A Guide to Frequently Confused Healthcare Services: 'Who ya gonna call?"

NHPCO RESOURCE SERIES

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Clinicians have a range of services available to support all aspects of patient care and professional conduct: consultation-based services such as Palliative Medicine and Ethics, as well as department services such as Risk Management, Legal, and Compliance. However, these services frequently have overlapping domains and responsibilities, leading to clinician uncertainty regarding which services to access. This document is intended to provide general guidance on which services may be appropriate to call or consult in complex clinical situations. In many of these situations, it will be appropriate to consult multiple services: for example, a care team considering the withdrawal of a legally authorized decision maker may consult its Ethics Service, Risk Management, and Legal Department for guidance on next steps. Thus, the list of "Potential Triggers" for each service described below should not be understood as the exclusive domain of that particular service; rather, the triggers are prompts for consulting a given service (among others which may be appropriate).

Given the heterogeneity of department structure and resource availability across sites, clinicians should (a) acquaint themselves with the specific services available within their organization and (b) confer with each service to ascertain its specific role and scope. This document provides a starting point to give a general idea of each service's function. While this guide is intended for both hospital and community-based care teams, the latter may not have standalone departments for some of these services, such as in-house legal counsel. In these cases, community-based teams may use the functions of each service described in this document to locate individuals in their organization that fulfill these roles or consult their expert advisory councils on this matter.

Ethics Consultation

(Committee or Consultant) (Bottom line: determining the ethically supportable or ethically permissible courses of action).

Scope/Purpose/Definition: An ethics service is provided by an individual or group to help patients, families, and health care providers *address uncertainty or conflict regarding value-laden concerns that emerge in healthcare*. Ethics consultation conveys knowledge of professional standards and ethical principles, how they are applied to specific clinical cases, and the communication and interpersonal skills to implement them successfully. However, ethics consultation does not provide specific knowledge of state law, nor does ethics consultation (or recommendations provided by ethics consultation) confer legal protection to the care team. In most situations,* recommendations from an ethics committee or consultation service are not binding or legally obligatory.

*There are, however, some state laws that *legally require* ethics consultation involvement in particular situations. For example, states such as Arizona require an ethics consultation in conjunction with two physicians to make certain medical decisions for patients without legally authorized decision makers. Clinicians should familiarize themselves with their state's requirements.

Unique/specific areas of expertise: identify, clarify, or resolve ethical/moral conflicts, dilemmas, or uncertainties related to patient care—answering the question, which courses of action are ethically supportable (rather than legally permissible)?

Potential Triggers/When to call them:

- Disagreement among the care team and/or family about what is best for the patient (regarding treatment—e.g. patient/family requests for potentially inappropriate or futile treatment)
- Code status/medical decision-making for a patient without decisional capacity and without a legally authorized decision-maker;

- Questions about a patient's or healthcare provider's rights and obligations (e.g. use of restraints, abusive patients/legally authorized decision makers, conscientious objection, safe discharge plan, etc.);
- Concern about withholding or disclosing information (e.g. HIV status, plan for hospice, terminal diagnosis, etc.);
- Competing obligations to prevent harm/promote health and respect for the patient's informed choice in a specific situation;
- Assistance discussing and exploring values and preferences with the patient and/or legally authorized decision-maker;
- Interpretation of a patient's advance directive;
- Concern about withdrawing or withholding a medical treatment (including life-sustaining treatment and voluntary stopping of eating and drinking).

Areas of Overlap:

With palliative care: "Cases that typically result in neither consultant alone being sufficient include those in which high stakes exist (eg, forgoing life-sustaining treatments), those cases representing very long hospital stays (as opposed to those focused upon care of the imminently dying) and those in which a breakdown of therapeutic alliances have occurred, or when efforts to negotiate and agree upon the goals of care are failing." In some instances, both consultants may prove helpful in assisting the clinical team when relationships and/or communication with patients or family members are strained (Carter and Wocial, 2012).

With hospice: For hospice-appropriate patients or their legally authorized decision makers who are considering hospice, but may be uncertain about their own goals, values, and preferences regarding their treatment.

With legal: When the legality of the care team's potential (ethically permissible) courses of action is called into question; or where a potential course of action could put care team members at risk of liability (for example, withdrawal of life-sustaining treatment). Example areas of overlap: uncertainty regarding the use of legal documents such as Advance Directives; uncertainty regarding the appropriateness of removing a legally authorized decision maker; withdrawal of life sustaining treatment; disclosure of patient information (when the course of action/plan of care/treatment could potentially result in risk of litigation, even if it may be the 'right' thing to do); cases of patient abuse, neglect, or exploitation.

With risk: After Ethics has identified a range of ethically permissible courses of action, risk can identify the potential consequences of those courses of action, particularly foreseen ramifications on 1) patient or care team safety, or 2) the organization's financial assets/reputation (i.e. risk of a lawsuit). Or, when the care team is considering a potential course of action/treatment plan, risk can identify legal or practical consequences, whereas Ethics can then identify the value-laden or ethical implications of those consequences. Potentially risky situations in which it may be appropriate to consult both ethics and risk include: unreconcilable conflicts between legally authorized decision makers and providers, questions about capacity to make serious decisions, withdrawal of life support without a clear directive or legally authorized decision maker, conflicts among legally authorized decision makers about important decisions.

Hospice

(bottom line: providing comfort oriented care at the end of life)

Scope/Purpose/Definition: Hospice care is a medical service that provides comfort-oriented (rather than curative) care for adult patients facing a terminal illness with a prognosis of 6 months or less, and pediatric patients facing a terminal illness with a prognosis of 12 months or less.* Patients who decide to pursue hospice care may be discharged home with home hospice (outpatient), or they may be transferred to inpatient hospice (typically, a designated unit of the hospital or a free standing inpatient facility). A formal or informal hospice liaison, in conjunction with physician and care coordination, can facilitate the most appropriate option for each patient.

*To qualify for hospice, adult patients must forgo curative therapies and have a prognosis of 6 months or less. Under the ACA, pediatric patients—typically ranging from newborn to 18 or 21 years old—must have a prognosis of 6 months or less but do not need to forgo curative/life-prolonging care, such as medications, treatments, and in-home nursing care, to

qualify for hospice. For pediatric patients, hospice is responsible for hospice-specific costs while the primary/sub-specialty care teams continue to bill as they had prior to hospice involvement. Palliative care may continue to follow both adult and pediatric patients in a supportive or consultant role.

Unique/specific areas of expertise: Comfort-oriented care for patients at the end of life; bereavement support for the patient's family

Potential Triggers:

For adult patients:

- The patient is facing a life-limiting illness (prognosis of 6 months or less) and no longer has curative options;
- The patient is facing a life-limiting illness, expresses an interest in forgoing aggressive treatment, and wishes for further education about hospice;
- The patient is facing a life-limiting illness and has chosen not to pursue aggressive treatment because the side effects outweigh the benefits.

For pediatric patients:

- The patient is facing a life-limiting illness (prognosis of 12 months or less);
- The patient and family are seeking additional supportive services.*

Areas of overlap:

With palliative: While palliative care and hospice both support individuals with life-threatening illness, palliative care is typically understood as a transitional model of care (to hospice when patient prognosis is 6 months or less). Thus, palliative care physicians who have been consulted may direct patients to hospice care if it is most appropriate, i.e. if the patient decides to forgo aggressive treatment or if it is determined that aggressive treatment would no longer provide benefit. Furthermore, palliative care teams may continue to follow adult patients once they are discharged to hospice, though only as a supporting consultant service, and degree of involvement varies: for example, palliative care may provide bereavement support to families, or may defer this to hospice.

*Pediatric patients at the end of life are more frequently followed by palliative care teams, in addition to receiving concurrent care from the primary/sub-specialty teams (providing curative treatments) and hospice (attending to symptom management and psychosocial/spiritual support). [Of note: Palliative care is an umbrella term that can cover a patient from the time of diagnosis through bereavement, while hospice focuses on a subset of this period at the end-of life through bereavement. However, because palliative care may continue to follow after hospice becomes involved, and given the overlap between some services provided, patients and family members frequently confuse or conflate palliative care teams with hospice teams.]

With ethics: For hospice-appropriate patients or their legally authorized decision makers who are considering hospice, but may be uncertain about their own goals, values, and preferences regarding their treatment. Hospice representatives may provide additional insight to the patient and family members as to specific services hospice provides, and whether the patient's values are consistent with these services.

Palliative Medicine

(Bottom line: providing care focused on quality of life, including comfort-oriented care and helping with medical decision-making with serious illness)

Scope/Purpose/Definition: An interdisciplinary consultation service dedicated to the specific goals of prevention and relief of suffering, and support of the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. This may be achieved through assistance with clinical decision making, as well as provision of psychosocial support.* Palliative care teams are typically composed of (but are not limited to) physicians,

advanced practice providers, registered nurses, social workers, and chaplains. Palliative care may be delivered concurrently with life-prolonging care, or it can be treated as the main focus of care at the end of the patient's life (depending on the composition and capacity of the team).

*Some palliative care teams may also work with case management/discharge planning to ensure appropriate community resources for a patient, including access to hospice; however, this depends on the size and scope of the team.

Unique/specific areas of expertise: Attention to alternative treatments, the limits of conventional or complementary treatments, redirection of clinical goals, specific actions and symptom management, meaningfulness of certain options, and support for the patient and family through end of life and bereavement.

Potential Triggers/When to call them:

- Patient diagnosed with a life-limiting, serious, or burdensome chronic illness (in which pain/suffering are anticipated);
- Need to clarify patient goals of care with patient and/or family in light of a life-limiting or burdensome chronic illness diagnosis
- Discussion regarding potential hospice referral, particularly if clarification of services is needed
- Critical illness whereby additional communication and support is needed to improve or enhance overall care of patient and family
- Patients with chronic illness that may require additional disease education and discussion regarding benefit and burden of future treatment options (anticipatory guidance)
- Patients nearing end of life requiring complex management of end-of-life symptoms

Areas of overlap:

With ethics: "Cases that typically result in neither consultant alone being sufficient include those in which high stakes exist (eg, forgoing life-sustaining treatments), those cases representing very long hospital stays (as opposed to those focused upon care of the imminently dying) and those in which a breakdown of therapeutic alliances have occurred, or when efforts to negotiate and agree upon the goals of care are failing." In some instances, both consultants may prove helpful in assisting the clinical team when relationships and/or communication with patients or family members are strained (Carter and Wocial, 2012).

With hospice: While palliative care and hospice both support individuals with life-threatening illness, palliative care is typically understood as a transitional model of care (to hospice when patient prognosis is 6 months or less). Thus, palliative care physicians who have been consulted may direct patients to hospice care if it is most appropriate, i.e. if the patient decides to forgo aggressive treatment or if it is determined that aggressive treatment would no longer provide benefit. Furthermore, palliative care teams may continue to follow adult patients once they are discharged to hospice, though only as a supporting consultant service, and degree of involvement varies: for example, palliative care may provide bereavement support to families, or may defer this to hospice.

Pediatric patients at the end of life are more frequently followed by palliative care teams, in addition to receiving concurrent care from the primary/sub-specialty teams (providing curative treatments) and hospice (attending to symptom management and psychosocial/spiritual support). [Of note: Palliative care is an umbrella term that can cover a patient from the time of diagnosis through bereavement, while hospice focuses on a subset of this period at the end-of life through bereavement. However, because palliative care may continue to follow after hospice becomes involved, and given the overlap between some services provided, patients and family members frequently confuse or conflate palliative care teams with hospice teams.]

With risk: If palliative care is considering a potential high-stakes course of action/treatment plan, risk can identify legal or practical consequences. Potentially risky situations in which it may be appropriate to consult both palliative and risk include: disagreement or uncertainty regarding forgoing or withdrawal of life sustaining treatment; withdrawal of life sustaining treatment without a clear directive or legally authorized decision maker, conflicts among legally authorized decision makers about important decisions.

With legal: When the legality of potential medical courses of action suggested by palliative medicine is called into question; or where a potential course of action could put care team members at risk of liability (for example, withdrawal of life-sustaining treatment).

Risk Management

Bottom line: identifying, and containing, risks and consequences associated with courses of action)

Scope/Purpose/Definition: The risk management department of a healthcare organization is primarily responsible for a) protecting patient, staff member, and visitor safety and b) protecting the healthcare organization's financial assets and reputation. The department consists of employees with formal risk management training, and sometimes legal training, who can assist care team members in proactively thinking through consequences of risky courses of actions, or in providing guidance to care team members after an adverse event has occurred.

Unique/specific areas of expertise: proactively identifying risks associated with particular medical decisions, estimating potential upsides and consequences of decisions, developing response plans for anticipated risks, developing and executing containment plans when mistakes or adverse events occur

Potential Triggers/When to call them:

- When the team is considering a course of action that could be risky for the patient/when the team is uncertain about potential consequences or risks associated with a particular course of action;
- When a team member commits a medical error;
- Whenever the care team is in a possible 'litigious situation' (anytime they are at risk of being sued—such as when a patient or family member threatens for example, when cooperation among family members breaks down during a high-stakes decision-making process.)

Areas of overlap:

With legal: When there may be legal or litigation-related risks associated with potential courses of action—risk departments may consult legal for additional expertise on potential legal ramifications associated with potential courses of action. For example, would the care team be liable for refusing to provide a controversial medical treatment the patient is demanding? However, note that the overlap of functions between risk management and legal departments varies widely across organizations. In many cases, risk and legal should both be consulted; one such example might be when the care team is considering the removal of a legally authorized surrogate decision-maker.

With compliance: When knowledge of current standards according to rules and regs is needed to determine whether there are legal risks associated with the potential course of action. For example, in which situations does HIPAA permit disclosure of patient information to family members or friends?

With ethics: when the risks associated with particular courses of action may have uncertain ethical consequences or value implications. For example, does this action violate patient autonomy?

Legal Department

(Bottom line: determining legally permissible courses of actions)

Scope/Purpose/Definition: Organization's legal departments are typically responsible for all aspects of law related to healthcare business, such as governance, employee/services contracts, and insurance/financial management. The area of legal department expertise specifically relevant to care team members, however, is knowledge of the legality of potential courses of action—and thus determination of whether the care team or the institution may be legally liable for any particular course of action/treatment plan. Legal department attorneys are able to interpret law—that is, to identify legal

'gray areas' with respect to permissible courses of action and use of documents [this distinguishes them from compliance officers, who keep track of the 'black and white' rules and regulations].

Unique/specific areas of expertise: Interpretation of legal documents; interpretation of state/federal rules and regulations, particularly where these are uncertain; providing counsel on the range of legally permissible actions regarding patient care. (Whereas compliance keeps track of the written policies, rules, and regulations, the legal department has specific expertise in the interpretation of these policies, rules, and regulations, particularly where they may be unclear or have unknown legal ramifications.)

Potential triggers/When to call them:

Whenever the care team is uncertain about whether a particular course of action violates any laws or puts the organization/care team at risk of a lawsuit. Examples:

- Forgoing use of a legally authorized decision maker (deviations from the legal hierarchy for surrogate decision making), when the care team has reason to believe that the legally authorized decision maker's instructions are inconsistent with the patient goals, values, and preferences;
- When a family member, or the care team, is in the process of seeking emergency guardianship for a patient;
- Uncertainty about use and validity of legal documents, such as Advance Directives, restraining orders, etc;
- Patient requests to go outside the standard of care, such as using non-approved drugs
- Disclosure of patient information (such as HIV diagnoses);
- Abuse of staff by a patient or legally authorized decision maker;
- Identified abuse of a patient (mandatory reporting situations).

Compliance

(Bottom line: ensuring that policies are compliant with state/federal regulations and law, and ensuring that the all members of the organization act in accordance with policies.)

Scope/Purpose/Definition: The Compliance Department is principally responsible for ensuring the healthcare organization adheres to organizational, state, and federal policies, regulations, and laws. This is accomplished by maintaining up-to-date knowledge of rules and policies, communicating appropriate employee standards, and monitoring employee adherence via conduction of audits and investigations, where necessary. Compliance departments are obligated to report breaches of state and federal law to appropriate authorities. Additionally, most compliance departments have 'compliance hotlines' through which employees can anonymously report breaches of internal policies, or government regulations, and laws .

Unique/specific areas of expertise: Communicating minimal legal standards that employees must comply with; Monitoring employee behavior to assess compliance with these standards; Instituting procedures to report employees who fail to comply; Disciplining offending employees (Jeurrisen, 2003).

Potential Triggers/When to call them:

- When the care team is considering a course of action that could violate organizational policy or government regulations and law.
- When the care team is uncertain about whether a particular course of action violates a policy, such as disclosure of patient healthcare information (e.g. HIV status disclosure; sharing of patient information such as family members, etc)
- Reporting observed violations of these standards, such as instances of insurance fraud, waste, abuse, or patient privacy/confidentiality.