AN EXAMINATION OF ETHICS CONFLICTS IN PIONEER ACCOUNTABLE CARE ORGANIZATIONS

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ABSTRACT

Craig River Westling: An Examination of Ethics Conflicts in Pioneer Accountable Care Organizations
(Under the direction of Kristin L. Reiter)

The findings of this study suggest that the Pioneer ACO model does create (or exacerbate) several critical ethical conflicts, and has the potential to mitigate others. These findings suggest that there is uncertainty associated with how to create clinical and business systems that support the ACO, how to manage and communicate the change, and how to reallocate resources.

Seven major ethical issues were identified:

1. **Incompatible reimbursement models.** The combination of fee-for-service and risk-based contracts creates conflicting incentives to simultaneously increase and decrease utilization.

2. **Two standards of clinical care.** Patients who could benefit from effective care management programs may not be enrolled because they are not attributed to the ACO.

3. **Financial incentives vs. patient choice.** Providers are incentivized to keep referrals in the ACO network even if they or a patient would prefer to go out-of-network.

4. **“Best” care disagreements.** Incentives to provide only the necessary and needed care can result in disagreements between physicians about the right care, and the perception of “rationing” resources.
5. **Required ACO metrics vs. evidence-based care.** CMS requires some metrics that do not reflect current evidence-based practices. This creates financial incentives to provide care that the literature suggests is inferior.

6. **Shifting resources to focus on prevention.** The ability to provide team-based, comprehensive primary care services may result in better patient outcomes at less cost; however, clinician burnout is a risk.

7. **Limited support systems for ethical conflicts.** A fragmented approach to dealing with ethics conflicts results in a mismatch between an ACO’s values and its clinical and business practices.

Overall the issues identified by this study reveal an underlying sense of moral distress experienced by physicians; this is despite an overall sense of optimism associated with the ACO model because it is “the right” way to provide care. This presents ACO leaders both an (1) urgent challenge to reduce physician moral distress (which other research has shown to have negative consequences on both worker health and job performance), and (2) opportunity to leverage the enthusiasm expressed for the overall ACO goals of better patient outcomes at lower costs.
To Holloway, Riley, Hollis and Caitlin.
For your unrelenting support and love on this journey. It was a family effort!
ACKNOWLEDGEMENTS

I owe many people a nod of thanks for their support and advice through this dissertation process, including my family, my committee, and the incredible professors who teach in the UNC DrPH program. I am especially grateful to my Cohort 8 mates, each of whom brought and shared unique experiences and perspectives that opened my eyes to a much more nuanced, layered world than I ever imagined before. I would also like to thank my friends and colleagues at The Dartmouth Institute for Health Policy and Clinical Practice who supported my pursuit of the DrPH degree over the last three years, offering key insights along the way.
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<th>Description</th>
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<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>ACO</td>
<td>Accountable Care Organization</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychology Association</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee for service (the method of paying for services rendered)</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MSSP</td>
<td>Medicare Shared Savings Program</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>PA</td>
<td>Physician assistant</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>PGP</td>
<td>Physician Group Practice</td>
</tr>
<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act (also known as the ACA)</td>
</tr>
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</table>
CHAPTER 1: INTRODUCTION

Statement of the Issue

The Centers for Medicare and Medicaid Services (CMS) defines an Accountable Care Organization (ACO) as: “A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.”

The Accountable Care Organization concept has been compared to the Managed Care Organization (MCO) experiment in the 1990’s, which was extremely unpopular and eroded trust with consumers. The primary similarity between the two care models is that they both are intended to help control health care costs. However, there are three significant differences between the MCO model and the CMS-sponsored ACO program:

1. ACO patients have a choice of which provider to see, and they can change providers at any time. This addresses the MCO problem of a patient being locked into an individual provider (or group) that he or she simply does not like, or likes but prefers another alternative.
2. Any money saved as a result of new care patterns is only shared with the ACO if specific quality-of-care thresholds are met. This addresses the concern that MCOs skimp on providing necessary care in order to save money.
3. ACOs are intended to put decision-making power regarding patient treatments directly into the hands of patients and physicians. This addresses the criticism of many MCOs that medical decisions were ultimately approved/denied by non-clinical administrators.
These differences are intended to reward ACO providers for improving the quality of patient outcomes while being mindful of costs, which is expected to result in (1) healthier patients and (2) a reduced growth rate in healthcare spending.*

Despite the differences from traditional MCOs, the transition to new incentives and rewards created by the ACO model could put providers in difficult ethical situations. It may be a particularly vexing problem when considering high-cost/low-benefit interventions, such as experimental or off-label oncology treatments, or some end-of-life care. On the other hand, the ACO model may mitigate currently existing ethical conflicts that are created by volume-driven incentives such as ordering more tests, or having patients come to the clinic (for reimbursement reasons) instead of answering questions on the telephone or via email.

Additionally, because the model is so new, virtually every ACO currently has a combination of fee-for-service (FFS) and shared savings contracts. This means that in order to generate revenues to support current business operations the ACO must simultaneously (1) increase utilization for FFS contracts, and (2) adjust utilization of all services to “appropriate” levels for shared savings contracts (the theory being that waste will be cut out, overall costs will go down, and quality will improve). This tension creates many opportunities for conflicts regarding treatment regimens. For instance, at the organizational level there is a risk of having multiple standards of care based on payer type. At the personal level there is a risk of clinical decisions being influenced by competing compensation incentives.

Every organization transitioning to an ACO must have a clear implementation plan and an effective change management strategy to support its physicians, staff and partners. The most obvious challenges involve financial decisions and clinical changes. For example, from a

*A non-ACO example of this commitment to weeding out care that does not add value is the “Choosing Wisely” campaign, which asks medical specialists to identify five tests or procedures commonly used in their field, whose necessity should be questioned and discussed (http://www.choosingwisely.org/)
financial standpoint hospitals must figure out how to stay in business as volumes decline. And medical groups must “churn” fewer healthy patients while taking on more responsibility for (and pay more attention to) sicker patients. From a clinical standpoint, all providers must be able to identify and effectively manage chronically ill patient populations. Table 1 summarizes the most significant implementation challenges identified by hospital-based ACO executives during professional (non-research related) conversations with the author:

Table 1: ACO Implementation Barriers

<table>
<thead>
<tr>
<th>Implementation Theme</th>
<th>Barrier(s)</th>
</tr>
</thead>
</table>
| Financial            | ☑ Managing revenue risks (internally, and of partners).  
                        | ☑ Navigating revenue cycle changes – moving away from fee-for-service reimbursement, over time.  
                        | ☑ Taking costs out of current systems.  
                        | ☑ Make vs. buy decisions for needed infrastructure. |
| Clinical             | ☑ Identifying and managing sickest patients.  
                        | ☑ Creating disease registries.  
                        | ☑ Creating disease management programs.  
                        | ☑ Focusing on prevention and health.  
                        | ☑ Identifying and sharing best practices.  
                        | ☑ Hiring or partnering with more midlevel providers. |
| Technical            | ☑ Sharing protected information with partners, patients.  
                        | ☑ Supporting new financial, clinical, and reporting needs. |
| Management           | ☑ Managing the entire organization when only a part of it is an ACO.  
                        | ☑ ACOs are currently paid on a fee-for-service basis, which typically rewards increasing volumes. This creates inherent conflicts with competing goals. |
| Board Oversight      | ☑ Intentionally decreasing volumes and (therefore) revenues is not an intuitive strategy for most board members, who are often corporate titans in the community.  
                        | ☑ For board members who understand the ACO concept, the biggest challenge is convincing community members that the future vision will be better than today...even though it will be different (e.g. more limited services.) |

As can be seen from this list, scant attention is being given to ethics conflicts that might occur by transitioning away from incentives to increase volumes and towards incentives to provide more

† The author created this list during discussions with ACO executives around the country. The conversations were part of his job at The Dartmouth Institute, and were not related to this study. The opinions regarding implementation issues may not be representative of all ACO executives.
efficient and less expensive care (which will likely result in decreased volumes for high cost interventions). Ignoring such conflicts could lead to physician dissatisfaction and a reluctance to embrace the ACO model, creating a grassroots resistance movement that is difficult to overcome.4-8

Thus, this dissertation seeks to (1) explore the ethics conflicts that are arising or are being mitigated by the ACO model of care, and (2) identify strategies to help leaders proactively address potential ethics conflicts. To be clear on terminology, for this dissertation an ethical conflict is: 9

A situation in which there is some evidence that indicates an action would be morally wrong and some evidence that the same action would be morally right, but all the evidence, taken as a whole, is not conclusive. In an ethical dilemma, if one does act, one’s actions could be seen as morally acceptable in some respects and morally unacceptable in other respects.

Background

In 2001 the Institute of Medicine (IOM) published a seminal report titled, Crossing the Quality Chasm: A New Health System for the 21st Century. 10 The report portrayed a dire U.S. healthcare situation, describing the delivery of care as “…overly complex and uncoordinated, requiring steps and patient ‘handoffs’ that slow down care and decrease rather than improve safety. These cumbersome processes waste resources; leave unaccountable voids in coverage; lead to loss of information and fail to build on the strengths of all health professionals involved to ensure that care is appropriate, timely, and safe.” The report also underscored the gap between the healthcare Americans currently receive and the care that could be possible in a well-designed system.

Asserting that needed improvements cannot be achieved without redesigning the entire health care system, the IOM report authors advocated a focus on improvement efforts in four
general areas: (1) patients’ experiences; (2) the “microsystems” (replicable units) that actually
give care; (3) the organizations that house and support microsystems; and (4) the environment of
laws, rules, payment, accreditation, and professional training that shape organizational action. 
Actions to improve these areas would inevitably force the supporting systems and processes to
change, too, thereby causing an organic redesign of the current one-size-fits-all approach. The
report called for improving performance in six specific, fundamental dimensions of care that are
central to creating an ideal delivery system, declaring that care should be: 

1. **Safe**: avoiding injuries to patients from the care that is intended to help them.
2. **Effective**: providing services based on scientific knowledge to all who could benefit, and
   refraining from providing services to those not likely to benefit.
3. **Patient-centered**: providing care that is respectful of and responsive to individual patient
   preferences, needs, and values, and ensuring that patient values guide all clinical
   decisions.
4. **Timely**: reducing waits and sometimes-harmful delays for both those who receive and
   those who give care.
5. **Efficient**: avoiding waste, including waste of equipment, supplies, ideas, and energy.
6. **Equitable**: providing care that does not vary in quality because of personal characteristics
   such as gender, ethnicity, geographic location, and socioeconomic status.

**Biomedical Ethics Foundation**

These six IOM aims for improving health care are based on the primary biomedical ethics
principles theorized by Beauchamp and Childress: autonomy, beneficence, nonmaleficence, and
justice. These principles are described in more detail by Ebbesen and Pedersen.

**Autonomy**
• As a negative obligation: Autonomous actions should not be subjected to controlling constraints by others.
• As a positive obligation: This principle requires respectful treatment in disclosing information, probing for and ensuring understanding and voluntariness, and fostering autonomous decision-making.

Benificence
• Prevent and remove evil or harm.
• Do and promote good.
• Weigh and balance the possible goods against the possible harms of an action.

Nonmaleficence
• Do not inflict evil or harm. Specifically: Do not hurt other people mentally or physically.

Justice
• Beauchamp & Childress propose that "society recognizes an enforceable right to a decent minimum of health care within a framework for allocation that incorporates both utilitarian and egalitarian standards."

These ethics principles can be mapped directly to the six IOM quality aims, as follows: ¹³

<table>
<thead>
<tr>
<th>Ethics principles</th>
<th>Applications of ethics principles to quality care</th>
<th>IOM's quality aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>Supporting, facilitating, and respecting self-determination in shared decision-making</td>
<td>Patient-centered</td>
</tr>
<tr>
<td>Beneficence</td>
<td>Promoting the patient's beneficial healthcare and best interest</td>
<td>Effective, safe, timely, patient-centered</td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>Avoiding and protecting the patient from actions that cause harm</td>
<td>Safe, effective, patient-centered</td>
</tr>
<tr>
<td>Justice</td>
<td>Allocating fairly the benefits and burdens related to healthcare delivery and equitable access to healthcare services</td>
<td>Equitable, efficient, patient-centered</td>
</tr>
</tbody>
</table>

It was within this context that the ACO concept was born.
Accountable Care Model

The ACO model was conceived in part to address the challenges put forth in the IOM report. Figure 1 illustrates the care system domains the IOM authors challenged leaders to address in order to manifest the desired outcomes of safe, effective, efficient, personalized, timely and equitable care. The ACO model creates a framework for all of these things to happen using an ethics foundation to link the quality of care (patient outcomes) and the value of care (the cost of care divided by quality). The ACO model is specifically designed to increase financial rewards for providers to better coordinate services and to provide the right care at the right time (no more and no less), thereby resulting in better outcomes and healthier patients. (Note: better care coordination may actually increase utilization in some areas of care, but overall costs are expected to decrease as a result of providing only truly useful interventions.)

Although the term “Accountable Care Organization” was coined in 2006 by Elliott Fisher at The Dartmouth Institute, the concept of risk-based contracting has been around since the 1970s when Health Maintenance Organizations (HMO) contracted with groups of providers. The 1990’s saw capitation (where financial risk is assumed by providers who are paid a per
member per month fee, regardless of services rendered) gain favor. This created an incentive for HMOs to “cherry pick” healthy patients, and try to exclude sicker, more expensive patients. This dilemma led CMS to launch the Physician Group Practice (PGP) demonstration project in 2005, which tested the viability of risk-based contracts that included quality thresholds as a replacement for FFS Medicare. The demonstration included 10 large PGPs (see Table 3) that, in addition to their regular Medicare reimbursements, could earn a share of savings generated above a 2% threshold if 32 specific quality metrics were met.\textsuperscript{19}

Table 3: PGP 5-Year Results

<table>
<thead>
<tr>
<th>PGP Site</th>
<th>Quality Benchmarks</th>
<th>Shared Savings Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yr 1</td>
<td>Yr 2</td>
</tr>
<tr>
<td>Billings</td>
<td>91%</td>
<td>98%</td>
</tr>
<tr>
<td>Dartmouth</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>Everett</td>
<td>86%</td>
<td>96%</td>
</tr>
<tr>
<td>Forsyth</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Geisinger</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td>Marshfield</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td>Middlesex</td>
<td>86%</td>
<td>96%</td>
</tr>
<tr>
<td>Park</td>
<td>95%</td>
<td>98%</td>
</tr>
<tr>
<td>St. John's</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Michigan</td>
<td>95%</td>
<td>100%</td>
</tr>
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As Table 3 indicates, in the fifth year, only seven participants achieved the quality benchmarks and the remaining three groups achieved at least 30 of the benchmark measures; however, only four groups managed to surpass the 2% savings threshold to earn shared savings payments from CMS in the fifth year.

Despite the mixed results of the PGP demonstration, the pay-for-value idea gained enough attention in Congress and the White House to include ACO-specific provisions in the Patient Protection and Affordable Care Act (PPACA or ACA) that President Obama signed into law in March 2010. Section 3022 of PPACA authorized CMS to define a program based on the
ACO provisions. CMS administrators borrowed ideas from the PGP Demonstration project to draft the ACO program rule, which after a public comment and feedback period was published in the Federal Register in November 2012 as part of the final Medicare Shared Savings Program (MSSP) rule. Thus, ACOs were officially born as part of the MSSP.

The central promise of the ACO model is to reward providers for improving the health of their patients versus relying excessively on ever-increasing volumes of acute interventions. Savings that result from a reduction in utilization and accrue to CMS (the payer) are shared with the ACO, provided that certain care quality benchmarks are met. Figure 2 illustrates how the basic shared savings model works. When the ACO is launched, a target benchmark is established based on three previous years of data on assigned beneficiaries (and adjusted for overall spending growth and beneficiary characteristics). Spending is tracked over time, and shared savings are distributed if thresholds and quality targets are met. Specific requirements depend upon the type of ACO program the organization is participating in.

Table 4 describes the two primary CMS-designated ACO programs, MSSP and Pioneer.

<table>
<thead>
<tr>
<th>Table 4: CMS ACO Program Summary</th>
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<tbody>
<tr>
<td><strong>MSSP ACO Program</strong></td>
</tr>
<tr>
<td>Risk Tracks⁴</td>
</tr>
<tr>
<td>Track 1: 1-sided risk only</td>
</tr>
<tr>
<td>Track 2: 2-sided risk only</td>
</tr>
</tbody>
</table>

⁴ In the MSSP program, ACOs can choose two different risk tracks. 1-sided risk allows the ACO to benefit from any shared savings, but it does not get penalized for missing cost or quality targets. 2-sided risk allows a higher percentage of any shared savings payout, but also creates a downside risk of penalties for missing cost or quality targets.
### Minimum Savings Rate

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>varies with size</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sharing Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track 1: 50%</td>
</tr>
<tr>
<td>Track 2: 60%</td>
</tr>
</tbody>
</table>

Increasing shared savings/losses up to 75%

### Patient Assignment Rules

- Preliminary prospective assignment with retrospective reconciliation
- Stepwise attribution first to PCP, then to all ACO providers (includes specialists, NP, PA, CNS)

- Option to select retrospective or prospective attribution
- Attribution to PCP, NP, PA and eligible specialists: (nephrology, oncology, rheumatology, endocrinology, pulmonology)

### Size Requirement

<table>
<thead>
<tr>
<th>5,000 beneficiaries</th>
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<tr>
<td>15,000 beneficiaries</td>
</tr>
</tbody>
</table>

### Quality Measures

- 33 measures, 4 domains
- Same as MSSP Program

### Private-payer collaboration

- Not required
- At least 50% of total revenues must come from outcomes based contracts by end of Year 2

The quality criteria are consistent across both programs, and thresholds must be met to be eligible for shared savings payouts in both. The four domains covered by the quality measures include:

1. Patient/caregiver experience
2. Care coordination/patient safety
3. Preventive health
4. At-risk populations

For a list of specific measures, see Appendix 1: ACO Quality Measures.

The Pioneer ACO program is of particular interest for three primary reasons. First, it is designed specifically for leading health systems that have “experience offering coordinated, patient centered care, and operating in ACO-like arrangements.” These are the systems that should be best positioned for success – only 32 applicants were accepted to become Pioneer ACOs. Second, by the end of year two at least 50% of total revenues must come from outcomes-based contracts, which will steer Pioneer ACOs towards risk-based contracts with private payers.
Third, the Pioneer program includes capitated payments: “ACOs that have shown savings over the first two years will be eligible to move to a population based payment model. Population-based payment is a per beneficiary per month payment amount intended to replace some or all of the ACO’s FFS payments with a prospective monthly payment.” This means that after two years eligible Pioneers will start receiving a combination of FFS reimbursement and population-based payments. The FFS rate is paid at 50% of the usual allowable fee, and the population-based payment (paid to the ACO each month) is estimated as 50% of the ACO’s expected fee for service costs (at 100% allowed amounts).

This experiment with population-based payments may indicate that CMS is considering a prospective payment system for all ACOs in the future. Such a shift will not be possible unless ACOs use their shared savings to bridge between FFS and capitation by investing in human resources (physician, staff, and administrative training) and the infrastructure necessary to manage population health and disease management programs.

**The Ethics of Accountable Care**

Traditional biomedical ethics focus primarily on single patient-provider episodes. The American College of Physicians Ethics Manual states, “The interests of the patient should always be promoted regardless of financial arrangements…a sense of duty to the patient should take

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**Box 1: Pioneer ACO Update**

In July 2013, CMS announced results for the first year of Pioneer activity. The results are similar to the PGP Demonstration, which saw quality benchmarks largely met by all participants, but financial thresholds more difficult to achieve:

- All 32 Pioneer ACOs successfully reported quality measures and achieved the maximum reporting rate for the first performance year.
- Thirteen out of 32 pioneer ACOs produced shared savings with CMS, generating a gross savings of $87.6 million in 2012.

However, CMS also reported that seven of the Pioneer ACOs that did not produce savings planned to apply for the MSSP program, and two sites left the ACO program entirely.

As of December 2014, a total of 13 original Pioneer sites had dropped out of the program.
precedence over concern about compensation.”

Additionally, a core principle of the American Medical Association Code of Medical Ethics is that “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” In general such a single-patient-only focus likely contributes to over-utilization and is also exacerbated in a FFS environment where income is driven by volume (for instance, ordering a new image for a patient who was just transferred from another hospital). ACOs, on the other hand, create incentives for physicians to be stewards of common resources (which might lead a radiologists working together to create regional imaging protocols to facilitate transfers, for example). This creates a population-focused ethic, which the American College of Physicians Ethics Manual addresses via the topic of stewardship: “Physicians have an obligation to…[be] steward[s] of finite health care resources so that as many health care needs as possible can be met, whether in the physician’s office, in the hospital or long-term care facility, or at home.” The American Medical Association Code of Medical Ethics is less prescriptive, but it includes a principle related to resource stewardship: “A physician shall support access to medical care for all people.”

Tension between the single patient-provider emphasis versus the stewardship of limited resources likely exists in every health system, because no system has unlimited resources. Therefore, the question is not whether ethics conflicts exist in ACOs, because they exist in all reimbursement models. Rather, the question is: What ethics conflicts are created and/or mitigated by ACOs? This leads to subsequent questions, such as: Are these dilemmas substantially different from the conflicts created in FFS and traditional MCO environments? And, what can organizations do as part of their change management efforts to support physicians and staff during the ACO transition?
Research Purpose and Specific Aims

The purpose of this study is to more fully understand how the ACO model of care affects ethics conflicts in organizations that originally joined the Pioneer ACO program. The study is limited to Pioneer ACOs because the entire census can be contacted without selection bias, and it includes 10 organizations that dropped out – which could be informative to learn if ethics conflicts were part of the decision to exit the program.

The questions being addressed by this study are:

1. What ethics conflicts arise in the Pioneer ACO model?
2. What ethics conflicts does the Pioneer ACO model mitigate?
3. How are Pioneer ACOs addressing ethics conflicts?

The research aims are:

1. Identify the ethics conflicts associated with the Pioneer ACO model of care.
2. Identify methods to mitigate existing or potential ethics conflicts found in Pioneer ACOs.
3. Recommend a plan for change that includes specific actions and products to help ACOs address organizational ethics challenges.
CHAPTER 2: REVIEW OF THE LITERATURE

Literature Review Method

The literature was reviewed for surveys of clinicians and administrators regarding ethics conflicts associated with reimbursement models. Due to the fact that ACOs are so new, only theoretical articles and papers address ethics questions and posit possible solutions related to the ACO model. However, despite the stated differences between ACOs and MCOs, they are similar in that providers in both models are incentivized to limit care to only that which is necessary, no more and no less. This potentially creates similar ethics conflicts in each type of organization. Therefore, the literature was searched for surveys administered in the United States that measured ethics domains and conflicts in managed care or accountable care organizations. To compare the domains of ethics conflicts, the literature was also searched for studies that utilized surveys to measure ethics conflicts created by a FFS reimbursement environment.

Sources

Two primary sources were used to identify relevant articles:

1. PubMed (by the National Center for Biotechnology Information)
2. Web of Science (by Thomson Reuters)

Additionally, several potential articles were identified via snowballing.

Key Words, search strategies

To develop keywords and search terms, the primary constructs “ethics survey” and “managed care” or “accountable care” were used to perform some practice searches in PubMED, which led
to more MeSH terms to include in (and fine-tune) the search string. Table 5 includes the primary constructs and related search terms for the MCO and ACO search:

Table 5: Constructs and Search Terms

<table>
<thead>
<tr>
<th>Ethics OR Moral philosophy</th>
<th>AND</th>
<th>Managed Care or Accountable Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Accountable care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Managed care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health maintenance organization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Integrated delivery system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
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<tr>
<td></td>
<td></td>
<td>Capitation</td>
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<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bundled payment</td>
</tr>
</tbody>
</table>

Putting all this together creates the following search string for PubMED:

- (ethics survey OR moral philosophy) AND (accountable care OR managed care OR health maintenance organization OR integrated delivery system OR capitation OR global payment OR bundled payment)

Additionally, the following filters were activated:

- Humans, English, Bioethics, Systematic Reviews, Core clinical journals, MEDLINE

To search the Web of Science database, the following search strings were used:

- TS=(ethic* AND survey AND managed care)
- TS=(ethic* AND survey AND accountable care)

For studies including FFS surveys, the following search strings were used:

In PubMED:

- ethics survey AND (fee for service OR FFS)

In Web of Science:

- (TS=(ethic* AND survey AND fee for service)) AND Language=(English)
Inclusion/exclusion criteria

For an article to be included in the final library, it had to meet the following criteria:

- The study includes a survey that contains questions about ethics.
- The outcome measure (dependent variable) is an individual’s perception of ethics conflicts.
- The independent variable is reimbursement model for services.
- The unit of measure is individuals who would be affected by a change in the independent variable.
- The study is based in the United States of America.
- The article is in English.
- Any type of study (descriptive, relational, causal) is acceptable.
- Pediatrics studies are excluded due to the extreme emotions associated with child morbidity and mortality.

Literature Review Results

The review process (Figure 3, below) identified the articles that met the inclusion criteria. The PubMed query returned 308 papers. The Web of Science queries returned 145 papers (124 related to managed care, three related to accountable care, and 18 related to FFS). There were 11 duplicates in the database queries. There were also 20 snowball additions. Of the 462 papers identified, a title and abstract review eliminated 431. Ten papers could not be located online, leaving 21 remaining for a full review. After a full review, 19 papers remained in the final library.

Results were tracked in a spreadsheet that included the following columns: Author | Year | Title | Journal | Volume | Number | Pages | Survey Method | Question Design Process |
The decision of whether or not to include an article in the final library was dependent upon meeting the inclusion criteria. The literature review details are described in the next section. A summary of results is illustrated in Table 6 below, which maps the most common ethical conflicts identified in the literature to the Beauchamp & Childress ethical domains:

### Table 6: Summary of Literature Review Results

<table>
<thead>
<tr>
<th>Ethical Conflict</th>
<th>Justice</th>
<th>Autonomy</th>
<th>Beneficence</th>
<th>Non-maleficence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-treatment of patients due to overt pressures or financial incentives.</td>
<td>X</td>
<td>x</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Breaches of patient confidentiality by the clinician that are required by the managed care plan.</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of disclosure to the patient of the financial incentives or overt pressures under which the [clinician] functions.</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overuse of practice guidelines (which gets into physician autonomy to diagnose or prescribe treatment in ways that do not exactly follow the guidelines).</td>
<td>X</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Managed Care Environment Surveys**

All of the 21 reviewed papers were related to MCOs. Three of them relied primarily upon open-ended survey questions to allow respondents to identify the ethics issues encountered in the
workplace. The other 18 papers relied upon surveys that were developed using some combination of literature reviews, expert contributions, and pilot testing. (It was not possible to identify the question development process in every paper, so some guesswork was involved.) Nineteen of the surveys were directed at clinicians, including doctors (12 studies), nurses (seven studies), and psychologists (two studies). Two of the surveys queried the perceptions of executives and administrators.

**Open-Ended Surveys**

The three surveys that included open-ended questions targeted different respective audiences. The responses varied greatly, as did the domain categories identified by the researchers; however, some consistent themes emerge in all three studies:

1. Justice is an issue regarding financial arrangements in MCOs and conflicts of interest for providers.

2. Autonomy is at risk concerning confidentiality (e.g. concerns that the MCO will not keep clinical information confidential), and consent (which could result in patients not being fully informed).

3. Beneficence and nonmaleficence are intertwined because helpful services may be withheld by MCOs, and strict adherence to approved clinical pathways could lead to harm.

Jurkiewicz (2000) asked senior and mid-level executives if (1) they ever experienced a conflict between what was expected of them as an efficient, effective employee and what was expected of them as an ethical person (and to describe the source of deepest concern because of the conflict); and (2) if they could eliminate one or two unethical practices in their organization, what would it/they be? In non-profit organizations, 59% of the executives agreed that there are
generally accepted business practices in their organizations that they think are unethical. The top unethical practices included hiring/personnel matters (62%); privacy/confidentiality violations (48%); board members' preferential treatment (45%). In for-profit organizations, 28% of the executives agreed that there are unethical practices in their organizations. The top unethical practices were over-diagnosis when over-insured (93%); unnecessary procedures done to make more money (87%); privacy/confidentiality violations (67%); budget improprieties (54%).

Pope et al. (1992) described the results of a national American Psychology Association (APA) survey. (The APA is unique in that it developed its original code of ethics in the 1950’s by directly querying its members versus having a committee develop it.) The survey contained a single, open-ended question: “Describe, in a few words or more detail, an incident that you or a colleague have faced in the past year or two that was ethically challenging or troubling to you.” The resulting responses were put into 703 categories, with the top three being: Confidentiality (18%); blurred, dual, or conflictual relationships (17%); payment sources, plans, setting and methods (14%).

Bell (2003) asked nurses to describe two ethical dilemmas they experienced while performing utilization reviews. This was followed up with a series of closed-response questions regarding the ethical principles most important to the respondent. Bell and colleagues assigned the open-ended results to Beauchamp and Childress categories. The ethics issues experienced most often by these nurses were associated with justice (distributing benefits, risks and costs fairly).

Closed-Response Surveys

The 16 papers in the final library that relied upon closed-response surveys identified remarkably similar ethics domains. This could be the result of researchers partially relying upon
literature reviews to identify relevant domains to query, and therefore each published study reinforced prevailing views. The four overarching issues identified in these surveys are summarized by Eastman and colleagues: 39

1. Under treatment of patients due to overt pressures or financial incentives.

2. Concern about breaches of patient confidentiality (particularly to employers) as managed care plans collect more and more patient information.

3. Lack of disclosure to the patient of the financial incentives or overt pressures under which the [clinician] functions.

4. Overuse of practice guidelines (which involves physician autonomy to diagnose or prescribe treatment in ways that do not exactly follow the guidelines).

Table 7 summarizes the 16 closed-response studies.
<table>
<thead>
<tr>
<th>Author</th>
<th>Yr.</th>
<th>Ethics Domains in Survey</th>
<th>Study Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulrich et al.</td>
<td>2006</td>
<td>1. Protecting patients’ rights; 2. Resource allocation; 3. Autonomy; 4. Business pressures overriding patients’ interests; 5. Compromising personal values.</td>
<td>Insurance constraints interfered with the ability to provide quality patient care by 72% of respondents; 47% have been asked by a patient to mislead insurers; the most significant predictor of ethical conflict is the perceived obligation to advocate for patients even if it means exaggerating the severity of a patient’s condition.</td>
</tr>
<tr>
<td>Ulrich et al.</td>
<td>2003</td>
<td>1. Legal or financial repercussions; 2. Manipulating system to benefit patient; 3. Professional autonomy; 4. Allocation decisions.</td>
<td>80% perceived it was sometimes necessary to bend managed care guidelines to provide care that is limited by the MCO. This resulted in conflicts regarding business decisions overriding patient decisions, unethical practices, agency, legal liability, autonomy, and values.</td>
</tr>
<tr>
<td>Nadler, et al.</td>
<td>1999</td>
<td>1. Transparency of financial relationship; 2. Financial incentives cause conflicts; 3. Relationship with patients.</td>
<td>In 1996 86% of respondents agreed with the statement: “the arrangements in capitation present a conflict of interest.” 1997 that was down to 75% agreed.</td>
</tr>
<tr>
<td>Bantz</td>
<td>1999</td>
<td>1. Equal care for all patients regardless of condition or setting; 2. Taxpayer paying for health care of medically indigent patients; 3. Use of nurse practitioners/advanced practice nurses to perform health promotion and illness prevention activities; 4. Relationship between staffing and patients' risk of complications.</td>
<td>Staff nurses reported perceiving that budget cuts had a greater negative impact on staff positions and the quality of patient care than the nurse executives reported. Both groups were in favor of taxpayers covering a greater part of the cost of medically indigent care.</td>
</tr>
<tr>
<td>Bell</td>
<td>2003</td>
<td>No domains reported (results focused on ethics committees and processes).</td>
<td>91% of respondents did not know if organization had an ethics committee. 92% did not know if organization had process for deciding ethical issues. Only 8% stated their organization had a process for dealing with ethical issues in utilization review.</td>
</tr>
<tr>
<td>Bernat, et al.</td>
<td>1997</td>
<td>1. Willingness to follow clinical practice guidelines; 2. Conflicts of interest or conflicts of obligation re care of MCO patients; 3. Legal ramifications of MCO clinical decisions; 4. Deception or gaming to achieve good patient care; 5. Professional prerogatives and autonomy; 6. Steward of limited resources.</td>
<td>Neurologists are generally willing to follow clinical practice guidelines if created by medical societies; experienced frequent conflicts of interest/obligation in the care of their MCO patients; feared legal ramifications of their clinical decisions on MCO patients; unwilling to employ deception or gaming to achieve what they perceived to be good patient care; believed professional prerogatives and autonomy were under attack by MCOs; the good of their patients should not be sacrificed for the good of society.</td>
</tr>
<tr>
<td>Cassells, et al.</td>
<td>2003</td>
<td>1. Confidentiality; 2. Managed care conflicts; 3. Informed consent; 4. Allocation of resources.</td>
<td>Applying ethical theories and principles was the skill that RNs were least prepared to undertake. Continuing education programs in ethics are needed to support nurses in developing their ethical decision-making skills.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Themes</td>
<td>Findings/Key Points</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
<td>----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Eastman, et al.</td>
<td>1997</td>
<td>1. Under treatment of patients due to overt pressures or financial incentives; 2. Breaches of patient confidentiality by the physician that are required by the managed care plan; 3. Lack of disclosure to the patient of the financial incentives or overt pressures under which the physician functions; 4. Overuse of practice guidelines.</td>
<td>30.2% of physicians indicated they were likely to extremely likely to tell the patient that they could not make a referral to a specialist when doing so would cost the physician a 25% salary bonus. 42.9% of the physicians stated that they were likely to extremely likely to wait until the HMO’s practice guidelines had been met before operating to remove a patient's appendix (even if other clinical indications supported the intervention).</td>
</tr>
<tr>
<td>Eastman, et al.</td>
<td>2001</td>
<td>1. Under treatment of patients due to overt pressures or financial incentives; 2. Breaches of patient confidentiality by the physician that are required by the managed care plan; 3. Lack of disclosure to the patient of the financial incentives or overt pressures under which the physician functions; 4. Overuse of practice guidelines.</td>
<td>Doctors are more likely to do what is best for their patients than for themselves or the HMO in situations that directly involve patient care. Doctors older than age 50 are less likely to do what is best for patient in scenarios that directly involve patient care.</td>
</tr>
<tr>
<td>Greene</td>
<td>1997</td>
<td>1. Physician-patient relationship; 2. Effects on quality of care.</td>
<td>&lt;25% of respondent’s organizations provide ethics training. 62% for-profit hospitals require senior management training in business ethic (versus 33% of managed care executives and just 15% of physician group administrators). For-profit hospitals most likely to have formal codes of business and medical ethics.</td>
</tr>
<tr>
<td>Feldman</td>
<td>1998</td>
<td>1. Conflicts of interest between patient needs and physician financial interest; 2. Respect patients' autonomy; 3. Patients' confidentiality; 4. Obtain patients' informed consent; 5. Provide all diagnostic and therapeutic options (not just covered).</td>
<td>Physicians reported conflicts as follows: Conflicts of interest between patients and physician's financial interest (56%); Placing patients' best interest first (54%); Respecting patients' autonomy (49%)</td>
</tr>
<tr>
<td>Ward</td>
<td>2008</td>
<td>1. Considering costs of treatment; 2. Use of cost-benefit analysis in treatment decisions; 3. Resource limitations; 4. Rationing.</td>
<td>11% of physician and 6% of nurse directors responded that rationing occurs in ICUs. 6% of nurses and 5% of physicians responded that cost constraints have a significant effect on care. 46% of all respondents said patients receive “too much” care “sometimes or frequently.”</td>
</tr>
<tr>
<td>Phelps, et al.</td>
<td>1998</td>
<td>No specific domains were measured (survey asked if ethical dilemmas are a concern).</td>
<td>42% of all respondents (all psychologists) indicated ethical dilemmas created by managed care is one of their top 5 concerns.</td>
</tr>
<tr>
<td>Murphy, et al.</td>
<td>1998</td>
<td>1. Control of patient care/treatment plan, including # of therapy sessions needed.</td>
<td>Survey of psychologists. Negative effects were loss of control over clinical decisions and potential harm to patients from erosion of confidentiality. A majority of respondents reported encountering ethical concerns not addressed by APA ethics code.</td>
</tr>
<tr>
<td>Hojat, et al.</td>
<td>2000</td>
<td>1. Quality of care; 2. Physician independence and freedom to provide optimal care; 3. Autonomy (physician and patient)</td>
<td>Survey of physicians. 94% perceived MCOs impair their autonomy; 84% said MCOs restrain their freedom to provide optimal care; 76% endorsed patients’ freedom to seek specialist care; 55% believed that capitation reduces motivation for long-term monitoring of patients.</td>
</tr>
</tbody>
</table>
Fee-for-Service Surveys

This literature review did not identify any studies related to FFS ethics conflicts that met the inclusion criteria. Specifically, none of the studies included a survey.

Discussion of Literature Review Results

As expected, no studies were found related to ethics conflicts in ACOs. However, several papers described the results of surveys that measured perceived ethics conflicts in MCOs. As described above, there are important differences between ACOs and MCOs (in ACOs patients choose providers, physicians and patients make the care decisions, and quality outcomes are as important as reducing costs), but there are also enough similarities (goals are to provide the right care and to lower costs) to consider ethics conflicts identified in MCOs as relevant background for extending this body of research to ACOs.

Many ethics conflicts were identified for MCOs, all of which get to the heart of provider-patient trust:

- Financial arrangements that put pressure on providers to deny care or under-treat patients.
- The loss of provider autonomy to communicate openly (including about financial arrangements), and to recommend the best treatment for a given patient. (This was mitigated by laws to prohibit “physician-gagging,” which eliminated barriers to making recommendations; however, there was still no guarantee that the recommended intervention would be covered by the MCO.)
- A risk to patient autonomy regarding (1) confidentiality, and (2) the ability to make fully informed decisions.
- The inability to do what’s best for a patient (beneficence) because of MCO-imposed limitations.
• The possibility of causing harm (maleficence) by following clinical guidelines that may not be best suited for a given situation.

Overall, it is clear that ethics conflicts arise when attempting to integrate effectiveness and cost-worthiness into care process considerations. While ACOs are designed to safeguard against this, there are both perception and implementation risks that financial decisions will once again rule the day.

As noted above, no studies were found that included surveys of ethics conflicts created by FFS reimbursement models. However, the literature contains many opinion pieces on this topic, and several studies that have examined the relationship between physician payments and utilization. In general, four primary ethics conflicts are theorized to result from FFS payment schemes:

1. There are financial incentives for physicians to over-treat.
2. The emphasis is on seeing volumes of sick patients versus promoting wellness.
3. Until recently, there has been little oversight of the quality of care provided (and conversely, few ramifications for providing poor quality care).
4. There is little incentive for providers to be cost-effective.

Overall, the literature review suggests that this is a topic that could be studied in more depth.

Implications for Future Research

There are two gaps in the literature. The first is that no studies have measured ethics conflicts in ACOs. This is not surprising given that the ACO model is so new (in fact, it is possible that some papers are in the publication queue now). The second gap is that no studies were found that used surveys to measure ethics conflicts in FFS models of care.
There are several reasons it is important to understand what specific ethical conflicts are being created and/or mitigated by ACOs. First, it is certain that unresolved conflicts are occurring and causing waste and potentially harm. Second, these conflicts impact provider satisfaction, as well as their buy-in to new payment and care models, and therefore their willingness to change. Ultimately this affects the entire culture of an organization. Third, it is important to identify possible interventions to help mitigate ethics conflicts in the workplace.

**Limitations of the Review Process**

The main limitation of this review is that the primary question addressed by the study, “What ethics conflicts arise or are mitigated in Pioneer ACOs?” has not been answered in the literature.

Using MCOs as a starting point means that the ethics domains and issues identified in the literature are potentially only a close approximation to what occurs in ACOs. It is also somewhat surprising that no studies were found that used surveys to measure ethics conflicts in the FFS environment.
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

Conceptual Framework

Using the biomedical ethics principles theorized by Beauchamp and Childress of autonomy, beneficence, nonmaleficence, and justice, the following matrix (modified from the Weeks original\textsuperscript{45} ) shows physical and financial harms present in all systems of care that are ethically fair (even if unfortunate) versus harms that are always unjustified:

<table>
<thead>
<tr>
<th>Table 8: Fair vs. Unjustified Harms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Harm</strong></td>
</tr>
</tbody>
</table>
| Physical | • Inconvenience  
• Foreseen complications | • Avoidable complications  
• Avoidable interventions |
| Fiscal | • Reasonable co-payments  
• Lost income / sick days | • Unreasonably high copayments and co-insurance  
• Low value  
• Waste |

Efforts to eliminate unjustified harms using a FFS model have not been successful on a national level. And given that CMS is the country’s largest payer, spending $472 billion to cover 48 million people in 2012,\textsuperscript{46} the federal government is in a strong position to (1) encourage and identify innovative solutions, and (2) lead the entire health care industry towards using them. The CMS-sponsored ACO model is designed to address these ethically unjustified harms by refocusing attention on improving care while lowering costs. As one CEO put it, “We’re going to become an ACO because it’s the right thing to do.”\textsuperscript{§}

\textsuperscript{§} Author notes from a non-research, executive meeting at a large regional medical center.
Figure 4 illustrates potential ethics conflicts created by relying upon multiple reimbursement methods, as well as a set of possible interventions to transition towards a standard approach to care activity that focuses on quality outcomes while reducing unjustified harms:

**Figure 4: Conceptual Model to Eliminate Unjustified Harms**

The question mark regarding ethics conflicts for ACOs was the focus on this study. Several authors have hypothesized about ACO ethics issues, identifying themes such as:

- **Patient autonomy versus savings**
  - How should ACOs balance control over referral patterns (and therefore revenues) with physician and patient preferences?
- **Cost shifting**
  - Increased market power achieved via mergers could lead to increased prices (thereby cost shifting to private payers).
  - ACOs could move care towards expensive therapeutics that are outside of the ACO benchmark calculation.
• Sharing of benefits
  o How should shared savings be distributed fairly? Should patients receive some of the shared savings?

• Resource allocation
  o Given limited resources, should the ACO focus on those who are the most sick, or on those most likely to benefit?

• Physician relations
  o Can physicians maintain their professional autonomy in an ACO?

This study provided evidence to inform the validity of the hypothesized issues.

Study Approach and Design

Overview

In order to answer the proposed research questions, the people who are creating, leading, and working in Pioneer ACOs must be queried. Therefore, this study employed a qualitative approach involving key informant interviews of (1) administrators who are responsible for ACO finances or operations, and (2) physicians who are making care decisions in the ACO (both primary care and specialist physicians were included). The research was intentionally limited to people whose decisions affect the provision of care in an ACO. It is a valid argument that associate providers such as nurse practitioners (NPs) and physician assistants (PAs) often provide primary care services; however, since licensed physicians are ultimately responsible for the orders in an ACO, associate providers were not included. This helped keep the scope of the study manageable.
Data Collection Process

The research involved semi-structured interviews of key informants at Pioneer ACOs. All of the original 32 Pioneer ACOs were invited to participate, including the nine that had dropped out of the program when the research began (one more dropped out during the research period).

The search engine Google was used to search public records to identify Pioneer ACO leaders, and often several names were identified (e.g. the CEO, ACO Administrator, or Medical Director). Invitations to participate in the study were emailed to at least one ACO leader at each Pioneer site. For people who did not respond, a reminder was sent two weeks later. For those that still did not respond, a third and final email was sent four weeks after the original invitation.

A list of key informants was derived through communications with the primary ACO contact to identify appropriate interview candidates. Interviews were requested with people who had the following roles within the ACO:

- 1 primary care physician
- 1 specialist physician
- 1 administrator responsible for financials or operations

Potential subjects were contacted by email to request their participation, at which time a brief description of the study was shared. When a participant agreed to be interviewed, an appointment was scheduled at a time convenient to her/him. The meetings were conducted face to face whenever possible, in a room that allowed adequate privacy to have an honest conversation. When face-to-face interviews were not possible, interviews were conducted via the telephone after verifying that the participant had adequate privacy to engage in a confidential conversation. All sessions were recorded with participant permission.

The principal investigator obtained written consent from the participants at the time of
face-to-face interviews, and verbal consent in the case of telephone interviews. The principal investigator reviewed the consent form orally and the participant was invited to ask questions about the study. Study participants were consented and interviewed in English. All study procedures were described in detail such that the participant was fully informed of their requirements while in the study. During this consent process the participants were reminded they were free to choose to take part in the research study or not. Those who consented to participate in the study were enrolled.

During the consent process, all participants were informed that information they provide through interviews is confidential (i.e. not shared with anyone outside of the research team) and voluntary (i.e. they were not obligated to answer any question). Interviewees were told that they were free to take breaks and/or terminate the interview at any time.

**Key Informant Interview Questions**

A key informant interview guide and questionnaire were developed for this study. The interview questions are listed below. The table associated with question #8 is derived from six health ethics domains to improve care identified by Porter, and specific topics identified by Nelson in an unpublished survey of primary care research network members. The author found these resources helpful to organize and group the key informant interview questions.

**A. Background Questions**

1. What is your title and role?
2. How have you been involved in implementing the ACO?
3. What are the values of the organization? How do they impact your work?
B. Ethics Conflicts Questions

4. How do care reimbursement models (such as fee-for-service, capitation or shared savings) affect your actions at work?
   a. What conflicts does this create?
   b. Would these conflicts be mitigated in another reimbursement model?

5. How is your job performance currently evaluated?
   a. Does this create any conflicts for you?

6. Has becoming an ACO changed (or will it change) the way your job performance is evaluated?
   a. Does this change either create or mitigate any conflicts for you?

7. Are you aware of any other ethical conflicts that have arisen specifically as a result of becoming an ACO?
   a. Why didn’t those ethical conflicts exist before? What has changed?

8. Are you aware of any other ethical conflicts that have been mitigated specifically as a result of becoming an ACO? Please explain.

9. There are some specific healthcare practices that commonly raise ethical challenges. I would like to ask you about the practices that we haven’t discussed yet, to see if you think they are impacted by becoming an ACO:

<table>
<thead>
<tr>
<th>Domains</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Ethics</strong></td>
<td></td>
</tr>
<tr>
<td>- Have you seen a change in how often conflicts of interest occur, such as incentives to increase or decrease services?</td>
<td></td>
</tr>
<tr>
<td>- Have you noticed a difference in how resources are being allocated? (Probe: e.g. rationing care)</td>
<td></td>
</tr>
<tr>
<td>- Has access to care changed for patients, such as access to needed specialized caregivers or services?</td>
<td></td>
</tr>
<tr>
<td><strong>Professional ethics</strong></td>
<td></td>
</tr>
<tr>
<td>- Have any of your professional standards been impacted? (Probe: e.g. practicing</td>
<td></td>
</tr>
</tbody>
</table>
defensive medicine; conflicts with facility policies)
• Have patient-provider relationships changed, such as disagreements over plans of care?

Decision ethics
• Are shared decision-making processes being used any more or less? (Probe: e.g. a formal program to base clinical decisions on patient values and their full understanding of options)

Clinical ethics
• Have treatment decisions been altered specifically to meet ACO requirements?
• Has the approach to end of life treatment changed? (Probe: e.g. withholding or withdrawing life-sustaining treatment; pain management)

Organizational ethics
• Is there a formal process to deal with ethical conflicts in your ACO?
• Does your ACO have an ethics training program? (Probe: is it mandatory? Who is eligible to participate?)
• What ethics resources are available to you? (Probe: Training; Internet-based materials, hardcopy resources, ethics committee case consultations; Are these resources helpful in your practice?)
• What additional ethics resources would you find useful?

C. End Question

10. Is there anything else that would be helpful for me to know about ethical conflicts being created or mitigated by ACOs?

The complete interview guide is attached as Appendix 2: Key Informant Interview Guide - Identifying and Mitigating Ethics Conflicts in ACOs.

Data Management and Analysis

To maintain confidentiality, each ACO entity and the interview subjects were given a numeric identifier so specific names were not directly linked to the data. Immediately after each interview, the digitally recorded files were uploaded and saved on a password-protected computer in the principal investigator’s office, and backed up on a password-protected server. The interview files were sent electronically to an individual on the research team for transcription. Interviews were transcribed verbatim and verified against the audio recording to ensure that all thoughts and opinions are included in the analysis. Once verification of the
transcripts was complete, the investigator conducted a content analysis, which involved identifying themes and categories prior to coding the data.

A variety of themes and patterns emerged through this coding process. Following the coding of all interviews, reports were generated for each code in order to systematically analyze and report on the information received during the key informant interviews.

Given the small sample, to be considered a true “finding” an issue had to either (1) be mentioned by at least two individuals or, (2) if mentioned only once have strong face validity. Findings were prioritized based on strength of evidence (for instance, mentioned by multiple people in multiple organizations or have strong face validity), and grouped into “themes” for deeper discussion. Themes were listed and ranked according to strength of evidence and perceived importance to the interviewees.

Anonymous examples (and re-worded to leave out any identifiable information, if necessary) were used to illustrate ethical conflicts that arise or are mitigated as part of becoming a Pioneer ACO.

Hard copies of data and collateral materials such as consent forms were stored separately in a locked cabinet in the office of the principal investigator. All interview data were stored in password-protected files at the principal investigator’s office and backed up on a password-protected server. After the study was complete, all recordings were destroyed to ensure that no responses can be linked to an individual.

**IRB Approval**

Ethics approval for the proposed research study was obtained through the Institutional Review Board at the University of North Carolina at Chapel Hill. The principal investigator’s employer, Dartmouth College, granted an IRB waiver for this study due to the UNC approval.
CHAPTER 4: RESULTS

Summary Description of the Study Sites

All 32 of the original Pioneer ACO sites were contacted via email with a request to participate in the study. Seven sites accepted the invitation to participate, and four sites declined. There was no response from the other 21 sites.

Three different people were interviewed at each site, including an ACO administrator, a primary care physician, and a specialist (five cardiologists, one general surgeon, and one psychiatrist). There were 21 total interviews.

The profiles of the ACOs ranged from clinic-centric to hospital-centric, and some had experience with managed care along with a robust care management infrastructure, while others were rapidly creating infrastructure to be able to meet the level of coordination required by the Pioneer ACO program.

The number of patients involved in the respective Pioneer ACO programs varied between ~20,000 and ~80,000 across the sites. Additionally, the number of patients “covered” by risk-based contracts varied from ~ 75,000 to ~450,000.

Table 9: Pioneer Site Profiles

<table>
<thead>
<tr>
<th>Site #</th>
<th>Admin</th>
<th>PCP</th>
<th>Specialist Interviewed</th>
<th># of Pioneer Patients (est.)</th>
<th># Risk-based Lives (est.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>✔</td>
<td>✔</td>
<td>Gen. Surgeon</td>
<td>60,000-70,000</td>
<td>300,000</td>
</tr>
<tr>
<td>2</td>
<td>✔</td>
<td>✔</td>
<td>Cardiologist</td>
<td>60,000-70,000</td>
<td>250,000</td>
</tr>
<tr>
<td>3</td>
<td>✔</td>
<td>✔</td>
<td>Cardiologist</td>
<td>30,000-40,000</td>
<td>170,000</td>
</tr>
<tr>
<td>4</td>
<td>✔</td>
<td>✔</td>
<td>Psychiatrist</td>
<td>70,000-80,000</td>
<td>450,000</td>
</tr>
<tr>
<td>5</td>
<td>✔</td>
<td>✔</td>
<td>Cardiologist</td>
<td>30,000-40,000</td>
<td>75,000</td>
</tr>
<tr>
<td>6</td>
<td>✔</td>
<td>✔</td>
<td>Cardiologist</td>
<td>30,000-40,000</td>
<td>180,000</td>
</tr>
<tr>
<td>7</td>
<td>✔</td>
<td>✔</td>
<td>Cardiologist</td>
<td>20,000-30,000</td>
<td>75,000</td>
</tr>
</tbody>
</table>
Summary of Major Findings

Seven major findings emerged from the key informant interviews regarding ethical conflicts that are created or mitigated by the ACO model. Only one of the findings has a potentially mitigating affect (shifting resources to focus on prevention), whereas the remaining findings point to ethical conflicts resulting from (or being emphasized by) the ACO model:

Table 10: Major Ethical Issues

<table>
<thead>
<tr>
<th>Ethical Issue</th>
<th>Description</th>
<th>Ethics Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incompatible reimbursement models</td>
<td>• The combination of fee-for-service and risk-based contracts creates conflicting incentives for an ACO to simultaneously increase and decrease utilization.</td>
<td>• Justice</td>
</tr>
<tr>
<td>2. Two standards of clinical care</td>
<td>• Medicare patients who would benefit from an ACO’s effective care management program may not be enrolled because they are not attributed to the ACO. As a result they receive uncoordinated and often inferior care.</td>
<td>• Beneficence • Justice</td>
</tr>
<tr>
<td>3. Financial incentives vs. patient choice</td>
<td>• Providers are incentivized to keep referrals in the ACO network even if they or a patient would prefer to refer out-of-network.</td>
<td>• Autonomy</td>
</tr>
<tr>
<td>4. “Best” care disagreements</td>
<td>• Incentives to provide only the necessary and needed care can result in (1) disagreements between physicians about the right care, and (2) the perception of “rationing” resources.</td>
<td>• Beneficence • Nonmaleficence • Justice</td>
</tr>
<tr>
<td>5. Required ACO metrics vs. evidence-based care</td>
<td>• CMS requires some metrics that do not reflect current evidence-based practices. This creates financial incentives to provide care that the literature suggests is inferior.</td>
<td>• Beneficence • Justice</td>
</tr>
<tr>
<td>6. Shifting resources to focus on prevention</td>
<td>• The ability to provide team-based, comprehensive primary care services could result in better patient outcomes at less cost; however, clinician burnout is a risk.</td>
<td>• Beneficence • Justice</td>
</tr>
<tr>
<td>7. Limited support systems for ethical conflicts</td>
<td>• A fragmented approach to dealing with ethics conflicts results in a mismatch between an ACO’s values and its clinical and business practices.</td>
<td>• Autonomy • Beneficence • Nonmaleficence • Justice</td>
</tr>
</tbody>
</table>

There was some variation regarding the distribution of these conflicts raised during the interviews. Table 11 (below) indicates the intensity (i.e. the frequency and consistency with which the issue was mentioned) of each key finding according to the role of the interviewee: red
cells indicate ethical conflicts that respondents consistently felt are either being created or felt more intensely as a result of becoming an ACO; yellow cells indicate areas that received roughly equal amounts of positive and negative comments from respondents, suggesting that some felt a conflict was being created while others felt it was being mitigated; white cells indicate areas that did not come up regularly by role across the sites.

Table 11: Ethical Issues by Role

<table>
<thead>
<tr>
<th>Ethical Issue</th>
<th>Admin</th>
<th>PCP</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incompatible reimbursement models</td>
<td></td>
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<tr>
<td>2. Two standards of clinical care</td>
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<tr>
<td>3. Financial incentives vs. patient choice</td>
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<tr>
<td>5. Required ACO metrics vs. evidence-based care</td>
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<tr>
<td>6. Shifting resources to focus on prevention</td>
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</tr>
<tr>
<td>7. Limited support systems for ethical conflicts</td>
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</tbody>
</table>

There was consensus across roles about conflict existing in four areas: incompatible reimbursement models; financial incentives versus patient choice; disagreements about what constitutes “best” care; and ACO metrics that are required but outdated. Administrators and PCPs stressed the issues of two standards of clinical care, and fragmented support for ethical conflicts. PCPs and specialists cited the shifting of resources towards preventive services as potentially mitigating some ethical issues, but with some unintended consequences that may create distress.

Each Pioneer site also had a range of reactions to the ACO model. The following chart reflects the number of times that all three roles at a respective site mentioned a specific theme:
The issue of incompatible reimbursement models was felt by all three roles at all seven of the sites. The issue of having two standards of care was expressed across all roles at six sites. Three issues received attention by all the roles at five sites: financial incentives versus patient choice; “best” care disagreements; and limited support systems for ethical conflicts. The issue of discrepancies between required ACO metrics and evidence-based care had consensus at three sites. The issue of shifting resources towards prevention was not consistently mentioned across roles at the sites.

Detailed Descriptions of the Ethical Issues

The following detailed findings section includes both (1) the ethical dilemmas sites are experiencing, and (2) mitigation strategies sites are employing to address the dilemmas.

1. Incompatible Reimbursement Models

ACOs have a combination of FFS and risk-based contracts. The FFS model relies upon seeing volumes of patients and increasing utilization of tests and procedures. The ACO risk-
based contracts rely upon bending the cost curve down and emphasizing quality outcomes over volume. Several interviewees referred to this as the “two canoes” dilemma, using the analogy of trying to navigate white water rapids with each foot in a separate canoe. Ultimately this dilemma is an issue of justice and leads to the question, “Can an ACO provide efficient, equitable care when reimbursement relies upon conflicting financial incentives?” This predicament was illustrated by an administrator who said:

The single biggest risk we face as an organization is the transition between payment models. If you move your contracts before you’re prepared to fully change the way you deliver care, or the other way around, either way you’ve lost. And how do you make that transition? There is not a proven way to do it.

The challenge of competing incentives showed up in several different ways, as described below.

1.1 Adjusting Resources to Meet Shifting Revenues

Several of the interviewed sites were hospital-centric ACOs, which are particularly affected by a shift in revenue from acute care to prevention. A physician administrator navigating the journey from being a profit center to an expense center offered an example of how the changing reimbursements affect hospitals:

It’s tough to be in an ACO world and a production-based world simultaneously. Let’s say you have someone who comes into the emergency room that doesn’t really need to be there. At an ACO your goal is to utilize the minimum amount of resources for the most effective quality of care; whereas in a private model, honestly you make money by those visits and encounters. We’re moving from revenue centers to expense centers, and that’s a very interesting, conflicting world.

This transition for hospitals and the resulting revenue shift is a major disruptor to a U.S. health care system that is built to deliver acute care. One way that ACOs are attempting to deal with this is through retention and referral streams, as described above and by this administrator:

We manage the care and we decrease utilization on a per person basis…but we take advantage of the fact that we do have a broad base of patients, who we can then keep all
of their care within our network, keep it local, keep it better coordinated. And therefore, the hospitals aren’t net losers in the equation because they’re benefiting from the stabilized volume.

Ultimately, however, excess capacity needs to be removed from the system. This idea of “right-sizing” is an important ethical issue of being stewards of resources and removing waste. As one administrator said:

We’re trying to balance decreasing volumes by helping our hospitals figure out what are the essential services. We realize that not every single hospital may need expensive machines, or needs to be the very best at providing a certain type of service, so we’re really trying to take some of that excess cost out of our health system.

### 1.2 Physicians Pulled in Many Directions

Several PCPs described the stress of being put in untenable situations by the changing and competing reimbursement pressures. Here a PCP describes the burden of being more available for patients outside the clinic walls, while also being compelled to generate more patient visits at the clinic:

Providers get a message that we need to manage a patient population more effectively. And that means managing patients in the office or out of the office. And yet, on the other hand, there's pressure on us to increase our volumes and generate more revenue. And those two things aren't necessarily able to coexist in a very effective way.

The same PCP goes on to explain the resulting budget dilemmas that come from competing reimbursement models. On the one hand physicians can generate more short-term revenue by seeing more patients in the clinic. On the other hand, seeing more patients takes time away from population management. The ultimate result is exhaustion:

And so how do you address budget cuts, which occur every year? If you cut out resources you lose the things to manage these populations. Or you see more patients, in which case you don't have as much time to take care of these patients in this [high touch] fashion. And that burns people out. It really, really does.
1.3 Physician Compensation

One of the by-products of this situation is the movement to change physician compensation models to more heavily emphasize quality outcomes. However, at least from this study it appears that physician compensation is slow to reflect the ACO emphasis on quality. This shows up in a number of ways at the Pioneer ACO sites that were interviewed. One administrator lamented the lack of funds to proactively modify compensation, which reflects the gap between shrinking revenues and the hoped-for share of savings:

Everybody's still getting paid fee for service. We're starting to change that, to realign the incentives so that there's an incentive for the physicians and other providers to meet the Pioneer quality metrics as opposed to how many patients they've seen. I think the difficult part is unless you've got significant enough shared savings to cover your expenses, you don't have any money left over to incent people.

Another physician administrator described the challenge of having employed physicians who have little incentive to change behavior. In this case the ACO is taking a phased approach to shifting compensation towards quality:

We have a very high employment model. So we said, ‘How can we incentivize PCPs to focus on quality and the satisfaction before we move into population-based payments?’ We started to roll out contracts with an incentive model to increase emphasis on quality, vision, satisfaction, citizenship, and contribution. It’s up to one half of the 40% of variable compensation. So making small changes, but I think it will take time to roll it out across the system.

Several sites mentioned a real or aspirational target of 20% variable compensation based on ACO quality metrics. One administrator described how they involved the PCPs in revamping the compensation model, which resulted in buy-in from the physicians and better-aligned incentives:

So for primary care physicians, we realized that RVUs [relative value units] are not an incentive that aligns appropriate behavior for beginning to take risk. So we let them actually pull together a proposal, and at the end of the day, a quarter of the potential
variable pull is still RVU-driven, but the rest is driven based upon cost and quality metrics. So they are no longer incented just to see patients.

1.4 Free Rider Problem

Several interviewees raised two issues regarding the alignment of incentives with non-ACO partners. The first is related to smaller hospitals that are still driven by volume, but refer to larger medical centers that are part of an ACO. One specialist described the situation like this:

I'd say the biggest problem in our system is all the little hospitals that have to make money by doing certain things and picking the low hanging fruit and all that. You don't always feel it on a doctor-to-doctor kind of basis, but you know that things could be done better if more of the specialty care was being done in the bigger environment. It's very difficult because at the end of the day, the little hospital chief executive officer has to report to the board of that hospital and until something becomes a true regional system where there's one person truly in charge of the whole system, then I think it's difficult.

The other non-ACO incentive alignment issue has to do with free-riding payers who benefit from a reduction in billable claims but do not have risk-sharing agreements with the respective ACO. Here an administrator describes this problem:

What do you do for those patients that nobody's paying you to do anything for? The core group of care management and other services affects everybody. I mean obviously if we come up with a policy that we're going to do this this way, that's everybody, no matter what. But there are a number of commercial payers and the state Medicaid agencies that are really not paying their fair share and I think that's part of the dilemma. From a financial perspective it’s purely downside for a system to take on all of that.

1.5 Issue Summary

The issue of incompatible reimbursement models results in several dilemmas:

- ACOs must “right size” their resources to capture revenues in both FFS and risk-based contracts.
- Physicians are being asked to deliver in both reimbursement models, which creates conflicting incentives and results in physician distress.
• Physician compensation models are slow to reflect a quality of care component.

• Some important stakeholders are benefiting from the ACO model, but are not yet participating in it. This creates a free rider problem.

Two mitigation strategies emerged to deal with the issue of incompatible reimbursement models:

• ACOs are attempting to capture more in-network referrals to maintain or increase patient volumes.

• Some ACOs are engaging physicians to design compensation models that reflect a fair balance of volume and quality.

2. Two Standards of Clinical Care

The conflict regarding two standards of care is created when (1) an ACO has a proven, effective care management program, and (2) Medicare patients who clinically qualify are not enrolled because they are not attributed to the ACO. The result is that patients are subject to less coordinated, likely inferior care. This raises the question, “Can an Accountable Care Organization morally justify two standards of care?” The primary driver of this conflict is patient churn, as described below.

2.1 Patient Churn Creates Uncertainty

Clearly the principles of beneficence and justice come into play for the patients when ACOs are deciding how to allocate resources. However, the ACOs must stay financially viable and care management programs are expensive to run. The situation is complicated by the fact that Pioneer sites interviewed are experiencing 15-30% patient turnover of patients every year, so a non-attributed patient who presents at an ACO could be attributed to that ACO in the future. Alternatively, a patient attributed in one year may drop off the next year. This makes it very
difficult (if not impossible) to definitively know which patients might be “eligible” for enhanced care management, which creates stress for physicians.

### 2.2 Patients Not Eligible for Better Care

The dilemma regarding two standards of care arises from the interviewees who felt that ACO care management programs are improving health outcomes (no data were requested to verify these claims), but not available to all. Consider this example offered by a specialist describing a recent patient visit:

Care managers really look into a lot of the patients’ medical, pharmacy, and social concerns, and the patient feedback I’ve had has been wonderful. I had an example a week ago of somebody who’s diabetic, very overweight with extensive heart problems, and on top of that is blind and lives in a very rural setting and is quite poor. He got in contact with care managers and just the phone calls to help him with his diabetes test strips and some medication issues, rather minimal things, but he described just somebody being in contact with him as changing his life. It was kind of a remarkable thing how a rather simple intervention helped his depression.

However, another example from a different ACO illustrates the frustration a physician feels when not being able to provide the best care to a patient in need:

It’s a bit of a struggle because we walk into a room and we don’t necessarily pay attention to the insurance products. We don’t provide varying levels of care or types of care for varying types or levels of people. So you might be in the room thinking, ‘Oh my goodness, this person really needs to have the CHF nurse follow them because their weight is going up and they’ve got more edema and they need that.’ And then you go to make the phone call, and then the resources say, ‘Hey, that sounds great. We’d love to pick them up. What’s their insurance?’ And, ‘Oh, you know what, they have Insurance X, which we don’t take risk for.’ Then they’ll say, ‘Well, I can give you some other general community resources and contact information, but I can’t pick them up and put them on our management program.’

This conflict exists in commercial FFS reimbursement models, too. However, interviewees expressed particular frustration about having to parse Medicare patients who may or may not wind up being attributed to the ACO. One physician said:
I know there are better outcomes. I know there are better scenarios for people as far as maintaining their health. It does get frustrating to have the resources, to have the programs in place, but not necessarily be able to get people appropriately plugged into them.

2.3 Aspiration: the Best Care for Every Patient

Several sites shared their strategies to address the two standards of care issue. First, every interviewee emphasized a primary focus on caring for a patient, and secondary focus on finances. For example:

We are trying to do what's clinically appropriate. But it could come to pass that we do have to make more difficult decisions where we offer potentially lighter touch care management for those who are not in the ACO contracts. We're in a pretty good financial position, relatively speaking. But this is quickly heading to a point where we might not be able to support it financially.

Fundamentally this patient-first orientation starts with the values of an organization, which some interviewees emphasized more than others. For example, one administrator described the importance of the overall population care model as being more important that the ACO experiment itself:

One of my conditions to take the job was to not restrict or limit access to care or decrease blanket utilization. I'm here to decrease inappropriate utilization and maximize the care at the right place. That was a big issue for me personally. So when we started, we built some valves and screen methods, so we make sure our practices don't start dumping patients because they're complex, or they're not compliant, or they don't fit the measurement that we have for incentives. Let's make sure there's high quality and patients have access and they're happy, and then look at the costs later.

2.4 Operations that Support Core Values

Placing patients first is easier said than done. On a practical level, several tactics emerged as being effective at respondents’ respective sites, including:
New Roles: most of the sites utilize a combination of case managers and population managers. The job roles varied by location, but generally speaking were defined as:

- Case managers are nurses who coordinate the care of high-risk patients. These are patients who have just been discharged or have acute exacerbations of chronic disease and need help navigating the health care system.

- Population managers are medical assistants (sometimes pre-medical or nursing school students) who do things such as run patient lists to identify high-risk patients, and help coordinate care by scheduling appointments. They are focused on outreach for the entire population with an eye on preventive care.

For the ACOs that divide up work like this, every Medicare patient falls under the umbrella of population management; however, only those at the highest risk are assigned a case manager. Delineating these roles and responsibilities helps the ACOs handle higher patient volumes, thereby helping mitigate the capacity dilemma.

Triage system: at least one site has implemented a triage system to determine who qualifies for care management services. The process looks like this:

1. If a physician thinks that a patient will benefit from enrollment, s/he completes an online clinical scenario.

2. The clinical scenario is judged on a point system. The request moves on if it meets a points threshold.

3. The request is ultimately reviewed by the administrator of care management to ensure there is capacity to take on the patient.
Buffer zones: At least one site allows up to 5% of its care management population to be from outside the ACO risk contract. To add more patients, current patients must first be un-enrolled.

An administrator who implemented buffer zones described the following benefits:

It is controversial because of the financial hit to the organization. However, it means a lot to the clinicians, and it’s beneficial to the patients. And quite frankly, when we're dealing with the issue of churn, this is a way that we can keep some of those patients in the program even if they're no longer in the ACO.

2.5 Issue Summary

The issue of two standards of clinical care results in several dilemmas:

• The formula used to attribute patients to an ACO means that there is about 15-30% patient turnover per year. As a result, an ACO cannot be certain which patients it sees will be attributed to it during subsequent years.

• The physicians interviewed generally agreed that the care management programs associated with the ACOs result in better patient outcomes. However, not every patient in need of the programs can be referred.

• Every site interviewed for this study has language in its mission, vision or value statements along the lines of “patients will receive the best care.” However, as these findings reveal, that is a hard standard to live up to and is not consistently accomplished.

The sites in this study are utilizing several strategies to deal with the issue of two standards of care:

• Clearly defining roles to streamline processes and match skills to task. This enables teams to handle more volumes of patients.
• Using a points triage system to determine and prioritize which patients should be enrolled in care management programs.

• Create buffer zones to allow non-ACO patients to be enrolled in the care management programs.

3. Financial incentives versus patient choice

The issue of financial pressures on providers conflicting with patient choice is related to providers trying to steer patients towards the ACO referral network. This potentially interferes with helping patients make fully informed choices, which raises the question: “Do financial incentives influence physicians to present information in ways that affect patient autonomy?”

This is sensitive for many providers because of the negative history of managed care. As one physician said:

The most frequent and ethical dilemma we face is the decision process between keeping care in network, which we all feel has certain benefits, but for which we also know that we have some potential financial gain, versus the idea of patient choice.

3.1 Better Care Coordination

The dilemma is nuanced, however, because as indicated in the quote above there is a strong patient-care argument for keeping patients within a system that is able to share patient information and coordinate handoffs. As one PCP said:

In the end it can help the patient get better by transitioning from one location to the other and decreasing the chance of complications. We share information better. It gives us less chance of medication errors. But of course we also know that we’re going to share the savings of the reduction, the cost of that care.

As mentioned previously, every person interviewed reported that patient care always comes before financial considerations. However, the interviews also revealed that many
providers are aware of reimbursement considerations. The sites reported different ways of dealing with the tension of referrals that are associated with financial gain. All the sites made an effort to increase provider awareness about how the ACO model works, with effects such as this described by a physician:

It has brought a renewed emphasis on the importance of population health and on efficient, effective care. I know when I see someone who is an ACO-based patient, I am that much more aware of making sure that we are working to keep the consultants and resources that we use as in-network resources. Much more so than if this was a private practice or a private-payer patient.

3.2 Engaging Patients

Several sites have attempted to facilitate patient/provider communication about the benefits of the ACO network via educational materials and conversations while in the clinic. This leaves the responsibility up to the providers for what and how to communicate with patients, which is the root source of why providers feel conflicted. A few sites reported the importance of culture and clinician buy-in to the quality of their programs, because then they naturally advocate for what they truly believe is best for the patient. One administrator described a conversation with a nurse after the introduction of a brochure about care options. The nurse reportedly said:

Why would I even introduce to the patient that going somewhere else would be equally good? It’s not equally good. You know, this VNA has better survey scores, they have better care, they share our health record. They come to meet with me. They do the case reviews with me. It would not be good for the patient if they went to a different VNA.

All of the sites felt hamstrung regarding patient communication due to the fact that CMS requires pre-approval of any direct-to-patient marketing materials, communications and activities about the ACO. CMS does this to “protect potential beneficiaries from being misled about Medicare services.” Several interviewees lamented the challenge of being responsible for the
health of patients and cost of care, while having only the ability to influence (versus limit) patient behavior. As one physician administrator said:

In no way, shape, or form are patients engaged. They don’t even know they’re in an ACO. If they’re on Medicare, they know they can pretty much go anywhere - they don’t need a referral. This leakage is one of our biggest concerns.

Part of the theoretical promise of the ACO model is aligning incentives and coordinating care. Without patient participation, however, providers lose incentive to invest in the required infrastructure and programs. That said, most of the Pioneer sites sounded an optimistic tone about the future direction of accountable care, recognizing that a shift of this nature requires overcoming the patient engagement challenges. One PCP stated:

There’s a saying that the best fence is a green pasture. So if you apply that kind of care coordination and high touch approach, I think patients appreciate it. And for the most part they will follow your directions because they typically don’t get that kind of focused attention. You need to take care of them in a way that they will respond. And most do.

3.3 Fully Informed Patient Decisions

One way to engage patients is to be transparent while helping them make fully informed decisions. Unfortunately, the outcomes data that could be useful for patients and providers when making decisions is rarely available, even at the relatively mature systems that make up the Pioneer group. This is particularly challenging for PCPs and hospitalists trying to make referrals:

Information is lacking about who the best providers are. Who has the best outcomes? Patients do have their preferences, which may or may not be based on fact. Until there’s a more explicit understanding about provider quality, it’s really not an informed decision.

Overall, this ability to share information came up often as both a barrier to transparency and care coordination, and also as a facilitator for the sites that are streamlining information flow.
As mentioned above, ACOs have an opportunity to help patients make fully informed decisions, thereby staying engaged and building trust with ACO providers. One administrator described how they are incorporating the formal practice of shared decision-making:

A lot of education goes into the care management plan, and patients have to decide on what's best for them. But from a delivery of care or physician perspective, we have been working on a formal structure for shared decision-making in three areas:

1. Orthopedic procedures for knees and back.
2. Cardiology in regards to insertion of pacemaker and defibrillators.
3. Chronic diseases, congestive heart failure, diabetes.

Our health coaches meet with a patient first and go through a medication session followed by a formal decision making process with decision aids. And so when the patient meets the physician, they're ready with questions and ready to make a decision about whatever the issue is.

3.5 Issue Summary

The issue of financial incentives versus patient choice creates several dilemmas:

- CMS limits direct ACO-to-patient communication, therefore the onus of fully informing the patient is on providers.

- The people interviewed for this study believe that ACOs offer better care coordination via information sharing and smoother hand-offs with partners. However, they also know that there is a financial incentive to keep patients in the network.

- There is a lack of objective outcome data regarding physician and partner performance. Such information would make conversations with patients easier and more objective.

The sites in this study are utilizing several strategies to deal with the issue of financial incentives versus patient choice:

- Some sites are using educational materials in waiting and exam rooms to tout the benefits of the ACO care coordination.
• There is some scattered reporting of outcomes, but this appears to be mostly subjective. To be most effective the outcomes would be formally measured and analyzed.

• A few sites appear to have cultures that are strongly oriented towards patient service. This results in creating programs that patients want to participate in, and is exemplified by the quote, “The best fence is a green pasture.”

4. “Best” Care Disagreements

The best care dilemma has to do with disagreements between physicians about appropriate care, which can be exacerbated by the patient’s perception that beneficial care is being rationed. A potential risk here is unintentional under-utilization, which involves a patient not receiving proven, effective care. Given the myriad of providers and hand-offs involved, the question raised is: “In what ways do financial incentives influence clinical judgments?” The results of this study indicate that this question has several dimensions, as follows:

4.1 When to Refer to a Specialist?

Several specialists and administrators raised the issue of the timing of referrals to specialists. Although no specialists reported a drop in referral volumes, there is at least perceived pressure that the ACO model will limit referrals and/or shift too much care (in the opinion of specialists) to the primary setting. The fear is that the pendulum is swinging too far towards minimizing short-term costs, and that avoiding specialty care now could result in worse health outcomes later. One cardiologist shared a plan to address this by creating an educational program to improve primary care skills while also providing guidance about when to refer patients:

I see all too many times patients that show up that would not have ended up in the hospital if they had seen a cardiologist sooner. I’m in the process of rolling out an ‘Everything you need to know about heart failure in thirty minutes or less’ talk to primary care physicians across the network. A piece of my discussion centers on when to refer
and why. My goal is to try and get the primary care doctors to realize that sending a patient to a cardiologist is not necessarily a bad thing when it comes to keeping patients out of the hospital. It may help with the overall care of the patient, as well as the economics.

4.2 Hand-offs Introduce Risk

Another challenge is managing the hand-offs between providers, which is essential to coordinating care. Here’s a vignette about a patient whose overall health appears to have been overlooked as physicians made specific decisions about whether or not to admit him:

I had a 90 year-old patient with a compression fracture, who was over to the hospital to get a vertebroplasty. And for whatever reason, he had a seizure. The doctor got a urine, and the urine was a little dirty, not necessarily an infection, and he cancelled the procedure. The doc wanted to put the patient in the hospital because he’s 90 years old and in intractable pain. He wanted to put him in observation. Nope. He was sent home. A 90-year-old with intractable pain failed on outpatient medicine, so you send him home? I mean that’s a no-brainer to me, but a patient went home. And the family was not happy. So those are the things as we get pushed, that line, you know, who is admitted and who is not admitted.

Part of the fallout from this episode was that the primary care physician, who was not part of the decision to admit the patient, was the one who was called by the family to resolve the situation. This creates stress and tension within the system:

The patient gets sent home, and the family rightfully gets upset. And now the primary care doc gets called to deal with the outpatient. She had nothing to do with the decision. But she’s got to smooth the feathers, and then of course she’s not happy with the system.

4.3 What is the Best Practice?

In the previous example it is clear that a process either broke down or needs to be improved. It also touches on the issue of “best” practice, which is a popular term but hard to define, let alone put into clinical pathways that may have prevented a 90 year-old patient in intractable pain from being sent home. As ACOs strive to create care management systems that
standardize care, they are uncovering disagreements between physicians and a lack of evidence for the best care. One specialist described the challenge of evidence-based care:

Doctors should also be thinking about evidence of what works. But it's very, very hard to apply the so-called clinical evidence to individual cases. Evidence in evidence-based medicine is generally derived from prospective, carefully-controlled studies. And the studies are about groups. They're not about individuals. So it's really quite tricky to know from a population statistic what's going to matter in your case.

Several interviewees said that they were using clinical guidelines produced by specialty societies to create awareness about evidence and standards. For example:

We had also had an initiative looking at applying the college of cardiology appropriateness criteria for nuclear imaging for cardiovascular disease. So it was really getting the physician’s to begin to apply more evidence-based practice consistently across the organization. And to look at their own personal data as well as the overall system performance.

4.4 Rationing Beneficial Care

There is a fear amongst many of the providers interviewed that the ACOs model will place too much pressure on the physicians to decide who receives beneficial interventions and care, and who does not:

The dilemma of balancing what's required to care for the individual right in front of you in your office versus worrying about the population is an unsolved ethical dilemma that's raised by ACOs. I don't know how doctors can make those decisions. They're social and ethical and societal judgment calls.

A frequently cited example during the interviews was the hepatitis C drug, Sovaldi, which is remarkably clinically effective and also very expensive. One administrator explained the bind Sovaldi creates for the ACOs due to their risk-based contracts (see Appendix 4 for more on this dilemma):

Sovaldi creates a big ethical dilemma. The U.S. preventative task force recommends screening all baby boomers for hepatitis C. If we actually do a full press screen like we should be doing and we uncover the patients, and they all get treatment, we will go broke.
We estimated, based on our population, if we did 100% it would cost us between 70-80 million dollars.

4.5 Issue Summary

Disagreements about what constitutes “best” care creates several dilemmas:

• With financial incentives moving care towards the primary setting, there is some concern amongst specialists that PCPs will not know when to make appropriate referrals. (This could range from not referring patients who need a referral to referring patients who should be handled in primary care.)
• Patient transitions that involve hand-offs require careful coordination between providers who have aligned incentives.
• It is not always clear what constitutes “best” practice, and therefore disagreements can be persistent.
• There is some fear that providers will be put in a position of rationing beneficial care.

The sites in this study are primarily using one strategy to deal with the issue of determining what is “best” care:

• Physicians are looking to specialty societies for best practice guidance.

5. Required ACO Metrics versus Evidence-Based Care

The Pioneer ACO program requires a set of specific quality measures and thresholds that must be met to be eligible for shared savings disbursements. However, a few of the measures do not reflect current medical best practice. The result is that the ACO may be incentivized to not provide what evidence suggests is the best patient care. This raises the ethical question: “Do physicians have a moral obligation to interpret and apply evidence-based care?”

Every interviewee emphasized the sentiment expressed by one administrator, “We're not going to practice bad medicine to meet [outdated] measures.” The dilemma, of course, is that
providing care in accordance with the latest research evidence may be detrimental to reimbursement. For example, as a PCP explained:

Some of the scientific evidence has changed in the last year or two, such as lipid criteria and blood pressure criteria. The Pioneers are still measuring based on standards that were written in the mid-2000’s, and the new guidelines just came out in 2013. They are completely different – and our clinicians are stuck in between. Our population health group made the decision to go with the latest standards, even if we take a beating on that by [CMS].

5.1 Local Teams Interpret Evidence

There are also instances where it appears that CMS measures are outdated (e.g. breast cancer screening), but the recommended care is still being debated. Most of the sites have dealt with this dilemma by creating teams to decide the best course of action. For example, one PCP explained how their process works:

Mammography is all over the place. American Congress of Obstetricians and Gynecologists has one set of recommendations, American Cancer Society has another set of recommendations, the U.S. Preventive Task Force has a third set of recommendations. So we put together a group of people who have the most knowledge in our organizations to come up with a recommendation that we all should be able to live with. Every once in a while individual physicians push back, but that’s how we guide ourselves. If it doesn’t get the money it doesn’t get the money. It’s really what is the right thing for the patient and that’s how we make our decision.

It can be challenging to communicate and spread desired actions, however. One specialist described the difficulty of getting peer buy-in to a program that was already proven to be effective:

It takes a long time to get doctors to start thinking differently and working more along the lines of guideline directed healthcare, along the lines of standardization of healthcare delivery and be focusing differently. They have habits that are hard to break. I should be pushing these changes actively with every cardiologist in the system but I only have so many hours in the day. It’s a program that works and at meetings we do encourage people to do it in this way but it hasn’t really been adopted by everybody in the system.
5.2 Measures Can Encourage Waste

Another dilemma is created by metrics that use claims data to measure achievement or compliance. In some situations a clinician knows that a patient has already had something done elsewhere, but also knows that they will get dinged if a claim is not generated through the electronic medical record:

We don’t always feel like claims-based measures reflect the true quality of the clinical care being provided. For example, a patient who could have a colonoscopy with a different payer comes to our system because they choose a new PCP…and that colonoscopy no longer counts because the claim didn’t drop with the correct payer. And so we end up running into a conflict. Do we get the patient another colonoscopy even though it’s not necessary, or do we just sacrifice on the metric?

5.3 Are Measures Worth the Effort?

Many sites attempt to use the electronic medical record system to create standard pathways that reflect best care, as well as billing and claims-measures requirements are met. However, this creates an issue regarding provider time to properly document patient visits. The feeling amongst many PCPs is that this is negatively impacting patient care:

The primary care docs are up to their eyeballs in what they’re being asked to do and document. And patient care is going to suffer because I’m spending more time in the chart just trying to click all the spots that need to be checked, and then I’ll miss something like doing the A1C.

However, despite some misgivings about the operationalization of the metrics, there was also overall support regarding their intent and purpose. For example, this PCP describes the benefit of a comprehensive (and funded) measurement program:

Before it was really more, ‘Hey, if I’ve got a six week wait time that’s a really good thing because patients like me.’ We really didn’t measure ourselves based on quality. Now we’ve actually gotten to the point we’re measuring outcomes. And so that is absolutely connected and required within the ACO world. Different than years ago, we didn’t have any measures.
5.4 Issue Summary

The issue of CMS requiring ACOs to meet outdated measures results in several dilemmas:

• ACOs must choose between providing the best care according to the literature, or meeting metric thresholds that affect shared savings disbursements.

• Meeting target measures can result in wasted resources. This happens when data for patients coming from outside the ACO are not complete in the EMR, so providers must decide whether to (1) duplicate a test (for example) (2) update the EMR without first-hand knowledge of what was done previously, or (3) risk not meeting population quality targets.

• Entering data that is used for metrics tracking can be burdensome to providers.

The sites in this study are utilizing several strategies to deal with outdated metrics that are required by CMS:

• Creating local teams that are charged to determine the best clinical care.

• Embracing metrics to measure quality of performance.

6. Shifting Resources to Focus on Prevention

According to the PCPs interviewed, shifting technical and human resources towards preventive care is resulting in better patient care and higher provider satisfaction (for ACOs “preventive care” also includes tertiary prevention for patients with chronic conditions).

However, as mentioned above a few specialists raised the concern that a focus on primary care is resulting in delayed referrals that result in bigger health problems for some patients. Overall, this raises the question: “Does the shift of ACO resources towards preventive care result in better patient outcomes?”
6.1 Patient Access to Better Programs

As mentioned above, this study did not collect data to analyze changes in patient outcomes. The vast majority of PCPs interviewed described their enthusiastic support for the ACO model because the care management programs are giving them more tools and resources to provide better patient care. For example, this PCP described the relief of gaining wider access to the resources available to other programs:

For the PCP’s it’s actually a big win, because all of the clinical tools and resources we had in place for Medicare Advantage are now available for the rest of our Medicare population. We’ve moved out of a payer-based approach and now we’re saying it doesn’t matter who the payer is. We’ve got case management, population management, home visits, and all of the good things that we do we now do for everybody. That is a big benefit to the PCP, who didn’t necessarily have all of that at their disposal before.

However, a potential risk of using legacy programs such as Medicare Advantage to extend systems, processes and tools is the challenge of quickly taking on new volumes of complicated patients:

What do you think happens to the program when you begin to add a large Medicaid population in? What happens is there's a whole new set of comorbidities that you need to manage that maybe the program's not necessarily structured to manage yet. And maybe the number of patients that can be effectively managed becomes different. We need to monitor that sort of thing very closely.

6.2 Clinics Reorganizing to Meet Demand

Another PCP described a new level of teamwork associated with care management programs that result in specific skills being matched to the appropriate clinical challenge, which optimizes the use of limited resources:

We’re taking much more of a team approach. We’ve begun to stratify the population that we take care of. We’ve said okay, high risk patients are going to have an RN care coordinator who is going to basically be involved in that patient’s care all the time. So when they’re in the hospital they’re making sure the time of discharge and the transition back to either the community or the transition to the nursing home [is OK]. They’re involved in that transition of care because most of the errors that occur or most of the
lapses in care occur at times of transition. It’s a way for us to prevent readmissions and to prevent emergency room visits.

The middle level patients is where the bulk of the quality work needs to be focused. We’ve created this collaborative care nurse position whose role is to interact with patients on the phone or face-to-face, managing patients with multiple morbidities attached to chronic disease. They manage the quality metrics for the individual patients and try to improve their outcomes, try to prevent them from moving into the high risk category.

The low risk population is the healthy well. Maybe some of them are the anxious well, but they’re managed by the registry function to proactively make sure they have all their preventive pieces. So this group of individuals that manage this are high school level trained people who have really great interpersonal skills, overseen by the physician saying, ‘Okay, this person does need to come in’ or ‘This person just needs their pneumovacs.’

All of this work is done outside of the exam room to try to get the physician back to managing people who have either acute or sub-acute problems related to their chronic disease. So moving physicians away from taking care of chronic disease that is stable. And we use the associate providers in the exact same way. In the past the associate provider just dealt with the acute stuff like sore throats, runny noses, but invariably they ended up taking care of the exacerbation of the chronic problem because the physicians were so booked with patients who had the chronic stable disease because there’s just so much of it in the environment.

6.3 Physician Need for Management/Leadership Training

An unintended consequence of the ACO model is the newly required skillsets for PCPs, especially regarding team management and quality improvement. As one administrator reflected:

For any one PCP it can feel like every week being told about something else they need to do. It can be overwhelming and we try and coordinate that as much as possible by supporting what the local practice is working on. These days we think about the role of the PCP as a team leader, not just a patient care provider. And that’s new, and some docs are not so good about it.

This touches upon the issue of balancing the pace of change for people doing the work. As one physician said:
There's more and more pressure to expect performance and outcomes and volume. And it's very important to balance those expectations against the capacities of the people who are delivering and doing the work. There is a tendency to put more and more upon them. And if that's not well balanced, the program fails.

For specialists, the issue of delayed referrals has already been discussed above. Another challenge mentioned by several interviewees is related to work shifting away from procedures and towards care management. This is potentially an important “growing pain” dilemma associated with rightsizing the over-supply of some specialty resources. However, because specialists tend to choose their respective areas based on what they like to do and were trained to do in residencies and fellowships, they could find their work less satisfying. Some jobs are starting to change already as a result of working in the ACO model:

One of our biggest gaps and one of our strategic initiatives is working with our providers to put much more emphasis into the outpatient management of patients. But the cardiologists and other providers get the most satisfaction out of doing procedures. Now we need to manage the patients more effectively in the outpatient setting so that they’re not sent to the emergency room where they’re likely to get admitted to the hospital. That’s going to be a challenge for us in the years to come because training programs for cardiology fellows still are much more procedurally-based focused.

6.4 Issue Summary

The issue of ACOs shifting resources to focus on prevention appears to be mitigating some issues and creating others at the sites interviewed:

• PCPs generally believe that they have access to more and better resources, which lead to better patient outcomes. This mitigates distress.

• There is some fear that volumes of new, complicated patients will swamp PCPs.

• PCPs are being asked to manage teams, and many have not been trained to be managers.

• The pace and amount of change can be overwhelming to the clinical practices.
Some specialists expressed dissatisfaction with their emerging roles in population health management.

Most sites in this study are primarily using one strategy to deal with the issues associated with shifting resources:

- Utilize teams with clearly defined roles to monitor patient populations and proactively intervene at the appropriate time with the appropriate resource.

7. Limited Support Systems for Ethical Conflicts

Given the findings above, including the daunting conflicts related to two standards of care and opposing reimbursement incentives, the sites interviewed inevitably have had to react to challenging situations along their ACO journeys. At least two of the sites have taken a deliberate organizational ethics approach to resolving systems and process dilemmas, to varying degrees of formality and success. Most sites, however, reported a fragmented, informal and limited approach to organizational conflicts. This results in organizational values being disconnected from business and clinical practices, which leads to the question: “Are ACOs morally obligated to provide effective ethics resources?” As one PCP said:

The new way of delivering and paying for health care is going to bring new ethical challenges. We're learning as we go, but we don't have a formal program to deal with the ethical challenges. I don't think there is such a resource available once you get into a population based payment and all the challenges that comes with it, both on the front line and the back line side, clinically and financially.

7.1 Ad-Hoc Resources

Perhaps as a reflection of physicians’ historical independence, there was a lot of evidence in this research that as-needed, informal systems are popping up to deal with ethical dilemmas. One specialist described a typical emphasis on more urgent concerns, such as legal and safety:
We don’t have an ethics committee. We don’t have any training. It gets talked about a fair amount, though. We have a lot of venues, however, such as a professional affairs committee where stuff of an ethical nature comes up. Legal helps us with this. And we have a patient safety person.

Another administrator described a distributed approach to ethics by clinic site, versus an ACO-wide approach:

There is no organizational-level ethics committee. It's variable based on the site. It's all managed locally, and some places do have more robust programs than others. We don’t have any training or materials available or anything like that.

The presence of a clinically based ethics committee was more common, although such committees are typically case-based and do not address overarching systemic issues:

So there is an ethics committee available for consults or for ethical clinical concerns. I don’t necessarily know that anyone has cracked the nut more on more of the big picture non-clinical ethical dilemma stuff.

7.2 Deliberate Organizational Support

A couple of sites have made an effort to create an atmosphere of collaboration and allow people the time to work on difficult issues. For example:

The ACO has been very supportive of making sure that we have the time and the resources to be able to have discussions about how we can impact care, how we can look at what these important metrics are, how we can look at what is going to give us good results. And then what are the ways that we can simplify and streamline those processes.

An administrator at another site described formal training programs and feedback mechanisms they use to create a culture of feedback and improvement:

There is lots of training that goes on with the folks who either sit on the committees or serve as sort of ethics consults or consultants. Some of them are at the facility level; some are at the system level. Often times if there are going to be issues raised or an employee is uncomfortable raising it within their own work unit, then it could come in through a compliance hotline, and then it gets turfed over if it’s an ethics issue. We try to make sure that everybody has broad access to be able to raise honest and concerning questions to the extent they have them in and around ethics or compliance issues.
7.3 Ethics Forum

Several PCPs expressed a desire for a forum to communicate with other providers, including specialists and hospitalists, about clinical cases and process issues:

I’m actually hoping that we can develop an open forum for the providers. So many of the issues that we all struggle with on a daily basis, whether it be who is the best orthopedic surgeon locally for hips versus shoulder, or the dilemmas of, ‘Oh, the other day I had this, and I didn’t know what to do, and I was really torn between what I felt was medically right versus what the family was requesting as far as pushing treatment to where actually hospice makes more sense.’ Those types of things. I just wish we had more of an open forum. So many of the docs now are only ambulatory, and more and more the inpatient care is taking care of the hospitals, that the primary care providers are kind of getting peripheralized for some of those discussions, and miss out on some of the collaborative and collegial interactions that used to take place when they were also doing hospital medicine.

At least one site cited an example of bringing in an outside ethics expert to help think through how to deal with the hepatitis C drug dilemma, because they did not have an appropriate in-house forum for such a discussion:

We don’t have a formal way of dealing with ethical conflicts that might come up on the front lines. We actually are bringing someone in from the outside to help us think about Sovaldi, the hepatitis drug. When we had a discussion about this a few weeks ago, people really felt torn between doing the right thing and the financial impact…so we had an ethical discussion to try and understand some framework to think through this problem. But you know, I think it would be useful to have quarterly ethical grand rounds to deal with the ethical issues in managed care – and around how you provide for a population in a fiscally responsible way.

7.4 Link to Quality Improvement

A common trait of both the formal and informal mechanisms cropping up to address organizational ethics is a link to quality improvement. This vignette from a PCP describes the central role of quality improvement, both in terms of culture and practical tools and application:

We do lots of tests of change looking at what we are doing and the outcomes. A good example is hypertension. For years before Pioneer we were involved in payment projects that were moving towards this shared risk approach, so we’ve been measuring
hypertension for probably about eight or nine years. We tried to get individual physicians to improve hypertensive outcomes. We did a full improvement project around what is the right way to actually check a blood pressure (you have to let the patient sit for ten or fifteen minutes before you check the blood pressure, and their feet need to be flat on the floor). So we trained the nurses on the specifics about good hygiene around blood pressure measurement to get the right outcomes. We did that work and we found that we were controlling our hypertensive patients about 75% of the time. It wasn’t enough to get us to the eighty-one percent that Pioneer expected. Then we said, if someone goes to specialty we’re going to make sure that we capture that blood pressure and then we’re going to make sure algorithmically they get plugged back into the right setting of care. So if their pressure is 200/110 and they have a headache, they’re instructed to go to the emergency room right from orthopedics. Or if their blood pressure is 180/100 they are instructed to go down to nurse clinic where they get a free blood pressure check and intervention based on what the algorithm says and the algorithm typically will say if the blood pressure isn’t under control the nurse talks to the primary care doctor. And so we added that and we got to about 81%, so we hit the benchmark but we felt we could do it better. So we’ve integrated even more with different places in the community, and now we’re actually at about 87%. We’ve slowly added these parts in by using continuous improvement and PDSA cycles.

7.5 Issue Summary

The issue of limited support systems for ethical conflicts results in several dilemmas:

• Most sites have ad hoc, inconsistent support for ethical dilemmas that emerges on an “as needed” basis.

• There are few opportunities for relevant stakeholders to discuss and debate clinical and organizational ethical issues.

Three strategies emerged from the interviewees about how to deal with the issue of limited support systems for ethics conflicts:

• A few sites have formal organizational ethics committees (in addition to clinical ethics committees) that address systemic issues.

• Some sites are bringing in outside resources to consult on ethical dilemmas, as needed.
• Several sites formally link quality improvement programs to ethics committees in order to resolve the root causes of conflicts.

**ACO Rules that Impact the Ethics Environment**

Interviewees mentioned many Pioneer ACO program rules that get in the way of optimal performance. These barriers are not necessarily unethical on their own; however, they appear to be contributing to an environment where conflicts arise, and are therefore relevant to the overall findings.

**Patient choice versus attribution**

Much of the frustration expressed was rooted in the lack of control ACOs have regarding (1) patient choice, which reflects the fact that patients are not locked into an ACO and can seek care anywhere, and (2) patient attribution, which reflects the fact that ACOs do not know who is going to be attributed to them year over year. These two issues pose a risk to the entire Pioneer ACO program because it is yet to be seen how many sites will ultimately feel like they can manifest their own destiny. One administrator described the frustration of being at risk for costs from other providers:

> To me, what’s wrong with Pioneer is that we can’t control where the people that are attributed to us receive their care. They can go anywhere they want. They could move to Miami for six months a year, and we just paid for that, essentially. I want a narrow network or to be able to control where people receive care; otherwise I’m taking risk without really any ability to mitigate it.

**Benchmark calculations**

Another administrator described the challenge associated with how CMS calculates base years to establish spending benchmarks. The further the ACO moves away from the baseline year, the more risk is associated with taking on new patients whose health has not been managed and therefore require expensive resources:
I don't think we're going to do much more expansion of the Pioneer. Without getting into too many details, I think what we've learned is there's a downside to bringing in new players. For example, in 2012, the initial population we had, the base years were '09, '10, and '11, so CMS calculated our base cost on what happened in that year. You're only a year away from it so there's not much variation, but as you get further and further away, there can be a lot of cost changes that aren't reflected in the base line. And that's more pronounced as you bring in new members that haven't been managed in prior years. So it just makes it more difficult to hit a target.

Will Future Rules Impact Success?

Several interviewees also expressed fear regarding the uncertainty of how the Pioneer ACO program methodology will evolve. The primary concern is about any negative financial impacts resulting from future rules changes:

The thing keeping us up [at night] right now is the uncertainty in the program in terms of how it is going to evolve, as we are now currently in program year three and looking forward to program year four, how are the methodology and calculations going to change and evolve and how will we perform under that new methodology? We’re always in this state of uncertainty in terms of how we’re going to perform in the future, not necessarily because of what we’re doing or even our population, but more due to methodology. Is the methodology going to overrule all the work that we’re doing and lead to a poorer or better result through no fault or credit to us?

Overall sense of optimism

Despite the frustration expressed about the Pioneer ACO rules, the majority of interviewees were optimistic about the ACO model. Simply the fact that Pioneer ACOs are willing to take on the challenge of implementing a new model illustrates that they believe it is an idea worth trying. As one administrator put it:

How do we as an organization manage the inherent conflict between fee-for-service service and Accountable Care? How do we manage expectations with stakeholders when over half their business is pure fee-for-service and the rest is based on risk? Obviously the incentives are different in each of those worlds and trying to convince people that the right thing to do is to be completely payer agnostic. You ignore where the patient’s coming from, do the right thing for the patient and it’ll work out in the end.
Summary of ACO rules impacting the ethics environment

The Pioneer ACO program rules make it difficult for ACOs to control their own destiny. For example:

• Attributed patients can choose to receive their care anywhere that accepts Medicare.
• The ACO is accountable for the costs incurred by attributed patients, regardless of where the care was provided.
• The benchmark calculations used for determining shared savings are a disincentive to take on new, complicated patients.
• Current efforts to meet shared savings targets may not be sufficient to in the future if CMS changes its Pioneer ACO program methodology.

However, despite the worries and challenges the interviewees expressed regarding ACO rules, there was an overall sense of optimism that becoming an ACO is “the right thing to do.”
CHAPTER 5: DISCUSSION

In order to address its central questions of how the ACO model of care affects ethics conflicts in organizations that originally joined the Pioneer ACO program, this study examined three key questions:

1. What ethics conflicts arise in the Pioneer ACO model?
2. What ethics conflicts does the Pioneer ACO model mitigate?
3. How are Pioneer ACOs addressing ethics conflicts?

The key informant interviews were designed to provide insights into these questions from three different roles within a Pioneer ACO: administrators, primary care physicians, and specialist physicians. Because the ACO model is so new, no examples of similar studies and questions were found in the literature. Therefore, the goal of the key informant interviews was to develop a more detailed understanding of the types of conflicts being experienced or mitigated as a result of being a Pioneer ACO, and also to find out how any conflicts are being dealt with.

Pioneer ACO Ethical Dilemmas

Most of the seven major findings in this study suggest that the ACO model is creating or exacerbating ethical dilemmas; however, one finding (shifting resources to focus on prevention) appears to have a potentially mitigating effect among the primary care providers at the sites interviewed. Still, even this finding comes with unintended consequences.

The major findings can be grouped into three general themes, (1) financial survival, (2) patient outcomes, and (3) organizational approach to ethics, as illustrated in the following table:
### Table 12: Key Finding Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Corresponding Ethical Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Survival</td>
<td>1. Incompatible reimbursement models</td>
</tr>
<tr>
<td>Patient Outcomes</td>
<td>2. Two standards of clinical care</td>
</tr>
<tr>
<td></td>
<td>3. Financial incentives vs. patient choice</td>
</tr>
<tr>
<td></td>
<td>4. “Best” care disagreement</td>
</tr>
<tr>
<td></td>
<td>5. Required ACO metrics vs. evidence-based care</td>
</tr>
<tr>
<td></td>
<td>6. Shifting resources to focus on prevention</td>
</tr>
<tr>
<td>Organizational Ethics Approach</td>
<td>7. Limited support systems for ethical conflicts</td>
</tr>
</tbody>
</table>

**Financial Survival**

The concern about financial survival is paramount and is reflected primarily in the “two canoes” problem of revenues coming from two competing reimbursement models that have diametrically opposed incentives and metrics. The ACO program was designed to bridge this gap by continuing a FFS reimbursement while creating a shared savings incentive. The idea was attractive enough to appeal to hundreds of regular Medicare Shared Savings Program ACOs and the 32 original Pioneer ACOs; however, navigating the gap is very challenging as evidenced by the findings of this research and the fact that 13 sites have withdrawn from the Pioneer program.

Two strategies were evident at the interviewed sites to mitigate this “two canoes” dilemma:

- Capture more in-network referrals to keep patient volumes up.
- Engage physicians to design compensation models that reflect a fair balance of volume and quality.

Capturing more in-network referrals is necessary from the standpoint of trying to control the quality of care an ACO’s attributed patients receive. However, there is a risk of being motivated to keep the supply of existing resources utilized instead of attempting to right-size resources. This is a contributing factor in several recent ACO acquisitions of primary care resources.
practices (who are the ACO gatekeepers) to attempt to control patient referral streams. However, acquiring practices is likely a short term solution that only delays the need to right-size the supply and location of resources, and could prove to be expensive in the future if (1) fixed costs are added (including guaranteed physician compensation) and (2) the matching shared savings do not materialize.

The practice of engaging physicians to design compensation models that reflect a fair balance of volume and quality appears to be a good way to get their buy-in, as well as develop innovative, local solutions to a difficult problem. The target of ~20% variable compensation for quality reported by some interviewees seems to be an important step in the right direction. However, 20% is less than the Pioneer ACO program target of 50% of total revenues coming from outcomes-based contracts (see Table 4). An issue for further study is to identify the optimal target for variable compensation related to care quality.

The example of engaging stakeholders to figure out solutions to new problems is something ACOs could benefit from in all areas, not just compensation. New knowledge about implementing the ACO model is being gained at a rapid pace, and deciding what to do and/or how to communicate widely is proving to be a challenge. The sites in this study that are taking an approach of, “We’re all in this together” are naturally creating opportunities for institutional knowledge to emerge in organic ways. This is important because, as Bohmer and Lee write, the move towards paying for outcomes is a team endeavor: “In outcome-oriented organizations, production knowledge — how to go about improving patients' outcomes — is as much an organizational property as an individual one.”

Ultimately the issue of being in two canoes illustrates a transition between payment models, not a permanent state. The real question is: What is the tipping point when the ACO can...
shift from a productivity-based payment to a population based payment? There were no
definitive answers from the interviewees, but there was air of optimism associated with sticking
to principles and having faith that challenges such as patient attribution, patient turnover,
questions about the “appropriate” level of quality, etc. will be resolved over time.

**Patient Outcomes**

The theme of patient outcomes encompasses the majority of the findings, but many of
them leak into the financial survival realm. For instance, there is a lot of tension between
providing the right care at the right time and also making sure limited resources are allocated to
patients who are (or will be) attributed to the ACO. This creates a system with two standards of
care, which is a troubling dilemma for providers and highlights the ethical dilemma of focusing
on one patient versus being stewards of finite resources.

While two standards of care are rampant in almost every system, the ACO is drawing the
dilemma into sharp focus because eligibility is expanded to more Medicare patients who may or
may not be attributed to the ACO. As a result, many providers feel like they cannot simply direct
patients to forms of care based on who their payer is. It is particularly challenging because each
ACO does have an incentive to care for patients who might be attributed to it in the future, but
there is no certain way to predict future attribution (see Table 4 for patient attribution rules). An
additional challenge is that a patient whose health is primarily managed by a specialist within the
ACO may drop off the ACO’s attribution list if that provider is not eligible to be counted in the
patient attribution formula (see Table 4 for a list of eligible specialties).

The universal statements from the interviewees in this study about always providing the
best care regardless of payer type are most certainly aspirational, as every site still must triage
patients and allocate finite resources. However, the point of emphasis should be on an ethical and
fair process for allocating resources (versus an inconsistent or ambiguous process). For instance, combining some of the mitigation tactics observed in this study into a single solution to help triage and prioritize patients who meet clinical criteria (thereby making it easier to decide who is in/out of the care management program) could prove to be effective at reducing the distress associated with the two standards of care dilemma. For example:

- Use an objective points system to triage patients, with a buffer zone to accept non-ACO patients.
- Clearly define roles and responsibilities to maximize care management capacity.

These tactics would likely be even more effective if they were accompanied by an open dialogue within the ACO about how to address gaps between how patient care should be delivered (organizational aspirations), and how it is actually delivered.

The tension between financial incentives and patient choice also straddles the patient outcomes and financial line. The real issue should be about what is best for the patient, and in some situations patients (and physicians) will likely believe that going out of network will result in better outcomes. In an ideal system there would be transparent outcome metrics to objectively inform patient decisions. Such a level of transparency would create competition amongst providers to continually improve services and outcomes, including those in the ACO network.

The issue of disagreements regarding “best” care is present in any system that involves dividing up reimbursement (such as capitation, global payments, or bundled payments). The ACO model brings these issues to the forefront because of the in-network referral pressure and the emphasis on shifting care from acute care towards prevention. Every site in this study reported the use of specialty societies for guidance on recommended practices. As noted above regarding team effort to address compensation, the concept of cross-boundary teams making
decisions about best practices empowers people at the local level, and would likely benefit the spread of recommended processes.

The comments from specialists about “too much” care being shifted away from them (resulting in the risk of poorer outcomes for patients who receive specialty care too late) is a symptom of the pain associated with the health system rightsizing itself as it adjusts to new incentives. Research has proven that the oversupply of health care resources drives unnecessary spending and often results in poorer health.\textsuperscript{59} Theoretically rightsizing will be good both for (1) patients (assuming resources are realigned to produce better health), and (2) those who pay into the system (including taxpayers). At the same time, rightsizing may be painful for those whose jobs go away or change dramatically from what they like to do. It is important to note that rightsizing is not an ethical issue in itself. The cardiologist quoted in the results section may believe that doing the procedures is best for patients; if he is correct then the ethical issue is whether limits have been set in a fair and justifiable manner, and not the fact that his job is changing.

The problem of ACO metrics conflicting with evidence-based care (as defined in scientific literature) is also more complex that it first appears. It is unreasonable for ACOs to be penalized for doing the right thing, which could happen with measures such as blood pressure. The Pioneer ACOs interviewed have clinical teams that determine the best care when a conflict with metrics arises. This tactic could be enhanced by leaders emphasizing the importance of measures as part of creating a culture of performance, which frames the message more positively. However, the ethical issue is really about getting the ACO to measure the right things, which partly requires convincing CMS to allow flexibility for certain rules.
Another aspect of this issue is how to interpret and apply research findings (“evidence”). Physicians have a moral obligation to seriously consider “evidence-based” recommendations, and if a given recommendation will not be offered they must be able explain the rationale. However, providing every evidence-based recommendation is not affordable, so the question is ultimately about how ACOs should deal with limits. Well thought out, ethically justified limits may be unfortunate in some cases, but they are not “bad medicine.” A process is needed to discuss and determine these ethically justified limits (this idea is covered in more in the Organizational Ethics section, below).

The challenges associated with shifting utilization towards primary care settings are largely being dealt with by the ACOs implementing tools and defining roles to monitor patient populations and attempt proactively intervene when warranted. In addition to the technical challenges of this focus on population health management, there is also the very real issue of PCPs being asked to lead teams through the changing health care delivery landscape without having formal management, quality improvement, or leadership training. This is a serious issue for PCPs and all ACO stakeholders who depend upon the primary care clinics to quickly adapt to rapid delivery changes in order to manage the health of their attributed populations. Without the adequate skills to manage and lead in a rapidly changing environment, there is a risk of burnout.

Organizational Approach to Ethics

The issue of adopting an organizational ethics approach encompasses all of the findings discussed above. Taking an organizational approach requires leaders to (1) be aware of conflicts arising, and (2) implement processes and tools to provide continual feedback to monitor the organization and address root causes of conflicts.
This starts with leaders living the values of the organization, which is exemplified by the sites that provide time for reflection, discussion and training to tackle organizational challenges. Very few sites had any formal training programs for people who are asked to sit on committees or otherwise lead some aspect of the ACO program, which ultimately is not fair to either the individual or the organization. Physicians are seeking tools to be productive and helpful, but all too often the interviewees expressed a feeling of being over-burdened by all that they are being asked to do (including work with and manage teams, utilize EMRs, etc.). It is important to provide time to train and prepare for activities that are important to individuals and the organization; unfortunately, this competes with the constant pressure to generate higher volumes.

Most sites in this study had clinical ethics committees (although this fact was not always known to the providers interviewed). Only two sites had formal organizational ethics committees to address non-clinical ethical issues. A major recommendation from this research is for every ACO to have a deliberate and formal ethics support system that includes clinical, organizational, and where appropriate research ethics committees. These resources should be centrally available across entity boundaries so all ACO participants have access to needed support. Additionally, several physicians requested a forum to discuss and debate ethical issues with their peers and other ACO stakeholders.

Related to the issue of using an organizational ethics approach is the role of quality improvement, which can be the link between solving systemic problems and creating more time (or at least reducing stress) for busy providers. The sites with the most mature quality improvement programs were able to align overall ACO goals with the work of quality teams embedded within the clinics, which both supported and enabled the local physician leaders. Clarifying roles and giving teams the tools and training to assess problems, design solutions, and
test for results creates a culture of continual improvement that supports an ethical foundation for work.

**Underlying Message of Moral Distress**

Taken together, the findings of this study point to a **dominant refrain of moral distress expressed by physicians**. This should be a major concern to all ACO leaders because, as Pauly et al. examined, there is mounting evidence that “moral distress has implications for satisfaction, recruitment and retention of health care providers, and implications for the delivery of safe and competent quality patient care.” Additionally, Epstein et al. suggest that even after episodes of distress are initially mitigated, “repeated exposure to morally distressing events can result in such a buildup of moral residue that the healthcare provider eventually considers a drastic action such as conscientious objection or withdrawal from the profession.” This is described as a “moral residue crescendo,” which results from an accumulation of stress over time, as illustrated below:

**Figure 6: Model of the Crescendo Effect**

Moral distress impacts the well-being of the very physicians upon whom the ACO program depends. Some of the causes are by-products of well-intentioned actions, such as asking physicians to lead teams (often without any management training), capturing patient information in specific (and sometimes laborious) ways to help with reporting, deciding who should be
enrolled in care management programs, dealing with many change projects all once, etc. Such an environment could contribute to physician burnout, particularly for PCPs who are already in short supply.

**Mitigation Strategies**

During the course of interviews for this study, participants shared their strategies and tactics for mitigating the ethical issues they are experiencing. In most cases these were one-off solutions that were not consistently being performed across the various sites. The mitigation efforts are discussed above, along with the author’s suggestions for (1) combining ideas from multiple sites into hybrid solutions, and (2) extending the ideas to make them potentially more comprehensive and effective. This is summarized in Table 13 below. Implementing the recommended solutions is the subject of Chapter 6: Policy Implications & Plan for Change.
Table 13: Summary of Mitigation Strategies

<table>
<thead>
<tr>
<th>Ethical Theme</th>
<th>Mitigation Evidence at Sites</th>
<th>Potentially Enhanced Mitigation Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Survival</td>
<td>Incompatible Reimbursement Models:</td>
<td>• Be clear on the long-term goals to increase the quality of care with the right amount of resources.</td>
</tr>
<tr>
<td></td>
<td>• Capture in-network referrals.</td>
<td>• Focus on rightsizing the supply of necessary and appropriate resources.</td>
</tr>
<tr>
<td></td>
<td>• Engage physicians to develop compensation plans.</td>
<td>• Variable compensation models should be co-created with the impacted physicians.</td>
</tr>
<tr>
<td>Patient Outcomes</td>
<td>Two Standards of Care:</td>
<td>• Align mission/vision/values about patient care with actions and plans.</td>
</tr>
<tr>
<td></td>
<td>• Define new roles to handle population management tasks.</td>
<td>• Combine the tactics being used at the individual sites in order to create (1) more capacity with existing resources, and (2) a triage system that includes a buffer zone for those in need of care management programs.</td>
</tr>
<tr>
<td></td>
<td>• Streamline processes to match skills to tasks.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Use a triage point system to prioritize patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Allow buffer zones to accept non-ACO patients</td>
<td></td>
</tr>
<tr>
<td>Patient Choice</td>
<td>• Use in-house materials (e.g. brochures) to inform patients about ACO care management benefits.</td>
<td>• Collect and report objective outcome measures about referral partners to allow patients to make fully informed decisions.</td>
</tr>
<tr>
<td></td>
<td>• Use of shared decision-making tools.</td>
<td>• Utilize shared decision-making aids for top diagnoses.</td>
</tr>
<tr>
<td>“Best” Care Disagreements</td>
<td>• Look to specialty societies for best practice guidance.</td>
<td>• Develop local pathways with cross-boundary stakeholders.</td>
</tr>
<tr>
<td>Outdated Metrics</td>
<td>• Charge local teams to determine best clinical care.</td>
<td>• Develop communication paths to disseminate critical information.</td>
</tr>
<tr>
<td></td>
<td>• Embracing metrics to measure quality.</td>
<td></td>
</tr>
<tr>
<td>Shifting Resources Towards Prevention</td>
<td>• Monitor patient populations to proactively intervene.</td>
<td>• Emphasize the importance of measures in a culture of high performance.</td>
</tr>
<tr>
<td>Organizational Ethics Approach</td>
<td>Limited Support Systems for Ethical Conflicts</td>
<td>• Develop management and leadership training programs for physicians, practice managers, and nurse leaders.</td>
</tr>
<tr>
<td></td>
<td>• Organizational ethics committees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Quality improvement efforts to resolve systemic issues.</td>
<td>• Create a network of formal ethics resources that are accessible to all ACO partners, including organizational ethics committee and ethics forums.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Link quality improvement efforts to ethics issues.</td>
</tr>
</tbody>
</table>
Comparing ACO Ethics Findings to Fee-for-Service and Managed Care

To prepare for this study the author investigated the ethical dilemmas created by various payment models, and also created a conceptual model to illustrate where this research might contribute to questions about ethical conflicts created by the ACO model. The table below compares the findings of this study to the ethical dilemmas either confirmed (via other studies) or hypothesized about other payment models:

Table 14: Comparison of Results to Predicted Ethics Dilemmas

| MCO (from the literature review) | Evidence in this Study?
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure to deny care/undertreat</td>
<td>YES</td>
</tr>
<tr>
<td>“Gags“ on recommending specific treatments</td>
<td>YES</td>
</tr>
<tr>
<td>Patient not fully informed</td>
<td>YES</td>
</tr>
<tr>
<td>Unable to do what’s best for a patient</td>
<td>YES</td>
</tr>
<tr>
<td>Cause harm with inappropriate guidelines</td>
<td>YES</td>
</tr>
<tr>
<td>FFS (hypothesized)</td>
<td></td>
</tr>
<tr>
<td>Financial incentives to over treat</td>
<td>PARTIALLY</td>
</tr>
<tr>
<td>Emphasize volumes of sick patients vs. wellness</td>
<td>NO</td>
</tr>
<tr>
<td>Few ramifications for poor quality care</td>
<td>NO</td>
</tr>
<tr>
<td>Little incentive to be cost-effective</td>
<td>NO</td>
</tr>
<tr>
<td>ACO (hypothesized)</td>
<td></td>
</tr>
<tr>
<td>Patient autonomy versus shared savings</td>
<td>YES</td>
</tr>
<tr>
<td>Cost shifting (market power)</td>
<td>--</td>
</tr>
<tr>
<td>Sharing of benefits amongst stakeholders (including compensation)</td>
<td>YES</td>
</tr>
<tr>
<td>Resource allocation (focus on most in need, or most likely to benefit?)</td>
<td>YES</td>
</tr>
<tr>
<td>Physician autonomy to make decisions</td>
<td>YES</td>
</tr>
</tbody>
</table>

The results of this study indicate that there is a risk of experiencing all of the ethical dilemmas that exist in the MCO model. While the ACO model attempts to put checks in place to ensure quality is paramount, interviewees in this study still expressed concerns about financial pressures, patient communications, and outdated measures that could result in inferior care. This should be a red flag for ACO leaders to address these concerns head-on.

The results indicate that the ACO model is mostly addressing the ethical dilemmas commonly associated with FFS payment models. However, the conflict created by the continued
reliance of Pioneer ACOs on FFS volumes to stay in business does create an incentive, at least temporarily, to over-treat. This presents ACO leaders an opportunity to communicate the desired future state (which will alleviate FFS ethical dilemmas) while working through any present difficulties associated with the two canoes problem.

The hypothesized ACO ethics issues were largely present in the results of this study, with cost shifting not being mentioned by any interviewees (but also not asked about). Specialist physicians in particular mentioned not having seen a shared savings payment from the ACO (sharing of benefits) and the loss of autonomy.

**Revised Conceptual Model**

The result of this study did inform the conceptual model, which is updated below to reflect the impact of the key findings:

**Figure 7: Updated Conceptual Model with Study Results**

Recognizing that these results are from a small sample, were derived qualitatively, and must be confirmed by future research, it is important to note the incompatible reimbursement models are likely a temporary issue, as the Pioneers will either (1) reach the tipping point and rely less and
less on FFS, or (2) will drop out of program and react to whatever payment models CMS comes up with in the future. The one issue that seems obdurate is disagreements about “best care,” as health care will always involve humans who have different opinions. However, the study results did indicate a general effort by the physicians interviewed to identify, communicate and use more evidence-based practices.

**Limitations of this Research**

This study has limitations that are typically found in key informant interview methods, and several that are specific to this effort. The primary issue was selection bias introduced by the relatively small sample size and the sampling methodology. This limitation was partially addressed through purposeful inclusion of three different roles at each of the seven sites; however, the domain of sites were all high-performing health care systems, the people willing to be interviewed were keenly interested in the Pioneer program, and in many cases the request for an interview came from a superior. Other limitations include:

- Contacts at all 32 Pioneer ACO sites were gathered through public sources. As a result emails were sent to people at various levels within the organizations. In some cases responses came from CEOs, and in some cases from the ACO administrators. Since there was not a public “contact” list to reach each Pioneer site, it is possible that requests to participate did not make it to the appropriate decision makers at the 21 sites that did not respond.

- The role of the “specialist” at each site was not consistent, as evidenced by the combination of cardiologists, a general surgeon, and a psychiatrist. The representation of three different types of specialties may have resulted in a wide range of answers that would have been more consistent were the same type of specialist contacted at each site.
A general limitation of the key informant interviews includes the fact the study relies heavily upon the knowledge, expertise and opinions of those interviewed. The key informants were most likely biased in their responses (even unintentionally so) due to the presence of the researcher or to the interviewee’s role in the Pioneer ACO program. A specific limitation to this study was the researcher’s role as both a graduate student at UNC and an employee of The Dartmouth Institute for Health Policy & Clinical Practice, which is well known for its research on ACOs. This dual role was explicitly disclosed to all participants; however, it likely introduced both selection and response bias.

An important limitation of the results of this study is that no patients or nurses were interviewed. The perspectives of both of these stakeholder groups are essential to investigate in future studies. Given the frustration expressed by the Pioneer ACOs regarding patient engagement, it is especially important to understand the patient perspective and nurse-patient dialogue.
CHAPTER 6: POLICY IMPLICATIONS AND PLAN FOR CHANGE

Opportunity

The findings of this study suggest that the Pioneer ACO model does create (or exacerbate existing) ethical conflicts, and also has the potential to mitigate some conflicts. These findings also suggest that there is a substantial amount of ambiguity and uncertainty associated with how to create clinical and business systems and processes that support an ACO, how to manage and communicate the change, and how to deal with the ramifications of rightsizing and reallocating resources. These are not easy challenges and there are not any definitive answers. The sum of the issues identified by this study is an underlying sense of moral distress experienced by physicians; this is despite an overall sense of optimism associated with the ACO model because it is “the right” way to provide care. This presents ACO leaders both an (1) urgent challenge to reduce physician moral distress, and (2) opportunity to leverage the enthusiasm expressed for the overall ACO goals of better patient outcomes at lower costs.

The following plan for change has two parts. Part one suggests addressing the core problem of moral distress by establishing an organizational ethics foundation upon which to make deliberate, transparent and fair decisions regarding issues for which there is “some evidence that indicates an action would be morally wrong and some evidence that the same action would be morally right, but all the evidence, taken as a whole, is not conclusive.” Part two addresses specific mitigation strategies for the remaining key findings in this study, each of which contributes in some way to moral distress.
Part 1: Organizational Ethics Foundation

An important dynamic of the ACO model is that it encourages the creation of partnerships to work together to improve the health of patients. This can result in a web of entities that transcend physical walls, and creates a challenge to address ethical conflicts together in a systematic, deliberate, and consistent way. Many (but not all) larger hospitals have clinical ethics committees, and a few have organizational ethics committees that look beyond isolated cases to the systemic problems that created the situations. The specific challenge inherent in the ACO model is to create mechanisms that result in a culture of ethics across a distributed environment. A fundamental ethical question leaders are faced with is, “Are ACOs morally obligated to provide effective ethics resources?” The results of this study suggest that the answer to this question is, “Yes,” and it starts with embracing ethics as part of an ACO’s culture. The purpose of part one of this plan for change is to help current and future ACOs create an ethical culture that is reflected in all business and clinical activities.

Leadership Commitment to an Ethical Organization

The findings of this study suggest that there is a strong imperative for leaders to explicitly address ethics support systems while implementing the ACO model. However, few of the Pioneer ACOs interviewed have proactively addressed ethics as part of their change plan. Therefore it is important to raise awareness amongst ACO leaders to establish a sense of urgency for action. This requires asking C-level administrators and physicians to view their decisions and actions through an organizational ethics lens, which should reflect the vision and mission of their respective ACOs. Rorty reminds us of the connections between leaders “walking the talk” and the success of the organization.51
1. Decisions made by individuals in the organization have ethical implications for 
organizational morale, reputation, and viability.

2. Decisions made and actions taken on the organizational level have ethical 
implications for individuals in the organization.

3. The operation of the organization has ethical implications for the social environment 
within which it operates.

In order to raise awareness about gaps in an ACO’s ethics support infrastructure, the 
results of this study were used to create an “ACO Ethics Readiness Self-Assessment” checklist 
(see Table 15 on the next page). This tool is meant to help ACO leaders establish a baseline for 
their current ethics support readiness, and to provide guidance for moving forward:
### Table 15: ACO Ethics Readiness Self Assessment Checklist

<table>
<thead>
<tr>
<th>Assessment Item</th>
<th>What To Look For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the ACO make a firm commitment to ethical decisions and actions via its mission statement, vision statement, or core values?</td>
<td>The ACO should make an explicit commitment to ethical concepts such as fairness, effective care, stewards of resources, patient autonomy, etc.</td>
</tr>
<tr>
<td>Does the ACO’s scorecard of critical measures reflect the commitment to ethics stated in the mission/vision/values?</td>
<td>Critical measures reflect what’s most important to the ACO. How are ethical decisions and actions reflected in its measures? Do the measures focus on variables that could lead to conflicts and cause distress for clinicians? The measures reflect whether the leaders walk the talk about “doing the right thing.”</td>
</tr>
<tr>
<td>Do all the partners in the ACO have access to organizational ethics resources that are focused on resolving systemic issues?</td>
<td>There should be robust support for resolving ethical issues, including an organizational ethics committee and forums for discussions and debates with multiple stakeholders. Smaller entities should have access to the ethics resources of larger ACO partners, including to their clinical ethics committees.</td>
</tr>
<tr>
<td>Are quality improvement efforts linked to the organizational ethics committee?</td>
<td>Issues that are brought to the organizational ethics committee’s attention should get a formal quality improvement plan, and explicit measures of success should be tracked over time.</td>
</tr>
<tr>
<td>Do physician compensation models incentivize quality of care? Have physicians been involved in creating the models?</td>
<td>The level of variable compensation reserved for quality patient outcomes should evolve over time to reflect the ACO’s outcomes-based reimbursement contracts. Physicians should be involved in creating compensation models that they feel are fair and achievable.</td>
</tr>
<tr>
<td>Has every specialty in the ACO agreed standard care pathways for its top five most common interventions?</td>
<td>Specialists should communicate with each other and others to locally determine the best care for the most common scenarios. There should also be a mechanism to identify new scenarios that need to be addressed by specialists and/or interdisciplinary teams.</td>
</tr>
<tr>
<td>Do clinicians feel like they can have honest conversations with patients about the best care options?</td>
<td>Does the ACO have formal shared decision-making aids for the top three procedures/interventions in each section or clinic? Does the ACO track and publish relevant procedure and outcomes measures for referral partners? Is physician-patient trust being measured?</td>
</tr>
<tr>
<td>Does the ACO allocate its care management resources to those most in need?</td>
<td>The ACO should optimize its resources by creating efficient teams that have clearly defined roles, and the appropriate role performing each task. It should also have a triage process for allocating care management resources, with a buffer zone to take non-ACO patients.</td>
</tr>
</tbody>
</table>
Organizational Ethics Infrastructure

This study revealed three critical components every ACO should consider as part of its organizational ethics infrastructure:

• An organizational ethics committee.
• A link between quality improvement and the organizational ethics committee.
• A regular forum for discussing and debating ethical issues with key stakeholders.

These resources should be available to everyone associated with the ACO, including smaller partners who do not have the resources to create their own components.

Several sites interviewed for this study indicated a mixture of clinical and organizational ethics resources, without a clear distinction between the two. The primary function of the organization ethics committee should be to address systemic issues, whereas the clinical ethics committee should handle individual patient cases. Clinical cases are generally more urgent, but they may be signals of deeply rooted problems that the organization committee should address. It is especially important for the organizational committee to consider the entire scope of ACO partners, as many challenges result from hand-offs across boundaries. One site reported a formal training program for people who are joining committees, which is an excellent practice to prepare people for new roles. This training can include systems thinking and quality improvement, as suggested by Nelson at al. as part of specific steps recommended to better link ethics and quality within an organization: 13

• Cultivate the collaboration between clinical staff, quality improvement professionals and ethics committee members to capitalize on the synergy of quality and ethics aims, including examining opportunities to jointly address recurring clinical ethics issues.
• Review and expand the current functions of ethics committees in light of the
preventive ethics literature.

- Expand the knowledge and skills of ethics committee members to include competency in system thinking and the application of quality improvement methods to enhance ethics quality.

- Consider the inclusion of ethics conflicts in the organization’s quality improvement priorities. Specifically, organizational leaders should encourage identification of recurring ethics conflicts and the addressing of those conflicts as part of the organization’s improvement plan.

Several interviewees expressed the desire for an organized, regular forum to discuss ethical issues. This is an important idea to encourage communication and trust building. As Rorty says, “Open discussion and transparency within leadership, and between leaders and their constituent members, contribute to an organization’s ability to move with mutual understanding toward shared goals.”\(^{51}\) This is especially relevant as the practice of medicine becomes more fragmented (even in the face of the ACO obligation to collaborate more and share information), as exemplified by hospitalist programs that effectively keep PCPs out of the hospital where they were formerly able to talk face-to-face with specialists and other clinicians. This study did not reveal any ethics forums that have been specifically crafted to meet the needs of ACOs; however, there are some promising models such as Harvard Pilgrim Health Care’s Organizational Ethics Program that can serve as a starting point for creating forums that are adapted for ACO needs.\(^{52}\) It is imperative that each forum appeal to a local audience, so key variables will differ from site to site. For instance, each forum should decide meeting frequency and location, who is invited, who runs the meeting, how the agenda is set, whether remote people can conference or video in, and how conclusions from the meeting are managed and shared (the level of transparency).
Overall, the majority of the physicians interviewed for this study communicated a strong desire for organizational ethics forums and committees. This indicates the potential for organic growth of an organizational infrastructure that could be warmly embraced by providers who view it as a welcome relief versus an additional requirement.

**Learning Collaborative**

Given the infancy of the ACO program, it is also important to share key practices and critical learnings amongst a wide audience. To this end, a major component of this plan for change is to establish an organizational ethics learning collaborative to share ideas and lessons learned beyond individual ACOs. The purpose will be for members to share what they are working on, how they are addressing ethical challenges, what is working, what has not worked, and to engage other members in discussion and feedback. The output will be whitepapers and presentations for members to use and share. To create this learning collaborative the author aims to secure the support of The Dartmouth Institute to launch the effort, and grant support from organizations such as the Hastings Center to fund it. Raising awareness of ACO ethics issues is critical to getting leaders to take actions, and sharing solutions will make leaders more likely to engage.

**Policy Change**

All of the Pioneer ACOs interviewed for this study are providing feedback to CMS about the program. However, in response to the study’s findings that limited attention is given to organizational ethics, the author recommends that CMS include a new requirement in the ACO application process related to organizational ethics support systems. Specifically, aspiring ACOs should be required to:

1. Use the “ACO Ethics Readiness Self-Assessment Checklist” to assess its current
state.

2. Create a quality improvement plan to address any ethics readiness gaps.

3. Monitor progress and take corrective actions to implement organizational ethics activities that adequately support physicians and staff working in an ACO.

The organizational ethics program activities could be self-reported by the ACO and submitted to CMS as part of regular program assessments.

**Part 2: Implementing Mitigation Strategies for the Key Findings**

Establishing a foundation of organizational ethics creates a framework and support for addressing ethical dilemmas. Part 2 of this plan for change addresses the specific key findings identified in this study, all of which create some form of moral distress. From an operational standpoint, below are recommended mitigation strategies for the key findings associated with the themes of financial survival and patient outcomes:

**Financial Survival**

1. **Incompatible reimbursement models.**

   This issue results in the question, “Can an ACO provide efficient, equitable care when reimbursement relies upon conflicting financial incentives?” At face value the answer to this question appears to be, “No.” However, there are few ways to mitigate the distress while awaiting a dominant reimbursement model to emerge:

   - First is the idea of replacing lost FFS volume by capturing all the available in-network referrals (and therefore more volume) to utilize existing capacity. This is a viable strategy assuming the ultimate goal is to provide the necessary and needed care for the attributed patient population. However, there is a risk of temporarily replacing FFS volumes without addressing the fundamental infrastructure problem of excess
capacity. The ACO should be clear on its long-term goals to increase the quality of care with the right amount of resources, versus avoiding the short-term pain of rightsizing.

- The practice of engaging physicians to develop compensation plans encourages shared goals and physician buy-in.

Patient Outcomes

2. Two standards of clinical care.

This issue results in the question, “Can an Accountable Care Organization morally justify two standards of care?” This is an incredibly difficult issue because it gets to the heart of the Hippocratic oath for physicians. An argument can be made that patients in different insurance systems are different from each other in relevant ways (for instance, one is part of an ACO and the other is part of a FFS plan). The ethical problem is more for society – do we want to clump people in these different ways. Physicians feel the impact of this societal problem, but they are not in a position to solve it on their own. There are a few ways to help mitigate this distress:

- Fundamentally, the ACO should have open conversations about its alignment of publicly stated mission/vision/values statements regarding patient care, and its actions. It is important to be transparent in this debate and invite all stakeholders to participate in order to develop trust and credibility.

- Defining new roles to handle population management tasks, then streamlining processes to match skills to both administrative and clinical tasks can potentially create additional capacity to treat more patients with the best possible care.
• It is also possible to create a triage system that uses points to objectively prioritize patients, and allow a buffer zone to include non-ACO patients in need of care management programs (one interview site used a 5% buffer).

3. Financial incentives vs. patient choice.

This issue raises the question, “Do financial incentives influence physicians to present information in ways that affect patient autonomy?” This is a difficult issue because every physician wants to say, “No,” but in reality incentives are prevalent in patient communication (even if simply knowing who the payer is to determine which options might be covered).

There are a couple of ways to mitigate this issue:

• As much as possible ACOs should use decision aids to ensure that patients are fully informed and making decisions that are aligned with their own values and goals.

• Part of helping patients make fully informed decisions is providing them with objective performance results about the ACO’s referral partners. This type of information is not widely available, and should be a priority to procure in order to create as much transparency as possible.


This issue raises the question, “In what ways do financial incentives influence clinical judgments?” Again, the default answer from the interviewees was, “Financial incentives don’t influence clinical judgments.” However, the results of this study indicate that there are disagreements about care, and at least some suspicion that some positions are financially motivated. There are several ways to mitigate this issue:
All of the Pioneer ACO sites interviewed were looking to specialty societies for guidance regarding best practices. However, this does not necessarily address cross-specialty hand-offs.

For the cross boundary hand-offs, it is important to develop local pathways that are agreed upon by the relevant stakeholders. There should also be a mechanism for identifying breakdowns and opportunities to develop new pathways (this can be done via quality improvement efforts).

All the work to resolve disagreements will be for naught unless communication plans are created to disseminate critical information and decisions. This should be done in a deliberate way that uses multiple media (face to face meetings, emails, newsletters, etc.) to meet people where they are most likely to pay attention.

5. **Required ACO metrics vs. evidence-based care.**

This issue raises the question, “Do physicians have a moral obligation to interpret and apply evidence-based care?” The short answer to this is “Yes,” but it is not practical because no physician could possibly keep up with all the literature. However, it is also incumbent upon a physician to be able to defend a decision to not use known evidence-based care. There are a couple of strategies to help mitigate this issue:

- The first is to charge local teams to determine the best clinical care. This encourages collaboration and communication, and with a goal of establishing the best care it also creates clinical debates that result in investigation and learning.

- A number of physicians interviewed also commented on the importance of measures in a culture of high performance. This is something that should be emphasized and openly
promoted by leaders across the ACO. The more transparency of fair and accurate measures, the more opportunity there is to have open dialogue and continually improve.

6. **Shifting resources to focus on prevention.**

This issue raises the question, “Does the shift of ACO resources towards preventive care result in better patient outcomes?” At face value this is a question that could be objectively studied over time to determine the answer. However, there are several factors that could influence the results depending upon how they are dealt with at the clinical level. These factors also potentially mitigate distress, as follows:

- All the Pioneer sites interviewed had tools and systems to monitor patient populations in order to proactively intervene with individual patients to prevent acute episodes. Such capacity is critical, along with the requisite roles to perform the relevant tasks (data management, patient contact, clinical encounter, etc.).

- An issue for ACO physicians (as well as practice managers and nurse leaders) is to gain the knowledge and skills necessary to perform in this new team-based, population health-centric care model. Creating or hiring vendors to deliver ACO management and leadership training can accomplish this.

These ideas for mitigating ethical issues created by the Pioneer ACO model are meant to be a starting point to determine what works best in this new model of care. Many of the sites interviewed for this study are already utilizing one or more of these ideas, but no site interviewed had put them all into practice. It is important to recognize that a strong organizational ethics infrastructure creates the foundation for mitigating ethical issues in a fair, deliberative manner. Additionally, ACOs can clearly learn a lot from each other, and it is the author’s hope to facilitate a national conversation through the ACO Organizational Ethics Learning Collaborative.
ACO Leader Map for Creating a Culture of Ethics

The following plan reflects a potential roadmap for ACO leaders to create an organizational ethics program that is comprehensive, deliberate, and impacts all partners and stakeholders. The steps are framed using Kotter’s 8-step model, and are presented as a set of promising ideas and practices to guide ACOs wishing to establish a foundation of ethics to proactively address difficult operational and clinical conflicts:

Figure 8: Kotter's Eight Phases of Change


Step one is to establish a sense of urgency, which Kotter argues must go beyond one’s sense of reason and appeal directly to the heart. Ethics topics certainly can appeal to the heart, but must be framed carefully to avoid unnecessary controversy (such as when a discussion about unhelpful end-of-life interventions gets framed as a discussion about “death panels”). Additionally, the word “ethics” itself can be a stumbling block because it often connotes accusation, such as “you are an unethical person.” To create a sense of urgency, a business case can be made to show the financial impact of ethical conflicts on the bottom line of an organization. Nelson et al. suggest a framework for understanding the potential costs of ethical conflicts on organizational performance, including variables such as efficiency, wages, turnover,
Additional measures associated with wasted resources can also be monitored, such as avoidable complications, avoidable hospital stays, and low value care (e.g. the http://www.choosingwisely.org/procedures lists). While the results will vary amongst organizations, these measures will point to unjustified physical and fiscal harms associated with the moral distress created by the key findings of this study.

The second step is to create a guiding coalition, as sustainable change is best tackled by groups of people versus individuals. To create awareness that leads to change based on this research it will be necessary to network with respected ACO and ethics experts. Wheatley says, “It is not the law of large numbers or critical mass that creates change, but the presence of a small disturbance that gets into the system and is then amplified through networks.” 55 One way to accomplish this is to participate in the ACO Organizational Ethics Learning Collaborative, as
described above. And from a practical standpoint, the “ACO Ethics Readiness Self-Assessment” checklist will allow ACO leaders to understand their respective baselines in order to craft appropriate improvement plans.

The third step is to develop a change vision. This is an iterative process, as incorporating the wisdom of the ACO’s internal coalition of stakeholders is crucial. It is important to share the mitigation strategies that this study described, recognizing that they may not be universally applicable but they do illustrate promising examples of success.

The fourth step is communicating a compelling vision in order to create buy-in. A key message is that ethics are not separate – they must be integrated into existing processes and systems to support the work of all physicians, staff and administrators. Since actions speak louder than words, the message will be best heard after there are specific success stories to highlight. This will require documenting examples of interventions that mitigate ethics issues, and then measuring progress. If The Dartmouth Institute supports the proposed learning collaborative, a possible channel for communicating these successes is through the High Value Healthcare Collaborative, which includes high-profile institutions that are committed to learning from each other and sharing best practices widely. Additional channels are through journals and ACO conferences.

The fifth step is empowering broad-based action. For an organization this includes removing structural barriers (such as communication silos created by reporting structures) and individuals (such as an ethics committee chairperson who does not want to consider a broader, organizational view). The mitigation strategies suggested for the key findings of this study can be incorporated immediately, as appropriate at each site.
The sixth step is generating short-term wins. Valuable and achievable short-term wins will include assessing and improving a commitment to organizational ethics, and progress mitigating any of the key ethical issues identified in this study. Also, simply having a public conversation that acknowledges the moral distress associated with an ACO is an important step in creating a culture of transparency and trust. As Wheatley says, “…stating, clarifying, reflecting, modeling, filling all of the space with the messages we care about…[then] a powerful field develops – and with it, the wondrous capacity to organize into a coherent, capable form.”

The seventh step is persistence, or not letting up. Related to this research, celebrating small successes (step 6) will be important, but the bigger goal is creating national awareness. So even if a handful of ACOs make significant strides towards addressing ethics conflicts, there will always be more that have not started. Generating some momentum and taking an active role in the proposed national learning collaborative will be key to sustaining the energy to be persistent.

The eighth, and last step is to make it stick. Success here means true cultural change. The key measure of cultural change is achieving high value care and high physician, staff, and patient satisfaction scores.

The following table summarizes this proposed eight-step roadmap for ACO leaders to create a comprehensive organizational ethics program:
<table>
<thead>
<tr>
<th>Change Step</th>
<th>Recommendation(s)</th>
<th>Goal(s)</th>
<th>Specific Action(s)</th>
<th>Measure(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase urgency</td>
<td>• Frame message re. mitigating unjustified physical &amp; fiscal harms, and moral distress.</td>
<td>• Get doctors/ leaders to align organizational decisions/ actions with vision and mission.</td>
<td>• Use the ACO Ethics Readiness Self-Assessment checklist tool.</td>
<td>• Completed self-assessment and a related plan of action to address any gaps.</td>
</tr>
<tr>
<td>2. Build coalitions</td>
<td>• Network with ACO and ethics experts to support a proactive approach to organizational ethics.</td>
<td>• Engage with high profile experts to create a culture of ongoing learning and collaboration.</td>
<td>• Participate in the ACO Organizational Ethics Learning Collaborative</td>
<td>• Active participation in the learning collaborative.</td>
</tr>
<tr>
<td>3. Vision</td>
<td>• Present a future for addressing ethical issues that is both desirable and achievable.</td>
<td>• Meet the expressed need to safely discuss, resolve, and learn from organizational ethics issues.</td>
<td>• Identify and describe effective organizational ethics forums.</td>
<td>• Approved plan for building or enhancing organizational ethics capacity.</td>
</tr>
<tr>
<td>4. Communication</td>
<td>• Affirm that ethics is built into every decision and action – it is not a separate committee.</td>
<td>• Create a culture that embraces and incorporates ethics.</td>
<td>• Document success stories of interventions that mitigated ethics issues.</td>
<td>• Internally and externally shared measures of success and progress; vignettes of success stories.</td>
</tr>
<tr>
<td>5. Enable action</td>
<td>• Remove structural and personnel barriers.</td>
<td>• Create a positive environment for organizational ethics to take root.</td>
<td>• Use the ACO Ethics Readiness Self-Assessment checklist to help identify issues related to structures and roles.</td>
<td>• Streamlined and effective organizational ethics support infrastructure.</td>
</tr>
<tr>
<td>6. Quick wins</td>
<td>• Achieve a few successes quickly to build momentum.</td>
<td>• Improve the ACO’s approach to reducing moral distress.</td>
<td>• Implement action plans to address organizational ethics infrastructure gaps.</td>
<td>• Specific project plans to address gaps, with progress reports.</td>
</tr>
</tbody>
</table>
| 7. Persistence | • Use the small successes to create ongoing momentum. | • Create national awareness regarding ACO organizational ethics opportunities. | • See above re. quick wins, national learning collaborative | • An effective organizational ethics infrastructure  
  • Participation in the national collaborative. |
| 8. Make it stick | • Do not stop working on creating an ethical culture. | • Achieve true, sustained cultural change. | • Track ACO metrics of high value care, and physician, staff and patient satisfaction. | • Achieve high value care and high physician, staff, and patient satisfaction. |
APPENDIX 1: ACO QUALITY MEASURES

This complete list is available on the CMS Web site: 23

ACO Quality Measures for Better Care for Individuals

1. Patient/caregiver experience (7 measures)
   - Getting Timely Care, Appointments, and Information
   - How Well Your Providers Communicate
   - Patients’ Rating of Provider
   - Access to Specialists
   - Health Promotion and Education
   - Shared Decision Making
   - Health Status/Functional Status

2. Care coordination/patient safety (6 measures)
   - Risk Standardized All Condition Readmission
   - Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults
   - Ambulatory Sensitive Conditions Admissions: Heart Failure (HF)
   - Percent of Primary Care Physicians who Successfully Qualify for an EHR Program Incentive Payment
   - Medication Reconciliation
   - Falls: Screening for Future Fall Risk

ACO Quality Measures for Better Care for Populations

3. Preventive health (8 measures)
   - Influenza Immunization
   - Pneumococcal Vaccination for Patients 65 Years and Older
   - Body Mass Index (BMI) Screening and Follow Up
   - Tobacco Use: Screening and Cessation Intervention
   - Screening for Clinical Depression and Follow Up Plan
• Colorectal Cancer Screening
• Breast Cancer Screening
• Screening for High Blood Pressure and Follow Up Documented

4. At-risk populations (12 measures)

• Diabetes Mellitus Composite (All or Nothing Scoring):
  ▪ Hemoglobin A1c Control (8 percent)
  ▪ Low Density Lipoprotein Control
  ▪ High Blood Pressure Control
  ▪ Tobacco Non-Use
  ▪ Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and Ischemic Vascular Disease

• Diabetes Mellitus: Hemoglobin A1c Poor Control

• Hypertension (HTN): Controlling High Blood Pressure

• Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (100 mg/dL)

• Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

• Heart Failure: Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

• Coronary Artery Disease (CAD) Composite (All or Nothing Scoring):
  ▪ Lipid Control
  ▪ Angiotensin - Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF 40%)
A. Welcome

Thank you for agreeing to participate in this interview to discuss the ethical conflicts that might arise or be mitigated by becoming an ACO. I am Craig Westling, a student in the UNC Doctor of Public Health Program. I am also a Managing Director at The Dartmouth Institute. The information I collect as a part of this study is for my dissertation research at UNC, not part of my work at Dartmouth.

I may publish portions of the dissertation, in which case the findings would become publicly available. This interview will be completely confidential and any information you provide will be released only as group summaries or as anonymous, non-identifiable quotes. Your name will not be connected to your answers. In order to fully capture your responses today, I would like to record our conversation. All tapes and transcriptions will be destroyed at the end of the research study. Do I have your permission to record our conversation?

[If yes]: Thank you. If you would like to have me stop the recording at any point in our conversation, please let me know and I will stop the recording. [Begin recording]. This interview is now being recorded.

B. Introduction

Thank you for agreeing to talk to me and participate in this research study. The purpose of this interview is to explore ethical conflicts that are either created or mitigated by becoming an ACO.

- *When I ask about “ethical conflicts” you might experience, I really mean, “What are the issues you deal with at work that get under your skin and keep you up at night?”*

I am interviewing about 15 people for this study, which includes up to three people at each of at least five different ACOs. The interview should take about 30 minutes. Do you have any questions about the research study or the interview?

C. Key Informant Interview Questions

**Background Questions**

1. What is your title and role?
2. How have you been involved in implementing the ACO?

3. What are the values of the organization? How do they impact your work?

Ethics Conflicts Questions

4. How do care reimbursement models (such as fee-for-service, capitation or shared savings) affect your actions at work?
   a. What conflicts does this create?
   b. Would these conflicts be mitigated in another reimbursement model?

5. How is your job performance currently evaluated?
   a. Does this create any conflicts for you?

6. Has becoming an ACO changed (or will it change) the way your job performance is evaluated?
   a. Does this change either create or mitigate any conflicts for you?

7. Are you aware of any other ethical conflicts that have arisen specifically as a result of becoming an ACO?
   a. Why didn’t those ethical conflicts exist before? What has changed?

8. Are you aware of any other ethical conflicts that have been mitigated specifically as a result of becoming an ACO? Please explain.

9. There are some specific healthcare practices that commonly raise ethical challenges. I would like to ask you about the practices that we haven’t discussed yet, to see if you think they are impacted by becoming an ACO:

   Domains

   Business Ethics
   • Have you seen a change in how often conflicts of interest occur, such as incentives to increase or decrease services?
   • Have you noticed a difference in how resources are being allocated? (Probe: e.g. rationing care)
   • Has access to care changed for patients, such as access to needed specialized caregivers or services?

   Professional ethics
   • Have any of your professional standards been impacted? (Probe: e.g. practicing defensive medicine; conflicts with facility policies)
   • Have patient-provider relationships changed, such as disagreements over plans of care?

   Decision ethics
   • Are shared decision-making processes being used any more or less? (Probe: e.g. a formal program to base clinical decisions on patient values and their full understanding
Clinical ethics

• Have **treatment decisions been altered** specifically to meet ACO requirements?
• Has the approach to **end of life** treatment changed? *(Probe: e.g. withholding or withdrawing life-sustaining treatment; pain management)*

Organizational ethics

• Is there a **formal process** to deal with ethical conflicts in your ACO?
• Does your ACO have an **ethics training** program? *(Probe: is it mandatory? Who is eligible to participate?)*
• What **ethics resources** are available to you? *(Probe: Training; Internet-based materials, hardcopy resources, ethics committee case consultations; Are these resources helpful in your practice?)*
• What additional ethics resources would you find useful?

End Question

10. Is there anything else that would be helpful for me to know about ethical conflicts being created or mitigated by ACOs?

D. Conclusion

Thank you for your time today. The information and insights you shared will be valuable to my study. After my dissertation has been approved and accepted by UNC, I plan to write a few articles. I will plan to send you anything I write up, and I will be very interested in your reactions and suggestions.
APPENDIX 3: INTERVIEW CONSENT FORM

Interview Consent Form

Title of Study: An Examination of Ethics Conflicts in Pioneer Accountable Care Organizations

Investigator: Craig R. Westling, MS, MPH, DrPH (candidate) Department of Health Policy and Management, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.

Purpose:
1. Explore the ethics conflicts that arise and/or are mitigated by implementing a Pioneer Accountable Care Organization (ACO) reimbursement model.
2. Explore how Pioneer ACOs address ethics conflicts.

Potential Benefits:
The research is designed to benefit the greater healthcare system and population health by gaining new knowledge about the impact ACOs have on ethics. You may not benefit personally from participating in this research study. However, you may benefit by gaining insights (1) about your ACO as a result of our discussion, or (2) from the overall study results.

Potential Risks:
1. Loss of Professional Standing or Reputation: It is conceivable that you could share a deeply personal ethical conflict that resulted in actions that might be embarrassing and/or harmful to your career. To mitigate this issue, all interviews are completely confidential and names are not connected to anything we discuss. Tapes and transcriptions will be destroyed at the end of the research study.

Privacy Protection: The researcher listed on the first page of this form is the only person who will have access to information that links individual participants to the responses from the interviews. Participants will not be identified in any report or publication about this study. Additional information about privacy protection is available on the Study Fact Sheet.
Consent

I, _____________________________, understand that I am being asked to participate in a University of North Carolina study to answer questions relating to ethics conflicts and ACOs.

I understand that it is my voluntary choice to participate in this study, and I also understand that I may refuse to answer any question during the interview and/or withdraw from the study at any time without penalty.

A summary of the results of my interview will be made available to me upon completion of the study, should I request a copy. I understand what this study involves and I freely agree to take part. A copy of this written consent form will be provided to me upon request.

I understand that my verbal consent after having this form read to me shall constitute my consent as if I had signed this consent below.

_______________________
Signature of participant

_____________________
Name of participant

________
Date

If you have any questions or concerns, either prior to or following your participation, please do not hesitate to contact me.

Craig R. Westling at 603/729-6118 or by email at cwestlin@live.unc.edu
APPENDIX 4: SOVALDI – AN ACO ETHICAL DILEMMA

The hepatitis C drug Sovaldi is forcing ACOs to confront several ethical dilemmas at once:

1. The drug has proven, superior clinical benefits and all evidence points to the fact that it should be used to treat hepatitis C.

2. It affects enough people (the entire Baby Boom generation is recommended to get screened for hepatitis C) that the combination of cases creates an urgent population health issue that requires fair stewardship of limited resources.

3. It would be crippling financially for the ACO to “do the right thing” by testing everyone at risk and then treating those with the disease (the example quoted by one Pioneer site was $70-80 million). This illustrates the near impossibility of always providing the evidence-based care regardless of payment.

One specialist described the Sovaldi dilemma like this:

Sovaldi cures the disease, but it's outrageously priced at something like $85,000 for a 12-week treatment course. And who pays for that? The ACO! That will single-handedly drive up the cost of healthcare in an ACO model. That’s going to break our budget. So what do we do?

In effect, ACOs are being asked to be a proxy for society to make decisions about rationing a highly effective drug, as they must decide who should get what care, and when. As one PCP said:

[Sovaldi] is making us consider delaying treatment on some patients because there are some other new drugs coming out in the next year or two and they may be less expensive, and more effective, and trying to kind of soften the financial expense.
The ethical issues do not go away in pure FFS payment models, but they are shifted to third party payers who make the coverage decisions (who hopefully use a deliberate, transparent and fair process for making coverage decisions). By accepting financial risk the ACOs are running headfirst into a very difficult dilemma. As one physician said:

ACOs are going to create a conflict between the American free-enterprise system and a more controlled system. Do we want big pharma to just make money for its stockholders and the consequences be damned? Or do we want society to say, "We want this regulated healthcare system, which has its budget controlled"? Well, then pharma is 16-18% of the budget. How about a little focus on that?

These are questions that society should grapple with. But given America’s seeming reluctance to engage in rational policy debates about health care, ACOs may be a venue for local stakeholders to debate the process by which such difficult decisions should be made. Clearly Sovaldi is an extreme example, and the decision regarding whether or not an ACO can afford to prescribe it is not one individual providers can or should make on their own. However, the results of this study indicate the even some of the most mature ACOs (those selected for Pioneer) have fragmented support systems for resolving ethical conflicts, and are therefore ill suited to tackle such difficult dilemmas. This issue is likely to be more exposed over time, as many hospitals have well-developed ethics activities (and a growing number have organizational ethics committees), but the other distributed components of the ACO may not.
REFERENCES


