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# Action Guide for Addressing Ethical Challenges of Resource Allocation Within Community-Based Healthcare Organizations

*Krista L. Harrison, Holly A. Taylor, and Maria W. Merritt*

## ABSTRACT

This article proposes an action guide to making decisions regarding the ethical allocation of resources that affect access to healthcare services offered by community-based healthcare organizations. Using the filter of empirical data from a study of decision making in two community-based healthcare organizations, we identify potentially relevant conceptual guidance from a review of frameworks and action guides in the public health, health policy, and organizational ethics literature. We describe the development of this action guide. We used data from a prior empirical study of the values that influence decision making about the allocation of resources in particular types of community-based healthcare organizations. We evaluated, organized, and specified the conceptual guidance we found in 14 frameworks for ethical decision making. The result is an action guide that includes four domains that

are relevant to the context of the decision to be made, eight domains that are relevant to the process of the decision to be made, and 15 domains that are relevant to the criteria of the decision to be made. We demonstrate the potential use of this action guide by walking through an illustrative resource allocation decision. The action guide provides community-based healthcare organizations with a conceptually grounded, empirically informed framework for ethical decision making.

## INTRODUCTION

Community-based healthcare organizations provide access to health services that are tailored to the needs of their local community members. Many of these organizations form the backbone of a safety net system intended to serve uninsured and other vulnerable individuals whose needs are not otherwise met within the fragmented American healthcare system.<sup>1</sup> Examples include federally qualified health centers, local health departments, public clinics and hospitals, and nonprofit healthcare organizations that are not affiliated with an academic medical center. Administrators of these organizations at times wonder what is the right policy or resource allocation decision, given the potential impact on the population they serve. Such community-based organizations are not unique in this regard, but their administrators may have unusual latitude to make decisions that are based on the values of the community or organization, rather than based on regu-

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lations or principles to maximize profit. A robust scholarly literature addresses general ethical questions about how to allocate healthcare resources in accordance with philosophical theories of justice.<sup>2</sup> It would be of little use, however, to simply hand this literature to an administrator of a community-based healthcare organization who is considering a specific policy change—for example, to facilitate equitable access to specialty healthcare services. Accordingly, ethics frameworks have been developed to help decision makers translate theory into practice in the context of specific problems. Yet among the many frameworks on offer, none are comprehensively useful specifically to stakeholders within community-based healthcare organizations that provide access to health services. We sought to address this need. Our effort was informed by data that we collected within two of these organizations regarding policy decisions with morally important consequences, such as who will receive care and how much care they will receive, given limited resources.<sup>3</sup>

We reviewed existing ethics frameworks published for use by organization-level decision makers. We identified potential normative elements of the frameworks that had been empirically demonstrated to be relevant to the type of community-based healthcare organizations we characterized in our prior research.<sup>4</sup> We used this empirical data to evaluate, organize, and specify the conceptual guidance available in 14 of the existing frameworks. The result is a conceptually grounded, empirically informed action guide that future empirical research can test and refine in a community-based healthcare organization practice setting. In this article we first describe the methods by which we created the action guide, then present the action guide, next provide a sustained example of how the action guide could be used, and finally discuss implications for future research and practice.

## METHODS

We reviewed the literature relevant to ethical healthcare resource allocation or policy decisions to identify guidance or frameworks relevant to meso-allocation decisions (that is, decisions made at the organizational level) as distinct from macro-allocation (that is, decisions made at the country level or multisystem level), or micro-allocation (that is, clinical rationing).<sup>5</sup> We consulted three main bodies of literature: public health ethics, health policy ethics, and organizational ethics. In recent years, frameworks have proliferated in the public health ethics

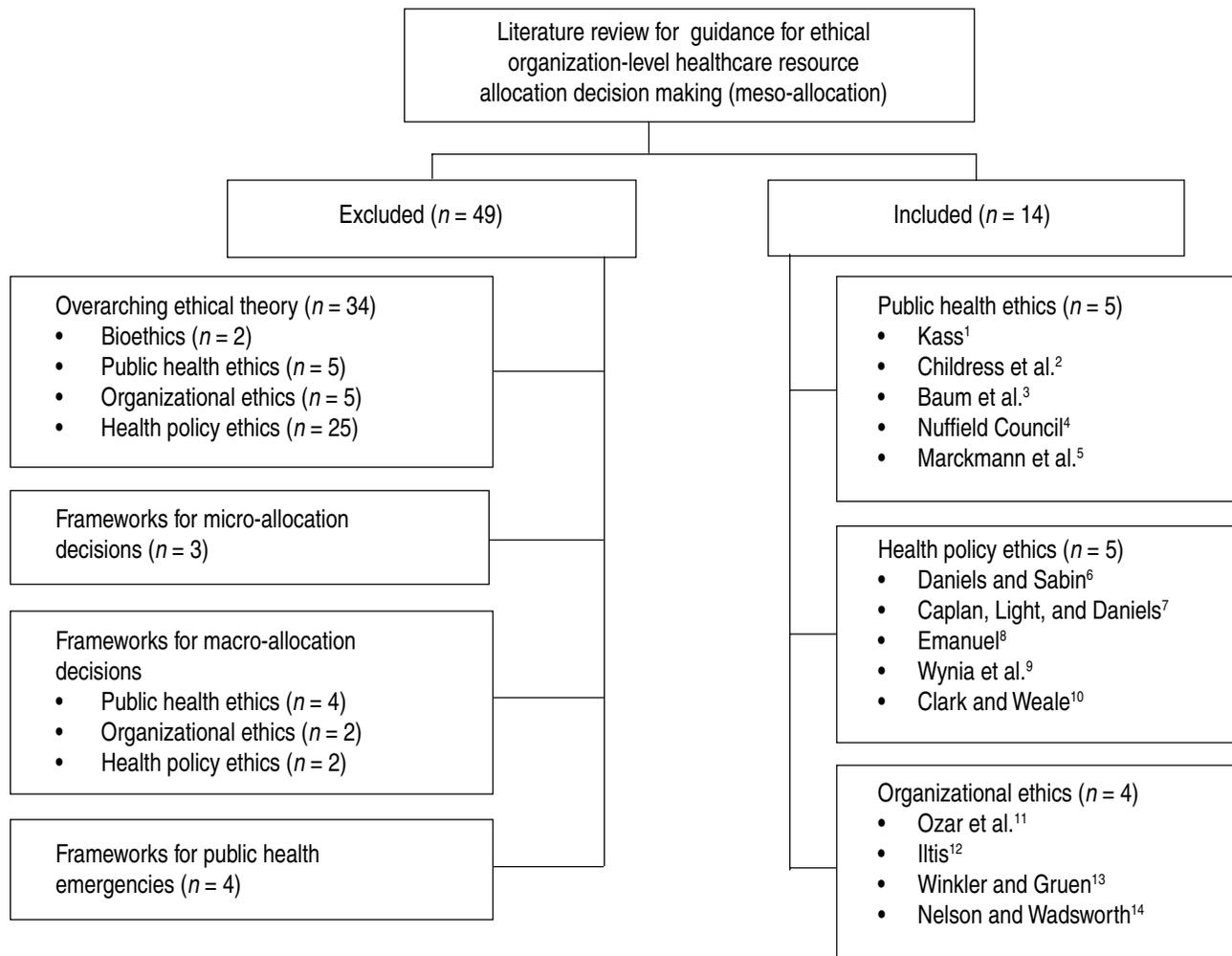
literature, as Nancy Kass wrote, to help “professionals identify and respond to moral dilemmas in their work”<sup>6</sup> designing and maintaining programs that promote population-level health. Because many public health ethics frameworks are oriented towards either macro-allocation or emergency circumstances, however, we also reviewed the health policy ethics and organizational ethics literatures for similar action-oriented guides relevant to dilemmas experienced by community-based health organizations. Health policy ethics examines the values underlying public program and policy decision making.<sup>7</sup> Organizational ethics helps organizations to sustain ethical cultures and make decisions consistent with their fundamental aims, examining issues such as integrity, responsibility, and choice.<sup>8</sup> From the literature we reviewed, we selected 14 ethics frameworks for further analysis: five frameworks from public health ethics,<sup>9</sup> five from health policy ethics,<sup>10</sup> and four from organizational ethics<sup>11</sup> (see figure 1).

An ethics framework should be grounded in theory but also be “approachable” enough for a professional decision maker to use it without specialized ethical training. One way to satisfy both criteria, relative to a specific type of decision-making context, is to work back and forth between the normative literature about how decisions *ought* to be made and empirical data on how decisions *are* made in that context. We used our empirical findings about decision making in a particular type of community-based healthcare organization<sup>12</sup> as a lens through which to filter, aggregate, and specify the normative ethical literature.

Normative frameworks sometimes distinguish between substantive normative criteria for decision making and an ethical process of decision making. For example, Georg Marckmann and colleagues<sup>13</sup> include both elements in their framework, whereas Norman Daniels’s “Accountability for Reasonableness” focuses exclusively on process.<sup>14</sup> In addition to those two categories of decision-making elements—criteria and process—we empirically observed that organizational decisions are impacted by the social context of the decision, much in the same way that individuals’ behaviors are influenced by social context.<sup>15</sup> Hence our three analytic categories were context, process, and criteria.

To develop the action guide, we first re-analyzed our empirical findings to create a table of the example decisions and the factors and values affecting them, which we categorized by context, process, and criteria for decisions (see figure 2). Second, we similarly categorized the normative considerations

**FIGURE 1:** Summary of inclusion/exclusion criteria for literature review and selected frameworks



**NOTES**

1. N.E. Kass, "An Ethics Framework for Public Health," *American Journal of Public Health* 91, no. 11 (November 2001): 1776-82.  
 2. J.F. Childress et al., "Public Health Ethics: Mapping the Terrain," *Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 170-78.  
 3. N.M. Baum, S.E. Gollust, S.D. Goold, and P.D. Jacobson, "Looking Ahead: Addressing Ethical Challenges in Public Health Practice," *Journal of Law, Medicine & Ethics* 35, no. 4 (2007): 657-67.  
 4. Nuffield Council on Bioethics, *Public Health: Ethical Issues* (London: Nuffield Council on Bioethics, 2007), <http://www.nuffieldbioethics.org/go/ourwork/publichealth/introduction>.  
 5. G. Marckmann, H. Schmidt, M. Sofaer, and D. Streh, "Putting Public Health Ethics into Practice: A Systematic Framework," *Frontiers in Public Health* 3 (2015): 23.  
 6. N. Daniels and J. Sabin, "The Ethics of Accountability in Managed Care Reform," *Health Affairs* 17, no. 5 (October 1998): 50-64.  
 7. R.L. Caplan, D.W. Light, and N. Daniels, "Benchmarks of Fairness: A Moral Framework for Assessing Equity," *International Journal of Health Services* 29, no. 4 (1999): 853-69.  
 8. E.J. Emanuel, "Justice and Managed Care: Four Principles for the Just Allocation of Health Care Resources," *Hastings Center Report* 30,

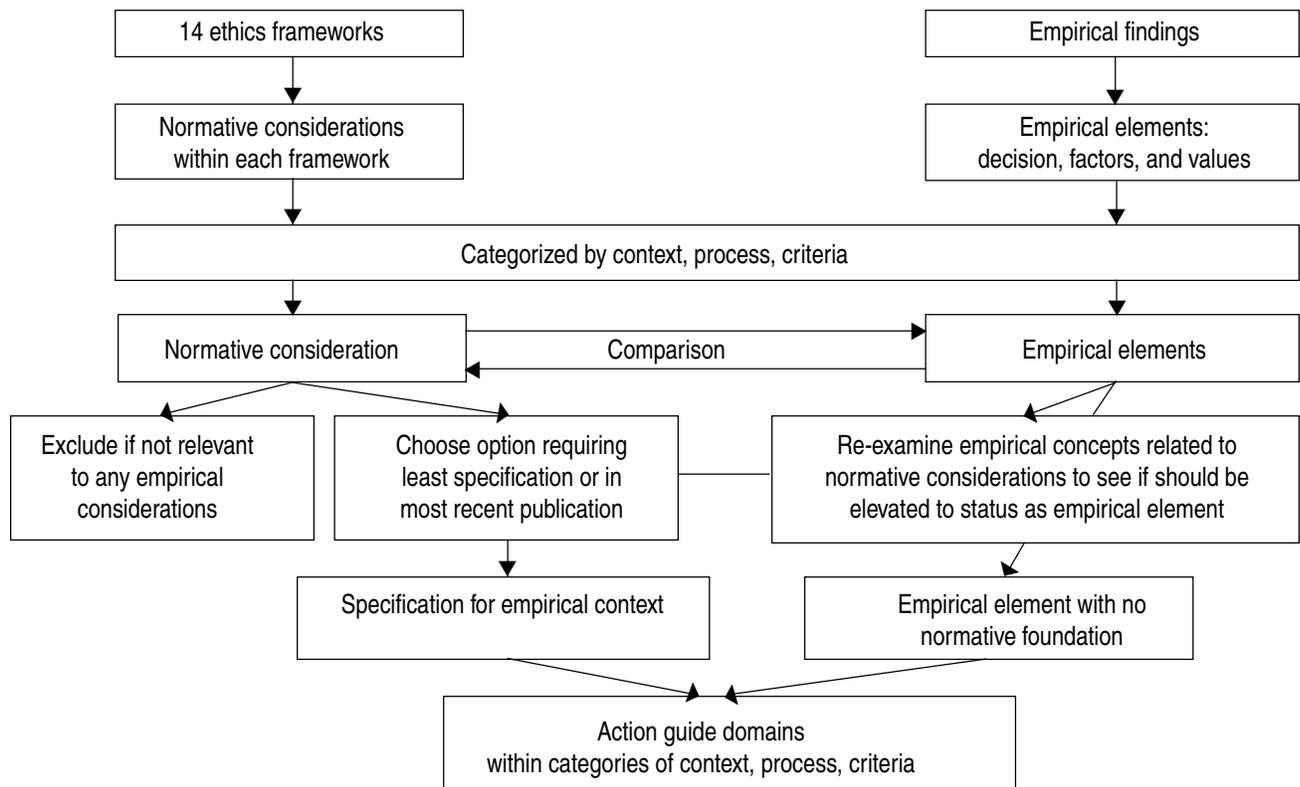
no. 3 (June 2000): 8-16.  
 9. M.K. Wynia et al., "Improving Fairness in Coverage Decisions: Performance Expectations for Quality Improvement," *American Journal of Bioethics* 4, no. 3 (2004): 87-100.  
 10. S. Clark and A. Weale, "Social Values in Health Priority Setting: A Conceptual Framework," *Journal of Health Organization and Management* 26, no. 3 (2012): 293-316.  
 11. D. Ozar et al., *Organizational Ethics in Health Care: Toward a Model of Ethical Decision-Making by Provider Organizations: National Working Group Report* (Chicago, Ill.: American Medical Association Institute for Ethics, 2000).  
 12. A.S. Iltis, "Values Based Decision Making: Organizational Mission and Integrity," *HEC Forum* 17, no. 1 (March 2005): 6-17.  
 13. E.C. Winkler and R.L. Gruen, "First Principles: Substantive Ethics for Healthcare Organizations," *Journal of Healthcare Management* 50, no. 2 (April 2005): 109-19; discussion 119-20.  
 14. W.A. Nelson and E. Wadsworth, "The Ethical Basis for Creating ACOs; Organizations Have a Moral Imperative to Deliver Cost-Effective, High-Quality and Safe Healthcare," *Healthcare Executive* 25, no. 4 (August 2010): 44, 46-7.

within the 14 selected ethics frameworks as relevant to the context, process, or criteria of decision making in our empirical data. Third, we compared the considerations within the normative frameworks to each element of the empirical findings with the goal of identifying a normative foundation for each empirical element (see table 1). When we found multiple normative considerations that aligned with an empirical element, we chose the normative consideration that required the least specification to be relevant to the empirical element; if all normative consideration options were similar, we chose the version in the most recent publication. When a normative consideration seemed related to a concept that appeared in the empirical data but had not been previously listed as an empirical element, we re-examined the empirical data to see if that concept was prevalent enough to warrant drawing it out as a separate empirical element.

We excluded from further analysis any normative considerations that were not relevant to any empirically observed elements of the context, process, or criteria for making decisions. Fourth, we reviewed the chosen normative foundations in comparison to the empirical element, and specified those normative foundations for use in community-based

healthcare organizations. No single conceptual framework adequately accounted for all of the elements that we found to be involved in the allocation of resources by community-based healthcare organization and in processes to make policy decisions. Only by combining normative considerations from all three sections of the ethics literature (public health ethics, health policy ethics, and organizational ethics) were the empirical elements sufficiently supported. In addition, not every empirically observed element had a normative foundation (for example, some elements were purely political). Consequently, our final version of the action guide uses only 10 of the 14 frameworks; the 27 domains include both normative and practical decision-making considerations (see table 2).

To refine the action guide for ease of use by decision makers in community-based healthcare organizations, we formatted each element as a question that decision makers could ask of themselves or their leadership teams. We tested the usability of the action guide by developing an example decision with data from one of the 10 example resource allocations that we have described elsewhere.<sup>16</sup> We also used the illustrative example decision to check for redundancies in the action guide domains and to



**FIGURE 2.** Process of creating the action guide

**TABLE 1.** Comparison of empirical findings and normative considerations

Empirical data on factors involved in resource allocation decisions	Ethics framework	Normative consideration from framework
Relevant to context of the decision		
Trends at the local, state, or federal level (e.g., Site 1 founded during a recession and election health reform debate. Site 2: movement toward managed care, attention to pill mills and narcotics addiction).	None	
Political factors (e.g., not allowing undocumented or people over 500% of the federal poverty level to be eligible at Site 1 or covering birth control at Site 2 due to perception or statement that doing so would jeopardize the program).	Baum et al.	"Consider political feasibility and community acceptance" <sup>71</sup>
Economic factors (e.g., when financial viability was threatened, organizations created policies to limit access to either a certain number of people (Site 1) or for a certain amount of participation (Site 2)).	None	
Mission referenced at both sites as a source of core values and goals.	Itlis	"Establish a mission, i.e., a set of fundamental commitments and values" <sup>72</sup> Understand "the implications of those commitments for various aspects of organizational life" <sup>73</sup>
Relevant to the process by which the decision will be made		
Common value of "organizational excellence" across sites defined as acting in a way that is aligned with their values, e.g., preserving access to care for the most poor or ill members even during organizational financial hardship.	Itlis	Integrate "organizational mission into decisions at all levels of an organization" Develop "a plan to resolve situations in which an organization's values call it to act in incompatible ways" <sup>74</sup>
Varied stakeholders were recruited to advisory boards at both sites, including clinicians, members, local business leaders.	Marckmann et al.	"Populations affected by the . . . intervention should be able to participate in the decision about the implementation" <sup>75</sup>
Participants referred to a goal of making decisions transparent.	Marckmann et al.	"Decision process including database and underlying normative assumptions should be transparent and public" <sup>76</sup>
Participants believed that their members should be treated decently, with compassion, respect, and dignity, and that members should be empowered.	Childress et al.	"Building and maintaining trust" "Keeping promises and commitments" <sup>77</sup>
Every participant explicitly discussed trade-offs made during decision-making processes.	Caplan, Light, & Daniels	"Comparability . . . all funds expended for health care should be explicitly gathered into a budget so that they can be weighed against other, competing social needs" <sup>78</sup>
Participants discussed the importance of making responsible decisions and using public dollars wisely; subdomain within common organizational value of stewardship.	Clark & Weale	"Accountability means being answerable to those who are affected by decisions made about health priorities—typically patients and the public—for how health resources are allocated." <sup>79</sup>
Participants discussed how several decisions were revised as data or conditions changed.	Marckmann et al.	"Implementations of . . . interventions should be open for revision (e.g., if data basis changes or certain aspects have been neglected)" <sup>710</sup>

Participants discussed how decisions were based on evidence about the characteristics of the county uninsured, best practices in healthcare delivery, and data from utilization review before and after policy changes.	Baum et al.	"Demonstrate evidence of need and effectiveness of actions" <sup>11</sup>
Relevant to the criteria by which options will be evaluated		
Core value of ensuring or facilitating access to healthcare for members, e.g., based on belief in universal right to affordable care (Site 1) or maximizing access to a temporary bridge to services (Site 2).	Caplan, Light, & Daniels	"Universal access—coverage and participation: Any fair health care system must make all needed and effective services equally available to everyone regardless of their health conditions or risks" <sup>12</sup>
Participants said they wanted to provide access to care that was described as: high quality, preventive, primary comprehensive, coordinated, medical-home based, and culturally appropriate.	Nuffield	"Ensure that people have appropriate access to medical services" <sup>13</sup>
Participants discussed potential impacts of decisions on various desired outcomes, e.g., reducing inappropriate use of pain-management specialists or changing mandated use of health coaching service.	Marckmann et al.	<p>"Expected health benefits for target population</p> <ul style="list-style-type: none"> <li>• range of expected effects (endpoints)</li> <li>• magnitude and likelihood of each effect</li> <li>• strength of evidence for each effect</li> <li>• public health/practical relevance of the effects</li> <li>• incremental benefit compared to alternative interventions"<sup>14</sup></li> </ul>
Sites sought to provide culturally appropriate care, e.g., Site 1 modified health coaching program to more effectively serve those with limited English proficiency but who wanted to participate.	Wynia et al.	"Compassionate. The design and administration of health benefits should be flexible, responsive to individual values and priorities, and attentive to those with critical needs and special vulnerabilities" <sup>15</sup>
Subdomain of organizational value of service to others was to providing a safety net and helping the most vulnerable people, e.g., even when limiting access to care, Site 2 made exceptions for the very least-well-off, ensuring pain management is still available for acute needs, and chronic care available to those with blood cancer or sickle cell	Clark & Weale	"The principle of solidarity implies a commitment to the idea that all members of society will stand together and will not leave any one behind, no matter how needy or disadvantaged" <sup>16</sup>
The organizational value of fairness encompassed a goal to treat individual members or providers the same way as other members or providers, e.g., Site 1 revised a policy mandating involvement in health coaching because members with limited English proficiency could not participate.	Clark & Weale	Justice/equity: "patients who are alike in relevant respects should be treated the same, and those who are unlike in relevant respects should be treated in appropriately different ways" <sup>17</sup>
Participants described considering who was in need that might not receive care, e.g., if colonoscopies not covered (Site 1), if chronic pain management services were completely excluded (Site 2).	Marckmann et al.	<p>"Potential harm and burdens</p> <ul style="list-style-type: none"> <li>• range of potential negative effects (endpoints)</li> <li>• magnitudes and likelihood of each negative effect</li> <li>• strength of evidence for each negative effect</li> <li>• public health (practical) relevance of negative effects</li> <li>• burdens and harms compared to alternative interventions"<sup>18</sup></li> </ul>

(continued next page)

**TABLE 1.** Continued

Empirical data on factors involved in resource allocation decisions	Ethics framework	Normative consideration from framework
One domain within a common organizational value of service to others was empowering members to be self-reliant.	Marckmann et al.	<p>“Impact on autonomy</p> <ul style="list-style-type: none"> <li>• health-related empowerment (e.g., improved health literacy)</li> <li>• respect for individual autonomous choice (e.g., possibility of informed consent, least restrictive means)</li> <li>• protection of privacy and confidentiality (e.g. data protection)<sup>19</sup></li> </ul> <p>Autonomy “used to refer to the ability of individuals to be self-directing and make decisions for themselves about important matters . . . those choices will be one’s own and thus also one’s own responsibility.”<sup>20</sup></p>
Common organizational value of supporting member independence and self-sufficiency.	Clarke & Weale	<p>“Equitable financing—by ability to pay: All direct and indirect payments and out-of-pocket expenses scaled to household budget and ability to pay”<sup>21</sup></p> <p>“How can the benefits and burdens of a program be fairly balanced?”<sup>22</sup></p>
Affordability was a subdomain within the common organizational value of access to care.	Caplan, Light, & Daniels	
A subdomain of organizational value of fairness included a goal to treat individual providers alike, e.g., Site 2 wanted to ensure that the provision of care for the indigent was spread evenly across their provider networks.	Kass	
Common organizational value of community well-being compromised a belief that providing people access to care would benefit the health of the entire community	Ozar et al.	Benefit to the community <sup>23</sup>
One domain within a common organizational value of service to others was advocating for public policies that would benefit their members.	Ozar et al.	Advocacy for social policy reform <sup>24</sup>
Decisions always included consideration of the impact of the organization’s financial viability, solvency, or sustainability (subdomain within common organizational value of stewardship), e.g., Site 2 was created to sustainably fund indigent healthcare.	Ozar et al.	Organizational solvency/survival <sup>25</sup>
Sites constantly considered where to set limits on access to services based on need, costs, and degree of staff resources needed; e.g., Site 1 decided to pay for colonoscopies because of substantial need in population and lack of access otherwise.	Baum et al.	“Assess expected efficiencies and costs associated with proposed action” <sup>26</sup>

**NOTES**

1. N.M. Baum, S.E. Gollust, S.D. Goold, and P.D. Jacobson, “Looking Ahead: Addressing Ethical Challenges in Public Health Practice,” *Journal of Law, Medicine & Ethics* 35, no. 4 (2007): 657-67, 662.
2. A.S. Iltis, “Values Based Decision Making: Organizational Mission and Integrity,” *HEC Forum* 17, no. 1 (March 2005): 6-17, 7.
3. *Ibid.*, 15.
4. *Ibid.*
5. G. Marckmann, H. Schmidt, M. Sofaer, and D. Strech, “Putting Public Health Ethics into Practice: A Systematic Framework,” *Frontiers in Public Health* 3 (2015): 23, 5.
6. *Ibid.*
7. J.F. Childress et al., “Public Health Ethics: Mapping the Terrain,” *Journal of Law, Medicine & Ethics* 30, no. 2 (2002): 170-78, 172.

8. R.L. Caplan, D.W. Light, and N. Daniels, "Benchmarks of Fairness: A Moral Framework for Assessing Equity," *International Journal of Health Services* 29, no. 4 (1999): 853-69, 857, 863.

9. S. Clark and A. Weale, "Social Values in Health Priority Setting: A Conceptual Framework," *Journal of Health Organization and Management* 26, no. 3 (2012): 293-316, 296.

10. Marckmann et al., "Putting public health ethics into practice," see note 5 above, p. 5.

11. Baum, Gollust, Gool, and Jacobson, "Looking Ahead," see note 1 above, p. 662.

12. Caplan, Light, and Daniels, "Benchmarks of Fairness," see note 8 above, p. 857.

13. Nuffield Council on Bioethics, *Public Health: Ethical Issues* (London: Nuffield Council on Bioethics, 2007), <http://www.nuffieldbioethics.org/go/ourwork/publichealth/introduction>, 26.

14. Marckmann, Schmidt, Sofaer, and Strech, "Putting Public Health Ethics into Practice," see note 5 above, p. 3.

15. M.K. Wynia et al., "Improving Fairness in Coverage Decisions: Performance Expectations for Quality Improvement," *American Journal of Bioethics* 4, no. 3 (2004): 87-100, 95.

16. Clark and Weale, "Social Values in Health Priority Setting," see note 9 above, p. 309.

17. *Ibid.*, 306.

18. Marckmann, Schmidt, Sofaer, and Strech, "Putting Public Health Ethics into Practice," see note 5 above, p. 3.

19. *Ibid.*

20. Clark and Weale, "Social Values in Health Priority Setting," see note 9 above, p. 310.

21. Caplan, Light, and Daniels, "Benchmarks of Fairness," see note 8 above, p. 858.

22. N.E. Kass, "An Ethics Framework for Public Health," *American Journal of Public Health* 91, no. 11 (November 2001): 1776-82, 1781.

23. D. Ozar et al., *Organizational Ethics in Health Care: Toward a Model of Ethical Decision-Making by Provider Organizations: National Working Group Report* (Chicago, Ill.: American Medical Association Institute for Ethics, 2000), 14.

24. *Ibid.*, 13.

25. *Ibid.*

26. Baum et al., "Looking ahead," see note 1 above, p. 662.

organize the domains of each category according to the order in which they were relevant to the example decision. We present below the resulting illustrative example decision.

## RESULTS

### The Action Guide

The result of our analysis is the action guide (see table 2). The action guide asks decision makers to consider the context of the decision, the process by they wish to make the decision, and what criteria they will use to choose between options or evaluate the quality of the options. Although we will present the action guide as if it is being used prospectively to make a decision, it could also be used retrospectively to evaluate the ethical quality of a decision. We anticipate decision makers would use the guide iteratively both to analyze the problem with which they are struggling and to evaluate proposed solutions.

### The Action Guide in Action

The following example illustrates how administrators in a community-based healthcare organization could use our action guide to review and revise a policy concerning the healthcare services available to the organization's members. We have developed this example as a hypothetical scenario, informed by historical data to make it as realistic as possible, presented from the standpoint of administrators at a community-based healthcare organization. The example combines data on what actually occurred with our analysis of what ought to occur in similar circumstances. To follow a realistic sequence of decision making, we demonstrate the iterative use of the action guide through multiple stages of a decision, from analyzing a problem in light of existing policy, to developing a revised policy, to implementing and monitoring the outcomes. As a result, we present five stages of using the action guide—one for *context*, two for *process*, and two for *criteria*—with the categories of *process* and *criteria* subdivided to reflect considerations relevant to revising a policy and to implementing it. The domains of the action guide are bolded in the text of the example and the domain number appears in parentheses.

### Identification of a Potential Policy Problem

In the course of conducting a routine review of how an organization's members have utilized available healthcare services, the organization's administrators notice that 2 percent of the organization's annual budget of roughly \$3 million has been spent on pain-management specialty services, including expensive procedures (for example, local anesthesia followed by an injection into the spine to administer anesthetic and anti-inflamma-

**TABLE 2.** Action guide for resource allocation and policy decision making affecting healthcare services in community-based healthcare organizations

Consider the context of the decision:

1. What are the fundamental commitments, goals, and values of the organization? How do they impact various aspects of the community health organization?
2. Are there policy priorities at the local, state, or federal level relevant to the decision?
3. Are there economic factors relevant to this decision that could impact the process or outcome of the decision?
4. Are there political factors that could impact the community feasibility and acceptability of the decision?

Consider the process by which the decision will be made:

5. How will the decision-making process enable the participation and contribution of affected stakeholders with different interests?
6. What is the quality of the data and evidence used in analyzing the problem or solution?
7. How will trade-offs be explicitly examined and compared, for example, using a budget that includes all funds and resources?
8. How will the decision-making process and result be made publicly transparent, including data and assumptions?
9. How will this decision build or maintain trust with members and other stakeholders, for example, by treating them with compassion, respect, dignity, and decency?
10. How will the decision-making process reflect organizational excellence and values, goals, and commitments? How will situations be resolved in which an organization's values call it to act in incompatible ways?
11. To whom will the organization be accountable for the process or outcome of the decision, justifying and taking responsibility for activities and prioritizations?
12. How will the decision be revised if conditions or data change?

Consider the criteria by which you will choose between options or evaluate the quality of options:

13. How will this decision impact access to care, given that all members should have access to comprehensive and uniform benefits?
14. To ensure ethical stewardship of the organization's resources, what are the expected efficiencies and costs associated with proposed action? Where should the organization set limits on services?
15. What is the expected clinical effectiveness of interventions, including expected health benefits or care outcomes? How will the decision impact the likelihood of effectively achieving those goals?
16. How will the organization define what type and quality of care will be available to ensure all members have appropriate access to medical services?
17. How will this decision impact the organization's ability to serve the diverse needs and preferences of its members given that the care provided to members should be compassionate, flexible, responsive to individual values and priorities, and attentive to those with critical needs or special vulnerabilities?
18. Does this decision prioritize or impact the most vulnerable population served, especially in terms of those who are the least well-off in terms of health?
19. Will this decision cause burdens or harms to any subpopulation of members?
20. Will this decision treat similar members alike? How are considerations such as age, personal responsibility, lifestyle choices, or family situation taken into account implicitly or explicitly in setting priorities? Are subpopulations of members treated fairly by this decision?
21. Will this decision help members be self-directing and achieve independence by taking responsibility for their own health or health outcomes?
22. Will the decision empower members or help them achieve their desired ends? Does it respect individual autonomous choices of members?
23. Will this decision maintain or improve equitable financing and affordability of healthcare for members by ensuring costs to members match their ability to pay?
24. Will this decision change the organization's financial viability, solvency, or sustainability?
25. Will the benefits and burdens of this decision be fairly balanced, for example, across clinician/provider partners?
26. How will this decision benefit the health of the community?
27. Will the decision broadly promote social policy reform or wellness?

tory medication as guided by live X-ray imaging). No restrictions on the organization's members' access to these services are in place; all claims that are submitted by service providers are paid in full by the community-based healthcare organization. The administrators seek to examine why these costs were high, to create a plan to manage the costs of pain-management services, and potentially to revise the organization's policy on access to pain-management services to address possibly inappropriate utilization.

#### *Consideration of the Context of the Current Policy*

The administrators begin by **re-establishing the fundamental commitments, goals, and values of the organization** (domain 1). Based on the organization's mission statement, key considerations include how the policy affects members' access to care (especially for vulnerable populations), the quality of the care available, and the efficiency with which the organization's resources are used. These administrators are not alone in their concern about how pain-management specialty services are being accessed. After a number of years focusing on the undertreatment of pain, since 2008 attention at the **federal, state, and local levels** (domain 2) has turned to the overtreatment of pain and associated rates of narcotics use and abuse, which have been blamed in part on the evolution of treatment practices in the management of chronic pain. At the time this policy is being reviewed, the organization's home state is identified as having the highest number of prescriptions written for opioids in the U.S., and rapid increases in the number of opioid-related deaths, problems blamed on the large number of specialty pain clinics and a lack of associated regulation. When considering **economic factors** (domain 3) relevant to a potential policy revision, the administrators are concerned that the relatively high proportion of funds being used for specialty pain-management services may have been driven by the resale value of narcotics on the street. To assess the **political feasibility and community acceptability** (domain 4) of revising the organization's policy, the administrators ask organizations in neighboring counties whether and how they provide access to pain-management services to medically indigent residents. They learn that these counties have completely stopped coverage.

#### *Consideration of the Process of Reviewing and Preparing to Revise the Policy*

The administrators want to **facilitate the participation and contribution of representatives from**

**the various stakeholder groups** who will be affected by the changes in policy (domain 5) in the process of reviewing and revising the policy. The administrators start by consulting with the medical committee of their oversight board—which includes the medical directors who are affiliated with their four member networks—and asking them to help determine whether the current utilization of pain-management services is reasonable and appropriate or whether changes are needed. In addition, the administrators speak with all of the primary care providers in the four networks, representatives from the local medical community, the local public safety committee (that is, the leadership of the Police Department and judges), the Sheriff's Office, and organization's two oversight boards, regarding whether those stakeholder groups would want pain management to change in the county, and what their suggestions might be for doing so. The oversight boards themselves have diverse representations of stakeholders, from medical professionals to community business owners to members receiving healthcare services through the organization. By engaging the members of the stakeholder groups, the administrators learn that the primary care providers do not feel comfortable prescribing narcotics for the members of the organization who ask for pain medication, and that all of the stakeholders are interested in changing the existing system of pain management. The administrators also begin to engage other community partners with whom they anticipate needing to collaborate in the implementation of any policy changes or revisions—for example, a detox unit and substance abuse inpatient programs.

The next step in examining the existing policy and preparing for potential changes is to review the **best quality data available to inform the decision** (domain 6). The administrators examine claims data on the utilization of services by current and past members; qualitative data from key informants who have network, pharmacy, or medical expertise; and systematic reviews from the peer-reviewed literature on recommended practices in pain management. Based on their analysis of the claims data, they see groupings of separate claims for a series of expensive procedures that do not align with the best practices reported in the peer-reviewed literature. They also see claims for ongoing high-dose narcotics prescriptions, sometimes with higher doses after procedures that were intended to reduce pain. Pharmacy and medical experts opine that the pattern of the claims data suggests that pain-management specialists were trying to bill the organization for a number of high-cost services, since the proce-

dures were not reducing the utilization of narcotics. In-network physicians provide anecdotes of patients reporting that when they asked pain-management specialists for narcotics prescriptions, they were required to get these expensive procedures first, perceiving that if they refused the procedure no prescription would be provided. Based on these data—which are of the highest quality practically available on a short timeline—the administrators decide to amend the current policy, which allows unfettered access to pain-management services. They create a supporting document that enables them to easily compare the costs of different services so that **trade-offs can be explicitly examined** (domain 7). The remainder of the process domains (domains 8 through 12) in the action guide are left to be evaluated at a later stage, as part of implementation of the revised policy.

#### *Consideration of the Criteria for Revising the Policy*

The first criterion to consider is **how revising the policy will impact access to care** (domain 13). As noted earlier, neighboring counties simply decided to no longer provide coverage for pain-management services. Because the administrators believe there will always be patients who need access to those services, for example, for cancer pain, they want to preserve access whenever possible. In an effort to be **ethical stewards of their resources, they also consider potential impacts of setting new limits on access to care** (domain 14): their goal is to reduce expenditures but not to the point of creating undue burden on those in need of pain-management services. Next, they look at the evidence on the **clinical effectiveness of treatments in achieving their desired goals** (domain 15)—of relieving members' pain and reducing the frequency with which long-term narcotics are prescribed. In addition to consulting the peer-reviewed literature, the administrators speak with experts in best practices for pain-management services, and seek information on how other healthcare organizations and insurers structure access to these services.

The administrators use their analysis of factors contributing to the problem and the evidence on the clinical effectiveness of the treatment to **define what type and quality of care will be available to ensure appropriate access to medical services** (domain 16). They want to encourage members to use their primary care providers as the main source of pain-management services, but also still allow access to pain-management specialists. For this reason, the administrators decide to require prior authorization of referrals to specialists before commencing treatment,

and to limit access to an initial evaluation and no more than two follow-up visits per problem-based referral. Based on their understanding of clinical effectiveness compared to costs, they decide to cover procedures to diagnose or treat pain only in cases of acute injury, dental pain, and pre- and post-surgical events, and to reimburse for a limited number of steroid injections restricted to specific diagnoses. Finally, the administrators decide to provide only those members who have a diagnosis of cancer, or a blood disorder such as sickle cell, with access to chronic pain-management services, defined as treatment for longer than 60 days, or 90 days post-surgery. The administrators will remove euphoric narcotics from their pharmacy formulary to address concerns about members who request narcotics because of addiction, or for purposes of drug diversion, rather than for pain treatment proper. They believe that this proposed policy revision will allow the organization to continue **to serve the diverse needs and preferences of its members by being compassionate, flexible, and responsive to individual values** (domain 17).

As they think ahead to implementation, the administrators consider how this proposed policy revision will **impact those who are most vulnerable in the sense of being least healthy** (domain 18), defined as members who are receiving high doses of pain-management drugs and who may be addicted. The administrators designate a 60-day transition period for the implementation of the policy. They also develop mechanisms to wean members off pain medication, including a collaboration with the organization's community partners to provide access to a detox unit or substance abuse inpatient program, in addition to the organization's existing coverage of substance abuse and some mental health treatment. This proposed policy revision may **cause burdens, or harms, to the subpopulation of members** (domain 19) who are currently receiving pain medication. If they do not fall into one of the protected categories, some members may be physically and mentally reliant on the treatments and may experience substantial emotional and physical distress as a result of the proposed revised policy. Other members may be engaged in the illicit diversion of pain medication; for them, the proposed revised policy might cause an economic setback from a loss of income. Nonetheless, the administrators believe that the proposed policy decision **treats similar members alike and fairly treats subpopulations of members without consideration of age or family situation** (domain 20). They believe it prioritizes access to symptom-mitigating care for those patients who

are **taking responsibility for their own health and aiming to become independent** (domain 21). The administrators further believe that the decision will help **empower members to achieve their desired ends** (domain 22) of receiving adequate pain management while reducing opportunities for addiction, or helping members to overcome addiction. While the policy does not restrict **autonomous choices made by members** (domain 22) about pain-management treatment, the proposed revised policy provides financial coverage only for a subset of those potential choices (for example, for short-term pain-management specialty treatment except for members with particular diagnoses). Under the proposed revised policy, the organization will continue to provide all covered services to members for free, thus **matching costs to members with their ability to pay** (domain 23). As a result of this proposed policy revision, the administrators anticipate that spending on pain-management services will drop significantly, thus improving the **organization's financial viability and long-term sustainability** (domain 24) and allowing funds to be re-allocated as needed. The remainder of the criteria domains (domains 25 through 27) are left to be evaluated as part of the criteria for implementing the revised policy.

#### *Consideration of the Process of Implementing the Revised Policy*

Having drafted the revised policy, the administrators enable the participation and contribution of **stakeholders with varied interests** (domain 5). For example, they present the data they have used to analyze the problem, their assumptions, and their proposed revised policy at public meetings of their oversight boards in order to seek reactions and recommendations, and in order to make the **input from the meetings and the process publicly transparent** (domain 8). The administrators also seek feedback from other stakeholders who were consulted earlier in the process. They make the final policy **publicly available** (domain 8) and actively educate members and providers about the changes. In the process of revising and implementing the policy, the administrators have sought to **maintain trust with members and to treat them with compassion, respect, decency, and dignity** (domain 9), by continuing to provide access to services for people in need, including those with blood disorders like sickle cell. They have strengthened their relationship with addiction treatment service providers to whom they can refer members who have, as an unintended consequence of the previously open coverage policy, developed addiction problems.

The administrators believe that the resulting decision reflects the **organization's fundamental values and goals, and their commitment** (domain 10) to providing access to care for the medically indigent in their community, while supporting responsible stewardship of the organization's resources. The administrators will hold themselves **accountable for the process and outcome of the decision** (domain 11) to their oversight boards and to the general public whose taxes financially support the program. The administrators will closely monitor key outcomes of the revised policy: specifically, overall costs of pain-management services for members, patients' utilization of the organization's services (for example, whether patients will remain members of the organization or switch to other forms of insurance like Medicaid), and the continuing provision of services to members by pain-management specialists. The administrators will implement transparent procedures for members and providers to appeal pain-management coverage decisions under the revised policy. After six months, the administrators will reconvene to assess whether, based on outcomes, appeals, or other conditions, the **policy should be revised** (domain 12).

#### *Considering the Criteria for Implementing the Revised Policy*

Analyzing **whether the benefits and burdens of the policy revision are fairly balanced** (domain 25) requires examination of its effect on both members and providers. The burdens will accrue only to those members who experience pain-management needs, while benefits will accrue to all members if the organization can re-allocate its resources to improve member services. Members who experience pain-management needs will bear an increased burden in the form of needing to seek referrals from primary care providers before being able to access pain-management specialists. As a result of the policy change, members who are illicitly diverting and selling narcotics for personal gain will no longer enjoy a type of economic benefit that would be inappropriate for the organization to subsidize. Particular benefit will accrue to those patients who are undergoing the serious health crisis of addiction (unwittingly facilitated or precipitated by the old policy) and who are willing to receive help from the newly supplemented services. Considering the impact on providers, the burdens of the decision will primarily fall on pain-management specialists—who will lose some income as a result of the policy change—and on primary care providers, who will now be required to take on greater responsibility for manag-

ing patients' pain and monitoring referrals. Burdens will commensurately fall on pain-management specialists to the extent that they were engaging in problematic practices. The **health of the community will benefit** (domain 26) if this policy revision reduces the prevalence of addiction. The net benefit to community health would be reduced, however, if this policy change exacerbates violence committed by criminal organizations. In order to mitigate this unintended but foreseeable adverse consequence, the administrators have explicitly alerted law enforcement regarding the possible impact on the local market in illicit narcotics. On the whole, if the new policy is successful, this decision will **promote social policy reform and wellness** (domain 27) by demonstrating the feasibility of providing responsible access to pain-management services for the medically indigent, in contrast to the more draconian option of not covering these important services at all.

In summary, this action guide provides decision makers with a conceptually grounded guide to making or evaluating changes in policy within their community-based healthcare organization. The action guide is responsive not only to those items classically included in ethical frameworks for decision making, but also to the values and mission of organizations themselves, and to practical considerations such as the political landscape within which a decision is made.

## DISCUSSION

In developing this action guide, we have taken a novel approach both to its construction and its elaboration. The most common guides or frameworks for ethical decision making are conceptual and provide guidance either at the level of macro-allocation, useful for leaders of countries or states (for example, to guide healthcare reform), or at the level of micro-allocation to guide clinical rationing at the bedside, often during emergency circumstances.<sup>17</sup> For organizations that operate at the level of meso-allocation, like community healthcare organizations, professional societies are a more common source of ethics guidelines.<sup>18</sup> Conceptually grounded action guides that are useful to administrators are rarely generated in the academic literature, and even more rarely are they informed by empirical data about the process of decision making. In developing our conceptually grounded, empirically informed action guide, we aimed to adapt the strong conceptual foundations available in the academic literature to the needs and context of community-based healthcare organizations, and thereby

to create a product that could be used "off the shelf" with no additional training. Our illustrative example shows what it might look like to use the action guide, and simultaneously models the process by which future empirical research can refine it.

Additional empirical research is warranted to continue to improve the action guide and to study how community-based healthcare organizations can effectively deploy it. One line of research should test whether the elements of decision making that we identified in the subcategory of community-based healthcare organizations appear in other types of community-based healthcare organizations, and whether there are additional elements that need to be included. This line of work could also examine how different sets of organizational values (part of the context of a decision) impact the trade-offs made by organizations. Such work would form the basis of a hierarchy for addressing decision-making trade-offs. A second line of research should test the pragmatic utility of our action guide for making health policy decisions at the level of meso-allocation. Using survey development techniques, researchers could cognitively test the language of the action guide for clarity and utility. Research should also be conducted to obtain feedback from community-based healthcare organization decision makers to improve the usefulness of the action guide—for example, to find out whether there is an order of the subdomains that would be particularly useful. Research could also be conducted to assess the extent to which the use of an action guide promotes explicit consideration of organizational values and ethical tensions and dilemmas, or whether the results of the deliberations produce resource allocation and policy decisions that are better aligned with ethical norms.

A community-based healthcare organization that incorporates routine use of the fully developed action guide into decision making could, at minimum, expect to see improvements in the degree to which decisions are made systematically, transparently, and in accordance with the organization's own stated mission and values. In addition, organizations could use the action guide to evaluate whether policies made in accordance with it are carried out consistently by frontline staff.

## CONCLUSION

Nancy M. Baum and colleagues argue that the value of providing a tool for ethical decision making is in helping public health practitioners clarify the ethical tensions in their work, balance the ex-

clusive use of economic analysis, and promote the explicit analysis of values and transparency.<sup>19</sup> These same benefits can be expected from a tool developed for community-based healthcare organizations. In this article we have drawn upon our prior empirical research<sup>20</sup> to evaluate, organize, and specify applicable elements of existing conceptual frameworks, so as to provide comprehensive, actionable guidance for resource allocation decision making that affects healthcare services available to members of community-based healthcare organizations. The action guide presented here represents a first step toward providing community-based health-care organizations with a conceptually grounded, empirically informed framework for ethical decision making.

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