

done under the traditional Medicare fee-for-service payment system. CMS is examining the use of incentives to recruit providers that care for underserved populations to join ACOs, leveraging ACO peer-to-peer learning systems to disseminate best practices, implementing data-collection and quality-measurement requirements with the goal of closing gaps in outcomes, and asking providers to consider beneficiaries' social needs in care plans.

Starting in 2023, the ACO REACH Model will test equity-enhancing features, including a benchmark adjustment designed to mitigate disincentives for providers to care for underserved populations, requirements for participating ACOs to collect beneficiary-reported demographic and social-needs data and to submit health-equity plans, and a new benefit enhancement that aims to increase access to primary care by expanding nurse practitioners' privileges. Successful features could be evaluated for possible incorporation into the Shared Savings Program.

CMS has also promoted ACOs' efforts to address social needs. For instance, ACOs have reported using Medicare's annual wellness visit to screen for social needs,

hiring community health and social workers as community navigators, and using technology to connect patients with community resources. Addressing social needs must be a central goal of ACOs going forward. Lessons from the Accountable Health Communities Model, which tested the effects of identifying and addressing beneficiaries' health-related social needs using screening, referral, and community-navigation services, will be examined for potential incorporation into the Shared Savings Program. We are also exploring whether new ACO quality measures related to identifying and addressing social needs could support these initiatives.

By better aligning CMS's ACO initiatives and policies, Medicare can create pathways for payers and providers to advance accountable care. This approach could bring improved quality and patient experience, as well as the ability to be part of a care relationship that meets medical and social needs, to more beneficiaries. For providers, alignment of initiatives and policies could increase participation rates and accelerate care transformation. We aim to send clear and consistent signals that the opportunities provided by the Shared Savings

Program and Innovation Center models represent a coordinated pathway for supporting participation in value-based care arrangements.

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Russia's War in Ukraine — The Devastation of Health and Human Rights

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Since February 24, 2022, Russia has been waging a war of aggression in Ukraine and blatantly attacking civilians and civilian infrastructure. The recent

shift in Russian strategy to a war of attrition carries ominous implications for civilian survival, the future of Ukraine as a nation-state, and the restraint that

North Atlantic Treaty Organization (NATO) countries must practice to ward off Russia's threat of nuclear escalation. This conflict, initiated by an unprovoked Rus-

sian invasion, has inflicted death and widespread suffering on Ukrainian civilians and military personnel. More than 7.1 million Ukrainians have been displaced within their country, and approximately 5.3 million have crossed borders to become refugees in other European countries. Appropriately, the war has prompted a massive humanitarian response — but Russia's assault has intensified and time is running out.

In the 1990s, the medical and scientific community began honing its capability for assessing and responding to armed conflict.¹ Recent wars and brutal conflicts have given rise to important discussions about the epidemiology of war-related morbidity and mortality, civilian suffering, health care capacity in the midst of war, consequences of abrupt population displacement, and parameters of humanitarian response, as well as legal and normative debates regarding the human rights and international legal dimensions of armed conflicts.

In Ukraine, as in the early stages of other wars, inadequate security, inaccurate or incomplete reporting, nonfunctioning data systems, displacement of populations, and indirect, distant, and delayed health effects have made it impossible to gather accurate morbidity and mortality data. Through June 20, the United Nations had confirmed 4569 deaths and 5691 nonfatal injuries among Ukrainian civilians, most caused by indiscriminate use of explosive weapons with a wide impact area, including shells from heavy artillery, missiles, and bombs. But the actual numbers of deaths and injuries are probably much higher.

For example, according to CNN, municipal officials in Mariupol believed that by May 25, at least 22,000 city residents had been killed.

As in other recent wars, the strategy of attacking health care facilities and health workers is now resulting in both immediate deaths and injuries and adverse consequences of reduced availability of health care.² Between February 24 and June 24, the World Health Organization reported 323 attacks on health care facilities in Ukraine, leaving 76 people dead and 59 injured.³

A substantial proportion of civilian morbidity and mortality in Ukraine is undoubtedly attributable to diseases resulting from forced displacement and damage to food and water supply systems, health care and public health facilities, and other civilian infrastructure.⁴ Communicable diseases are more easily transmitted because of crowded living conditions, decreased access to safe water and food, compromised sanitation and hygiene, inadequate medical care, and lapses in immunization campaigns. During war, civilians are at especially increased risk for diarrheal diseases, such as cholera, and respiratory disorders, such as measles, Covid-19, and tuberculosis. In addition, antimicrobial resistance often increases during war.

Another risk is malnutrition — a particular concern for infants and young children, which may lead to detrimental effects on physical and cognitive development as well as increased morbidity later in life. As a deliberate war strategy, Russian military forces have disrupted agriculture, damaged food storage and distribution systems, and restricted

access to food. Indirect consequences for nutrition may extend far beyond Ukraine; destruction of farmland and grain-storage facilities, theft of grain, and blockade of food exports will contribute to malnutrition in low- and middle-income countries that depend on Ukrainian grain exports.

Rates of pregnancy complications, maternal deaths, premature and low-birth-weight infants, and neonatal deaths will increase because of reduced access to maternal and infant care. The incidence of some noncommunicable diseases will increase, and preexisting cases will be exacerbated, because of limited access to medical care and essential medicines. Rates of depression, post-traumatic stress disorder, and other mental and behavioral disorders — with both short- and long-term consequences — will increase because of trauma, family separation, deaths of loved ones, loss of employment and education, forced displacement, and witnessing of atrocities. Furthermore, the great loss of men, the mass displacement of women, and their shift in status to single heads of household may substantially affect the age and sex distribution of Ukraine's population for decades.

Russian forces are also causing extensive environmental devastation. Explosions and fires are contaminating ambient air with toxic gases and particulate matter and threatening the integrity of nuclear reactors. Destruction of industrial facilities is contaminating water and soil with hazardous chemicals. Russian military activities in the Black Sea are reportedly causing extensive pollution and disruption of sea

life. Deployment of antipersonnel land mines and cluster bombs and the presence of unexploded ordnance are presenting short- and long-term health and safety threats.

The war has led to many documented violations of human rights and international humanitarian law that should be of grave concern to us all. Russian forces have targeted health care facilities, schools, and civilian neighborhoods. They have executed unarmed civilians. They have raped women. The Russian military has claimed to have deported to Russia 1.9 million Ukrainian civilians, including 307,000 children. Russia has wreaked widespread damage on cities, towns, farmland, forests, and water sources, which will plague Ukraine long after the war ends.

On February 28, the International Criminal Court (ICC) announced its jurisdiction over potential war crimes in Ukraine, relying on recent requests from its government. On March 2, governments of 39 signatory states to the Rome Statute, which had created the ICC, also submitted formal requests for the ICC's jurisdiction in this instance. However, the ICC, in assuming jurisdiction over the international humanitarian law crime of aggressive war in 2018, stipulated that it apply only to signatory states to the Rome Statute. Neither Russia nor Ukraine is a signatory state. Prosecution for war crimes and restitution will be complex and probably take years to complete.

National and local government agencies in Ukraine and humanitarian assistance agencies of the United Nations and many countries have provided robust aid to civilians within Ukraine and in

countries of refuge. These efforts have included protection of civilians; direct provision of food, water, shelter, medical care, and other humanitarian assistance; and support to Ukrainian government agencies and nongovernmental organizations that are caring for displaced populations and those choosing, or forced, to remain in their homes.

Protecting civilians by moving them out of harm's way has proved challenging, however. Many civilians chose to remain in their homes, which became increasingly unsafe as Russian forces captured and executed civilians and bombarded civilian neighborhoods. In addition, restricted access to food and safe water made it increasingly untenable for many Ukrainians to stay in place. Yet it was often impossible to establish safe corridors for civilians wishing to leave, as demonstrated by widely reported fatal attacks on civilians in transit, such as the bombing of the Kramatorsk train station, in which at least 50 people died.

It has become exceedingly difficult to protect civilians who remain in their communities, especially in eastern and southeastern Ukraine, where Russian military forces have implemented scorched-earth strategies, mainly with the long-range missile and shelling attacks that have destroyed Mariupol and many other cities and towns. These attacks have accelerated the killing of civilians and further damaged health care facilities and educational institutions.

Over the same period, humanitarian assistance has greatly expanded, and many countries are hosting Ukrainian refugees. Nevertheless, since late April, the conflict has become a war of

attrition, as Russia attempts to wear down Ukraine by slow, relentless depletion of its resources, including manpower, supply chains, and weaponry.⁵ This strategy now aims to inflict increasingly brutal losses with deployment of powerful weapons that kill indiscriminately, often from great distances. Russia has also blocked Ukraine's access to the sea.

During this fraught time, it is essential to increase humanitarian assistance to Ukrainians in need and to support local, national, and international efforts to gather and preserve evidence of Russia's possible war crimes. And it is imperative to use this moment of peril to reflect on — and address — the profound and existential threat posed by nuclear weapons.

Russia's war of aggression in Ukraine provides the latest demonstration of the catastrophic health-related consequences of war and eclipses Russia's previous destruction of Chechnya and bombardment of health facilities and neighboring populations in Syria. While nations and their peoples take essential action to isolate this dangerous state, we also believe that health professionals have responsibilities not only to respond to the needs of current victims but also to engage in preventing the devastating, long-lasting, intergenerational effects of war on human health and life.

Disclosure forms provided by the authors are available at [NEJM.org](https://www.nejm.org).

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Tackling Implicit Bias in Health Care

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Implicit and explicit biases are among many factors that contribute to disparities in health and health care.¹ Explicit biases, the attitudes and assumptions that we acknowledge as part of our personal belief systems, can be assessed directly by means of self-report. Explicit, overtly racist, sexist, and homophobic attitudes often underpin discriminatory actions. Implicit biases, by contrast, are attitudes and beliefs about race, ethnicity, age, ability, gender, or other characteristics that operate outside our conscious awareness and can be measured only indirectly. Implicit biases surreptitiously influence judgment and can, without intent, contribute to discriminatory behavior.² A person can hold explicit egalitarian beliefs while harboring implicit attitudes and stereotypes that contradict their conscious beliefs.

Moreover, our individual biases operate within larger social, cultural, and economic structures whose biased policies and practices perpetuate systemic racism, sexism, and other forms of discrimination. In medicine, bias-driven discriminatory practices and policies not only negatively affect patient care and the medical training environment, but also

limit the diversity of the health care workforce, lead to inequitable distribution of research funding, and can hinder career advancement.

A review of studies involving physicians, nurses, and other medical professionals found that health care providers' implicit racial bias is associated with diagnostic uncertainty and, for Black patients, negative ratings of their clinical interactions, less patient-centeredness, poor provider communication, undertreatment of pain, views of Black patients as less medically adherent than White patients, and other ill effects.¹ These biases are learned from cultural exposure and internalized over time: in one study, 48.7% of U.S. medical students surveyed reported having been exposed to negative comments about Black patients by attending or resident physicians, and those students demonstrated significantly greater implicit racial bias in year 4 than they had in year 1.³

A review of the literature on reducing implicit bias, which examined evidence on many approaches and strategies, revealed that methods such as exposure to counterstereotypical exemplars, recognizing and understanding others' perspectives, and appeals

to egalitarian values have not resulted in reduction of implicit biases.² Indeed, no interventions for reducing implicit biases have been shown to have enduring effects. Therefore, it makes sense for health care organizations to forgo bias-reduction interventions and focus instead on eliminating discriminatory behavior and other harms caused by implicit bias.

Though pervasive, implicit bias is hidden and difficult to recognize, especially in oneself. It can be assumed that we all hold implicit biases, but both individual and organizational actions can combat the harms caused by these attitudes and beliefs. Awareness of bias is one step toward behavior change. There are various ways to increase our awareness of personal biases, including taking the Harvard Implicit Association Tests, paying close attention to our own mistaken assumptions, and critically reflecting on biased behavior that we engage in or experience. Gonzalez and colleagues offer 12 tips for teaching recognition and management of implicit bias; these include creating a safe environment, presenting the science of implicit bias and evidence of its influence on clinical care, using critical reflection exercises, and