IntegratedEthics in Action

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Preventive Ethics in Action: Using the ISSUES Approach to Improve Ethics Quality in Facility Settings

Almost two years have passed since facilities received training in Preventive Ethics (PE) and formed dedicated PE teams. Since then, teams have measurably improved ethics quality by applying the ISSUES approach (see sidebar). How has this been accomplished?

In this issue of IntegratedEthics In Action, PE teams from five facilities describe their work on specific ISSUES cycles and how that work led to improved ethics quality at their facilities. In addition, they offer recommendations for forming teams, finding resources, and identifying matters that can be appropriately addressed using this approach. Their names, IE roles, and facility affiliations are listed in the "Contributors" box below.

Contributors

- **Jeanette Alvarez, LCSW,** Member, Preventive Ethics Committee, VA New York Harbor Health Care System
- **Paul B. Bauck, MEPD,** IE Program Officer, VA Puget Sound (WA) Health Care System
- **Gwenda Broeren, RN, JD,** Chair, Preventive Ethics Committee, VA Illiana (IL) HCS
- **Robin S. Cook, RN, MBA,** Preventive Ethics Advisor, VA Puget Sound (WA) Health Care System
- **Kathleen Figaro, MD, MS,** Member, Preventive Ethics Committee, VA Tennessee Valley Health Care System
- **Arlene D. Houldin, PhD,** Preventive Ethics Coordinator, Philadelphia VAMC
- **Veronica J. Scott, MD, MPH,** Preventive Ethics Coordinator, VA Tennessee Valley Health Care System

NOTE: Details of contributors' ISSUES cycles are provided in the accompanying chart, "Moving Through the ISSUES Cycle: Real-World Examples from Five Facilities."

How can PE teams identify ethics issues that can benefit from a quality improvement approach?

The contributors to this newsletter learned about issues at their facilities either in the normal course of their work, or via input from their IE Council, ethics consultation committee, or leadership.

- **Jeanette Alvarez**, for example, learned that many patients in the Dialysis Unit lacked complete and accurate advance directives while reviewing the directives as part of her social worker responsibilities.
- **Dr. Veronica Scott**, a geriatrician and the PE Coordinator, learned from one of her PE team members, **Dr. Kathleen Figaro**, a primary care physician (PCP), about problems encountered by PCPs when treating patients for whom they had insufficient medical information because the patients had received some of their health care outside of VHA. "This problem of 'dual care' brought up multiple concerns, including patient safety," said Dr. Figaro. "Without a patient's complete medical record, providers don't feel that they can provide the best quality care".
- At **Gwenda Broeren's** facility, nurses, residents, families, and others were continually questioning whether the practice of denying medications and follow-up appointments to patients who left the hospital against medical advice (AMA) was ethically justifiable. "Many of the people…had valid reasons for not staying

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in the hospital. One man, for example, was the sole caretaker of his disabled wife, and had to return home. Another was concerned about the welfare of his animals." Ms Broeren included the ethics consultation service to help answer the ethics question, and to define ethics best practice before considering what changes needed to be made to improve clinical practice.

What are other important factors to consider before deciding to use the ISSUES approach?"

PE teams will first need to assess the ethics issue's importance to the facility as a whole. As Dr. Scott explained, "We have a way of prioritizing how we get to issues. Is it an urgent concern, in other words, what is the cost to the patient in terms of safety or what is it costing the facility in terms of money? Then it has to be related to the strategic plan of the facility, VISN, or VHA as a whole. And, finally, we have to have the manpower resources to look into it."

Address ethics issues that are measurable and discrete enough that completion of the ISSUES cycle will have an impact

Contributors also noted that ethics issues need to be measurable and discrete enough so that the cycle can make an impact, and the team working on the cycle must possess the expertise and authority to make a difference. "We chose the issue of increasing iMedConsent utilization because it was solvable—other facilities were clearly doing it, and it was a topic that would be supported by leadership," added **Paul Bauck** and **Robin Cook**. "The real take-home message here is to take on a piece that you can have impact on. For our iMedConsent issue, we looked at what we could impact now, and where we had to wait."

Finally, added **Dr. Arlene Houldin**, teams have to realize that any important and complex issue can possibly spawn five or six related concerns, requiring additional cycles to reach a comprehensive solution. Any pilot project will generate a lot of feedback that needs to be evaluated. The important thing, she said, was to "clarify the boundaries of the issue because there can be many layers." In addition, teams need to acknowledge that "you can't please everybody all of the time."

How are PE teams accomplishing the work of Preventive Ethics?

In each of the contributors' facilities, the ISSUES approach was spearheaded by the PE Coordinator and the core team, and supported by ad hoc content and process experts who provided specific content and process knowledge, as well as background information. "We tried to keep the number on the core team very small, and bring in people who touch the process as we need them," Mr. Bauck and Ms. Cook explained. "However, such an approach does leave you vulnerable if team members become unavailable." They suggested that the IEPO should also be involved, especially in the early projects. Mr. Bauck and Ms. Cook added, "If you involve QI [quality improvement] people, you have a head start."

Ms. Broeren's PE team consists of a Quality Management (QM) person, a patient advocate, and the Chief of Nursing of Acute Care, who can give clinical feedback as well as have the authority to make decisions. "The team works well in terms of being able to provide complementary pieces of information," she commented. For the ISSUES cycle described in this article, the team's effort was supported by her facility's ethics consultation group, which performed a literature review and developed a summary on how other organizations were handling the issue.

Dr. Scott's PE team is interdisciplinary; it includes an outside ethics consultant and 10 staff members representing primary care, long-term care, pharmacy, rehabilitation, nursing, mental health, business office, social work, system redesign, and education (patient, family, staff). Over time, each team member is expected to chair an ISSUES task force. When composing her task forces of two or three people to work on an ISSUES cycle, Dr. Scott's first criterion is personal interest. "Everyone who refers an ISSUES cycle to us has the opportunity to work on the issue," she said. "After all, they know the problem and can implement the solution." Often, the

members of the task force can bring different backgrounds and perspectives to the issue. "We came at the 'dual care' problem from different angles," noted Dr. Figaro, who chaired the Dual Care Task Force. "We came up with different solutions, which expanded our choices."

Moreover, as an ISSUES cycle progresses, team roles can change. Ms. Alvarez, for example, performed many tasks for the advance directive issue. "During the initial phase of this project, I assumed the role of studying and gathering information about the issue," she said. "However, when implementing one of the strategies identified to resolve this issue, I assumed the role of educator to help those patients whose advance directives had errors to understand the advance directive process and how to complete the forms correctly."

In most cases, this work is considered a collateral duty, even though several contributors reported that leadership gave them some protected time to attend meetings and perform analyses. "Because this is an add-on to their day job, this is always an issue," recalled Dr. Houldin. "But people rise to the occasion. One member of our PE team asked for eight hours per month, which was granted to help with education on the issue."

Dr. Scott also encourages her team members to negotiate for release time, which may or may not be granted. In addition, her committee uses the funds they receive from the Ethics Center to purchase program materials.

The ISSUES Approach

Identify an issue
- Identify ethics issues proactively
- Characterize the type of issue
- Clarify each issue by listing the improvement goal

Study the issue
- Diagram the process behind the relevant practice
- Gather specific data about best practices
- Gather specific data about current practices
- Refine the improvement goal to reflect the ethics quality gap

Select a strategy
- Identify the major cause(s) of the ethics quality gap—do a root cause analysis
- Brainstorm about possible strategies to narrow the gap
- Choose one or more strategies to try

Undertake a plan
- Plan how to carry out the strategy
- Plan how to evaluate the strategy
- Execute the plan

Evaluate and ajdust
- Check the execution and the results
- Adjust as necessary
- Evaluate your ISSUES process

Sustain and spread
- Sustain the improvement
- Disseminate the immprovement
- Continue monitoring

What are some recommended practices for working an ISSUES cycle?

- "Follow the steps of the ISSUES cycle closely," commented Ms. Alvarez. "They will guide your team and help them to resolve the issue."
- Dr. Scott recommended paying a lot of attention to the first step, Identify an issue. "I learned how important it is to get buy-in from the group that is targeted for improvement," she said. "Make sure your team or task force does early brainstorming around the problem itself. Learn who is experiencing it, and listen to their proposed solutions. They need to feel empowered and included in the process."
- Build relationships. Often, the personal touch afforded by a one-on-one conversation can prove essential. As Dr. Houldin explains, "Without technological support, we could have never been successful in creating a new Code Status note. Our IT person is very busy with her own tasks, and asking her to make this change was over and above her scope of work. I had to go and explain how important this was, and get her buy-in on a personal level. If I hadn't done that, I probably would not have been successful."
- Mr. Bauck and Ms. Cook found that the PE storyboards were a valuable tool for docu-

menting their process as it unfolded. "Many people think of using the storyboards to tell the story after it happens. We, however, used it as a template to guide us through the process so we could get the best possible outcome."

- Consult with colleagues. Ms. Broeren suggested that PE teams use the collective expertise of the PE teams within the VISN. "If you get stuck somewhere, ask someone who's been there. We have a PE call once per month within the VISN where we discuss practices, roadblocks, and methods for collecting data."

How does using the ISSUES approach help to close the ethics quality gap?

Even in cases where the problem seems obvious and the "fix" appears to be simple, the ISSUES cycle provides the structure to help ensure a systematic process and common understanding. "It enables people to follow your logic and thoughts," Dr. Scott said. Ms. Alvarez added, "The value of working on an ISSUES cycle is that it allowed me to break the issue down into small pieces and focus on more controllable and measurable sub-issues. This made the goal of the project easily attainable without the use of many resources."

"The process keeps you on track," said Ms. Broeren, "so that you don't miss anything."

Most importantly, the ISSUES approach can yield measurable results that improve the lives of patients and providers. Ms. Broeren said, "As a result of the ISSUES process, we were able to define what the gap was, so we had a better idea where to start. We were able to dig deep enough and discover that our practice of denying medications and follow-up appointments to AMA patients was not dictated by policy even though it had become ingrained within the facility culture."

Now, according to Ms. Broeren, "Patients are being treated in a more patient-centered manner. They feel like we're hearing what's really going on with them, and are grateful. On the other hand, residents were thrilled to have the option to help patients in a new way. It's refreshing and exciting to see VA take this on with such gusto."

Looking for . . .

IntegratedEthics Technical Assistance?
http://vaww.ethics.va.gov/integratedethics/TA.asp

National Ethics Teleconference call summaries?
http://vaww.ethics.va.gov/pubs/netsum.asp

National Ethics Teleconference call schedule?
http://vaww.ethics.va.gov/activities/net.asp

Ethics-related pandemic influenza material?
http://vaww.ethics.va.gov/activities/pandemic_influenza_preparedness.asp

IntegratedEthics Reference materials?
http://vaww.ethics.va.gov/integratedethics/ieresources.asp

Moving Through the Cycles: Real-World Examples from Five Facilities

Facility	What issue was identified	How was the issue studied?	What were the major causes of the ethics quality gap, and what strategy was selected to address them?	What plan was executed in support of the strategy?	How were results evaluated? What was accomplished?	How did you sustain and disseminate the resulting improvements?
Illiana (IL) HCS	Patients who left the hospital against medical advice (AMA) were being discharged without medications and follow-up pointments.	• Hospital policies were examined. • A chart review was done to establish baseline information. The review found that no AMA patients had received new discharge appointments, and previously scheduled appointments were cancelled. While some of these patients did receive prescriptions, this was not documented in the patient notes. • A literature review was conducted by the ethics consultation service to determine ethics best practice and how other medical centers have handled this issue.	**Cause:** • Informal culture supported and reinforced this practice among physicians including new residents. **Immediate strategies selected:** • Create CMO and CNO directive to clinicians to ensure that AMA patients receive prescriptions and follow-up appointments. • Notify scheduling office that future appointments for AMA patients should no longer be automatically cancelled. **Longer-term strategies selected:** • Write policy that delineated appropriate procedures for AMA patients. • Formally educate everyone on the policy. • Consider revising the AMA form to change status of these patients to "irregular discharge" to reduce stigma and negative connotations associated with AMA.	Chiefs of Medicine and Nursing sent out directives that no more appointments of AMA patients were to be cancelled, and that residents needed to be immediately educated regarding new practices for handling AMA patients.	AMA patient records were analyzed to determine how many were receiving prescriptions and follow-up appointments since the practice was changed. By March 31, 2009, 25% of these patients received follow-up instructions and 60% received medications; and by May 31, 2009, 63% received instructions and 63% received medications. In addition, the literature review summary demonstrated to staff how a practice can become pervasive even when it is not part of formal institutional policy.	To sustain the practice, the team acknowledges that formal education of residents and nurses will be necessary. The numbers of AMA patients who receive medications and follow-up appointments will continue to be monitored.

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New York Harbor HCS	Routine social worker reviews revealed that advance directives completed by patients in the Dialysis Unit contained errors.	• A chart review was conducted to understand the scope of the problem and identify what types of errors were being made. • An informal focus group was held with patients to assess their understanding of advance directives.	**Cause:** • Patients have a limited understanding of advance directives. • Staff practices with respect to advance directives are inconsistent with policy. **Strategies selected:** • Institute quality checks. • Simplify process. • Educate patients on the purpose of advance directives.	• A new quality check was developed prior to scanning to ensure directives are accurate. • Patients received education on the advance directive process and how to fill out advance directive forms.	The percentage of dialysis patients with correct and valid advance directives increased from 58% to 96%.	Advance directives continue to be monitored to ensure they are being filled out correctly and scanned into the patients' electronic chart.

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Philadelphia VAMC	Advance directive and code status information contained in patient transfer documentation between the Community Living Center (CLC) and the ER was often unclear and incomplete, which resulted in an inability to correctly identify patient treatment preferences.	A chart review was conducted of 121 CLC residents who had been transferred to the ER over a six-month period. The findings revealed that 8% of the transfers were conducted against the documented wishes of the residents; 25% had no documented advance directives; and over 90% had incompletely documented advance directives in which critical information such as treatment preferences for blood products, dialysis, IV hydration, artificial nutrition, etc., was missing.	**Cause:** • The sections on the electronic forms where staff enters advance directive and code status information had been rediseigned, and staff were insufficiently trained to correctly enter information into the new forms. **Strategies selected:** • Create a Code Status template that could be accessed under the CWAD that would generate an automatic DNR order and Social Work consult once the order has been co-signed by the Attending Physician. • Provide staff education about correct advance directive documentation, specifically targeting CLC MD's, Nurse Practitioners, and Social Workers.	• The electronic code status note was completed and posted electronically. • Immediately after posting, four formal educational sessions were conducted with CLC staff about the overall advance directive policy and documentation process.	• Data gathered from a chart review of CLC residents (n=38) transferred to the ER over a three month period (2/09-4/09) after the code status note was implemented revealed that: • The number of residents transferred to the ER against their documented wishes was reduced from 8% to 0%. • The number of CLC residents with documented advance directives increased from 25% to 100%. (77% of these documented advance directives used the newly developed electronic code status note.) • The number of CLC residents with incompletely documented advance directives decreased from 90% to 4%. • 100% of CLC charts with completed advance directives had a corresponding DNR order. All statistics surpassed performance objectives. • As of July 2, 2009, an electronic chart review indicated that 220 code status notes have been completed by providers. These notes are standardized and, for the most part, comprehensively document patients' treatment preferences and choice of health care agent. • An analysis of qualitative/descriptive data, however, found improved clarity, frequency, and specificity of code status documentation.	Staff education will be ongoing, and will be extended to providers in the care units and outpatient clinics, with the ultimate goal of starting the advance directive conversations with patients earlier in the clinical relationship.

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Puget Sound (WA) HCS	The use of iMedConsent was behind performance goals two years after iimplementation.	The iMedConsent Coordinator had been tracking utilization rates, and discovered they were below national averages, and that utilization varied significantly between providers within specialties.	**Cause:** • Consents signed in outpatient clinics often expire prior to the performance of a procedure. • Rotating providers were forgetting how to use iMed between rotations/shifts. • Providers encountered technical barriers as well, including unfamiliar signature pad locations and lack of functional wireless computers in many areas. Often, they would not report these problems. **Strategies selected:** • Mandate iMedConsent documentation for entry to the OR. • Include iMedConsent use as one factor for physician performance pay. • Increase the number of wireless computers on inpatient units. • Train ADPACs to handle most user calls about iMed failures.	• Chief of Staff and Chief of Surgery issued mandates requiring iMedConsent documentation before a patient could enter surgery. The Nurse Manager in the OR was responsible for monitoring compliance, and halted any cases where documentation was lacking. Exceptions needed to be documented in the patient record. • Use of iMed was entered as a factor that affects physician performance pay.	The iMedConsent Coordinator discovered that after these two practices were instituted, utilization increased to nearly 100% in Q1 FY09 from an average of 47% in Q1 FY08 in 5 specialties.	The iMedConsent Coordinator continues to monitor use every quarter. Attention is now focusing on technical issues, including the wireless computer system.

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Tennessee Valley HCS	Several providers in primary care have complained of the lack of information from non-VA providers about veterans for whom they are prescribing medications. This could result in impaired ability to provide quality health care to these patients.	• A literature search was conducted by the Dual Care TF regarding utilization of dual care within VHA. • Related VHA Directives were reviewed and VHA Directive 2002-074 was identified for delineating "best practice" policies for dual care within VHA. • Providers at other VA facilities were contacted and queried about their experiences with dual care at their facilities in an effort to identify current and best practices within VHA.	**Cause:** • Providers are not given sufficient written and verbal information on the dual care process, clarification of their responsibilities, and the Release of Information (ROI) procedure. • Providers do not obtain necessary outside documentation prior to prescribing or changing treatment for co-managed chronic conditions. • Clerks and other personnel of the Business Office are not provided with the training and tools to obtain documenting information on dual care patients. • CPRS and DSS do not have fields/codes for Dual Care information. **Strategies selected:** • Provide patients with instructions that they can bring to their non-VHA providers on how to release medical information. • Provide Business Office staff with information and tools they can use to facilitate the appropriate use of ROI. • Educate providers about dual care, VHA Directive 2002-074, and ROI policies and procedures. • Add a field on the patient's electronic chart where provider can document that patient is receiving non-VHA care and that provides an electronic template that authorizes the release of patient-specified information to the non-VHA providers. Once signed, this release will be sent to the Medical Records office that then will handle the records exchange with the non-VHA providers in a secure manner.	• Providers and patients were educated via verbal and written communication (e.g., posters, flyers, brochures). • Brochures describing Dual Care definition, uses, policies, procedures and ROI were developed and distributed by providers to all patients in Primary Care and Senior Care clinics at both Campuses over a 5 day period (~1,200 veterans were reached). • A single page flyer describing the ROI process was developed and distributed by Business Office clerks to all veterans attending the targeted clinics during the 5 days.	Provider (physicians and nursing staff) satisfaction and comfort level with dual care improved. Providers feel that the information dissemination efforts and the shared decision making between patients and both VA and non-VA providers will improve quality of care. An analysis of utilization of ROI pre-/post-cycle #1 is being conducted. The evaluation data on the information dissemination efforts are being analyzed for effectiveness and impact.	Sustainability practices will be developed and implemented once the analyses are completed in Aug '09.

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: vhaethics@edc.org.