A Workshop on Standard Process for Assessing the ROI of Clinical Ethics Consultation

The field of clinical ethics currently has no standard process for evaluating its return on investment (ROI).[1] The most recent Catholic Healthcare Innovation in Ethics Forum (CHIEF) provided an opportunity to leverage the expertise of participants through a workshop format to develop a draft process to support ethicists in collecting and analyzing the data needed to show the ROI of clinical ethics and collaborate with operational partners to this same end. The workshop started from the position echoed by the American Society for Bioethics and the Humanities' (ASBH) Core Competencies which acknowledges that "[e]thics consultation services should be able to assess and demonstrate their value to the recipients of the service, as well as to hospital leadership who support the service."[2] Our goals for the workshop were ambitious: (1) identify relevant metrics for clinical ethics consultation, (2) craft early formulations of those metrics as an ROI, (3) determine who and how to ask for similar data across participant health systems, and (4) structure an ROI "pitch" for clinical ethics consultation using a needs assessment framework for system leaders. Where we ended was more realistic. Namely, knowledge and process gaps were identified by participants in an effort to guide future work. This piece is therefore more descriptive than argumentative in an effort to summarize the insights of workshop participants and provide a bit of a roadmap for the ethics community as to where the subgroup's work will head over the coming months.

DEFINITIONS

We began the workshop with a set of definitions to ensure participants were approaching the topic similarly. Most important of these definitions included ROI itself. We used the following formula to define ROI to conceptually think about value:

ROI = (Net Profit / Cost of Investment)[3]

Using the metric of volume (i.e., the number of clinical ethics consults performed in a year) as an example, we emphasized that an ROI has to demonstrate a benefit to the organization through a relationship among a set of metrics.

Clarifying how we would define and explore an ROI for the participants also required clarifying a few terms that would be essential to the exploration:

Metric	require both a means of measurement and interpretation; used to evaluate a business strategy, e.g. ROI, improved efficiency
Benchmark	measurement or standard against which comparisons can be made
Benchmarking	comparing business processes and performance metrics to industry bests or best practices from other industries
Key Performance Indicator (KPI)	*limited number* of financial and operating indicator metrics that measure performance critical to the success of an organization
Outputs	direct products of program activities
Outcomes	specific changes in program participants' behavior, knowledge, skills, status and level of functioning

Table 1. Definitions[4]

We concluded the opening portion of the workshop with a brief overview and a brainstorming exercise on commonly used metrics in healthcare – length of stay (LOS), readmission rate, reimbursement (cost vs. charges), throughput times, volume, case mix index (CMI), and voluntary turnover rates. This exercise served as a catalyst for participants to think about clinical ethics consultation in the context of how healthcare already thinks about demonstrating value through relationships of common quantitative metrics. From this discussion, we were able to illustrate how ROI has evolved through distinct "generations," shifting from simple financial arithmetic to complex, multi-dimensional strategic frameworks. Thus, volume of clinical consultation is an important metric, and while likely critical to calculating an ROI, it is not an ROI itself.

GENERATIONS OF ROI

During our discussion, we wanted to demonstrate to participants the longitudinal changes and more sophisticated metrics being employed to study ethics consultation. In what we termed "Traditional or Generation 1" metrics, studies included the number of consultations as well as other descriptive statistics about the study population, e.g. age, race. Generation 1 quality improvement studies were (and continue to be[5]) more qualitative[6] in composition and look at the decreased variation[7] in practice. Generation 2 studies examined the impact ethics consultation has on reducing a patient's length of stay[8] and comparison[9] of the ethics consultation between similar facilities. Generation 3[10] studies took us one step further into interventional research by demonstrating that ethics consultations improved contribution margin and there was a

decrease in the variance of length of stay, not just a decrease in overall days past expected discharge. This is an important distinction because the biggest payers (government and commercial) utilize very sophisticated modeling to predict the length of stay for patients with the same type of diagnosis which is especially critical when many patient populations are shifting from traditional fee-for-service models to value-based care models. This then led us to discuss with the group what would Generation 4, an advanced and predictive ethics model, look like.

CORE COMPONENTS OF A NEEDS ASSESSMENT

We utilized a standard needs assessment framework[11] with our workshop participants to ensure each of the three groups were aligned in their approach while also creating an opportunity for replicability for post-workshop utilization in each respective participants' healthcare system. This framework served as a roadmap for the remainder of the workshop to help participants move from current reality to early concepts of an ROI.

1. Describe the problem	• How to describe problem to operations leader (i.e., why should s/he care)?
2. Proposed Solution	• What's the connection to the work? Why is this necessary in the first place? • What metrics are important? How will you gather data?
3. Proposed Methodology	• What do you propose the structure to be like?
4. Current State	• What is currently happening with our structure?
5. The Ask/Future State	• Where do you envision next steps lie? • What are the early essentials to get there? • How will you measure success?

Table 2. Gap Analysis Framework

Perhaps the most important issue identified through the workshop was a general feeling among participants that they did not know where to begin. For some, the idea that there is a "problem to solve" seemed to suggest that there is something to eradicate within the healthcare industry. For others, the concepts of metrics and KPIs were entirely new and thus unclear. Similarly, the terminology of finance and operations were foreign, creating a very high bar for entry. After all, most ethicists did not study healthcare management in graduate school.

There also seemed to be some sense that clinical ethics consultation, by its very nature, is self-evidently of importance and therefore not necessarily in need of an ROI and therefore no real problem to solve. However, this led to discussion on how or why clinical ethics consultation should be "set apart" from innumerable healthcare fields where performance, efficiency and cost effectiveness dominate. Participants ultimately struggled with articulating the overall empirical improvements in the ethical dimensions of care that result from clinical ethics consultation, much less a causal relationship between the work and the claimed outcomes.

For those groups who did see a role for an ROI, linking an ROI to full-time equivalents (FTEs) seemed to too narrowly focus value on "saving roles" and not the value of clinical ethics consultation itself. Trying to move away from FTE associated ROIs, the discussion quickly stagnated with little certainty of how to proceed among the participants.

Interestingly, although the needs assessment framework and exercise envisioned for this workshop did not lead to early concepts of an ROI for clinical ethics consultation services, it did lead to broad consensus that a primer or a "101 course" on data analytics in healthcare would be extremely useful for those who lead clinical ethics consultation services or programs in order to begin to better communicate the value of the work to operational leadership. While some participants may have this expertise, in general the participants felt ethicists as a field lack familiarity with financial terms and data analytics or data management skills.

WHERE TO GO FROM HERE

Over the next year, a subgroup will take the gaps identified in the workshop to create an easy-to-use tool for ethicists to analyze ROI for their own clinical ethics programs. Several workshop participants volunteered to work on the project with us. Our goal is to develop a straightforward process that requires the ethicist to have little to no specialized knowledge of finance, data analytics, or healthcare operations. Ethicists will be able to take this tool to leaders in their own system in departments like IT, operations, and finance to help them identify and collect the data needed to calculate and analyze an ROI. We hope this will help ethicists in Catholic healthcare, or anywhere in the country, show the operational value that clinical ethics provides to the organization. ✠

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ENDNOTES

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