's PE/EC teams visited each of the 11 sites, and provided education on the national and facility IE program and an introduction to ethics resources. In addition, lunch was served, and small trinkets with the IE logo were distributed. During the visit, the members facilitated a discussion with staff on their ethical concerns. After the visit each clinic was asked to designate an ethics champion.

Phase 3 was originally planned to be a face-to-face educational meeting for all ethics champions at the main facility. However, after clinic staff reported that coping with the logistics of travel and time away from their patient care duties was stressful, we changed it to a virtual training. The training was attended by the champions from 9 of the 11 clinics.

What activities have the rural ethics champions completed?

Since the program launch, the champions have involved their staffs in education efforts. The Santa Fe Clinic held a half-hour in-service training session on confidentiality issues in the waiting room. Afterward, the clinic installed signs to inform patients that, to protect their privacy, no clinical discussions would be held in waiting rooms.

At short in-service trainings the Artesia Clinic held staff discussions about what constitutes an ethical concern and how even the building blueprints can affect ethics. A nurse and the health tech are leading an effort to ensure that doors are closed during patient visits. As a group they are learning that many elements in our daily care of patients can carry ethical consequences.

We are also making plans to send PE/EC team members to the Las Vegas and Espanola clinics to introduce the IE program to new staff using the same approach of providing lunch, resources, and facilitated discussion.

What challenges have the champions faced?

As IE responsibilities are generally a collateral duty, the biggest challenge has been finding time. Many clinics are staffed by only a handful of people, so it is inspiring that they agreed to participate. Our other great challenge has been to find the hours needed to continue the momentum of the initial grant and further develop the role of the champions. We have an e-mail group that has not been fully utilized and are also considering quarterly calls.

Overall, how have your efforts to expand IE into rural settings impacted ethics consultations and overall ethics quality in these areas? How do you measure this impact?

The primary way we are measuring impact is through the increase in ethics consults from these clinics. Since we first visited the clinics in May 2010, we have completed 4 case and 1 non-case consults. By comparison, only two requests for consults were received in the entire fiscal year 2009.

We have also introduced two 24/7 resources, "Ask Dr. Ethics" and the Ethicsline. "Ask Dr. Ethics" is an e-mail service that enables any member of the HCS staff to submit general questions or concerns about IE, and to contact the EC team. It also enables the IE team to provide additional education on ethics-related policy. No confidential patient or staff information is permitted, and we respond to questions about compliance, legal, or human resource concerns with appropriate referrals. The Ethicsline is a dedicated phone line where people can leave voicemails.

Ms. Eutsler takes calls from staff in other clinics requesting assistance and also responds to any rural consults submitted to the main facility. She receives patients in her

office and also travels to make home visits. EC team members, who are usually physicians, often participate in the consults by phone.

The most common ethics domain and topic that is being addressed in the rural consults is professionalism in patient care (difficult patients). The community clinics report difficulty managing patients who ask for inappropriate treatments or refuse appropriate treatments. These problems raise dilemmas about how to apply the principles of nonmaleficence and beneficence in the areas of patient autonomy, informed consent, and professional duty. We did not anticipate this would be such a large problem because most of our medical center consults are focused on more traditional end-of-life and informed consent issues.

From this experience, I also realized that accessibility was a true barrier to implementing various components of the IE program, including ethics consultation. This is when I began to realize the potential of telehealth ethics consultations, which enable ethics consultants to participate virtually in consults at the rural clinics when site visits are not feasible. I am now trying to figure out how to most appropriately utilize telehealth ethics consultation in our facility and VISN and respond to the field's keen interest in this modality.

Have any ISSUES cycles been initiated to address these areas?

While we focused more directly on EC questions during the grant period, this month our PE Coordinator will be visiting some of our community clinics to further assess systems gaps in rural ethics. As you can imagine, the PE issues are complex as they involve both community and contract clinics in different settings.

Recently, our PE team decided to introduce more formal informed consent processes at our medical center for our rural patients because these patients drive long distances to receive procedures like colonoscopies from specialists with whom they have not established treatment relationships. To facilitate shared decision making, we want to engage the primary care team in an informed consent discussion with the Veteran before he or she comes to the medical center for the procedure. ❖

Fiscal Year 2010 Competitive Enhancement Grantees		
VISN	**FACILITY**	**PROPOSAL**
2	Canandaigua VAMC	Improving the ability of staff to respond to everyday ethics issues through collaborative training with community partners
3	VISN 3 Office	Promoting ethical leadership practices through the development and piloting of an ethical decision-making tool for use by VISN leadership
7	Birmingham VAMC	Promoting ethical leadership practices among executives and middle managers through systematic mentoring and coaching
10	VISN 10 Office (profiled in this issue)	Enhancing patient dignity and satisfaction through improving clinician knowledge of the benefits and burdens of artificial nutrition and hydration at the end-of-life
18	New Mexico (profiled in this issue)	Bringing IntegratedEthics to rural stakeholders: expanding preventive ethics and ethics consultation to community-based and contract clinics
19	Cheyenne VAMC	Incorporating ethical considerations into the staff hiring and selection process at the medical center and the community-based outpatient clinics served by this center
22	VA Greater LA HCS	Expanding preventive ethics activities through inclusion and mentoring of students and trainees

FY11 Competitive Enhancement Grantees are listed on page 6.

Fiscal Year 2011 Competitive Enhancement Grantees		
VISN	**FACILITY**	**PROPOSAL**
4	Philadelphia VAMC	Developing a training-of-trainer program on "Driving and Dementia, Ethical Dilemmas: Finding the Middle of the Road"
6	Salem VAMC	Providing education and promote discussion amongst employees at every level concerning ethical practice as it relates to boundary issues
10	Cleveland VAMC	Using videoconference equipment to incorporate primary care providers into inpatient end-of-life discussions to enhance the shared decision making process
15	Wichita VAMC	Incorporating humor to educate on difficult ethical issues
20	Walla Walla VAMC	Creating an interconnected system of consultative ethics services within a multi-site rural health care environment
22	VA Long Beach HCS	Spreading medical professionalism and shared decision-making by offering Advance Directive Days that encourage Veterans to learn more about conveying end-of-life preferences
22	VA Greater LA HCS	Improving IntegratedEthics consult communications through "Ethics Consultation Road Shows"

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Improving Ethics Quality in Health Care

Developed by the IntegratedEthics team at the National Center for Ethics in Health Care, IntegratedEthics *in Action* is published on the IE website vaww.ethics.va.gov/integratedethics/IEaction.asp, listserv, and via other IE venues. Its purpose is to rapidly disseminate promising practices and feature emerging IE champions to help facilities and VISNs in their implementation of the IE initiative. We welcome your comments and suggestions for topics to: integratedethics@va.gov.