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QUARTERLY

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CHA Catholic Health Association of the United States

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The Fourth Annual Catholic Healthcare Innovation in Ethics Forum

The fourth annual Catholic Healthcare Innovation in Ethics Forum (CHIEF) was hosted by OSF HealthCare in September 2022. Based on feedback from the previous year and ongoing concerns due to the COVID-19 pandemic, CHIEF was again held completely virtually. The CHIEF planning committee — made up of ethicists from Ascension, CHRISTUS Health, CommonSpirit Health, Hospital Sisters Health System, Mercy, OSF HealthCare, and Providence Health & Services — affirmed the goals of CHIEF: to provide a venue for ethicists working in Catholic health care to present innovative ideas or projects, receive critical feedback, and contribute to evolving the way Catholic health care thinks about and implements ethics.

In years past, we solicited talks on specific focal areas. For CHIEF 2022 we welcomed all proposal topics and encouraged submission in:

- Diversity, equity, and inclusion
- Organizational ethics
- Data ethics

As in previous years the two-day conference primarily relied on lightning talks for the presentations. Each presenter was limited to seven minutes and three slides (plus a title slide). Presenters were grouped by subject area, and each group was followed by a 45-minute panel discussion and Q&A with the presenters from that session. Over the two days, there were 21 presentations from 17 ethicists on topics ranging from "Ethics on TV: Connecting 'Armchair Ethics' to the Bedside" to "Organizational Interbeing: Bioethics, Strategic Planning and Climate Change."

Following the success of workshop sessions at CHIEF 2021, we solicited proposals for a workshop session at CHIEF 2022. We had one workshop session led by Dr. Alexandria Lescher, Manager of Clinical Ethics at Ascension Wisconsin, and Jessica Ullrich, Manager of Clinical Ethics at Ascension Oklahoma. Their workshop was titled: "Sharing the Practice: Five Reflections to Challenge Bias in Fertility Awareness Based Medicine."

We were once again blessed this year with a keynote presentation from a leader in the field, Ron Hamel, PhD. Dr. Hamel preserved the tradition of CHIEF keynote presentations offering more of a retreat-like engagement, his being "'What Are You Doing Here?' Musings on a Journey." Throughout the keynote, Dr. Hamel allowed for moments of reflection on key passages from 1 Kings 19:9-13 and we utilized break out rooms to discuss in small groups.

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Evaluation data indicates that CHIEF 2022 was again a success. While CHIEF 2021 saw higher registration numbers (79), CHIEF 2022 had very similar participation across all sessions (around 50 participants) with lower total registrations (64). We received 26 survey responses after CHIEF. Over 73% of participants thought the event had a "high" or "higher quality" when compared to other professional events attended. Over 60% of survey respondents indicated that they would "likely" or "very likely" make changes to the ethics services at their respective organizations as a result of attending CHIEF. Such changes include but are not limited to increase time and space for personal reflection and silence, incorporation of person-first language in EMR documentation, increased conversation about Fertility Awareness Based Medicine, and more intentional integration of ethics into organizational workflows. Nearly 90% of survey respondents rated the format of CHIEF as "higher value" and "much higher value" compared to other professional conferences. New to CHIEF 2022 was a $50 registration fee, which was waived for students. All survey respondents found a registration fee appropriate for CHIEF and 92% of respondents indicated that a $50 registration fee was appropriate. Finally, it appears from the collected data that regardless of whether we proceed in-person or virtual, CHIEF will continue to be well received as over 50% of survey respondents said, "CHIEF was great no matter the format."

We remain grateful to the Catholic Health Association for their offer to publish summaries of presentations in Health Care Ethics USA for presenters who wished to submit. We look forward to CHIEF 2023 again this fall, preserving its well-received format.

ENDNOTES

1. You can find more information about CHIEF 2022 here: https://www.missiononline.net/chief-2022-0920/.
2. Rachelle Barina, Ph.D., SVP, Chief Mission Officer, Hospital Sisters Health System; Becket Gremmels, Ph.D., VP, Theology and Ethics, CommonSpirit Health; Russell Keithline, MBA, System Director, Mission Innovation, CommonSpirit Health; Nick Kockler, Ph.D., VP, System Ethics Services, Providence Health & Services; Christopher Ostertag, MA, Ph.D.(c), Director of Mission Services OSF HealthCare; Jenna Speckart, MA, DBe, VP, Mission and Ethics, Mercy; Steven Squires, Ph.D., VP, Ethics, CHRISTUS Health; Birgitta Sujdak Mackiewicz, MA, Ph.D., Central Region, Director of Ethics, OSF HealthCare; Jessica Ullrich, MS, DBe, Manager of Clinical Ethics, St. John Ascension

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Ethics Integration: Other People's Processes

Mark Repenshek, Ph.D.
Matthew R. Kenney, Ph.D.

In a traditional or "reactive" model of ethics consultation, the ethicist or ethics services were available to clinicians and organizational leaders on an "as-needed" basis. In such a model, ethics services were almost entirely reliant on the ethics expert, and increasing the capacity to respond to ethical crises meant hiring more ethics FTEs. Ascension's Proactive Ethics Integration (PEI) paradigm began with the recognition that this expert-centered approach to ethics integration was not sustainable, nor did it allow for optimal integration. The PEI Paradigm calls for both an embedded and integrative service modality.

The embedded service modality consists of equipping and empowering individuals in key clinical and organizational roles who are not trained ethicists to participate in ethics processes (e.g. institutional ethics committee members and key operational leaders, referred to as Embedded Ethics Resources or EERs). The role of these EERs is not necessarily to resolve ethical issues, or replicate the role of trained ethicists, but to integrate to a greater-than-usual degree an "ethical lens" in the daily work for which they have primary responsibility. In this way, the EERs can help identify and triage ethical issues, and perhaps, in some instances, address some of the more common and less complex issues with the support of tools and resources developed by ethicists. One primary goal of this embedded approach is to expand the number of people paying attention and responding to the ethical issues that most impact spiritually-centered, holistic care in the clinical context and our identity as a healing ministry of the Church in the organizational context. This, in turn, helps support a culture of mutual accountability for our mission, vision, values and Catholic identity across the entire organization and its daily operations.

The integrative service modality, which is the focus of this article, requires the integration of ethics into other people's processes. This approach seeks to integrate the principles of Catholic identity along with Ascension's mission, vision and values into clinical and operational processes in such a way that ethical issues are addressed with the ethicists serving in the role most appropriate to the circumstances. In this way, integration goes beyond the embedded modality of providing ethics services insofar as it strives to integrate ethical considerations into the key processes through which various operations occur with minimal support from a professional ethicist. This is done through mutual collaboration between ethics and relevant subject matter experts within other primary disciplines, departments, and ministry wide functions in developing the operational processes owned

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by those other subject matter experts that include an explicit, if not prominent, ethics component. Here the key distinction between "embedded" and "integrative" is that, in the embedded modality, ethics creates resources, tools and processes into which others are integrated, or embedded, into the delivery of ethics services, whereas in the integrative service modality, ethicists are collaborating with other disciplines to integrate ethical considerations into their processes, resources, and tools. In this way, ethical considerations are accounted for within the primary clinical or operational process itself. That said, neither the embedded nor integrative approach precludes the need for professional ethicists' subject matter expertise as the complexity of the situation warrants. When this type of integration occurs, the ethical considerations inherent in a business or clinical process are accounted for in a self-sustaining way, and consultation with an ethicist is only needed when the process itself is limited or the complexity of the issue requires it. This kind of integration is truly self-sustaining and responsibility for ensuring ethical issues are addressed within the process is owned by the very persons who make up the department or service line. In this case, the role of ethics becomes continuous monitoring of the processes to make sure they are functioning as intended, to catch any misses, and provide back-up support only when the process is not sophisticated enough to account for every possible ethical nuance. Two examples of such an approach are outlined below.

INTEGRATION OF ETHICS INTO ASCENSION MEDICAL GROUP

By way of context, Ascension operates about 2,600 sites of care in 19 states and the District of Columbia and has about 9,000 employed providers and 40,000 aligned providers. Ascension Medical Group (AMG) is Ascension's physician-led national provider organization. As care delivery continues to move from a volume to value-based system, and from an acute care focused delivery model to one which focuses on the continuum of care, AMG is a key service line within which ethics must integrate in order to meet the needs of the clinicians and patients we serve.

One key area of focus for integration into an AMG-owned process is service line committees and workgroups, especially high priority service lines such as maternal health and perinatal medicine, behavioral health, palliative care, patient safety and quality, and ad hoc work groups such as those established during the onset of the COVID-19 pandemic. Ethics integration into these service line committees and workgroups at both the national and ministry market levels contributes to both improved awareness and utilization of ethics services as well as the ability to respond real-time to ethical considerations that arise within the context of the committee's scope of work. In addition, it has proven to contribute to collaboration in other areas such as education, policy development and review, and both organizational and clinical consultations.

Another significant area of integration has been AMG processes for recruitment, selection, onboarding, and orientation of new providers. This includes the development of Catholic identity and Ethical and Religious Directives for Catholic Healthcare Services (ERDs), talking points for recruiters, and, in collaboration with AMG, the development of

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talking points and other resources for medical directors and physician leaders regarding hiring for fit, ERDs, and Catholic identity, which provide guidance on responses to clinical questions that may be raised by clinicians both in the hiring process as well as during onboarding. In addition, Ascension's Ethics Advisory Community (EAC) developed a standardized, national New Clinician Orientation which is facilitated by an ethicist, but integrated into the existing AMG orientation process. Lastly, as was expounded upon in a previous issue of Health Care Ethics USA[1] the EAC has collaborated with Ascension's Graduate Medical Education (GME) Council to develop and implement a three-year Medical Resident Ethics Curriculum, which is co-facilitated by ethicists, medical residents, and GME faculty from across the system and available live and on-demand to all Ascension associates. These examples illustrate both a responsive and integrative approach to ethics services which, ideally, leads to a self-sustaining model through which ethical considerations are accounted for within the primary clinical or operational processes of AMG itself.

INTEGRATION OF ETHICS INTO THE PROCESS FOR SOCIALLY JUST TRANSACTIONS

Another benefit of integrating ethics into other people's processes is the ability to ensure that ethics services are engaged in the right way at the right time. This enables the ethics services to better facilitate the completion of the individual tasks required to ensure both that the operational outcome is achieved, and that it is achieved in a way consistent with Ascension's Catholic ministry identity. One area in which this is particularly important concerns those processes in which Church relations has a role and, specifically, when our local ordinaries have input relative to particular decisions or actions. One example of this type of process is an Ascension procedure which governs all transactions including divestitures (and alienation when divesting of stable patrimony). The critical tasks and responsibilities for canon law, ethics, and Church relations have been integrated in each stage of this procedure. Depending on the stage of the transaction, responsibility for ensuring that our commitment to our identity as a healing ministry of the Catholic Church is outlined within the procedure and corresponding process maps associated with the procedure.

By way of example in the context of a transaction that would involve a divestiture, through this integration, we are able to ensure that every divestiture is structured in a such way as to:

- Minimize any potential negative impact on the ability of the community's needs to be met;
- Minimize any potential negative impact on the ability of those who may struggle with economic poverty and/or suffer the effects of social marginalization to access health care;
- Ensure fair and just treatment of the impacted associates consistent with Ascension's own policies and practices;
- Assess any impact on the Catholic presence throughout the community;

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- Ensure the transaction is consistent with practices of good stewardship;
- Attend to the canonical requirements of alienation;
- Obtain the support and/or necessary approvals of the local ordinary (i.e., bishop); and,
- Facilitate any potential agreements between the purchaser and the local ordinary relative to any continuing Catholic commitments post-close, should either party desire such.

Some of these tasks require a collaborative effort across some or all members of the transaction team along with subject matter experts in canon law, ethics and Church relations. This approach of integrating into the existing collaboratively-owned procedure results in a seamless integration of considerations regarding Ascension's Catholic identity, mission, vision and values are included throughout the entire process in a way that is not dependent on any one person. This further ensures that the appropriate communications required to secure the support and/or approval of the local ordinary are completed at the appropriate time within the process and in the appropriate way so as to avoid any unforeseen delays.

The PEI paradigm continues to mature across all of Ascension. Through this maturation, we continue to gain new insights that enable us to more clearly articulate the different ways in which ethical considerations (i.e., our mission, vision, values, Catholic social, moral teaching and Catholic moral principles) are integrated into clinical service lines and operations. What we have come to realize through this maturation, is that the PEI paradigm calls us to think differently about how we do ethics. Within this paradigm, the goal is to influence an organizational culture that prioritizes the fulfillment of our mission, vision, values and Catholic identity amidst competing pressures. PEI, then, is best understood as a systems-thinking approach that includes but goes beyond a "service delivery model" and enables organizational transformation. ✠

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ENDNOTES

1. Kenney, M and Ward, C. "Standardizing virtual medical residency ethics curriculum- a high reliability endeavor. Health Care Ethics USA, Winter/Spring, 2022, 29-32.

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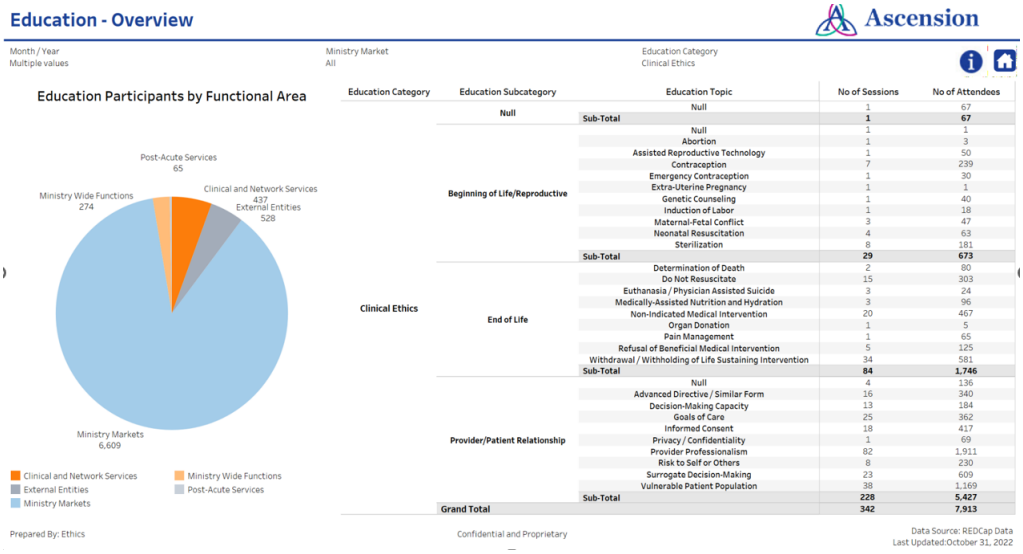
Ethics Consultation and Education: The Chicken or the Egg?

Matthew R. Kenney, Ph.D.

By comparing data visualization charts utilizing Tableau which delineate both clinical consultation and ethics education categories, this article will explore a correlation between the proportions of the number of attendees in clinical ethics education sessions and the number of clinical ethics consultations in the same subcategories. This correlation gives rise to a question:

Is clinical ethics education being provided in response to the level of clinical consultation requests, or do education sessions lead to a greater awareness of the topic and a correspondingly higher volume of related consultations?

The graphic below shows the total of clinical ethics education activities and participants broken down by functional area (see pie chart on the left) and by education topic (see table to the right), for FY21 - FY22 combined. Ascension's Ethics Center of Expertise provided or co-presented 342 clinical ethics education opportunities reaching 7,913 participants in FY21 and 22, in addition to the 475 Ethics Integration Committee members who participated in 57 virtually-delivered or in-person Clinical Ethics Intensive events. Of those 342 education sessions, the vast majority (228 sessions reaching 5,427 attendees) were related to provider-patient relationship topics.



Education Category	Education Subcategory	Education Topic	No of Sessions	No of Attendees
Clinical Ethics	Null	Null	1	67
		Sub-Total	**1**	**67**
	Beginning of Life/Reproductive	Null	1	1
		Abortion	1	3
		Assisted Reproductive Technology	1	50
		Contraception	7	239
		Emergency Contraception	1	30
		Extra-Uterine Pregnancy	1	1
		Genetic Counseling	1	40
		Induction of Labor	1	18
		Maternal-Fetal Conflict	3	47
		Neonatal Resuscitation	4	63
		Sterilization	8	181
		Sub-Total	**29**	**673**
	End of Life	Determination of Death	2	80
		Do Not Resuscitate	15	303
		Euthanasia / Physician Assisted Suicide	3	24
		Medically-Assisted Nutrition and Hydration	3	96
		Non-Indicated Medical Intervention	20	467
		Organ Donation	1	5
		Pain Management	1	65
		Refusal of Beneficial Medical Intervention	5	125
		Withdrawal / Withholding of Life Sustaining Intervention	34	581
		Sub-Total	**84**	**1,746**
	Provider/Patient Relationship	Null	4	136
		Advanced Directive / Similar Form	16	340
		Decision-Making Capacity	13	184
		Goals of Care	25	362
		Informed Consent	18	417
		Privacy / Confidentiality	1	69
		Provider Professionalism	82	1,911
		Risk to Self or Others	8	230
		Surrogate Decision-Making	23	609
		Vulnerable Patient Population	38	1,169
		Sub-Total	**228**	**5,427**
Grand Total			**342**	**7,913**

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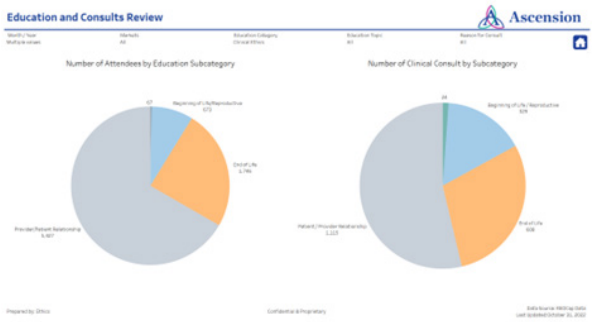
The remaining sessions were divided across beginning of life/reproductive topics (29 sessions reaching 673 attendees) and end of life topics (84 sessions reaching 1,746 attendees). The pie graphs below illustrate a correlation between the proportions of the number of attendees in clinical ethics education sessions and the number of clinical ethics consultations in the same subcategories. In other words, the number of attendees in clinical ethics education regarding beginning of life subcategory and the number of clinical ethics consultations in the beginning of life category are the smallest segments of the pie; the end of life subcategory in both number of education attendees and clinical consultations are the next biggest segments; and, finally, the provider-patient relationship subcategory is the biggest for both clinical ethics education attendees and subcategory of reason for consults.



This correlation gives rise to the above-mentioned "chicken or egg" question: is clinical ethics education being provided in response to the level of clinical consultation requests, or do education sessions lead to a greater awareness of the topic and a correspondingly higher volume of related consultations? Two competing hypotheses emerge in response to this question. The first concerns whether the education topics are determined in response to the volume of clinical consultations, implying that education efforts are predominantly within the "responsive service modality." The responsive service modality essentially consists of ethicists responding to clinical consult requests and supporting organizational decision-making at the discretion of clinicians and operational leaders. The responsive service modality is more like traditional consult support but with the goal of being less reactive (i.e. putting out fires in the 11th hour) and -- to a greater extent -- informed by communal reflection in light of shared experience, data analysis and best practices from across Ascension. The goal, here, is to use the data collected through our Ethics Integration Database (EID) and the collective wisdom and experience of Ascension's Ethics Advisory Community (EAC), comprised of ethicists across the system, to minimize those scenarios where the urgent and emergent issue does not allow time for critical thinking and reflective practice. The second hypothesis concerns whether more clinical consults arise as a result of attendees' ability to better recognize when a consult is appropriate as a result of the education. In this sense, Ascension's education efforts serve a more "embedded service modality," insofar as they are equipping and empowering those receiving the education to more effectively participate in the ethics process. Further analysis of these hypotheses is merited, as we have now seen a significant correlation in this trend over two fiscal years (FY21 and FY22). It would not be surprising if the answer turned out to be a "both-and" where we both provide additional education in response to increasing or significantly complex clinical consults in a given area, and where increased education on a topic leads to a greater awareness of the ethical dimensions of care at play within the topic, and the need for ethics support in navigating these issues.

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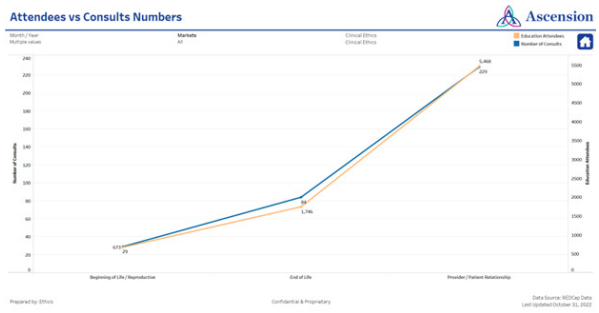
Though we will not undertake that additional analysis here, the graphs below provide a view of how the number of attendees of education sessions on particular topics in the clinical realm correlate with the number of consults per clinical consultation on the same topic. At this level of generality, the correlation is close enough that the two lines representing the number of attendees in relation to the number of consults per clinical consultation subcategory (i.e., Beginning of Life, End of Life and Provider-Patient Relationship) overlap almost perfectly, suggesting a strong relationship.



When we look even deeper into the attendees of education sessions by topic relative to the same reason for clinical consultation within the subcategories (i.e., Beginning of Life, End of Life and Provider-Patient Relationship ordered as such below), as demonstrated in the line graphs below, we see that there is only slight variation. Even without being able to read the full details of the chart, one can see that the general shape of the lines of the graph still follow the same pattern, suggesting that the substantial correlation between the number of education attendees and the number of clinical consults extends beyond the broader categories of Beginning of Life, End of Life and Provider-Patient Relationship to the more granular level of "reason for consult."

BEGINNING OF LIFE/REPRODUCTIVE (FINANCIAL YEAR '21 AND '22)

END OF LIFE (FINANCIAL YEAR '21 AND '22)

PROVIDER-PATIENT RELATIONSHIPS (FINANCIAL YEAR '21 AND '22)

Although we have not delved deeply enough into these data to answer the questions posed by the two hypotheses above, we already know that the responsive modality of ethics education is an important activity that supports an ethical culture of care and strengthens

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Ascension's identity as a healing ministry of the Catholic Church. Ascension's Proactive Ethics Integration (PEI) paradigm was never intended to eliminate the need for ethicists to be available to respond to requests and needs of the organization. To the contrary, the idea of being responsive to the needs of those we serve and those with whom we serve is critical to the success of the PEI paradigm. What this approach does seek to eliminate is a reactive posture, in which the need to respond urgently and quickly takes precedence over reflection regarding all relevant values given our Catholic identity and both short-term needs and long-term solutions. In short, it is much more difficult to provide high quality ethics services that shape the ministry identity and culture of the organization consistent with our Catholic values, if one is only and constantly "putting out the next fire." A responsive posture, on the other hand, enables a quick and timely but still comprehensive response at the right time, in the right place, by the right person.

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The Ongoing Journey of Data Visualization in Ascension

Mark Repenshek, Ph.D.

[1]In 2021 I was privileged to join Drs. Trancik and Ostertag to write on the first data visualization elements coming from our use of Tableau and REDCap as part of the third annual Catholic Healthcare Innovation in Ethics Forum.[2] We mentioned in that article how the visualization of our data helped to "tell our story" in ways we had not been able to in the past. As that journey continues, it is the goal of this piece to share more of that story.

A development on the data entry side, is the capturing of data that reflects our appreciation for the fact that the work we do has just as much to do with whom we collaborate with to deliver ethics resources as it does our own professional practice. As such, we have been able to construct access to our database to take advantage of the work of our Chief Mission Integration Officers (CMIOs) relative to proactive ethics integration (PEI). Ascension ethicists and CMIOs have gathered data in a standardized and systematic way through the Ethics Integration Database (EID) for over two consecutive years. The data in Table One, for example, utilizes data visualization to illustrate the volume levels of different types of services provided through the Ethics Centers of Expertise (CoEs) and the CMIOs. Capturing this more comprehensive set of data helps inform how we understand the work of ethics across multiple service types and roles.

SERVICE TYPES OVERVIEW

The pie chart in the upper, left-hand corner of Table One conveys the volume of ethics activities by the service types. This pie chart shows the proportion of activity in each service type in relation to the whole of all services. As in years past, consultation represents just over half (53%) of all service activities. (It is important to note "consultation" here includes both clinical and organizational as those terms are understood within Ascension). The table below the large pie chart quantifies those proportions. These data are not reflective of the time commitment required, or time spent, providing these services. These numbers and percentages are better understood as representing "demand" rather than time. It is also important to clarify that the services listed here are not to be viewed as comprising all domains of our work. The five listed -- consultation, committee work, education, church relations, and discernment facilitation -- comprise those services which the organization understands as that which the Ethics CoEs commit to delivering across the system. The smaller pie charts on the right side illustrate the proportion of those services performed by the different roles within the ethics structures along with the CMIOs. These smaller pie charts provide a quantitative picture that confirms that each of the individual roles within the structure are functioning as they have been designed across the Clinical Ethics CoE and

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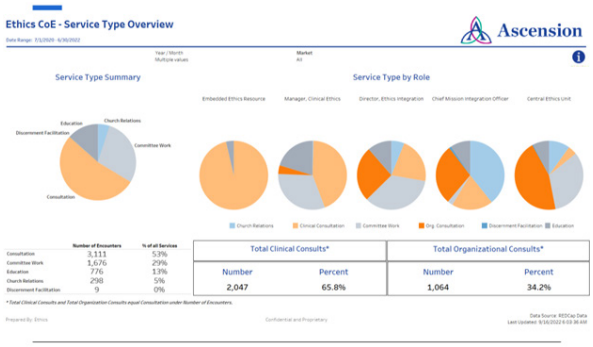
the Organizational and Church Relations CoE. The number and division of consults between the clinical and organizational consult service types is as expected and consistent with the data of previous years within Ascension (i.e., 65.8% and 34.2% of service type "consultation," respectively).

TABLE ONE

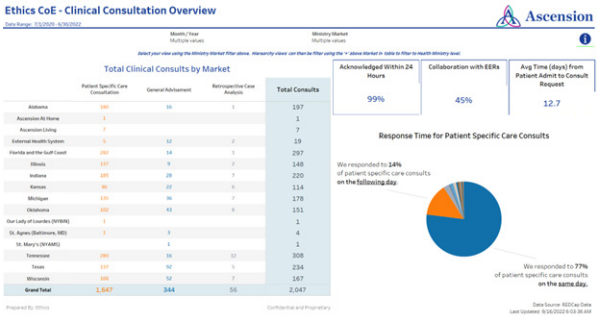


CLINICAL ETHICS CONSULTATION

In looking at the clinical consultation volumes by ministry market relative to our consultation taxonomy (i.e., patient specific care consultation, general advisement, retrospective case analysis), we continue to see an upward trend in patient-specific care consultations year over year (FY21: 705 and FY22: 946 -- not illustrated here). This is significant insofar as patient-specific care consultations constitute the primary way in which ethics supports spiritually-centered, holistic care in the clinical setting as articulated within Ascension's mission statement and explicitly called out as a principle of Catholic identity.

Within Ascension, it is also important to keep in mind that patient-specific care consultation is only one subtype of one service type out of many and does not constitute the whole of the responsibilities of the ethicists, including, and perhaps more importantly, the managers of clinical ethics. Along with clinical consultation, the managers also have primary responsibility for leading the Ethics Integration Committees (EICs), participating on clinical workgroups, clinical ethics education, clinical policy review and development, and identifying and developing integrated solutions to recurring ethical needs within clinical care processes (i.e., ethics programming, services and integration). The larger the ministry market, the more these other responsibilities compete for the time, attention and presence of the ethicists.

TABLE TWO



The additional quantitative data regarding clinical consultations, pictured to the right of the table "Total Clinical Consults by Market," also tell us a little about the quality of the service provided. For example, in Table Two, we note 99 percent of all patient-specific care consults are acknowledged within 24 hours, whether by an ethicist or by an Embedded Ethics Resource (i.e., Ethics Integration Committee Members identified as EERs). Moreover, 77 percent of all patient-specific care consults are responded to, (i.e., the work of addressing the issue began in earnest), on the same day, with another 14 percent responded to on the very next day after the request was made. Considered together, these data suggest that the structures and processes we have put

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in place for identifying and addressing the ethical dimensions of patient care are effective, responsive, and highly reliable.

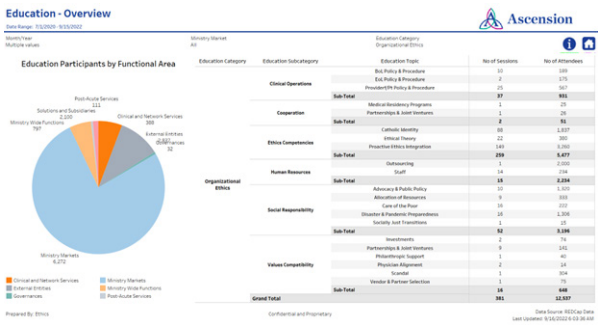
Likewise, the fact that across the entire system, 45% of all patient-specific care consultations involve collaboration with an EER indicates that the capacity to identify and respond to ethical dimensions of patient care is being integrated in organizational structures, processes and operations. Moreover, this capability is not solely dependent on a trained expert being involved in a clinical care process in order to identify and respond to ethical dimensions of patient care. Together these clinical consultation metrics suggest that the organizational layers of a director, ethics integration, manager of clinical ethics, and EERs ensure high reliability in support of spiritually-centered, holistic care.

EDUCATION OVERVIEW

Although we capture data on education in the clinical context as well as organizational, the presentation from the Catholic Healthcare Innovation in Ethics Forum (CHIEF) Presentation 2022 focused entirely on the latter. In large part, this is because work done by my colleague, Matthew Kenney (also featured in this volume of Healthcare Ethics USA), which focuses on education in the clinical context, offers a more in depth analysis of the relationship between clinical consultation and education.[3]

Table Three shows the total of organizational ethics education activities and participants broken down by functional area (see pie chart on the left) and by education topic (see table to the right). The Ethics CoEs provided or co-presented 381 organizational ethics education sessions reaching 12,537 participants over the period July 1, 2020 through September 15, 2022. While FY20 saw the first decrease in participants in organizational education sessions (184 education organizational ethics sessions with 3,290 participants–not shown here), largely due to the disruption of COVID, FY21 and FY22 saw a sharp increase in organizational ethics education. Of the 381 organizational education sessions, a majority (259 sessions reaching 5477 attendees) were related to Ethics Competencies topics. The remaining sessions were divided across Social Responsibility (52 sessions reaching 3,196 attendees), Clinical Operations (37 sessions reaching 931 attendees), Human Resources (15 sessions with 2234 attendees), Values Compatibility (16 sessions reaching 648 attendees), and Cooperation (2 sessions reaching 51 attendees).

TABLE THREE



The value of these data is in the fact that it helps us to quantify the impact we have based on the number of associates in a given geography or within a particular operational or clinical service line. For example, ethics leadership provided an education session to nearly 2,000 associates at the request of Ascension Technologies. The focus of this session was on Ascension's use of the Organizational Ethics Discernment Process (OEDP) for major decisions. This example of

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a requested education session was designed to address an outstanding need for a large number of associates to understand how Ascension Technologies was taking Catholic identity and the principles of Catholic social teaching into account as part of its strategic decisions, and how those decisions reflect Ascension's values and ministry identity. This education was particularly important given a new approach to engaging the OEDP that is more integrated -- employing principles of agile thinking -- into the business decision-making processes that helped clarify how Ascension's mission, vision, values, and Catholic identity are considered alongside and on par with the business objectives. These data can help us to illustrate, as in this specific example, the magnitude of the education as a percentage of total associates who fall under Ascension Technologies (i.e., 2000 as X% of total Ascension Technology associates).

These data can also be used to highlight integration of ethics education initiatives. An example of a more integrated approach to education is illustrated by the inclusion of two courses, one on catholic social thought and one on Catholic bioethics, in Ascension's Executive Ministry Leadership program. Previously, ethics led only one course on Catholic healthcare ethics. These two foundational courses now kick off Ascension's two-year formation program and are designed to empower and equip leaders from various areas across the system to recognize when and how the principles of Catholic social teaching and Catholic healthcare ethics are relevant in their daily work.[4] Using these data to examine educational programs within a particular strata of the organization allows us to explore the impact of these educational programs beyond the episodic requests.

CONCLUSION

As we continue to explore the benefit of the interface between REDCap (data entry) and Tableau (data visualization), we find ourselves asking new questions. It seems that it is often through visualizing the data that we come to new insights demanding further study. We know this work will be ongoing as we continue to explore new questions, but it is also through this exploration that we refine the data entry itself. Regardless, as was true in 2020 and remains to date, "a single data repository for analytics has been incredibly beneficial to improve both the quality of the work we do and inform decision-making for the Ethics CoEs across the entire organization." ✣

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ENDNOTES

1. All tables illustrating data in this manuscript are only those shared during the fourth annual Catholic Healthcare Innovation in Ethics Forum (CHIEF) Presentation 2022 and so may be a bit outdated based on current analytics.
2. M. Repenshek, C. Ostertag and E. Trancik, "Data Entry and Analytics: One Year with Ascension's Ethics Integration Database." HCEUSA volume 30, number 1 (Winter/Spring 2022): 4-7.
3. M.R. Kenney, "Ethics Consultation and Education: The Chicken or the Egg?" HCEUSA (Witner/Spring 2023).
4. M. Repenshek, M. Kenney and C. Mueller, " Integrating Ethics in Formation: Exploring Courses in Leadership Formation." HCEUSA volume 29, no. 1 (Winter 2021): 21-23.

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Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, Executive Director, supervised contributions by Caela M. Camazine, J.D./M.P.H. anticipated 2024 and Mary Schnellmann, J.D. anticipated 2024.

CDC SIGNS OFF ON UPDATED COVID-19 BOOSTERS

Brenda Goodman, *CNN*, September 1, 2022. https://www.cnn.com/2022/09/01/health/acip-cdc-updated-covid-booster/index.html

In early September, Dr. Rochelle Walensky, director of the CDC, approved an independent vaccine adviser's recommendation in favor of updated Covid-19 booster vaccines from Pfizer/BioNTech and Moderna. The updated boosters have been formulated to better protect against more recent variants of Covid-19 and may, "help restore protection that has waned since previous vaccination." The CDC emphasized that the decision followed a comprehensive scientific evaluation and, "robust scientific discussion." Pfizer/BioNTech's updated vaccine is a 30-microgram dose authorized for people 12 and older. Moderna's updated vaccine is a 50-microgram dose authorized for people 18 and older. An individual is eligible for the updated booster if they have completed all primary doses in the recommended vaccine series. Analyses of the cost-effectiveness of the boosters suggest potential savings of over $63 billion between August 2022 and March 2023 if as many people get these boosters as got flu shots during the 2021-22 season. At the time of publication, nearly two-thirds of the total U.S. population was vaccinated against Covid-19, though less than half with the initial series has also gotten a booster.

JUUL TO PAY $438.5 MILLION IN SETTLEMENT WITH DOZENS OF STATES OVER MARKETING TO UNDERAGE PEOPLE

Jen Christensen. *CNN*, September 6, 2022. https://www.cnn.com/2022/09/06/health/juul-settlement-marketing/index.html

The e-cigarette manufacturer will pay over $438 million to 34 states and territories following a finding that the company deliberately marketed to young people, even though cigarette sales to children are illegal. The company marketed to young people by offering free samples, utilizing social media campaigns, and casting young actors in advertising campaigns. In addition to paying out the settlement, Juul's sales and marketing abilities will be restricted regarding people under 35. Additionally, in-store displays, as well as online and retail sales will be limited. Prior to this settlement, the FDA rebuked Juul for its marketing practices and ultimately ordered the company to stop selling its products, though a court blocked that ban. As the company works through the FDA's administrative appeals process, it continues to sell its products, though subject to the restrictions as described in the multi-state settlement. The states and territories involved in the settlement include: Alabama, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maryland, Maine,

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Mississippi, Montana, North Dakota, Nebraska, New Hampshire, New Jersey, Nevada, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, Vermont, Wisconsin, and Wyoming.

BIOTECH CO-FOUNDER, FACING MURDER-FOR-HIRE CHARGES, ACCUSED OF FABRICATING DATA

Joseph Walker, *The Wall Street Journal*, October 24, 2022. https://www.wsj.com/articles/biotech-co-founder-facing-murder-for-hire-charges-accused-of-fabricating-data-11666634272?page=1

Enochian BioSciences Inc. has sued co-founder Serhat Gumrukcu and his husband, Anderson Wittekind, for contractual fraud. Enochian claims that the company has suffered a substantial loss due to Gumrukcu providing them with altered and fabricated scientific data and is seeking $25 million in damages. The complaint alleges that Mr. Gumrukcu repeatedly gave the company falsified data for experiments related to research agreements to develop gene therapies for certain viruses, including hepatitis B and Covid-19. Allegedly, Gumrukcu sent the company data from lab experiments showing promising results of his drugs in mice. An internal review showed that he had given Enochian data showing his drug reduced hepatitis B DNA levels by 98.6% in mice, but original experiment data showed only a 25.1% reduction. Additionally, the suit states that Gumrukcu presented data to Enochian's board showing that his gene therapy prevented Covid-19 infection in mice, but the experiment had not been conducted at the time of Gumrukcu's presentation. The data triggered a series of milestone payments totaling $25 million, and allegedly Gumrukcu and Wittekind used the funds to help purchase an $18 million property in Los Angeles last year. An attorney for Gumrukcu did not respond to a request for comment about the lawsuit, and Wittekind denies the allegations, holding that the purchase was for commercial buildings used to support biotech and medical research.

WITH PROMISE OF LEGALIZATION, PSYCHEDELIC COMPANIES JOUST OVER FUTURE PROFITS

Andrew Jacobs, *The New York Times*, October 25, 2022. https://www.nytimes.com/2022/10/25/health/psychedelic-drug-therapy-patents.html

With the increased interest in the potential of psychedelic medicine, there is a growing crowd of psychedelic medicine companies seeking to gain a financial edge through a blizzard of patent claims. One psychedelic medicine company valued at $450 million, Compass Pathways, is part of this fray. Being aggressive with its intellectual property filings, the company has filed over 100 patent claims asserting that the company's patent strategy was necessary to ensure that psilocybin therapy would one day be available to people across the globe. Compass Pathways claims it must raise hundreds of millions of dollars to conduct clinical trials at 150 sites in Europe and North America to accomplish this goal. This will convince private and government insurers to cover psychedelic therapies and that patents are often necessary to protect a company's investment in that process. However, scientists and patient advocates are scoffing patent claims like this by Compass Pathways and other companies, warning that trying to profit from psychedelic drugs like psilocybin, LSD, and ecstasy could deter academic research and

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prevent public access to new therapies. With the potential to, "revolutionize the treatment of depression, substance abuse, post-traumatic stress disorder, and other mental health conditions," the debate about psychedelic-related intellectual property seems valuable. But, Robin Feldman, an expert on pharmaceutical intellectual property at the University of California Hastings College of Law, said this conflict is indicative of larger problems in our patent system, including some of the highest prescription drug prices in the world. She says, "With psychedelics, what we're seeing is a clash of cultures between the altruism of those who want to use existing compounds in new and exciting ways crashing up against the realities of the patent system."

EMPLOYERS ARE CONCERNED ABOUT COVERING WORKERS' MENTAL HEALTH NEEDS, SURVEY FINDS

Michell Andrews, *Kaiser Health News*, October 27, 2022.
https://khn.org/news/article/kff-employer-health-insurance-survey/

In the wake of the Covid-19 pandemic, employers are grappling with a new "normal" where demand for mental health services has increased. In a survey of large employers — those with at least 200 workers — employers report a growing share of employees using mental health services. This increase includes use of services related to substance use, and requests for leave related to mental health conditions under the Family and Medical Leave Act. Employers have also reported high telemedicine usage among their employees. Recognizing this trend, many large employers have added mental health care providers to their plan's network, either in person or through telemedicine. Premium costs, however, have been "remarkably" stable; employers and economists speculate that the stability in premium costs is the "calm before the storm" of inflation and larger premium increases.

CLOCK RUNS OUT ON EFFORTS TO MAKE DAYLIGHT SAVING TIME PERMANENT

Dan Diamond, *The Washington Post*, November 4, 2022.
https://www.washingtonpost.com/health/2022/11/04/permanent-daylight-saving-time/

The Sunshine Protection Act aims to, "permanently 'spring forward,'" but remains stalled in Congress after seven months as support remains staunchly divided. House officials say they have experienced an influx of split opinions from stakeholders like voters and sleep specialists over the nearly century-old practice. Congressman Frank Pallone, Chair of the House Energy and Commerce Committee, is wary of a "hasty change" followed by an equally hasty reversal. Stakeholders are divided on the issue. The "Big Sleep" lobby opposes the change, claiming it would disrupt entrenched sleep cycles; they are supported by the American Academy of Sleep Medicine who, in recent years, has significantly bolstered its lobbying spending. Jewish religious groups also oppose the change, claiming it would prevent them from conducting morning prayers after the sun rises and still get to work or school on time. Floridians, however, support the change because it would maximize sunshine for residents in the winter months. The White House has avoided taking a stance on this divided issue but conceded its influence on "matters of trade and health".

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HOSPITAL GIANT HCA FENDS OFF ACCUSATIONS OF QUESTIONABLE INPATIENT ADMISSIONS

Blake Farmer. *Kaiser Health News*, Novermber 4, 2022. https://www.washingtonpost.com/health/2022/01/30/nurses-fake-vaccination-cards-long-island/

U.S. Rep. Bill Pascrell and the Service Employees International Union have been pressing the Department of Health and Human Services to investigate allegations against HCA for potential Medicare fraud. The Centers for Medicare & Medicaid Services have said they are reviewing a letter from Pascrell that details the claims that HCA forced doctors to meet unofficial quotas, or targets, for the number of patients admitted to the hospital. A previously sealed whistleblower case is shedding new light on such internal policies. Pascrell's concerns stem from a 58-page investigative report from the SEIU published in February, estimating HCA overcharged the Medicare program at least $1.8 billion over roughly a decade through excessive admissions, according to the report. Dr. Camilo Ruiz, a whistleblower at a 400-bed HCA hospital in suburban Miami, accused the health system of threatening his job if he didn't admit more patients, instead of sending them home from the ER. Ruiz's attorneys used publicly available Medicare data to show that HCA hospitals nationwide routinely admitted patients for low-level illnesses such as abdominal pain, lower respiratory problems, dizziness, and nausea. Meanwhile, non-HCA hospitals sent patients with the same conditions home. At the 41 HCA hospitals with the highest admission rates, the attorneys found that from 2013 through 2016, 84% of Medicare patients were admitted for eight common diagnoses, compared with 55% at non-HCA hospitals. An HCA spokesperson refuted the accusations saying that the HCA, "categorically reject[s] any allegation that physicians admit patients to our hospitals based on anything other than their independent medical judgment and their patients' conditions and medical needs."

MEDICARE ADVANTAGE OR JUST MEDICARE?

Paula Span, *The New York Times*, November 5, 2022. https://www.nytimes.com/2022/11/05/health/medicare-seniors-health.html?searchResultPosition=1

Researchers have found that Medicare Advantage plans performed better than fee-for-service Medicare on a few measures. Beneficiaries are more likely to use preventive services and vaccinations and to say they had "a usual source of care." Advantage plans provide numerous different plans to find the best individual coverage without need for a separate supplemental policy. Medicare Advantage may appear less expensive due to low or no monthly premiums and capping out-of-pocket expenses. Traditional Medicare beneficiaries experienced fewer affordability problems if they had supplementary Medigap policies and were more likely to use high-quality hospitals and nursing homes. In addition, there are no networks -- you can see any doctor that accepts Medicare and use any hospital or clinic while avoiding the delays and frustrations of "prior authorization." Consumers can switch between Medicare Advantage plans easily but switching from traditional Medicare to Advantage requires caution. Consumers using traditional Medicare typically also use Medigap policies, to cover the uncapped out-of-pocket expenses. Beneficiaries who have moved from

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traditional Medicare with Medigap to Medicare Advantage and then seek to move back to traditional Medicare may not be eligible for another Medigap policy. "Determining the best Medicare plan, including a Part D drug plan, can be challenging. The best allies, along with Medicare's website and its toll-free 1-800-MEDICARE number, are the federally funded State Health Insurance Assistance Programs, whose trained volunteers can help people assess Medicare and drug plans."

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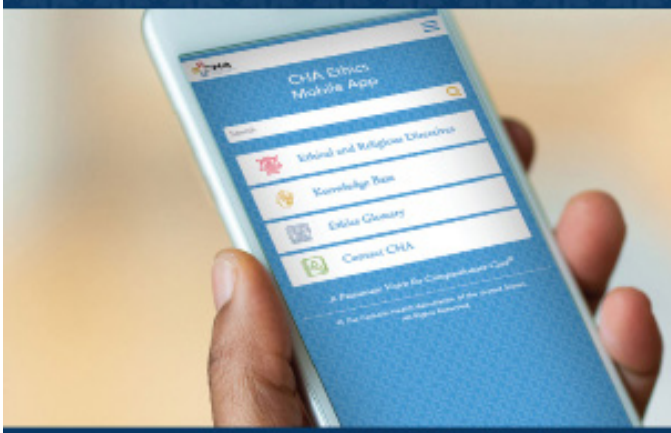

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