Revising Repenshek's Minimum Standard Set of Data

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Establishing a minimum standard set (MSS) of data to collect is key for Catholic health care as Clinical Ethics Consultation (CEC) Services and Ethics Committees increasingly base their work and strategy on consultation data. An MSS that is widely agreed-upon and implemented would allow Catholic healthcare to: (1) compare data between hospitals, ethics consultants, Ethics Committees, and health systems; (2) develop standard methods of calculating the return on investment (ROI) for clinical ethics consults, similar to palliative care;[1] and (3) create a baseline for quality assessments of individual consults and CEC services.

Mark Repenshek has outlined a minimum standard set (MSS) of data that Ethics Committees should include in a database on clinical ethics consultation (CEC).[2] He lists nine data points as "the bare essentials for starting a CEC database" (see Table 1). Repenshek emphasizes that "an MSS is truly that — the minimum set necessary." CEC Services and Ethics Committees can and should add other data points that they see as relevant, but should at least include capture these elements. He describes his MSS elements in detail elsewhere and makes the case for why they should be included. To clarify, the Patient Encounter Number is the identification number unique to the hospitalization in question, and Location means what kind of unit the patient is in such as ICU, oncology, emergency department, ambulatory, etc.

However, several other fields appear necessary to achieve the goals of an MSS for CEC in Catholic health care (see Table 1). Each of these fields has unique benefits for assessing a CEC service. For example, the patient's discharge date allows for a calculation of the patient's total length of stay (LOS) which is required for many ROI metrics.[3]

A few fields can provide a quick snapshot of the patient's clinical situation, specifically the patient's discharge disposition, primary diagnostic related group (DRG) or ambulatory payment classification (APC), and type of decision maker.[4] This in turn provides context for the ethical issues in the case. For example, a patient discharged to hospice with renal failure and a medical power of attorney typically presents different kinds of ethical issues and requires different actions than a patient discharged home with substance abuse who is unrepresented. Including the APC, and visit date in addition to admission date, ensures the MSS does not focus exclusively on inpatients. These fields do not provide a complete picture of the clinical situation, and other additions may improve the expanded focus to non-acute settings, but they are enough for a minimum standard set of data.

Other fields describe the consult itself. The names of the ethics consultant(s) involved,

the actions they took in the consult, the type of consult, and the secondary reason for the consult provide a brief glimpse as to what the consult was about and what occurred. The names of the consultant(s) and actions taken allow for quality assessment of individuals and teams. Stratifying consults by type permits cursory analysis of the consult's complexity, depending on how the categories are defined. Finally, adding a second reason for the consult gives more detailed insight into the ethical issues involved. Comparing actions in the consult, consult type, and the reasons for the consult between health systems would require standard terms, classifications, and definitions for these fields. While some examples exist, there are no standards as of yet.[5] However, even a standard within a system would be more informative than none at all. Again, this does not give a full picture of what occurred but it is a minimum.

Lastly, the number of licensed beds in the hospital and number of ICU beds are required to calculate the Consult to Bed Ratio (CBR) and Consult to ICU Bed Ratio (CiBR).[6] These recently developed metrics to assess the volume of consults in a hospital. Case Mix Index provides insight into the acuity and complexity of the patients in the hospital. These three fields are static and do not change for each patient, which reduces the time needed to input the data.

TABLE 1

Revised Minimum Standard Set of Data*			
1. Medical Record Number	6. CEC Request Date	**11. Patient Discharge Disposition**	**16. CEC Type**
2. Patient Encounter Number	7. CEC Consult Date	**12. Primary DRG \ APC**	**17. Secondary Reason for CEC**
3. Patient Admission \ **Visit** Date	8. CEC Time Commitment	**13. Type of Decision Maker**	**18. Licensed Beds in the Hospital**
4. Discipline Requesting	9. Primary Reason for CEC	**14. Ethics Consultants Involved**	**19. Licensed ICU Beds**
5. Location	**10. Patient Discharge Date**	**15. Actions Taken by Ethics Consultants**	**20. Hospital Case Mix Index**

*Elements 1 through 9 are Repenshek's proposed MSS. The revised MSS proposed here includes his and adds those in bold.

A significant obstacle to collecting data in these fields is the time needed for data entry. Most ethics consults are still performed by volunteers, i.e. physicians or employees who have other full time jobs. An additional request could push them to stop volunteering to do ethics work, or they may simply not enter any data at all. Of the 20 data points proposed here, nine (eleven if the EMR documentation already captures type of decision maker and ethics consultants) are able to be automatically pulled in a report from the EMR or a data repository. Only the eleven (possibly nine) specific to the ethics consult, such as CEC Request Date or the reasons for the consult, need to be documented by the consultant. However, it is likely that many of these fields are already included in the consultant's EMR documentation and again can be pulled automatically. Automating the process of data collection improves the volume of data collected and likely the quality of data as well. The patient encounter number can serve as a flag to easily identify the patients in question.

The revised MSS proposed here increases the ability for continuous quality improvement related to CEC, enhances comparisons of CEC work between ethics consultants and Ethics Committees, and improves analysis of relationships between the kind of work done in a consult and the consult's outcomes. A commitment to implementing this MSS, or a similar one if agreed upon, would benefit all Catholic hospitals and could change the field of clinical ethics in Catholic health care.

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ENDNOTES

1. For an example, see the Hospital Impact Calculator by the Center to Advance Palliative Care (CAPC). www.capc.org/impact-calculator
2. Mark Repenshek, "Creating a Clinical Ethics Consultation Database." *In* Catholic Health Care Ethics: A Manual for Practitioners. *National Catholic Bioethics Center*, 3rd edition, 2020, p 6.39-6.46.
3. Homan, Mary E. "Factors associated with the timing and patient outcomes of clinical ethics consultation in a Catholic health care system." *The National Catholic Bioethics Quarterly* 18, no. 1 (2018): 71-92. Repenshek, Mark. "Examining Quality and Value in Ethics Consultation Services." The National Catholic Bioethics Quarterly 18, no. 1 (2018): 59-68.
4. An alternative to primary DRG worth considering is the Major Diagnostic Category (MDC) which has fewer, more generic categories. However, this presentation at CHIEF 2021 mentioned primary DRG.
5. For consultation types, see Kenney, Matthew R. "A System Approach to Proactive Ethics Integration." *The National Catholic Bioethics Quarterly* 18, no. 1 (2018): 99. American Society for Bioethics and Humanities, Core Competencies for Health Care Ethics Consultation, 2011, 2nd edition, 10-11. For reasons for consultation, see Armstrong Clinical Ethics Coding System, 2013.
6. Glover, Avery C., Thomas V. Cunningham, Evelina W. Sterling, and Jason Lesandrini."How much volume should healthcare ethics consult services have." *The Journal of Clinical Ethics* 31, no. 2 (2020): 2-16. Feldman, Sharon L., Sundus H. Rias, Joshua S. Crites, Jane Jankowski, and Paul J. Ford. "Answering the Call for Standardized Reporting of Clinical Ethics Consultation Data." *The Journal of Clinical Ethics* 31, no. 2 (2020): 173-177.