High Reliability in Clinical Ethics: Creating Best Practice Criteria in Structure and Process

PROMOTING HIGHLY RELIABLE CATHOLIC MINISTRY IDENTITY

Many in healthcare, especially in the clinical realm, are familiar with what it means to be a High Reliability Organization (HRO), as defined by the Agency for Healthcare Research and Quality. High reliability is often understood as a "systems thinking" approach to evaluating and designing initiatives, structures and processes that optimize particular endpoints. Systems thinking emphasizes the relationship among a system's parts, rather than a focus only on a particular part of the system when attempting to effect change. Often persons engaged in systems thinking will start from a position of curiosity or discovery that may include an exploration of the fundamental concepts or ways of doing things that were previously thought to be true. In this way, systems thinking can offer a new perspective on the complexity of the initiative, structure or process, and in particular, on how things influence one another within the whole.

It was the idea of taking a systems thinking approach to how our ethicists in Ascension were leading their ethics programs, both in structuring Ethics Integration Committees (EICs) and the provision of clinical ethics consultation services, that led to the collaborative redesign to optimize our ethics services. In the following sections, we will explore two key initiatives as part of our systems thinking redesign: (a) the shift away from an ethics committee-centric model to an ethicist-driven model and the concurrent restructure of EICs through this lens, and (b) the optimization of clinical consultation process flows.

AN ETHICIST-DRIVEN MODEL AND ETHICS COMMITTEE REDESIGN

The Ethicist-driven model is distinguished both from the traditional Ethics Committee-centric model and the Ethicist-centric model, which views the ethicists as a "Lone Ranger" consultant. The Ethicist-driven model retains a role for Ethics Committees but the roles of those committees and their members change with the goal of facilitating access to the right level of ethics expertise in the right way at the right time and supporting the (Ethicist-driven) Ethics Programming (a systems-thinking approach to all things ethics) within the Ministry Market. The following chart (Table 1) illustrates the differences in the roles of ethics committee members in a committee-centric model vs. an ethicist-driven model. These differences in role also highlight the essential strategic, leadership and subject matter expertise the ethicist must evidence within this framework:

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TABLE 1

Function	Role of Members in an Ethics Committee-centric Model	Role of Members in an Ethicist-driven Model
Consultation	Perform a large percentage of consultations	• Identify clinical ethics consult needs on the units • Escalate consults to Manager/ Director of Ethics • Support consultations by providing clinical SME and multiple perspectives to the ethicist-led consult team
Education	Provide Education (usually through an annual conference)	• Identify education needs on the units • Advise on how the ethicists can best meet those needs • Help integrate into "other people's" curricula/processes • Build support for attendance among peers
Policy Review and Development	Review and Develop policies	• Identify policies that need review • Identify issues for new policy • Provide input and recommendations on policies
Marketing the Ethics Service	None	• Educate peers regarding Ethics services • Educate other staff on when to use Ethics Services • Keep peers updated on changes to Ethics services
Member Succession Planning	None	Make recommendations to Ethicists about peers as appropriate candidates for future members and develop their interest for future membership

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As Mary Homan notes in her article within this issue, many academic medical centers favor an ethicist-centric model of consultation, where the professionally trained ethicist handles all consults, and the volume of consults justifies their FTE. An ethicist-driven approach is not this, nor is it a model where the ethicist is at the service of the ethics committee or the committee chairs. An ethicist-driven approach is one where the ethicist(s), with their specific subject matter expertise, in collaboration with clinical and organizational leaders, and the EIC, set the agenda and direction for a systems-thinking based ethics program. This includes setting strategic priorities, determining optimal EIC structure and consultation processes, and aligning membership, expectations and training of members to these structures and priorities. Put simply, an ethicist-driven approach leverages the relationship among the parts within the complexity of the whole of the healthcare system to inform the right level and type of ethics service and to help ensure that ethics subject matter expertise, resources and tools are integrated into the operations of the entire health system.

As part of this work to apply systems thinking to the clinical ethics setting, in addition to revising the role of the committees themselves, we have been simultaneously redesigning the structure of the ethics committees away from the traditional model of facility-based committees. Instead, the Ministry Markets are moving to one committee that serves a specific service line or population of patients with representatives from all the facilities across the market. Within this model, for example, there may be one Women's and Perinatal Health Ethics Committee that serves the whole market, another committee that serves Pediatrics across the entire market, another that serves the adult acute care population, another that serves Behavioral Health and still another that serves the smaller community hospitals across the Ministry Market. Which service-line or population-based committees are present in which Ministry Markets will depend on the makeup of the types of facilities and service lines within those Ministry Markets. This results in both a substantial increase in member engagement (insofar as everything discussed in every meeting is relevant to everyone on the committee), and a significant increase in the ability of the Ethicist-led committee to integrate into operations in a sustainable manner, given the new membership and the roles of those members as outlined in the chart above. Systems thinking here allowed us to question whether the long-standing structure of facilities-based ethics committees is still the right structure to deliver high quality clinical ethics consultation services.

Based on anecdotal feedback, this structure provides the committee members with a greater sense of meaningful contribution to the operations, Mission and ministry identity of the organization. Insofar as the Ethicists drive, i.e., lead not just support, the work of these committees, this also results in higher quality, greater accountability and increased coordination of activities and programming (for example, education can be connected to frequent consults, and policies can be designed in response to process gaps, etc.). The "Best Practice Criteria" for Ethics Integration Committee Structure outlined below represents our ethics community's efforts to apply systems thinking to how best to integrate characteristics of high reliability into the structure and design of our Ethics Integration Committees (EICs)

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across the system, while at the same time allowing for the above-mentioned variability based on Market structure and needs.

BEST PRACTICE CRITERIA FOR EIC STRUCTURE AND CONSULT PROCESS FLOW

In addition to promoting high reliability in clinical ethics as an outgrowth of our application of systems thinking to the entire body of work to improve ethics services, the development of "Best Practice Criteria" for both EIC structure and Consult Process Flow was in large part due to the need to both read and respond to the "signs of the times" and to respect the principle of subsidiarity in practice. Through the lens of systems thinking, we began to look at the way in which clinical services were realigning within Ascension. Clinical services lines were no longer operating independent of other markets or the system as a whole. Rather, they were beginning to align from the bedside to the system office. It seemed natural, therefore, to rethink EIC structures that would align in parallel to the clinical services lines rather than be locked into a structure that could not adapt. Systems thinking enabled us to view the transformation of clinical service lines as an opportunity to re-examine the traditional facility-based ethics committee structure given the importance of the relationship of the two within the complexity of healthcare delivery. Doing this effectively, however, meant attending to subsidiarity in developing the "Best Practice Criteria."

The "Best Practice" criteria came from the people closest to the work. For the EIC Redesign, we took many of the criteria from our Texas Ministry Market, where our ethicists in the market had already completely "blown up" their old structure of ethics committees to create "network" or regional specialty-focused EICs. For the Ethics Consultation Process flow, Our Ascension Indiana ethics team had already made great headway in the integration of a consult-team based approach using Voalte technology (an alert system to EIC members on the consultation subcommittee to ensure timely response from those with consultation responsibilities). So, relying heavily on these insights, we developed the following "Best Practice Criteria" and brought them to our Ethics Advisory Community for review, feedback, and refining. What you see in both Table 2 and Table 3 are the result of this process. The other key point is that the criteria are just that. They are not a "one size fits all" model. Our Ministry Market ethicists, who know their market the best, decide how to implement these criteria in their market, and what this will look like, supported by agreed upon "Standards of Performance Excellence (SOPE) for Ethics Services" data to demonstrate these, where applicable.

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TABLE 2

Best Practice Criteria for Ethics Integration Committee Structure

An Ethics Integration Committee is said to be a "best practice" model when:

1. The committee structure and membership promotes and enables integration of Ethics subject matter expertise and resources into the clinical and operational processes of the organization.
2. The committee membership includes adequate numbers of influential and/or highly visible representatives from critical/high utilizer units/areas across the market, including administration, and the committee is highly visible to key utilizers not on the committee.
3. The committee has an established reporting relationship to the Mission Committee of the Board and an appropriate Clinical Leadership committee.
4. The committee provides a structured forum for training members (and others) to identify, escalate and support clinical consultation and other types of Ethics services and support (e.g., programming and integration).
5. Responsibility for supporting and participating in committee work is shared appropriately across members; all standing members are required to be active participants, with different responsibilities of ex officio members acknowledged.
6. Committee membership and operations ensure sustainable expertise (independent of any one particular individual) and diverse representation (roles as well as representative of communities served)
7. The committee structure supports and promotes ethics education throughout the institution (i.e., beyond EIC meetings)
8. The committee structure promotes quality ethics consultations and supports the Ethicists in fulfilling their Quality Assurance and Continuous Quality Improvement responsibilities.
9. The committee structure provides a foundation for a “Best Practice” consultation process.
10. The committee structure enables member engagement through highest and best use of their time.

As mentioned above, the second way that we have sought to promote high reliability as an approach to systems thinking in the clinical ethics context is by ensuring that the ethicists have appropriate involvement and oversight of all clinical ethics consultations and, when possible, the consultation process flow is integrated into and utilizes existing clinical processes. These characteristics are reflected in the Best Practice Criteria for Consultation Processes (Table 3 below). When met, these criteria ensure that the ethics consultation processes involve the appropriate expertise as enabled by the new EIC structure and member roles as well as other clinical and operational leaders in light of their own subject matter expertise. In addition, they ensure that stakeholders know when and how to access an ethics consult, and that these are responded to in a highly reliable manner.

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TABLE 3

Best Practice Criteria for Ethics Consult Process Flow

An Ethics Consultation Process is said to be a "best practice" model when:

1. The process leverages the EIC Committee Structure to ensure timeliness and quality of consultation services.
2. The process has full support of clinical leaders.
3. Reliable mechanisms for providers, staff, associates, patients, and families to request ethics consultation services are established, integrated and marketed throughout the ministry market.
4. The process includes an escalation mechanism that consistently results in the right person(s) addressing the right type/level of consults.
5. The "Assess, Analyze, Act" deliberation process is utilized in addressing patient-specific care consults and retrospective case analyses.
6. The process favors an interdisciplinary team-based approach to patient-specific consults when appropriate.
7. The process allows for and promotes appropriate involvement of the Ethicist(s) for oversight of consultations, consultation trends, education needs, and quality of recommendations.
8. The process aligns with and leverages existing clinical processes and tools already utilized within the market (for example, but not limited to, Voalte as a primary means of communication).
9. The process includes appropriate follow up and communication of recommendations, including conversations with relevant staff and documentation in the EHR, per the existing ethics criteria.
10. The process promotes reliable and efficient data collection in Ascension's Ethics Integration Database.

PLANNING, PILOTING, PIVOTING

One of the most significant outcomes of this work has been the organic collaboration and sharing of "lessons learned" that has been occurring amongst our ethicists in various Ministry Markets, which has contributed to the development of education curricula designed to support our new EIC structures, as well as increased energy and engagement in this work. In light of our systems thinking approach this collaboration did not come as a surprise, but it did highlight the importance this approach places on interconnectedness and relationship when working within complex systems. Although it is early days, our initial data looks promising, and attests to this increased engagement by key stakeholders (see Table 4).

TABLE 4

Standards of Excellence for Ethics Services - Ascension

Ascension

In the chart below green indicates at or above threshold, yellow indicates slightly below threshold and red indicates significantly below threshold.

Fiscal Year FY 2023

	Performance Excellence Metric	Q1	Q2	Q3	Q4	FY
Clinical	Markets with an annual Net Patient Service Revenue (NPSR) of **greater than $2B** perform **30** or more clinical consults per quarter. Average result based on: Florida, Illinois, Indiana, Michigan, Tennessee, Texas and Wisconsin	25	26	32	38	30
	Markets with an annual Net Patient Service Revenue (NPSR) of **less than $2B** perform **15** or more clinical consults per quarter. Average result based on: Alabama, Kansas and Oklahoma	34	27	25	36	30
	Embedded Ethics Resources (EERs) are engaged in **40%** or more of Patient specific-care consultations.	46%	45%	53%	60%	52%
	At least **95%** of all Patient specific-care consultations are acknowledged within 24 hours of the request.	100%	98%	98%	100%	99%
Organizational	Total Organizational Consultations for the entire system occur at a rate of at least **115** per quarter.	167	137	162	197	171
Education	The average number of participants across all Ethics Education is **23** or greater per session.	26	37	27	26	28

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As of now these standards are primarily based on volume data across the previous three years of data collection. While there is nothing inherent in these prior years of volume data that would suggest thresholds demarcating national standards in "excellence," there are in fact no "industry standards'' or even accepted metrics for measuring excellence in Ethics Services within the professional field of Bioethics, either secular or Catholic, as of yet. Thus, while merely a starting point from which to develop an understanding of what a quantitative picture of service excellence looks like, these data have and will continue to prove valuable in helping us understand the impact that our structural changes are having on the services that we provide. It is important to note that the SOPE standards themselves are not about maximizing consult volume, like in the Ethicist-centric model where the FTE is justified by volume alone, but about ensuring that we are catching all appropriate consults relative to the subject matter expertise of ethicists, and in support of high reliability. These SOPE metrics and data are reviewed on a quarterly basis with each of the in-market Ethics teams, their Chief Mission Integration Officers and leaders at the Central Ethics Unit. The chart above provides the SOPE metrics and the system-wide performance relative to those metrics for FY23.

Clearly there is more work to be done in the area of standards of excellence in the field. However, "holding tight" until the field agrees on such standards seems ill-advised. Perhaps just as important as Ascension's work on the Standards of Performance Excellence for Ethics Services is the degree to which the work served as a catalyst for systems thinking innovation. Monitoring the impact of Ascension's innovation in the area of "Best Practice Criteria" for both EIC structure and Consult Process Flow will be instrumental in ongoing transformation efforts. ✣

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