

ETHICAL RESOURCE ALLOCATION: A PROPOSED FRAMEWORK

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ABSTRACT

The purpose of the essay will be to discuss an ethical resource allocation decision support tool the author of this essay helped design for use by United States Department of Veterans Affairs (VA) health care administrators. This will include discussions of the process of the tool's purpose and design, related business ethics and management literature, and ways in which the tool was improved through multiple revision cycles based on user feedback and the management literature.

As civil servants, VA health care administrators are fiduciaries of public funds and are accountable to the public for their disposition of those funds and other public resources. They are obligated to allocate the limited resources provided to them from tax revenues as effectively and efficiently as possible and in accordance with public wishes.

The success of VA in allocating its limited resources also has significant public health relevance. Public health, as broadly defined by the National Academy of Science's Institute of Medicine, is "what we as a society do collectively to assure the conditions in which people can be healthy." Given that VA is publicly funded and government-run, its public health actions are our actions as a society. Focusing primarily on a specific but large population, viz., military Veterans and their immediate families, VA engages directly in many various activities that ensure people can be healthy and that help them return to health when they become unhealthy.

These activities include a full range of direct health care services, population-level infectious disease management, epidemiological research, and health and wellness promotion.

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I. INTRODUCTION

The purpose of the essay will be to discuss an ethical resource allocation decision support tool the author of this essay helped design for use by United States Department of Veterans Affairs (VA) health care administrators. This will include discussions of the process of the tool's purpose and design, related business ethics and management literature, and ways in which the tool was improved through multiple revision cycles based on user feedback and the management literature. Data sources will include Decision Support System (DSS) data from the Veterans Health Administration Support Services Center (VSSC) database, survey data, data from personal interviews, and scholarly journals such as the *Journal of Business Ethics*, the *Journal of Medical Ethics*, and the *Academy of Management Review*.

Over the past few years, VA has been rocked by a series of major ethics scandals. One concerned VA's long lack of success in processing a huge, crushing backlog of claims for Veterans' benefits (which peaked in March of 2013 at about 611,000 claims, about 588,000 of which had been waiting to be processed for over 125 days and about 43,000 of which had been pending more than 2 years) (Office of the Inspector General, 2014c) and the loss and manipulation of benefit application documents (Office of the Inspector General, 2015a). There have also been allegations of widespread deadly mismanagement of Veterans' opiate prescriptions that have resulted in multiple internal and external investigations and congressional hearings (Office of the Inspector General, 2015c).

A third major scandal, which erupted in early 2014, concerned long wait-times for health care that allegedly resulted in Veterans' deaths and manipulation of appointment wait-time data by administrators in many VA health care facilities. VA's Inspector General was willing to go so far as to say that "inappropriate scheduling practices are a systemic problem nationwide" (Office

of the Inspector General, 2014a), and indeed the problems were taken to be widespread and serious enough that they eventually resulted in the resignation in disgrace of then-Secretary of VA, Eric Shinseki.

Of course there has been quite a bit of demagoguery, rhetoric, and sensationalism. VA's many strengths and successes have been frequently overlooked in favor of its weaknesses, and the many hard-working, conscientious public servants working in VA have been overlooked in favor of its worst employees. Nonetheless, the public and media outcry surrounding these events have made clear that the American people hold VA to very high ethical and operational standards (rightfully so), and that they currently have little faith that VA has been meeting those standards. Unfortunately, the preponderance of evidence seems to be in favor of that view in at least some cases.

As civil servants, VA administrators are fiduciaries of public funds and are accountable to the public for their disposition of those funds and other public resources. They are obligated to allocate the limited resources provided to them from tax revenues as effectively and efficiently as possible and in accordance with public wishes.

The success of VA in allocating its limited resources also has significant public health relevance. Public health, as broadly defined by the National Academy of Science's Institute of Medicine, is "what we as a society do collectively to assure the conditions in which people can be healthy" (Institute of Medicine of the National Academy of Sciences, 2003). Given that VA is publically funded and government-run, its public health actions are our actions as a society. Focusing primarily on a specific but large population, viz., military Veterans and their immediate families, VA engages directly in many various activities that ensure people can be healthy and that help them return to health when they become unhealthy. These activities include a full range

of direct health care services, population-level infectious disease management, epidemiological research, and health and wellness promotion.

In sum, in light of the recent ethics scandals and the public health relevance of VA's activities, the resource allocation tool discussed in this essay presents VA with a fantastic, timely opportunity. It is the hope of the author of this essay that his ethics research and development have produced a foundation that VA can build upon to improve its resource allocation processes and improve transparency and accountability to the American public.

II. RELEVANT STRUCTURAL COMPONENTS OF THE TARGET ORGANIZATION

The project that is the subject of this essay was created for use by managers working within a specific segment of VA. VA is a federal executive department led by a Secretary appointed to the Cabinet by the President of the United States (The White House, 2014). As of this writing, the three major bureaus of VA (outside the divisions of VA Central office) are the Veterans Benefits Administration, the Veterans Health Administration, and the National Cemetery Administration (Office of Administration, 2009). The focus of this project is on the Veterans Health Administration, VA's primary provider of direct health care services.

The Veterans Health Administration (VHA), led by the Under Secretary for Health (USH), is made up of numerous divisions led by Deputy Under Secretaries and a Chief of Staff. VHA's core management and clinical operations fall under the purview of the Deputy Under Secretary for Health and Operations Management (DUSHOM). The division of Health Operations and Management contains 4 subdivisions, one of which is comprised of the 21 Veterans Integrated Service Networks (VISNs) (Veterans Health Administration, 2013). The VISNs are regional networks of the Department's various health care systems, medical centers,

community-based outpatient clinics (CBOCs), community living centers, Vet centers, and Domiciliaries (United States Department of Veterans Affairs, 2014e). The VISN regional offices, each led by a Network Director, are the primary interfaces among these facilities and between these facilities and the other organs of VA.

The resource allocation tool was designed at the VISN level; specifically, it was designed by administrators in the VISN 4 regional office in Pittsburgh, Pennsylvania for use by administrators in VISN 4 facilities. As of this writing, VISN 4 is a network of 10 medical centers and 45 CBOCs (United States Department of Veterans Affairs, 2014g). VISN 4 contains 2 large tertiary referral centers: one each in Pittsburgh (United States Department of Veterans Affairs, 2014a) and Philadelphia (Office of the Inspector General, 2008). The other 8 medical centers are smaller secondary facilities. VISN 4's designated catchment area includes nearly all of Pennsylvania, all of Delaware, and significant parts of Ohio, West Virginia, New York, and New Jersey. In federal fiscal year (FY) 2014 VISN 4 served about 320,000 Veterans with an operating budget of about \$2.5 billion (United States Department of Veterans Affairs, 2014g).

In the final pilot stage, the resource allocation tool was tested nationally. This was accomplished with the permission of and utilizing the communications networks of VHA's National Center for Ethics in Health Care (NCEHC). As of this writing, NCEHC falls under the purview of VHA's Deputy Under Secretary for Health for Policy and Services (DUSHPS) (Veterans Health Administration, 2013). NCEHC is empowered by VHA's USH to set certain operational requirements and program performance standards related to ethics for VISNs and medical centers through, for example, the issuance of VHA Handbook 1004.06 (VHA National Center for Ethics in Health Care, 2013).

VISN-level oversight of NCEHC operational requirements and program performance standards related to ethics for VISNs and medical centers is the responsibility of VISN IntegratedEthics™ (IE) Advisory Boards (IEABs). IEABs are typically comprised of representatives from internal units that are supposed to contribute to the ethical environment and culture of the organization, such as Compliance and Business Integrity Officers, Privacy Officers, and Regional Counsel. IEABs are chaired by the VISN IE Senior Lead, who is typically the VISN Chief Medical Officer, Quality Management Officer, or other senior VISN official (VHA National Center for Ethics in Health Care, 2008d).

The resource allocation tool is intended for use by medical-center-level resource-allocation decision-makers often referred to in VISN 4 as ‘the leadership QUAD’ or simply ‘the QUAD.’ These are loose terms. The QUAD is always made up of a medical center’s executive officers; however, depending on the facility, this group of officers includes some combination of the Director, the Deputy Director, the Chief Medical Officer, the Nurse Executive, and an Associate Director. Despite the clear implication that the QUAD includes 4 officers, depending on the facility it may contain anywhere from 3 to 5. Also depending on the medical center, the QUAD may simply meet informally to discuss high-level issues, or there may be specific authority reserved to them as a group, or they may do both at different times with regard to different issues.

Facility Ethics Consultation Services (ECCs) also played a distal role in the creation of the tool. There are clear procedures and policies in place for ethics consultations in VA, and every VA Medical Center has an Ethics Consultation Service trained to work with patients, staff, and other stakeholders to address specific ethical concerns or answer general questions about policy, hypothetical or historical cases, or broad organizational ethical issues. The procedures

and policies concerning ethics consultations in VA are described in detail in the NCEHC document *Ethics Consultation: Responding to Ethics Questions in Health Care* (Fox, Berkowitz, Chanko, & Powell, 2007).

III. NCEHC OPERATIONAL REQUIREMENTS AND THE FIRST ITERATION (ALPHA TOOL)

The first iteration of the resource allocation tool (Alpha Tool) was created in early 2013. The project was overseen by VISN 4's IE Program Senior Lead and Chair of the VISN 4 IEAB, Dr. David S. Macpherson, MD MPH. In part, the purpose for creating the Alpha Tool was to fulfill a specific operational requirement set for VISN 4 by NCEHC under authority of VHA Handbook 1004.06. The NCEHC program performance standard the tool was designed to satisfy was a FY 2013 IE program achievement metric called PE2-VISN. The relevant text of the FY 2013 *IE Program Reporting Metrics and Technical Manual* reads:

“PE2-VISN–Goal: The VISN IE Advisory Board (IEAB) will support the oversight of IE deployment and integration throughout all facilities in the VISN as outlined in VHA Handbook 1004.06.

Requirement: The VISN IEAB will address at least one Network-wide cross-cutting ethics issue identified through IE tools (e.g., Facility Workbooks, IE Staff Survey, ISSUES logs, ECWeb reports) or other resources (e.g., accreditation reports, SOARS, SHEP, Patient Advocate data)” (VHA National Center for Ethics in Health Care, 2012).

The “Network-wide cross-cutting ethics issue” that that VISN 4 identified and that the Alpha Tool was intended to address was resource allocation.

The Alpha Tool is included in its entirety as Appendix A. It was designed to prompt QUAD members to briefly articulate the nature of a difficult resource decision at hand, and then to reflect on certain moral ‘values’ or ethics ‘value domains’ they deemed relevant to their decision making. The instructions and the first two original prompts are as follows:

“Instructions: Resource decisions made by leaders are often challenging and may require tradeoffs. This form should be utilized by those at the QUAD level when making resource decisions. The form should take less than 5 minutes to complete and has two steps.

1. Write below briefly the nature of a difficult resource decision you had to or are making:

2. Think about which values listed below apply to your decision making and check off if they are influential. Look at the boxes you checked and think about how they may have or will influence your resource decision.”

The Alpha Tool’s simple ‘value domain’ table appeared as shown in Table 1.

Table 1. Alpha Tool Value Domain Table

Domain	Explanation/Example	Check the one Value Domain that most influenced your decision
Quality of Life	Funds used for my decision is likely to improve the quality of Veterans lives	
Survival	Funds used for my decision is likely to allow Veterans to live longer lives	
Financial	Funds used for my decision is likely to allow Veterans more financial resources (less private sector out of pocket costs, etc)	
Autonomy	Funds used for my decision will provide more choice for Veterans in making decisions about their healthcare	
Functional	Funds used for my decision will lead to Veterans being more functional (able to walk, etc)	
Convenience	Funds used for my decision will lead to more convenient (timeliness, location) of health services for Veterans	
Emotional	Funds used for my decision will lead to Veterans feeling more emotionally engaged with VHA (more trusting)	

Table 1. continued

Sensory/Aesthetic	Funds used for my decision will lead to a healthcare environment that is more pleasing to Veterans
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As can be seen, the second column of the table included a brief explanation of each value domain. The value domains were common themes and issues identified through a review by the IEAB of ethics consultations performed in VISN 4 facilities throughout early FY 2013. Resource allocation was also identified as an issue through that review. The review produced the data in

Table 2.

Table 2. Results of Pre-Alpha IEAB Ethics Consultation Review

FY13 CASE Consults	
Facility	Topics / Themes
Altoona	Shared Decision Making; Resource Allocation
Erie	Safety in home oxygen use; Appropriateness of Care Setting for 100% SC Vet for TBI
Lebanon	<p>General issue: Patient with chronic illness and no functional status with continued resuscitations at family's request.</p> <p>Ethics Question: "Given the patient's (poor) quality of life, is maintaining life with extraordinary measures indicated?"</p> <p>Themes:</p> <ol style="list-style-type: none"> 1. Physician Hippocratic Oath 2. Ethical principles of beneficence, least harm, and respect for autonomy 3. VHA and local policy includes MCM 20-06, Informed Consent, and MCM 00-24, Code of Ethical Behavior 4. Patient's Rights
Pittsburgh	Advance Directives / Living Wills; Code Status; Surrogate Decision Maker and Power of Attorney; Care planning; Withdrawal of Care; Refusing Treatment; Potential harm to self
Wilkes-Barre	Shared Decision Making (2); End of Life; Professionalism of treating physician
Wilmington	Patient centered care (allowing the patient to make good, bad, or in between informed decisions regarding their care) versus a provider's duty to protect patients from harm. Several of our active cases have centered on this conflict.

With the exceptions of the "Convenience," "Emotional," and "Sensory/Aesthetic" domains, each of the domains in the Alpha Tool value domain table appears fairly clearly somewhere in the case consultation review results. The influence of the aforementioned *Ethics*

Consultation: Responding to Ethics Questions in Health Care (Fox et al., 2007) document upon the case consultations and, in turn, upon the Alpha Tool, is also apparent. Much of the terminology used to describe the topics and themes found in the case consultations and to describe the value domains in the Alpha Tool is taken from that document.

Shared decision making, ethical practices in end-of-life care, professionalism in patient care, and ethical practices in resource allocation (among others) are all described in the document and cited as “content domains” that capture “ethical concerns that commonly arise in VA.” Interestingly, the Convenience, Emotional, and Sensory/Aesthetic domains do not appear in the consultation review or in *Ethics Consultation: Responding to Ethics Questions in Health Care*, but rather were added to the Alpha Tool after discussion among the IEAB of the cases in question.

Additionally, in early-to-mid calendar year (CY) 2013, facility “action groups” were polled and asked to rank the value domains that were proposed. Unfortunately, precisely who it was in each facility who answered the poll is not known since the records are no longer available. Summary statistics of the rankings were calculated with the apparent intention of using them in the Alpha Tool; however, this approach was eventually abandoned. The summary statistics from the value domain ranking poll are shown below in Table 3. The relevance of the rankings will become clear later in this essay, as they were used in later versions of the tool.

Table 3. Pre-Alpha Value Domain Ranking Poll Results Summary Statistics

Domain	Mean Rank	Range	Mode
Quality of Life	9.30	5	10
Survival	9.20	5	10
Financial	8.10	3	10
Autonomy	7.90	4	8
Functional	7.70	7	8
Convenience	7.70	5	8
Emotional	7.40	7	7
Sensory/Aesthetic	5.10	5	5

So, despite the simplistic procedure called for by the Alpha Tool, it was actually a relatively carefully planned and constructed tool. However, after the Alpha Tool was completed, it was felt that a more focused, robust tool was needed. About this time (early February of 2014) the author of this essay took over the project and began revising the Alpha Tool.

IV. ALPHA TOOL REVISION PROCESS AND THE SECOND ITERATION (BETA TOOL)

The Alpha Tool revision process was relatively brief and the revisions were relatively minor. This revision process was undertaken by the author of this essay and it marked the beginning of his ownership of the project. As the VISN 4 IntegratedEthics staff requested, the scope of the tool was narrowed to include only decisions concerning full-time equivalent employee (FTEE) position funding. The prompt and each value domain explanation were modified accordingly in the Beta Tool. For example, “Write below the nature of a difficult resource decision...” was

changed to “Write below briefly the nature of a difficult FTEE resource decision...” in prompt 1, and “Funds used for my decision” was changed to “Funds used for my FTEE decision” in the value explanations.

Although the scope was narrowed considerably by this change, the Beta Tool added some flexibility via the addition of two new rows in the domain table:

Table 4. Rows added to the Beta Tool value domain table that were not present in the Alpha Tool’s table

Mandated Action (VACO or otherwise)		
Other value (specify)		

The author of this essay added “Other value (specify)” simply to allow users to add further value domains they felt were important.

The author added “Mandated Action (VACO or otherwise)” because, in many cases, FTEE resource decisions are not entirely within the power of local administrators to control. VACO in particular has a penchant for requiring VA Medical Centers to add certain positions, often in pursuit of implementing policy changes made by Congress.

One might think that such mandates make FTEE decisions easy because there appears to be no decision to be made. These mandates do, in fact, make things easy when it comes to the initial creation of these new positions. However, the mandates sometimes are linked to special-purpose funds tied to specific initiatives that fund the positions *for one or two fiscal years at a time*. If that particular special purpose funding is decreased, is not renewed, or is discontinued but (more or less) rolled into general-purpose funding, local administrators must find ways to

fund the positions from their General Purpose funds or ask the VISN for further funding that sometimes require trade-offs and sacrifices.¹

The Beta Tool also added a third prompt below the value domain table:

“3. Rate whether this tool was helpful (expanded your thinking, clarified your choice, etc) in your resource decision.

_____ This tool was very helpful

_____ This tool was somewhat helpful

_____ This tool added little to my decision

_____ This tool was of no help to my decision

Other comments about this tool are welcome and can be entered below:”

The goal was to gain feedback, both quantitative (calculated using the helpfulness rating choices on modified Likert scale) and qualitative (via the free-text comments).

These revisions were completed by mid-February of 2014 and the Beta Tool was then piloted. An e-mail requesting trial use of and feedback on the Beta Tool was sent to the Medical Center Directors at each of VISN 4’s 10 primary facilities: Altoona VA Medical Center; Coatesville VA Medical Center; Erie VA Medical Center; Lebanon VA Medical Center; Louis A. Johnson VA Medical Center (in Clarksburg, West Virginia); Philadelphia VA Medical Center; VA Butler Healthcare; VA Pittsburgh Healthcare System; Wilkes-Barre VA Medical Center; and Wilmington VA Medical Center.

As mentioned above, in FY 2014, VISN 4 served about 320,000 Veterans with an operating budget of about \$2.5 billion. Additionally, VISN 4’s research budget totaled around \$43.4 million. VISN 4 facilities had about 13,900 employees who staffed or supported 2,282 beds and completed or supported the completion of about 3,568,000 outpatient visits, 99,000 emergency or urgent care visits, and 23,000 surgical procedures (VHA Veterans Integrated

¹ For a brief discussion of General Purpose funds, Specific Purpose funds, and big-picture resource allocation under the Veterans Equitable Resource Allocation (VERA) system, see pp 5-9 of (Panangala, 2010).

Service Network 4, 2014). All of this was overseen at the facility level by the 10 QUADs who received the Beta Tool pilot e-mail via their Directors.

After approximately one month in which the facilities were asked to pilot the tool and respond, six of ten replied, including the two largest, VA Pittsburgh Healthcare System and Philadelphia VA Medical Center. Two facilities, Louis A. Johnson VA Medical Center and VA Pittsburgh Healthcare System, each used the tool many times. All facilities' helpfulness ratings are summarized in Figure 1.

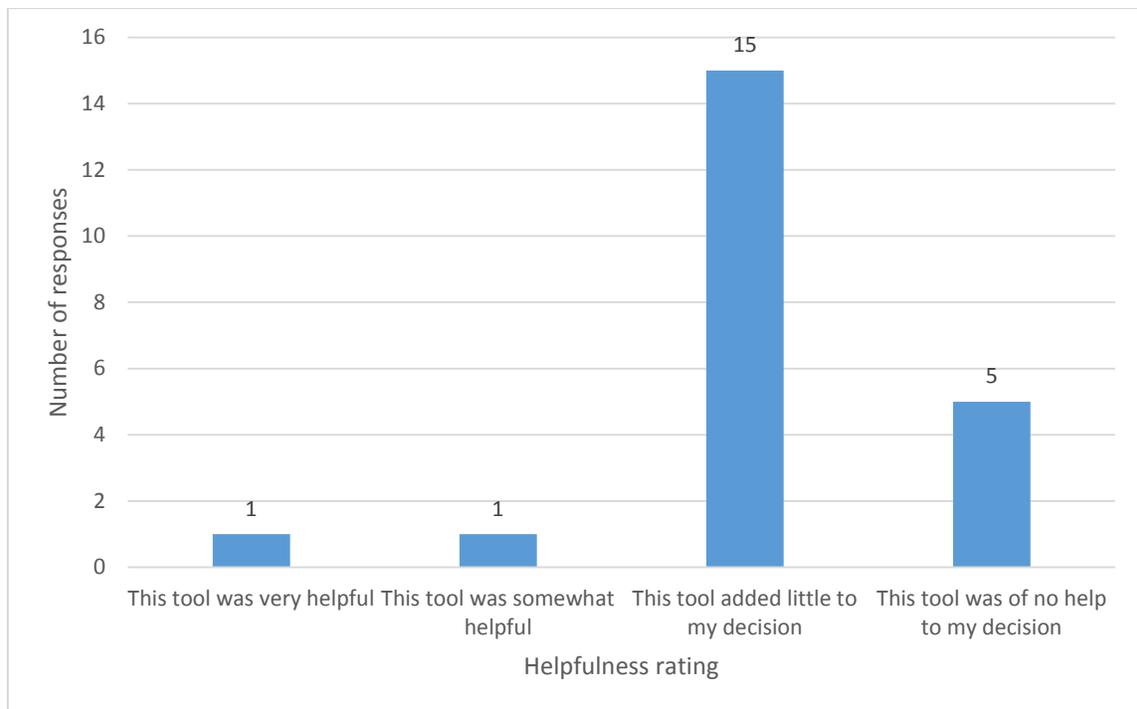


Figure 1. Aggregate Ratings of Beta Tool Helpfulness

As can be plainly seen in the figure above, the responses were overwhelmingly negative: 20 of 22 times, users felt the Beta Tool added little or nothing to the FTEE resource decision making process.

The free text responses were few and were also negative. The three quoted below are fairly representative of them.

“This tool was not as helpful as I hoped it would be. Currently, budgetary constraints are dictating the manner in which FTEE is [*sic*] approved. All of the domains listed have some impact, but the domains I usually focus on are patient safety, quality of care provided, timely access, and patient satisfaction.”

“The [QUAD member] used the revised integrated ethics [*sic*] tool during two [human resources] budget execution sessions in March 2014. This tool was primarily used when making decisions regarding requests for changes or additions to FTEE. During the budget execution meetings, a number of issues are discussed and weighed when making FTEE decisions. The process used by [facility] requires that the program requesting the FTEE provide substantial justification for the request. The program must describe how this FTEE will impact elements such as patient safety, quality of care, timeliness of service, and performance improvement.... [We] determined that this tool is not significantly helpful because our current process provides a mechanism that requires the program and the Quad member to consider several domains of value in making resource decisions.”

“Since viable alternatives did not exist, this tool did not change our decision making process. However, had alternatives existed the elements of this tool would need to be incorporated with a cost benefit analysis to be effective.”

We can draw at least two conclusions from these results. First, users clearly thought that in order for the tool to be “effective,” it must be used alongside a traditional cost-benefit analysis. This is not an unreasonable nor a surprising response from users accustomed to working in a data-rich, data-driven environment with limited resources. It seemed clear that the tool needed to either incorporate or be ready to interface with other more traditional decision making tools, like cost-effectiveness analysis.

Second, and somewhat more subtly, it seemed that users were having a difficult time seeing the *ethical dimensions* of their everyday decisions. Another way of putting this might be that they were having trouble distinguishing the *business case* in favor or against certain resource allocation decisions from the *moral case* for or against them. The second comment certainly conflates the two where it treats domains of ‘value’ like “performance improvement” as interchangeable with the values listed in the Beta Tool. “Look!” they were saying. “We require

substantial justification related to a bunch of value domains! We already do this! This is a waste of our valuable time.”

The users were thinking in terms of patient safety, quality of care, access to care, patient satisfaction, and performance metrics. They were not considering why they ought to bother worrying about these domains in the first place. I.e., they were not asking themselves “*Why* care about patient safety? *Why* do performance metrics exist?” The answer is, of course, that worrying about those things is the right thing to do.

Certainly we do not create performance metrics for their own sakes. They are means rather than ends in themselves. Maybe the real ends are not all moral, or at least are not all obviously moral; there are plenty of more and less superficial or business-related reasons to care about these. Not getting fired or sued, for example. Nonetheless, if VA’s mission and core values are any indication, VA’s top leadership publicly, explicitly acknowledges that there are moral reasons to strive for high quality of care and generally advance Veterans’ interests. For example, the very first of VA’s core values is Integrity, which is defined in part as “act[ing] with high moral principle” and “adher[ing] to the highest professional standards” (United States Department of Veterans Affairs, 2014c), where “the highest professional standards” presumably include various professional codes of conduct.

Being the foundation of what VA administrators do, ethics should not be disconnected from it during every-day resource allocation decision making. Rather, VA administrators must be constantly aware of their fiduciary duties to the American public, and also to their public health duties to Veterans and their families. Private, for-profit businesses, and even not-for-profit health care businesses, have very different ultimate aims from public entities. In particular, profit or net revenue are usually emphasized in favor of doing the right thing for the public.

As Joan McIver Gibson might put it, the pilot users of the Beta Tool were framing their decisions solely in terms of *economic values* like efficiency and *institutional values* like quality without also considering them in terms of *moral* or *social values* like fiduciary responsibility and fairness (Gibson, 2002). Focusing solely on the *business case* in favor or against certain resource allocation decisions, the interviewed administrators were not thinking in terms of their ultimate duties as public servants.

So, based on this feedback and subsequent analysis, it seemed clear after the pilot that the Alpha and Beta Tools' simple prompts were not effectively encouraging users to consider their resource allocation decisions in ethics terms. Perhaps users need a tool that makes more explicit connections between the 'values' they applied in practice and *moral* values, virtues, and ultimate ends. With this hypothesis in mind, the author of this essay conducted interviews in an attempt to test it. Thus began the revision process leading to the Gamma Tool.

V. BETA TOOL REVISION PROCESS AND THE THIRD ITERATION (GAMMA TOOL)

In early May of 2014, a request was sent to QUAD members in VISN 4 facilities for participation in interviews regarding the Beta Tool. Over the following month, seven QUAD members from seven VISN 4 facilities were interviewed via videoconference or teleconference for 30 minutes to 1 hour. The interview questions focused on the following: level of resources, training, guidance, and support QUAD members felt were available to them for making ethical decisions; how difficult resource decisions were usually made; how QUAD members employed extant policy and available data in making ethical judgments; and how they thought the Beta Tool could be improved in general. The full interview form is attached as Appendix D.

The responses fell into three broad categories: existing processes and approaches, the Beta Tool's domains and domain weighting, and the need for education and training. The following is an outline summarizing the responses gathered from the interviews:

- Existing Processes and Approaches
 - Most interviewees said that their facility had a requirement that supervisors requesting FTEEs submit some sort of formal justification for their requests.
 - Coatesville has a particularly good process and has submitted some relatively strong examples of justification.
 - Wilmington's resource committee regularly pulls in clinical or administrative subject-matter experts for consultation to fill in gaps in data and policy.
 - Some interviewees admitted that these justifications are not always submitted or reviewed.
 - At some facilities, decisions concerning emergent needs are expedited. They bypass the committee process and are made more quickly by fewer individuals.
 - Most interviewees gave the impression that their committees did not draw a clear distinction between the 'business case' and the 'ethics case' for or against a decision.
 - Some interviewees also struggled to distinguish legal and policy issues from ethics issues.
 - In one case, an interviewee reported that "ethical" issues are often referred to regional counsel due to the political difficulties associated with making potentially unpopular decisions locally.
 - All interviewees were senior leaders and most expressed strong reluctance to consult IE program staff who were their subordinates.
- The Tool's Domains and Weighting
 - Several interviewees believed the tool should prompt decision-makers to consider the health and welfare of employees.
 - Interviewees almost universally rejected the use of domain weights derived from the averages of all facilities' responses.
 - Few were able to clearly articulate the reason for their discomfort with the proposed approach.
 - Some complained that using general or universal weights was inappropriate in specific circumstances.
 - Some complained that the differing characteristics and missions of different facilities meant that the weights should be facility-specific.

- Some argued that the weights should be set based on Veterans' values rather than by administrators.
- Education & Training
 - Most interviewees agreed that education on ethical theory and training in the use of the tool should be provided.
 - One interviewee advocated scrapping the tool and only receiving education in ethics.

As can be seen, the interview responses raised a plethora of issues that required extensive analysis. The first revision that resulted was the addition to the Gamma Tool of instructions that drew on the general, formal resource allocation justification and decision processes submitted by the two facilities with the most robust practices. These practices were not specifically intended by QUAD members for ethical decision making, but rather for responsible, data-driven resource allocation decision making in general. They called for the examination of resource data and suggested several specific data sources, examination of how the decision would impact performance measures, and examination of the potential collateral or indirect costs that could result from the decision.

In response to the interview responses that seemed to confirm the hypothesis that users were having trouble thinking about their resource allocation decisions in ethics terms, the author of this essay integrated with these data and policy prompts four core questions taken from an existing IntegratedEthics resource: the NCEHC-produced *IntegratedEthics Triage Tool for Ethics-Related Leadership Decisions* (VHA National Center for Ethics in Health Care, 2008a), which explicitly ask users to consider numerous ethical dimensions of their decisions. These will be discussed in further detail in section VI. Literature Review.

It also became clearer that users who were most comfortable dealing with measurable, quantifiable output data and performance metrics might be more comfortable with quantitative approaches to ethical decision making. This led to the incorporation of the pre-Alpha Tool

domain weights, which had been unused since before the original pilot. However, they would be (literally and figuratively) only half of the equation: the author of this essay decided to attempt to draw on clinical decision analysis procedures.

In one approach to clinical decision analysis, the probability of each treatment option's success based on published medical literature is multiplied by the number of years of life the patient could expect to have with that treatment (also based on published medical literature). The product is an 'adjusted life expectancy' that can guide clinicians in their choice of one treatment over another. In another approach, years of life expectancy can be substituted with a quantitative rating score representing the patient's expressed preference for that outcome (Drummond, Sculpher, Torrance, O'Brien, & Stoddart, 2005).²

In the Gamma Tool, the preferred outcome or life expectancy half of the equation is occupied by the ethical domain weights. On the other hand, the probability of success of treatment options is substituted with a probability rating between one and ten that is supposed to be based on a combination of hard data and professional judgment. VHA is an extremely data-rich system and, as mentioned just above, the Gamma Tool includes instructions for examining available sources of data. Just as in clinical decision analysis, after the process is completed and the numbers are crunched, the Gamma Tool provides quantitative scores for each potential decision option.

In response to the broad rejection of the imposition of domain weights from outside a facility or outside a specific situation, the author of this essay added text encouraging users to consult with facility IE Program Officers, IE Councils, or ethicists if they wished to alter the domain weights that came with the tool. Senior leaders' aforementioned reluctance to consult subordinate IE program staff, who may have ethics subject-matter expertise and experience,

² For an excellent brief explanation of clinical decision analysis, see also (van der Velde, 2005).

combined with interviewees' stated interest in further education in ethics and training in the use of the tool, together militate strongly in favor of educating the leaders themselves. Unfortunately, this is an organizational need the tool itself seems unlikely to be able to address independently.

Also very significant were the interviewees' suggestions that domain weights ought to be based on Veterans' values rather than being set by administrators. This was certainly a good idea and one that will be addressed below, in section VI. Literature Review. Regrettably, the idea was not incorporated into the Gamma Tool.

VI. LITERATURE REVIEW

Perhaps the criterion for allocating health care resources that has the strongest intuitive appeal is need. It seems obvious that limited resources ought to be allocated first to those with the greatest burden of illness or the greatest capacity to benefit. However, we ought not to accept this unreflectively or without question. There are plenty of good reasons to doubt whether it is the best criterion to rely upon. At very least, it needs further analysis and development.

One obvious problem that both Jeremiah Hurley (Hurley, 2000) and Gavin Mooney (Mooney, 1998) point out is that 'need' is often difficult to define. Hurley discusses three potential general definitions. The first defines a need for health care as being in ill health and the degree of need as the severity of illness. The most serious problem with this definition, Hurley says, is that it ignores the fact that there are no effective treatments for some illnesses. I.e., no matter how sick someone is, if there is no effective treatment for the illness she has, then there is no need for health care, although there may be a need for other kinds of care (Hurley, 2000), e.g., hospice or palliative care.

The second definition Hurley discusses defines need with respect to particular objectives or outcomes, as in "Y is needed to achieve X." Implicit in this goal-oriented definition, Hurley

says, is the fact that Y can only be needed if Y has been demonstrated to be effective in achieving X. It might be added that Y must also be the most efficient or cost-effective method of achieving X. A further caveat may be added in the case of publicly funded health care: X must be an objective endorsed by the community as deserving of merit or as worthwhile. If not, it may be categorized as a mere 'want' rather than a real 'need.'

The major shortcoming of this definition is that, although it can establish when a need for health care exists, it does not clearly address questions concerning "how much health care is needed" (Hurley, 2000), i.e., how badly or how sorely health care is needed to care for a given condition, or in each person's case. Thus although it provides guidance in setting specific objectives based on effectiveness and community endorsement, when there are more objectives than can be accomplished with the available resources, this definition provides no guidance concerning which needs are greater and thus must be prioritized.

The third definition Hurley discusses defines need as whatever expenditure is required to reduce an individual's capacity to benefit to zero, or, in other words, to provide the maximum possible health improvement. One problem with this definition is that seems to confound extent of need with resources required to meet that need. I.e., under this definition, what is needed is whatever can reduce someone's capacity to benefit to zero and there is no difference between level of resource requirement and extent of need. In that case, if x units of resources are required to reduce an individual's capacity to benefit to zero, that person therefore has need equivalent to x units. This is a problem because, for example, a person with a bee sting allergy who would require a very cheap, simple shot of epinephrine to prevent a quick and certain death would have less need than someone with a moderate cataract in need of relatively costly, complex surgery (Hurley, 2000).

Another problem Hurley points out with need-based allocation in general is that, at least if it is formulated at the individual level, the principle is coercive; i.e., it implies that a person should receive health care if he needs it regardless of whether he wants it. This coerciveness clashes with other important principles like right of refusal and respect for individual preferences concerning methods of health improvement. However, it is less problematic in this respect when formulated at a higher level. We might say, for example, that the average expenditure on residents of a region corresponds with the need for health care in that region, but no one is forced to consume health care and heterogeneity of preferences can be preserved (Hurley, 2000).

Gavin Mooney points out that there has been little effort by providers, administrators, or politicians to use communities' values to determine what constitutes a legitimate health need or how resources ought to be distributed to meet health need. He writes:

“[n]eeds are defined by medical doctors, by health service planners and occasionally by politicians rather than by the community. It is normally the case too that there is no attempt made to determine the relative weightings that might be attached to health gains to different people or groups in a society.... It is assumed that what society wants from its health service is to have its health needs met and that it is indifferent with respect to the distribution of health gains to different potential participants (e.g. the very sick as opposed to the sick or indigenous populations vs non-indigenous populations)” (Mooney, 1998).

He argues that citizens *do*, in fact, care about the principles upon which health care policy is made and how resources are allocated. However, providers, administrators, and politicians often focus narrowly on the “epidemiological imperative of health maximization,” ignoring as inconsequential other principles that may be important to the community (Mooney, 1998).

In response to these issues with the principle of need, Mooney proposes replacing it with a different, more complex basis for health care resource allocation. However, despite all its shortcomings, it is difficult to ignore the value of the strong intuitive appeal of the principle of need, not to mention the ease with which the basic idea can be quickly grasped by almost

anyone. Therefore, in what follows, rather than an endorsement of Mooney's radical new approach, we shall see an attempt to defend the principle of need as a viable principle upon which to base the resource allocation tools that are the topic of this paper.

Probably the most straightforward of the definition three definitions given by Hurley, and also the most defensible in light of the characteristics of our tools, is the second one, i.e., the one that defines need with respect to particular objectives or outcomes, as in "Y is needed to achieve X." Even quite unsophisticated consequentialists would most likely be willing to endorse such a definition, as it is very flexible and carries very little normative ethical baggage. For example, to persuade a crude consequentialist, all one would have to say is that "the good consequence or outcome is X. To achieve X, Y is needed."

In the face of any objections concerning the efficiency of some potential Ys that might be raised by somewhat more sophisticated consequentialists like, e.g., greatest-happiness-for-the-greatest-number utilitarians in the tradition of Jeremy Bentham (Bentham, 2007) and John Stuart Mill (Mill, 2001), we could add that Y has been shown to be the most cost-effective means of achieving X.

Recall that Hurley's objection to this definition was that although it can establish when a need for health care exists, it does not clearly address questions concerning "how much health care is needed" (Hurley, 2000). This might be interpreted to mean that although this definition sets objectives, when there are more objectives than can be accomplished with the available resources, it provides no guidance concerning which needs are greater and thus must be prioritized. Whether intentionally or not, a clue to a reply to this objection is provided by Hurley himself. Recall that he suggested a caveat that may be added in the case of publicly funded health care, viz. that X must be an objective endorsed by the community as deserving of merit or

as worthwhile. To determine which objectives ought to be prioritized, we have only to consult the community, as Mooney and others suggest we do anyway.

Admittedly, under this definition all Xs are ‘needs’ and the definition itself does not allow for prioritization. However, without altering the definition, can we not acknowledge that some needs simply must go unmet? Why must the fact that some needs are greater or lesser be a part of the core definition? Alternatively, can we not, after consultation with the community, simply abandon some consequences as being good enough to rise to the level of being ‘needs’? Hurley acknowledged that we can make a distinction, particularly in the case of publicly funded health care (to which our tools are meant to apply), between two levels of goods: wants and needs. It is not difficult to imagine that we could be mistaken about what communities’ Xs are, i.e., what they need and what they merely want, before we ask them. Therefore, the Delta tool should contain explicit encouragement of community collaboration with regard to the prioritization of value domains.

In John Abbott Worthley’s book *The Ethics of the Ordinary in Healthcare*, he dedicates Chapter 7 to approaches to and tools and methods for ethical analysis. Specifically, in contrast with Mooney, Worthley is concerned in Chapter 7 with the process of ethical decision making rather than with analyzing ethical decisions in themselves. He delineates and discusses in detail multiple approaches to the ethical reasoning process (Worthley, 1997). This makes this particular discussion of Worthley’s particularly salient to our purposes in this section, which are primarily to analyze our tools and critique them from the standpoint of extant relevant scholarly literature.

Worthley argues that a well-developed ethical reasoning process is characterized by two things: community collaboration and systematic methodology. Regarding community

collaboration, he says the process of making masterful, clear, balanced ethical decisions “goes beyond one’s ‘internal thought experiment’ to dynamics such as asking friends, elders, and colleagues for advice, looking up precedents, and conversing with stakeholders.” He says, for example, that we must be able to draw upon first-hand experience of ethically complex situations, and that dialogue is crucial for sound ethical reflection. He sums up his arguments and those of the numerous others he cites in support of his claim in the following words: “[t]he message of all these ethicists is that a single-minded ethical reasoning process inevitably degenerates and debilitates judgment” (Worthley, 1997). Recall that Mooney raised similar concerns regarding the determination of what constitutes need and how limited resources ought to be distributed (Mooney, 1998).

The Alpha, Beta, and Gamma tools all certainly lacked any explicit encouragement of community collaboration in all cases. It might be argued that they contained some implicit encouragement in the language “The form should be utilized by those at the QUAD level when making resource decisions...,” but that is probably too subtle. It does not even go so far as would saying “The form should be utilized *by the QUAD* when making resource decisions...,” which would still be too unclear and weak.

The Gamma tool did strongly encourage the user to collaborate with others *if* she is not a subject-matter expert in ethics *and if* she wishes to alter the provided domain weights; however, that is not enough to meet Worthley’s standard. Therefore, the Delta tool should contain explicit encouragement of community collaboration with regard to the decision making *process*, as both Worthley and Mooney argue.

Regarding the second key to a strong ethical reasoning process, systematic methodology, Worthley writes that ethical decision making methodologies

“can be viewed as crutches that help us bear the weight of complexity and time constraints in the ordinary routine of healthcare, and as catalytic tools to help open airways for ideas that otherwise might be clogged over overlooked. A good methodology – customized to each healthcare professional’s thinking traits – opens the mind, frees reasoning capacity, and broadens awareness...” (Worthley, 1997).

Thus he views such methodologies as ways of helping us organize our thoughts more formally so that we can focus them in a hectic environment, and also as ways of spurring more thorough consideration so that we can expand our horizons. Furthermore, the quotation above implies, and later text makes clear, that Worthley does not include all the various methodologies he includes just for the sake of providing the reader with a thorough overview of common approaches; rather, he includes them all so that the reader can review them all and choose which is best for her as a professional. The “trick,” Worthley says, is to look for an approach that seems best for *oneself*, as an individual. Then one can test, customize, and refine the method until it reaches maturity and becomes habitual.

The first methodology Worthley describes is the ‘Check List.’ “Check Lists,” he writes, “are reminder notes. In ethics they help us to remember to factor into our reasoning items we tend to forget.” Just as they are helpful to pilots in boiling down the complexity of flying a jet, they can be helpful in simplifying ethical decision making (Worthley, 1997). The Alpha and Beta tools are both fundamentally examples of the Check List methodology.

A similar methodology to the Check List is Questions methodology. One approach to this methodology involves prompting the user to ask himself questions like “what might happen if...?” to consider the foreseeable effects of a decision, or simply “what?” to prompt the user to lay out all the facts at hand. A great feature of this approach is that the question list can very easily be adapted according to an individual professional’s needs, blind spots, and emotional hot buttons. (Worthley, 1997).

The Alpha, Beta, and Gamma tools all include a prompt similar to the latter question above, except it is not in interrogative form. The Gamma tool includes questions in the spirit of the former of these two questions in its section 3.b.iv., which, as mentioned above, was adapted from NCEHC's *Integrated Ethics Triage Tool for Ethics-Related Leadership Decisions* (VHA National Center for Ethics in Health Care, 2008a). These will be discussed further in section VI. Literature Review.

The third methodology Worthley discusses is called the Principles approach. In this approach, the user incorporates principles adapted from the normative ethics tradition of academic philosophy in order to examine an ethical situation from multiple dimensions, which the user may or may rank in order of overriding importance. The advantage of this methodology, Worthley writes, is that it recognizes that individual principles express only portions of the truth. Examining an ethical situation from multiple dimensions increases the complexity and insightfulness of moral reasoning.

These principles might include the principle of utilitarian benefit, or the principle that one should never take any action that does not result in greater good than harm (Worthley, 1997), which is apparently adapted from works in the tradition of the British philosopher and political economist John Stuart Mill's *Utilitarianism* (Mill, 2001). They might also include the universal rules principle, or the principle that one should never take any action that she would be unwilling to see another take in similar situations (Worthley, 1997), which is apparently adapted from the universalizability formulation of the great German philosopher Immanuel Kant's categorical imperative (Kant, 2012). They might also include more general principles like benevolence and justice

The fourth methodology described by Worthley, “for those whose minds are better opened with a nudge from numbers,” is the Decision Science approach. Using things like matrices, weighted utility models for attributes of various options, Likert scales, or performance data tables, this methodology provides a framework for organizing information and thoughts to assist the user in the ethical reasoning process. Worthley readily admits this methodology will involve subjective judgment, but nonetheless argues that it can be a valuable, systematic approach that can help a professional consider more clearly how each of the values in play is affected by each decision option in a complex situation (Worthley, 1997).

The reader will recall that the heart of the Gamma Tool is in fact a Decision Science matrix. Its quantitative characteristics are not unlike those of the tools used in clinical decision analysis and cost effectiveness analysis. Various kinds of data are fed into the tool, weighted, and the results are compared to aid in decision making.

More generally, though, the Gamma Tool aims to be a framework – like a flowchart, or perhaps more like a child’s coloring book with outlines to be filled in with color – to stimulate the user and guide him through the decision making process. Another metaphor is that of a bare skeleton, where the user is free to put flesh on the bones as she sees fit, but, again, with the aid of certain normative suggestions concerning what the product ought to finally look like.

The final methodology described by Worthley is one he calls the Consequentialism methodology. This methodology calls on the user to identify possible outcomes of various decision alternatives and compare those outcomes on a matrix in terms of positivity or negativity overall on one axis and likelihood on the other. That is, consequences may be classified on the matrix as, for example, possibly, probably, or certainly positive or negative. The advantages of this approach, Worthley argues, are that the user can organize his thought process, and in along

the way the people and groups who may be affected will be (one hopes) clearly identified by the user. Thus the user will be forced to countenance the harm of his decisions (Worthley, 1997).

The Gamma Tool does contain something this sort, though not in a matrix. In section 3.c.iv., taken verbatim from the *Integrated Ethics Triage Tool for Ethics-Related Leadership Decisions* (VHA National Center for Ethics in Health Care, 2008a), the Gamma Tool asks users to consider whether the likely benefits of their decision will outweigh any potential harms, whether their decision would keep a problem from recurring or establish a good precedent, and how it might look to people outside the organization. These three questions (particularly the first one) certainly have a consequentialist bent. Nonetheless, a purely consequentialist methodology, perhaps in the form of a matrix, seems to be another good candidate methodology for the Delta Tool.

VII. CONCLUSIONS AND RECOMMENDATIONS

Based on the findings of the preceding literature review, the Delta Tool should include the following revisions. First, the Delta tool should contain explicit encouragement of the kind of community collaboration Hurley, Worthley, and Mooney all argue for, viz., community participation in the decision making process. Furthermore, in light of Hurley's and Mooney's objections to reliance upon the principle of need, Hurley's caveat that X must be an objective endorsed by the community must be respected in order for the principle of need to be a viable foundation for decision making in the case of publicly funded health care. Community participation must be sought in both the initial prioritization of needs and the deliberation that follows.

In light of Worthley's arguments, it seems worth considering whether the Delta Tool should also include a way for users to choose from among multiple decision making

methodologies according to their individual talents and situations, and a way to encourage them to customize their chosen methodology to suit them even better. Should the Delta Tool, then, include a way for users to choose from among multiple methodologies for decision making instead of paternalistically choosing and pressing upon the user a one-size-fits-all methodology, as all three extant iterations do?

On one hand, this might help users find whatever methodology they are most comfortable with and encourage them to engage actively and thoughtfully with whatever methodology they choose. Above all, having these choices might make it more likely that users will bother themselves with using any version of the tool at all.

On the other hand, some of these methodologies are certainly much better than others. For instance, as discussed earlier, the abandonment of the Check List methodology of the Alpha Tool was the result of a considered decision based on its demonstrated shortcomings. For all the merits attributed to it by Worthley, the Questions methodology, on its own, does not include a ready framework for making evidence-based decisions. Likewise, for all its normative richness, the Principles approach includes no such framework. By all appearances, the Consequentialism methodology seems to be really just the Principles approach narrowed to include only consequentialist principles.

The Decision Science approach has what all the others lack, viz., a ready framework for systematically making evidence-based decisions. However, it lacks the kind of normative guidance provided by the Questions methodology and especially by the Principles approach and the Consequentialism methodology. While all of these individual methodologies have merits that would make them good candidates to be included as *parts of* the Delta Tool, none should stand alone.

Ideally, much like the Gamma Tool attempts to do, the Delta Tool should incorporate the best qualities of each of these methodologies. Specifically, it should include as its core a decision science matrix as a robust, ready framework for systematic, evidence-based resource allocation. Furthermore, it should include firm normative ethical guidance in the forms of questions and stated principles based on the core values of the organization as a whole. In light of our considered endorsement of Hurley's goal-oriented principle of need, in which goals endorsed by the community as deserving of merit or as worthwhile are indicative of what is needed, and in light of the above discussed compatibility of this principle of need with consequentialism, the Delta tool should take a consequentialist approach in which the goods or consequences aimed at are those endorsed by the community.

In the face of objections to the paternalism of this approach or questions about the practicality of identifying and consulting 'the community,' it might be pointed out that, despite its local activities in many communities throughout the country, VA is a federally-funded and federally-administered entity. VA administrators are therefore accountable not only to Veterans and their families in their local communities, but also to the American public as a whole. VA administrators everywhere are bound by the core values and policies of the national organization. In theory, these values and policies are representative of the collective wishes of the American people because they are promulgated by the people's elected representatives and their representatives' appointees.

Where discretion is deemed appropriate and granted to local, facility-level administrators, seeking participation in the decision making process by local community stakeholders could be accomplished in a variety of ways. Many VA administrators have, in the past, periodically hosted town-hall style meetings or developed focus groups in order to solicit general feedback

from local stakeholders. In August 2014, Secretary of VA Robert McDonald launched an aggressive listening campaign, requiring all VA health care and benefits administration facilities to hold town-hall meetings by the end of September of that year (United States Department of Veterans Affairs, 2014i), and in October ordered that they continue to be held quarterly thereafter (United States Department of Veterans Affairs, 2014k). These focus groups and town-hall meetings have been and will continue to be valuable sources of stakeholder input of all kinds.

There is solid evidence that there is sore need for a decision support tool that formalizes resource allocation decision making and renders it more transparent and participative. A 2007 study conducted on VA employees concluded that

“Clinicians commonly reported that they did not (a) understand their facility’s decision-making processes, (b) receive explanations from management regarding the reasons behind important allocation decisions, or (b) perceive that they were influential in allocation decisions. In addition, clinicians and managers both perceived that education related to the ethics of resource allocation was insufficient and that their facilities could increase their effectiveness in identifying and resolving ethical problems related to resource allocation” (Foglia, Pearlman, Bottrell, Altemose, & Fox, 2007).

Using something like the Delta Tool would change VA clinicians’ perceptions and take advantage of their valuable input by bringing them into the decision-making process. It would also increase effectiveness in identifying and resolving ethical problems related to resource allocation and, in addition to being a source of ethics education in itself, could spur more VA employees to take advantage of the educational resources provided by their local IntegratedEthics programs.

Using the Delta Tool or something like it might also help prevent major fiascos like, for example, the recent scheduling data falsification scandal. If lower-level employees could clearly see that their superiors were concerned about making resource decisions ethically, they would be

less inclined to misinterpret their superiors as having directed them to falsify data, or as aware of and passively allowing falsification of data, to make their facilities look better.

This is not entirely conjectural. Published research performed within VA itself has indicated that “[s]pecific ethics-related behaviors by leaders, such as talking about the importance of ethics, tend to encourage ethical practices and discourage unethical practices in the workplace.” It also pointed to other studies indicating that [l]eaders play an instrumental role in shaping an organization’s environment and culture...[and,] in turn, the environment and culture create the boundaries of permissible behavior for employees” (Foglia, Cohen, Pearlman, Bottrell, & Fox, 2013).

One major issue in the broader context that the Delta Tool and its predecessors are all ill-equipped to address directly, and perhaps one that cannot be directly addressed by the proposed Delta Tool nor anything like it, is the categorical and mercurial nature of Special Purpose funding. Local discretion is only so broad. Even VISN-level administrators are subject to politics and the whims of Congresspersons in the form of categorical funds appropriations and of national-level administrators in the form of regulatory interpretations of legislation. Even when Congresspersons and higher-level administrators have the best intentions, they are sometimes ill-informed and out of touch with day-to-day operations and Veterans’ local needs and preferences.

So, even if local administrators might be willing to use something like the Delta Tool in the decision making processes in which their limited discretion allows them to meaningfully engage, it is easy to imagine them becoming discouraged about pushing back against decisions made at higher levels that are well-intentioned and relatively well-informed but contrary to local ethical reasoning, or even against those that are ill-informed or misguided altogether. In fact, this

kind of discouragement was easily observed almost everywhere in VA this author has experience.

In a very large, bureaucratic organization like VA, some discouragement and frustration of this kind is unsurprising. It is an almost inevitable side-effect of the inflexibly hierarchical and rule-driven nature of machine bureaucracy, greatly exacerbated in VA's case by its large size and broad scope.

However, perhaps these side-effects are not truly inevitable, and the Delta Tool could be useful, indirectly, in mitigating them. Armed with well-reasoned, evidence-driven proposals and broad stakeholder buy-in (the foundations for which the Delta Tool could provide), administrators and clinicians at lower levels of the organizational hierarchy could provide their superiors with valuable input. Even if their proposals were not accepted, valuable dialogue could occur that would improve transparency, engage employees in the lower levels of the organizational hierarchy, and instill in those employees a sense of empowerment.

All of this is not to mention that evidence-based, well-reasoned, ethically-driven decision making is the right thing to do. For these reasons, VA should work to develop and promulgate resource allocation decision support tools like the proposed Delta Tool.

Emotional	Funds used for my FTEE decision will lead to Veterans feeling more emotionally engaged with VHA (more trusting)	
Sensory/Aesthetic	Funds used for my FTEE decision will lead to a healthcare environment that is more pleasing to Veterans	

Convenience	Funds used for my FTEE decision will lead to more convenient (timeliness, location) of health services for Veterans	
Emotional	Funds used for my FTEE decision will lead to Veterans feeling more emotionally engaged with VHA (more trusting)	
Sensory/Aesthetic	Funds used for my FTEE decision will lead to a healthcare environment that is more pleasing to Veterans	
Mandated Action (VACO or otherwise)		
Other value (specify)		

3. Rate whether this tool was helpful (expanded your thinking, clarified your choice, etc) in your resource decision

- This tool was very helpful
- This tool was somewhat helpful
- This tool added little to my decision
- This tool was of no help to my decision

Other comments about this tool are welcome and can be entered below:

APPENDIX C: GAMMA TOOL

Helping Leaders Make Wise Resource Decisions A Tool to Clarify Values

Instructions: Resource decisions made by leaders are often challenging and may require tradeoffs. The goal for this project in 2014 is to focus the use on FTEE issues. The form should be utilized by those at the QUAD level when making resource decisions about FTEE. The tool is designed to provide a framework for combining data, policy, and ethics. Its goal is to help decision makers think through difficult decisions by comparing their options in a clear, formal manner.

3. Write below briefly the nature of a difficult FTEE resource decision you had to make or are making:
4. Think about which of the value domains listed in the table on page 2 of this document apply to your decision making. If an important value domain is not listed, add it at the end and explain it.
5. Use the decision support worksheet to calculate decision support scores. **Obviously you cannot make an ethical decision with a calculator. Use the worksheet to help you organize data and articulate your thoughts.** Note that for each decision option:
 - a. Column A should contain the names of each of the value domains that you believe would be significantly impacted if you chose that option.
 - b. Column B (or a separate document) should contain a detailed **justification** of the impact estimate. The justification should clearly cite and discuss relevant policy and data. It should include:
 - i. workload data as appropriate (e.g., staffing methodology, DSS, nursing dashboard, panel size, comparative VHA data, etc.) to clearly show that workload supports the need for the position,
 - ii. a discussion of how filling the position will affect the accomplishment of the medical center's mission (the effect on performance measures, monitors, strategic planning initiatives, etc.),
 - iii. a discussion of what will happen if the position is not approved (cost of overtime, contract costs, impact on performance measures, etc., and **especially** impact on stakeholders), and
 - iv. answers to some or all of the questions below.

1. Does this decision reflect organizational, professional, and social values?

2. Do the likely benefits of the decision outweigh any potential harms?
 3. Will this decision keep a problem from recurring or establish a good precedent?
 4. How would this decision look to someone outside the organization?
- c. Column C contains each domain's fixed weight. The value domain weights in the sample worksheet were derived from VISN-wide consensus: action groups at each facility were asked to rate the importance of each domain on a scale from one to ten and these are the simple averages of their ratings. **If you are not a subject-matter expert in ethics, you should not alter these weights** without guidance from the facility's IE Program Officer, IE Council, or an ethicist. A brief explanation of each domain can be found in the table on page 2 of this document.
6. Fill each option's support scores for each domain in the table below.

Domain	Explanation/Example	If the domain will be significantly impacted, enter "Yes" and the domain weight.		
		Option 1	Option 2	Option 3
Quality of Life	Funds used for my FTEE decision are likely to improve the quality of Veterans lives.	Yes (9.22)	Yes (9.22)	
Survival	Funds used for my FTEE decision are likely to allow Veterans to live longer lives.	Yes (9.11)	Yes (9.11)	
Financial	Funds used for my FTEE decision are likely to allow Veterans more financial resources (less private sector out of pocket costs, etc.)	Yes (8.44)		
Autonomy	Funds used for my FTEE decision will provide more choice for Veterans in making decisions about their healthcare.			
Functional	Funds used for my FTEE decision will lead to Veterans being more functional (able to walk, etc.)			
Convenience	Funds used for my FTEE decision will lead to more convenient (timeliness, location) of health services for Veterans.			
Emotional	Funds used for my FTEE decision will lead to		Yes	

	Veterans feeling more emotionally engaged with VHA (more trusting).		(7.44)	
Sensory/Aesthetic	Funds used for my FTEE decision will lead to a healthcare environment that is more pleasing to Veterans.			
Mandated Action (VACO or otherwise) or law				
Other value (specify)				
	SUM:	26.77	25.77	

7. Rate whether this tool was helpful (expanded your thinking, clarified your choice, etc) in your resource decision

- This tool was very helpful
- This tool was somewhat helpful
- This tool added little to my decision
- This tool was of no help to my decision

Other comments about this tool are welcome and can be entered below:

Carefully review the instructions in the embedded document before completing this worksheet.

Option 1: ED RN FTEE							
<u>Impacted Domain</u>	<u>Discussion of Impact Estimate</u>	<u>Domain Weight</u>				Domain	Weight
Survival	See attached document	9.11				Quality of life	9.22
Quality of Life	See attached document	9.22				Survival	9.11
Financial	See attached document	8.44				Financial	8.44
						Autonomy	8.00
						Functional	7.78
	SUM:	26.77				Convenience	7.67
						Emotional	7.44
						Sensory/Aesthetic	5.11
						Mandated Action	
Option 2: MH FTEE							
<u>Impacted Domain</u>	<u>Discussion Impact Estimate</u>	<u>Domain Weight</u>					
Survival	See attached document	9.11				 VALUE FTEE Tool Instructions_ November 2014	
Quality of Life	See attached document	9.22					
Emotional	See attached document	7.44					
	SUM:	25.77					

APPENDIX D: BETA REVISION INTERVIEW TEMPLATE

Our goal is to create a tool that provides a framework for decision making. It should help decision makers think through difficult resource decisions (FTEE and others) based on relevant data, extant policy, and careful, formal examination of the ethical implications of their decisions. In order to make the tool as useful as possible, it is important for us to learn about what kinds of processes decision makers currently use and what kind of data and ethics guidance would be useful to them.

1. Do you feel you have adequate resources, guidance, and support to help you make difficult ethical decisions?
2. Does your facility have an ethics officer or committee that can be consulted when difficult resource decisions with significant ethical implications arise?
3. Please discuss a recent example of a difficult resource decision and how you or your resource committee decided what to do.
4. How often does data assist you in making an ethical judgment?
 - a. What strategies do you employ to predict the impact of your decisions? How useful is the available data?
5. How often does policy assist you in making an ethical judgment?
 - a. Which policies are the most clear and specific?
6. How comfortable are you relying on ranked domain weights that were derived from consensus? Would you be tempted to re-evaluate the assigned weights in some situations?
 - a. If you did wish to re-evaluate the assigned weights or take an altogether different approach, would ethical theory guidance or other formal training be useful?
7. In general, what could be added or subtracted to make the tool more useful?

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FIELD HEARING OF THE COMMITTEE ON VETERANS AFFAIRS, UNITED STATES HOUSE OF REPRESENTATIVES, AND THE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS, UNITED STATES SENATE, ON THE OPERATIONS OF THE TOMAH VA MEDICAL CENTER, TOMAH, WISCONSIN

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