

# Ethical Responsibilities of the Case Management Professional

Over the past several years, we have witnessed a dramatic change in the nation's healthcare landscape. New models of care, from medical homes to consumer-driven healthcare insurance to medical tourism, have given way to ever-more perplexing challenges for case managers. Perhaps the most dramatic impact on our system has been from the recent enactment of the ACA; regulations for the ACA are still unfolding while employers, corporations, and consumers try to figure it all out. The proliferation of new regulations, along with new options and broader rights and protections for consumers, means case managers will be held more accountable than ever before. All consumers are required to have insurance, yet how this will be enforced by the federal government remains unknown.

Although it addresses many of the problems of those seeking access to the care and services they need, the legislation also has raised many concerns. Some of them are still being debated, others are in the courts, and others have raised ethical challenges. Among the ethical concerns are the following:

- Are we requiring consumers who can afford insurance and do have insurance to ultimately assume the burden of paying for the have-nots?
- By mandating insurance for all Americans, will the poor be forced to make decisions between compliance with the law and perhaps putting food on the table for their families?
- By requiring EHRs, does this new law pose threats to consumers' rights for privacy and confidentiality under HIPAA?<sup>1</sup>

Closely connected with questions of legality are questions of ethics and morality. In any healthcare delivery system, our primary motivation should be the health, welfare, respect, and dignity of the individual. The moral principles and ethical values attached to this—autonomy, beneficence, fidelity, justice, nonmaleficence, and veracity—are at the core of patients' rights and case managers' responsibilities.<sup>2</sup> In the medical home model, what will the ethical challenges be to case managers in balancing the goal to reduce readmissions with improving patient care outcomes? How will case managers address situations where elderly, chronically ill patients, for example, become less adherent in the home setting, asserting their rights regarding their care in a manner that jeopardizes not only their health, but also the readmission scorecard for the practice?<sup>3</sup>

Autonomy is respect for the patient's right to self-determination; that is, we ought to respect his right, as much as possible, to make his own decisions about his care. Beneficence is

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our charge to promote and act for the patient's good, to further a person's legitimate interests, and to actively prevent harm or remove him from harm. Fidelity involves faithfulness, trustworthiness, and duty—keep your promises. Justice is the maintenance of what is right and fair; nonmaleficence means to do no harm (and as ethicist Mark Meaney points out, repair harm caused); and veracity requires that we tell the truth.

It is not illegal for a case manager to accept a finder's fee from a durable medical equipment supplier, but neither is it ethical. There is no law prohibiting a case manager from taking the season football ticket from a rehabilitation center contact, but it does cloud the objectivity of the relationship. Whether self-employed or working in a healthcare setting or insurance firm, case managers have to make clear decisions regarding their ethical standing.

Money is shifting to case management. Providers understand the purchase power case managers wield and their ability to refer to one facility over another. It has been an accepted marketing strategy in the medical industry for providers and pharmaceutical companies to wine and dine physicians and others who might recommend their institutions or products. Given the relative newness of case management and its professionals (e.g., nurses just entering the field from hospital settings), such perks are unexpected, and they look very good. To avoid the criticism that case managers have become just another part of the "fat" medical bureaucracy (and, even more important, to avoid the possibility of litigation), case managers must rely on their inner conscience to remain free from associations in which objectivity could be questioned.

As a stronger incentive, association directives and legislation are putting handcuffs on any type of overemphasis on a certain drug when the pharmaceutical company making the drug is sponsoring the conference on the condition the medication is used to treat. The Pharmaceutical Research and Manufacturers of America (PhRMA) adopted a voluntary code on interactions with healthcare professionals in 2002, which was subsequently revised and was effective January 2009. This code includes comprehensive guidelines limiting offers of scholarships and educational funds, practice-related items, gifts (stethoscopes versus golf balls, for example), travel, lodging, use of a corporate box at a football game, and more.

There are ethical dilemmas on the patient side of case management as well. John appears fit, is begging to return to work, and has mentioned his readiness to his employer, who is eager to have him back in the machine shop at his old station—the only job that is available to him at this time. However, John has not been able to control a hand tremor completely, which will jeopardize his safety at the drill. Does the case manager fudge her report on his capabilities and release him to work?

Jane, while recuperating from a skin graft, has returned to a drug habit she had kicked 3 years ago. Her employer and family are unaware of the problem. Does the case manager keep this secret to herself or take steps to enroll Jane in a drug rehabilitation program?

Mary has made it clear to her family and the case manager that she does not want her life prolonged by any artificial means under any circumstances. The treating physician has authorized the insertion of a feeding tube, and family members are reluctant to challenge the doctor's authority. Does the case manager raise the issue or let it pass?

Three cases that involved ethical and/or moral concerns are included in **Tables 12-1, 12-2, and 12-3**. In each case example, we address the choices made to resolve the challenges we faced.

**TABLE 12-1** Ethics Case Study 1

The case of a 29-year-old female with an extremely communicable disease was reported to Options Unlimited by the acute care treating facility 1 day after admission. In speaking with the patient directly, we learned that she had recently been overseas, visiting her native country. She is married and has two very young children. One week after her return to the United States and her job (through the client group with which we are affiliated), the patient demonstrated symptoms of her illness and shortly thereafter was admitted to the hospital.

During her course of treatment (while inpatient), questions arose at Options:

1. Was the case, with this diagnosis, reported to the CDC?
2. What risk factors pertain to the patient's immediate family and to her coworkers with whom she was in contact after her return to work?
3. Should measures be taken (and if so, what and how; and with, to, or for whom) regarding notification to the employer to prevent exposure to other employees, the patient's coworkers?
  - a. How will this affect confidentiality issues?
  - b. Specifically, what are Options Unlimited's responsibilities in this matter?
4. What, if any, responsibility does Options Unlimited have with regard to protection of the patient's immediate family (spouse and two very young children, ages 1 and 3)?

What we did:

1. Verified that the CDC was provided with appropriate, reported information.
2. Discussed with CDC and treating physicians and researched (from our end) the necessary precautions that must be taken by the patient, her family, her employer, and her coworkers to prevent spread of the disease.
3. Educated the patient and her family regarding the necessary precautions to take; verified her understanding and willingness to comply with and adhere to the necessary precautions.
4. Asked the patient whether she had discussed her illness with her employer or coworkers. (We found that she had, in fact, discussed her condition with her human resources department and coworkers, which opened the door for us to intervene.)
5. Spoke with human resources department at the patient's job (with her permission) and verified the necessary precautions and measures needed or taken to prevent contamination or spread of the disease.

Thought-provoking concerns/dilemmas:

1. What was the responsibility to the patient versus the responsibility to the employer and/or coworkers had the patient not previously discussed her condition with them?
2. What should have or could have been done in that scenario?
3. Did Options perform actions appropriately in this case as noted?
4. Is there something else that should have or could have been done?

**TABLE 12-2** Ethics Case Study 2

A 50-year-old female was admitted to acute care for treatment of substance abuse (opioid dependence). During the course of her treatment in acute care, Options Unlimited learned of her history of drug use and abuse, which she said began after a motor vehicle accident many, many years ago. Her “neck problems” continue, she is “in constant pain,” and she needs further care and treatment of her cervical disc situation. The MD who prescribed all of her addicting drugs was (per the patient) “recently brought up on charges for issuing too many prescriptions for drugs.” We also learned that she was molested as a child and that she is currently employed as an individual who works with mentally handicapped young adults.

Concerns/questions that arose:

1. Ability of patient to perform her job requirements.
2. Concern of abuse for those committed to her care:
  - a. Neglect due to her drug use.
  - b. Possible physical abuse to those in her care due to her own history of abuse.
  - c. What, if any, responsibilities or obligations does Options have in this matter?
3. Need to determine (or rule out) actual medical–surgical concerns that need to be addressed in addition to her substance abuse and psychological issues.
4. Do we have any obligation with regard to the report about the physician who ordered the numerous addictive drugs?

Dilemma:

1. What are our responsibilities to the patient versus responsibility to her employer and the young adults in her care (as far as disclosure of our information obtained and the concerns that followed)?
2. What are the legal ramifications of any actions taken on the part of Options Unlimited in all regards?

What we did:

1. Consulted with psychiatrists and medical doctors to rule out any physical conditions that would or should be monitored or addressed.
2. Followed the case through discharge from acute care.
3. Set her up with outpatient care for follow-up treatment regarding psychiatric and substance abuse issues and continued treatment of same.
4. Negotiated fees for care and treatment by nonparticipating providers.
5. Monitored monies used because of a limited dollar benefit to maximize her care and treatment.
6. Reported the patient’s information with regard to her past history (social and medical) and job function, as well as her statement regarding her physician being brought up on charges to the benefit plan so they could note their system. We also encouraged the plan to have this physician removed from their preferred provider listings.

What we wanted to do but did not (because of concerns over breach of confidentiality and legalities):

1. Report our findings about the patient’s job functions and our noted concerns regarding the same to the employer’s human resources department.
  - a. No evidence of abuse toward those in her care was found, which tied our hands in the matter. We understand that without reported misconduct or question of abuse, no action is possible.

Outstanding questions:

2. Should we or could we have intervened further: If so, in what regard and to what degree?

**TABLE 12-3** Ethics Case Study 3

A 33-year-old pregnant female is deemed to be high risk for preterm labor and delivery, and she is placed into case management to monitor and assist in coordinating care and treatment to prevent the threat of complications, the early birth of the infant, and so forth. During our initial interview with the patient, we were advised that she is unmarried but lives with the father of the child. She is HIV positive. She contracted the disease from her deceased husband, who acquired it from a blood transfusion after injuries sustained in a motor vehicle accident many years ago. The father of the child she is currently carrying (her significant other) is aware of all facts. The rest of the patient's family are aware of the pregnancy, but none are aware of the positive HIV status; that's the way the patient wants it.

As far as the patient's job function, she reported that she is employed in a manufacturing plant and works on a line in which small pieces of glass and/or metal frequently "fly off" and hit her in the legs, causing bleeding and the necessity for her to "pick out the pieces with tweezers." She states that she has "never put anyone on the job at risk." She adamantly wants any and all information related to her HIV status to be kept from her employer, especially the occupational health nurse in the plant, who she describes "too noseey."

Within a very short time of obtaining the noted information, the patient (unfortunately) informed our case manager that she did not want to continue with our intervention because she had others (social workers, physician's nurses, supportive boyfriend, etc.) following up with her frequently. We believe (but cannot confirm) that she became skittish over the fact that we are affiliated with the benefit plan whose client is her employer. We asked if that concerned her, but she said no and simply wanted her case to be closed.

We did so, reluctantly.

What we did:

1. Discussed the possibility of her transitioning into another job function that would not expose her to flying debris. Advised her that she could say her request was due to her pregnancy to make it less taxing on herself by coming off the line, which would also prevent any coworker, the occupational health nurse, or the employer from becoming suspicious about her HIV positive status.
2. Role-played with the patient to build the confidence she needed to have such a conversation with her employer or superior.
3. Offered the possibility for psychological treatment intervention (to assist the patient in dealing with her family and their lack of knowledge of her condition, and also to assist in her fears of the occupational health nurse and her employer finding out about her status).
4. Notified the benefit plan of the patient's status and job function.
5. Notified the benefit plan and the physician of case closure per the patient's request.

Dilemma/frustrations/concerns:

1. We believe that our first and foremost concern and responsibility is that the patient's confidentiality issues not be breached regarding her HIV. However, we are also very concerned about the risk of exposure to her coworkers. Are we appropriately prioritizing?
2. Is there a way to decrease the risk of exposure to the patient's coworkers without breaching her confidentiality? If so, how, and what could we have done?
3. Is there anything else we should have done in this case?

## PATIENT RIGHTS AND CASE MANAGER RESPONSIBILITIES

Case managers have access to a great deal of information. What will the decision be regarding the disclosure of someone's substance abuse or HIV status when the choice involves either compromising one's principles or losing a client? What about when the choice involves telling the patient's wife or not?

When I talk to case managers across the country about the push and pull of ethical issues—for instance, autonomy versus beneficence—sometimes the patient's right to autonomy is in direct conflict with some of the other principles. The individual has the right to make his own decisions about treatment, the right to refuse, and the right to information, which are all rights we want to safeguard. Although that is true, questions arise with regard to beneficence, doing no harm, or promoting good. Does the patient have the right to select treatment even if it is going to drive up the cost? Does he have the right to continue poor health habits? In patient advocacy versus resource control, a case manager will advocate for the patient and protect his rights. How can one protect the life of a 1-pound baby and still strike a balance vis-à-vis plan resource control? Questions arise regarding end-of-life issues: Does the 80-year-old person requesting an organ transplant have fewer rights than a 5-year-old child? How can one make those decisions?

It is a difficult, introspective challenge. You must know what your values are and respect the rights and values of the individuals upon whose behalf you are working. Ethical matters do not have easy answers, and the continuing emphasis on cost containment and our improving technical abilities contributes to the rising concerns of healthcare professionals. We have not anticipated the horrible outcomes that people live with as a result of some of the wonderful advances. To save that 1-pound baby who then becomes dependent on his family for every activity of daily living may be acceptable for the family during the initial stages when the family unit can care for the infant. However, when the baby becomes a young adult and then a full-grown adult, the family and society shoulder a huge burden in caring for this individual. Technology creates both wonders and nightmares.

Many hospital networks today are very competitively pursuing profit margins, perhaps by discharging patients in a timely fashion so they can capture more of the resources, especially in capitated contracts. The hospital-based case manager or social worker involved in discharge planning may not feel comfortable sending a person home, yet there is a push on the utilization review team to free the bed, or there is a productivity level to be met (a certain number of cases to be carried). When does our professional concern for that patient outweigh the financial motivations and concerns of the institute that employs us? On one hand, the case manager's role and responsibilities have been defined by her employer; on the other hand, she knows how complex some of these issues are. When does she say enough is enough? Not only is this not fair, it puts the patient, the hospital, and me at risk.

With home care contracts designed for the patient and family to become their own care providers, some case managers in home care agencies are being pushed to transfer patients to less supervised home care far earlier than we would normally deem wise. I think there are many home care case managers with very mixed feelings about the capabilities of patients and families to take on the care programs.

A case manager in a rehabilitation facility may find herself in a different situation. She may know that a person might well go home, deriving more use of the benefit dollars if discharged. Perhaps there are only \$50,000 in lifetime benefits for rehabilitation needs. Yet the rehabilitation facility that employs her has a need to keep the beds filled as long as possible. Her job viability and security might depend on it.

To illustrate how realistic this push-pull dynamic is, allow me to share something that occurred during our Best-in-Class Case Management seminar in the summer of 2008 in New York City. There were several hospital case managers in the audience, and I was attempting to have them consider that providing case management and discharge planning only up through the day of discharge was inadvisable and quite possibly resulting in many needless readmissions. I suggested that to more clearly demonstrate that case management could be effective and realize savings to the bottom line, I proposed that they take a look at the kinds of patients that were most frequently readmitted shortly after discharge (e.g., patients with congestive heart failure). I proposed that they develop a pilot program that would identify these patients and then proactively follow them for those critical days, or possibly weeks, after discharge. Encouraging them further, I recommended that they specifically look at patients that had this same diagnosis for the previous 6 months, look at the rate of readmissions, the length of stay, and so on, then compare those in the pilot case management program. I assured them that they would absolutely see a marked decrease in readmissions. Feeling quite confident with this suggestion, especially when seeing some in the audience nodding in enthusiastic agreement, I then saw a few with raised hands. Indicating that I welcomed the questions, one of the attendees said: “Well, that sounds good, but that’s not going to help my facility . . . we’ll be losing revenue if we don’t have those readmissions!” Regrettably, there were several others who nodded in agreement. I was concerned and challenged them: Is this the right thing for the patient? Is it right to have him readmitted so your facility can increase its revenue? Is it right to subject the patient to the risks and discomfort of another hospital admission when we could have, and possibly should have, done something to keep him safely in his home? This situation, and there are so many others, has no easy answer for case managers, but these questions and issues need to be raised.

In a managed care organization, a case manager might find herself participating in a bonus arrangement for the most number of days saved or the highest dollar amount saved. With this incentive to cut days for a personal or team award, she might do something that is, if not illegal, ethically questionable. At the very least, the bonus system creates competition rather than coordination among departments.

We were never divided in quite this way. Under the traditional healthcare system, there was no question that our role was as an advocate for the patient. I am not sure that nurses or employers (or patients) still wholeheartedly believe that we serve solely in the patient’s best interests, especially for those employed by managed care organizations.

Many of these issues are money driven. I believe most case managers feel the ethical pull now because of finances. As nurses and social workers, we never really had to be involved with money matters, never had to make those kinds of decisions, and were not directed to push patients out of hospitals. There was no reason for it. They remained in hospital care until they were well enough to go home. We did not have the technology to enable them to survive,

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so it was not an issue, and no one lived long enough to use a million dollars' worth of benefits. Money is certainly driving many healthcare decisions—who gets it, for how much, and for how long. Healthcare professionals, physicians, social workers, nurses, and therapists now are all involved in these financial issues and are no longer so well guided by the standards of practice and codes of conduct that gave us answers earlier in more traditional settings.

Case management was a direct response to both technological advances and monetary constraints and issues, but because we sit squarely in the middle of the healthcare process, we must deal with these ethical problems. Because health care is now managed like a business, healthcare professionals often find themselves reporting to business managers who might not understand or be sympathetic to ethical dilemmas. We are working in buildings that look the same but are run quite differently. To survive, we must respond in kind. We need to know more about the financial issues of health care. Just as we want the CEO, hospital director, or medical director to understand our role, we have to comprehend their need to balance the budget. They face the same ethical dilemmas and are as unequipped as we are to address them. Whereas earlier we experienced overutilization of services, possibly driving costs up, now we have underutilization as an area for fraud and abuse because patients are not being given access to services. Futility of treatment is another issue. Are we being empathetic professionals? Is this patient really suffering, or are our actions really driven by another motive: profit?

More dialogue needs to take place among healthcare managers, financial managers, and case managers. Certainly, when dialogue happens, some of the issues are so confrontational and confusing that we need ethicists and legal professionals to assist us in the decision-making process. Are the treatment paths we are considering legal? What is the appropriate ethical choice? I believe our healthcare colleagues feel they are swimming in the same deep waters we are trying to navigate. On Long Island, New York, the Stony Brook University Hospital formed the nonprofit Long Island Center for Ethics, designed to increase the practical application of ethics in the academic, medical, and business worlds.

Groundwork is being laid to bring outdated codes of conduct into line with the realities of the healthcare industry's day-to-day practices. The American Academy of Physical Medicine's Rehabilitation Code of Conduct includes sections on ethics relating to the patient and his or her family, the practitioner's relationship with members of the rehabilitation team, physician-to-physician relationships, relationships with the community and government, and research and scholarly activity ([www.aapmr.org](http://www.aapmr.org)).

The ethical challenges and responsibilities we face heighten in direct proportion to a patient's degree of impairment; when a patient cannot be a partner in care due to cognitive or speech difficulties, acting out, or inappropriate or impulsive behaviors, a case manager's ethical responsibilities increase. When cost-control issues are involved, ethical dilemmas multiply as well. If an insurance company initially refuses to pay for a medically indicated treatment, is it ethical for a primary care doctor to lie to get coverage for a patient? Should a doctor deceive an insurance company to gain coverage for bypass surgery in a patient with severe angina or chronic atherosclerosis? How many case managers might misrepresent a condition to get the coverage a patient desperately needs?

Our industry is focusing on these ethical dilemmas. John Banja, PhD, assistant director for Health Sciences and Clinical Ethics, Center for Ethics, and associate professor of Clinical



Ethics at Emory University, speaks and writes on the ethical accountabilities of case management and the medical industry in general. During one intense session, topics under discussion included futility of treatment, continuation versus withholding of treatment, the injury of continued existence, and distributed justice. The concept—that we, as case managers, take or do not take action based on our professional interpretation of ethical conduct—led to some passionate exchanges.

At issue was the case of a 4-year-old, unconscious and in a persistent vegetative state since age 2, loved by his family and fully treated as a family member, who develops frequent respiratory infections that require ventilatory support and occasional pediatric intensive care support. Further, the child is developing contractures that interfere with his home care and that physicians believe will require surgical intervention.

The child's physician is under pressure to deescalate the child's treatment. Given the prognosis, the hospital staff questions the clinical appropriateness of continued ventilatory support and future surgery. Other physicians in the pediatrics group wonder about spending significant resources on a child who will not improve and whose care might have adverse repercussions on accessing care for other children in the plan. The HMO considers the proposed surgery to be heroic, whereas the family insists that everything possible be done.<sup>4,5</sup>

Selected responses from panel and audience members portray the multiple considerations that constitute an ethical dilemma and decision:

It is true that case managers are often caught in the middle, and I guess that's where I think they ought to be. What I would like to suggest is that the case manager is going to have an increasingly important role as a mediator. You advocate for the patient, yet you also balance cost and quality. In the process of mediation, there is a lot of emotion. It is very important to provide a forum where we can vent these emotions and patients can voice their concerns.

—Mark Meaney, Executive Director,  
Institute for Clinical and Corporate Ethics<sup>6(p138)</sup>

This case is fairly typical of cases that we as case managers find ourselves in. In the previous fee-for-service system with unlimited funding available for care, anything that was clinically possible was considered clinically appropriate and necessary treatment. Now, we are hearing more discussion about whether or not care is futile, or inappropriate.

—Author as a panel member<sup>6(p138)</sup>

The whole idea of futility is important to look at, but I'd like to address two issues that relate to the family and the child. Is this child any longer a person? I would like to suggest that there is a philosophical difference between having a life and being biologically alive. Also, it is not necessarily the responsibility of society to give that family everything it wants for this child. The family can elect to act with their own discretionary resources. It is a harsh view, but we

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must also consider the obligations to the other siblings in the family. And, what happens to other members of the health plan if the resources are spent on this child? It is possible for people, such as these parents, to make themselves moral heroes at the expense of others.

—M. Jan Keffer, assistant professor of family health nursing,  
Indiana University School of Nursing in Indianapolis<sup>6(p138)</sup>

When case management is done well, it is pursuing at least two moral goods. One moral good is patient advocacy and the other is proper use of resources. The key issue is distributive justice. Whenever case managers are faced with a managed care case where the health plan is pushing for conservative care, they should ask the following questions before jumping to any conclusions: What is going to happen to the money and resources saved by our not doing this? Who said that doing everything possible for the patient is in the patient's best interests? Until we start making decisions about what constitutes good managed care and unethical managed care, and what constitutes good case management and unethical case management, any situation involving a health plan denying payment will be greeted by cries of "rationing" and I think that's bunk.

—Emily Friedman, adjunct assistant professor,  
Boston University School of Public Health<sup>6(p138)</sup>

There is suffering on the part of the family caregivers; there is suffering on the part of the professional caregivers, and there certainly seems to be suffering on the part of the child. There is a concept called "the injury of continued existence." Is there a point at which being dead is better than being alive?

— M. Jan Keffer<sup>6(p138)</sup>

A couple of years ago I went back and looked at what my nursing license says I can do. All it says I can do is teach and advocate. That's all; teach and advocate.

—Audience member<sup>7(p24)</sup>

How do we measure the worth of this little child against someone who may grow up to be 16, 17, 18, and who becomes sexually promiscuous, on drugs, and we're spending a lot for that as opposed to this?

—Audience member<sup>8(p16)</sup>

There isn't one option; there are many options. Parents may opt for everything, but they need to know the consequences of what that everything may be. Frequently they do not because no one has taken the time to explain it to them. Ethics panels help bring to the forefront all of those issues in making

sure that everyone understands fully not only the rights and responsibilities, but the possible consequences as well.

—Author, during the keynote<sup>9(p17)</sup>

I also voiced my concern that many case managers seem reluctant to enter the ethical arena, to speak up, to take a stand as the patient advocate, or to blow the whistle on unbundled billing practices, upcoding, or Medicare fraud. We are waiting for a committee to be formed. We are waiting for someone else to take the first step. I would like to see a heightened empowerment of case managers, with an understanding that being a patient advocate is not something we do in name only. We must be willing to confront employers, confront physician groups, and confront plan administrators.

## ETHICS AND MEDICAL ERRORS

There is another issue often left unsaid but gaining importance. We live in the days of swift technological advances that can sustain life longer than was ever possible. We also live in the age of increasing medical errors. Who pays for the surgery that included a gross medical error? Does the insurance company pay, or is a bill ever sent back to the provider? In a pilot program, does a full-disclosure report go back to the insurer?

Case managers sometimes stumble across legal or ethical problems. Among the issues a case manager has an ethical responsibility to report are patients who are potentially or habitually dependent on medication, who are overmedicated or overtreated by multiple physicians, or who are lying to their physicians regarding compliance. If a patient has not been receiving the treatment that claims are filed for, if an occupational therapist is treating a patient outside practice guidelines, or if a physician inappropriately refers a patient to a center he or she has a financial interest in, the circumstances should be reported to the plan administrator, the treating physician, or a peer review organization. A case manager must develop knowledge of professional ethics, standards of practice, and the appropriate code of behavior, and she must report through proper channels whatever is intolerable, fraudulent, or abusive in hospitals or private practices.

In another CMSA conference in 2004, there was a session moderated once again by Banja that addressed medical errors. (Banja had been working on his book dealing with medical errors, mentioned in the Look to Your Resources section at the end of this chapter.) His presentation focused on the moral, ethical, and legal issues surrounding the increasing numbers of medical errors occurring in health care, but with increasing frequency in our hospitals, and the possible role that case managers and other healthcare professionals could have. At the end of his formal presentation, he introduced members of a panel that represented a medical error response team in a large hospital. Panel members described in detail how they had developed a strategy that would proactively respond when errors were discovered. They developed a team that would promptly review the particulars of the error then go directly to the patient and advise him what had occurred. They would offer their sincere apology and provide additional information as to what steps would be taken to ensure that the error would not happen again to other patients. Although it has long been a practice in healthcare settings for an incident report to be completed by the employee who committed the error, and an internal process to review the matter and determine what education and/or disciplinary action

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would be needed, in the majority of cases, the error was rarely, if ever, disclosed to the patient. In its white paper in 1999, the IOM acknowledged that health care in the United States was not as safe as it should be and defined medical error as “the failure of a planned action to be completed as intended.”<sup>10</sup> In 2001, The Joint Commission on Accreditation of Health Care Organizations (now known as The Joint Commission) issued the first nationwide disclosure standard to require that patients be informed about medical errors. In 2005, 69 percent of healthcare organizations had established disclosure policies, which ranged from simple statements to detailed disclosure statements.<sup>11</sup> Although disclosure is not necessarily a legal matter, it most certainly is an ethical one.

In a series of articles he contributed to *The Case Manager*, Banja acknowledged that the disclosure of an error is easier said than done. He believes “that many remain undisclosed for two primary reasons. One is the fear of inviting a lawsuit from disclosure; the other is the embarrassment and assault on the professional’s ego that such a conversation poses.”<sup>12</sup> Banja acknowledges that when the case manager is employed by the organization, the inclination to protect the organization, which is the same one that provides one’s salary, benefits, and so forth, may challenge the case manager’s ethical obligations. He cautions that regardless of whether they are internal or external case managers, one must not allow the advocacy for the patient to diminish and notes that “as painful as they are to confront, harm-causing errors demand deep ethical commitment and moral courage from everyone in the healthcare industry.”<sup>13</sup>

In another article in the same edition of *The Case Manager*, Banja proposed some specific recommendations regarding the disclosure of harm-causing medical errors and suggested the following:

- The causal connection between the error and the harm that the patient experienced should be reasonably established.
- There should be a conversation with the patient (and, as appropriate, the family as well) that specifically addresses the nature of the error, that problems from the error that have already occurred or are likely to occur (an explanation of these should be given), and that these problems may require additional treatment (again, an explanation of what this treatment might include should be provided).
- An organizational policy should be developed to clearly delineate the disclosure process. (Banja advised that this responsibility should not be defaulted to the case manager.)<sup>14</sup>

## CODES OF ETHICAL CONDUCT

To assist case managers in their day-to-day practice, our industry (and others) has responded with standards of practice and codes of conduct. The CMSA issued the CMSA Statement Regarding Ethical Case Management Practice (**Appendix 12-A**) to “provide guidance to the individual case manager in the development and maintenance of an environment in which case management practice is conducted ethically.”<sup>15</sup> The CCMC adopted its Code of Professional Conduct for Case Managers with Disciplinary Rules, Procedures, and Penalties for the first time in 1996 (a portion is excerpted in **Appendix 12-B**), incorporating three kinds of standards (principles, rules of conduct, and guidelines for professional conduct) along with guidelines and procedures for processing complaints and possible sanctions. It was completely revised for a third time in 2004, and the most recent revision occurred in 2014 and was released in 2015

following approval by the CCMC Board of Commissioners. What is notable in the update to the original code and subsequent revisions is that the ethical foundation was essentially unchanged, but in light of all of the changes that had occurred in the years since the previous revision in 2014, these periodic reviews continue to be an important step in ensuring quality care and protection of the public. The current code, as with previous versions, is not a rule book, but rather serves as a foundation and guidance for an ethical decision-making process. The complete and current version of the code is available on the CCMC website ([www.ccmcertification.org](http://www.ccmcertification.org)). In its preamble, it is stated that the code was designed to achieve goals that include the following: CCM certificate holders accept the responsibility that their actions or inactions can aid or hinder clients in achieving their objectives; that they provide services in a manner consistent with their education, formal training, and work experience; and that they demonstrate their adherence to certain standards. In its code, CCMC provides the definitions of case management as developed by CMSA and CCMC (**Figure 12-1**), the Principles of the Code of Professional Conduct for Case Managers (**Figure 12-2**), the Rules of Conduct (**Figure 12-3**), and the Standards for Professional Conduct—Six Areas of Practice (**Figure 12-4**).

### **FIGURE 12-1** Example Definitions of Case Management

**CMSA:** A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, 2002).

**CCMC:** A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human services needs. It is characterized by advocacy, communication, and resource management and promoted quality and cost-effective interventions and outcomes (CCMC, 2005).

Data from Case Management Society of America. (2016). What is a case manager? Retrieved from [www.cmsa.org](http://www.cmsa.org); Commission for Case Manager Certification. (2015). Definition and philosophy of case management. Retrieved from [www.ccmcertification.org](http://www.ccmcertification.org).

### **FIGURE 12-2** Principles of the Code of Professional Conduct for Case Managers

Principle 1: Certificants will place the public interest above their own at all times.

Principle 2: Certificants will respect the rights and inherent dignity of all of their clients.

Principle 3: Certificants will always maintain objectivity in their relationships with clients.

Principle 4: Certificants will act with integrity in dealing with other professionals to facilitate their clients' achieving maximum benefits.

Principle 5: Certificants will keep their competency at a level that ensures each of their clients will receive the benefit of services that are appropriate and consistent for the clients' conditions and circumstances.

Principle 6: Certificants will honor the integrity and respect the limitations placed on the use of the CCM designation.

Principle 7: Certificants will obey all laws and regulations [relevant to case management practice].

Principle 8: Certificants will help maintain the integrity of the Code.

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**FIGURE 12-3** Rules of Conduct

Rule 1: A certificant will not intentionally falsify an application or other documents.  
 Rule 2: A certificant will not be convicted of a felony.  
 Rule 3: A certificant will not violate the code of ethics governing the profession upon which the individual's eligibility for the CCM designation is based.  
 Rule 4: A certificant will not lose the primary professional credential (or licensure) upon which the eligibility of CCM designation is based.  
 Rule 5: A certificant will not violate or breach the Standards for Professional Conduct (i.e., professional misconduct).  
 Rule 6: A certificant will not fail to pay required fees to CCMC.  
 Rule 7: A certificant will not violate the rules and regulations governing the taking of the certification examination.

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**FIGURE 12-4** Standards for Professional Conduct: Six Areas of Practice

Standards	Areas of Practice
Advocacy	Acting on behalf of clients and ensuring that a comprehensive assessment identifies the client's needs. Options for necessary services are provided to clients. Clients are provided with access to resources to meet individual needs.
Professional Responsibility	Representation of practice, competence, representation of qualifications, legal and benefit system requirements, use of CCM designation, conflict of interest, reporting misconduct, and compliance with proceedings.
Case Manager/Client Relationships	Description of services, relationships with clients, termination of services, and objectivity.
Confidentiality, Privacy, and Recordkeeping	Legal compliance, disclosure, client identity, medical records, electronic recording, reports, and records maintenance/storage and disposal.
Professional Relationships	Testimony (judicial or non-judicial forum), dual relationships, unprofessional behaviors, fees, and advertising and solicitation.
Research	Legal compliance and client privacy.

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In addition, CMSA's Standards of Practice for Case Management, revised in 2010, and Case Management Practice Guidelines, discussed further in Chapter 3, offer guidance to direct case management practice.

What I have yet to see is the real use of these documents to empower the case management community. I think if more case managers were to use these documents as they define

roles and responsibilities within their departments and make them active, working documents, it would help eliminate some of the problems they are having. It would give them recourse when faced with a choice, presented by an employer, that they feel is unethical.

## OBJECTIVITY AND COMMON SENSE

As a commissioner for 6 years on the CCMC and a member of its Ethics Committee, Banja gained additional perspective on the ethical challenges that case managers face. Case managers who are charged with ethics violations can face a reprimand, suspension from CCM certification, or revocation of the CCM credential. Banja and members of the committee review each of the cases. In an interview with the *Case Management Advisor*, Banja shared that the vast majority of case managers do not commit ethics violations but added, “Overwhelmingly, case managers are good-hearted, well-educated professionals who advocate intensively for their patients, but there are about 100,000 people out there who call themselves case managers and not all of them are that careful, professional and discreet.”<sup>16</sup>

In some instances we may allow our personal feelings to dictate the way we manage a case; other times we become frustrated and discouraged, and this may be apparent in the wording of our reports or documentation in our records. Banja cited a few examples: “The injured worker was clearly exaggerating his pain”; “The client’s wife is argumentative and obnoxious.”<sup>17</sup> He advises case managers that ethics violations occur when we overstep our limits or make determinations outside our scope of practice, and he provided examples of this as well: “I will not authorize this MRI; the client doesn’t need one,” or “Physical therapy is not indicated after this procedure.”<sup>17</sup> Based on our many years of experience, these assumptions or judgments may indeed be accurate, but determining the medical need for something is clearly within the scope of practice of a physician, not a case manager. Banja offers this “no-brainer test of ethical behavior”<sup>17</sup> and recommends:

Ask yourself three questions:

1. Is it legal?
2. Would my mother approve?
3. What if my behavior was described on the front page of tomorrow’s *New York Times*?<sup>18(p3)</sup>

In an article titled “Ethics in Case Management: Making the Right Decision in Tough Times,” published in *Care Management*, author Frank D. Lewis, PhD, recognized the growing complexity of the challenges facing case managers today and proposed utilizing a framework to address the issues. Lewis cited the Seven Step Model for Moral Reasoning, which was adapted from Arthur Anderson’s Program in Business Ethics. In summary, the steps are as follows:

1. Recognize the existence of the conflict and write it down. Writing down the conflict helps to clarify it.
2. Get the facts. Make certain that the information represents the positions of those involved.
3. Disclose the conflicts to all parties. Share the facts as you know them; do not withhold any information.

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4. Generate possible solutions to the conflict. Enlist input from others.
5. Ask questions. It helps to learn and clarify the issues.
6. Select the best alternative and implement it.
7. Review the outcome and critique it.<sup>19</sup>

## LOOK TO YOUR RESOURCES

Because the decisions and challenges we face are likely to continue and become even more complex over the next several years, it is important for us to surround ourselves with individuals, organizational resources, and an ongoing examination of our responses to these ever-changing situations. The ethical course of action is not always obvious, but it is attainable through the pursuit of excellence and by following the sound principles, guidelines, and practices of our profession.

I have encouraged every managed care organization and every case management department to create an ethics panel or review board to help mediate some of these problematic cases. I do not think any single case manager should have to face alone the kinds of issues touched upon in this chapter. Mediation, collaboration, and input from other professional disciplines will assist in some of these tough calls. A case manager needs a network of people to bounce around ideas about ethical challenges. Perhaps there is an ethicist at a local college or other case managers who are not in direct competition and can act as sounding boards. The unexpected case will arrive, and case managers need resources for ethical counseling.

Additionally, case managers have an obligation to be as knowledgeable as possible to promote the best outcomes for patients, and they have a professional and an ethical obligation to pursue continuing education. Thankfully, our professional associations provide sessions that address not only the most current treatment guidelines for the conditions we help to manage, but also those that help to provide us with guidelines for best practices, which of course include and encompass our standards of practice and codes of professional conduct.

Because not every case manager can attend conferences, books such as Kenneth Blanchard and Norman Vincent Peale's *The Power of Ethical Management*, and magazine and newspaper columns that address the issues of professional ethics are valuable resources. Look for the 2005 book titled *Medical Error and Medical Narcissism* (Jones and Bartlett) by medical ethicist John D. Banja, PhD, an associate professor of clinical ethics education at Emory University Hospital, on the ethical issues that arise from medical errors. Ethics issues are also addressed consistently in *Case in Point* (Dorland Health), *Professional Case Management* (Lippincott), and *Case Management Advisor* (AHC Media).

Books that are helpful in exploring ethical issues include the following:

- Beauchamp, T., & Childress, J. (2013). *Principles of biomedical ethics* (7th ed.). New York, NY: Oxford University Press.
- Bennahum, D. A. (2000). *Managed care: Financial, legal, and ethical issues*. Cleveland, OH: Pilgrim Press.
- Burtulo, R., & Doherty, R. (2010). *Ethical dimensions in the health professions* (5th ed.). St. Louis, MO: Elsevier Saunders.



- Churchill, L., Fanning, J., Schenck D. (2013). *What patients teach: The everyday ethics of health care*. New York, NY: Oxford University Press.
- Dolgoff, R., Lowenberg, F. M., & Harrington, D. (2009). *Ethical decisions for social work practice* (9th ed.). Belmont, CA: Brooks/Cole Cengage Learning.
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- Levine, M. L. (Ed.). (2004). *The elderly: Legal and ethical issues in health care policy*. Burlington, VT: Ashgate.
- Morrison, E., Furlong, B. (2014). *Health care ethics: Critical issues for the 21st century*. Burlington, MA: Jones & Bartlett Learning.
- Pozgar, G. D. (2012). *Legal and ethical issues for health care professionals* (3rd ed.). Burlington, MA: Jones & Bartlett Learning.

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# APPENDIX 12-A

## CMSA Statement of Ethical Conduct



## CMSA's Statement Regarding Ethical Case Management Practice

### ***Introduction***

This statement is intended to provide guidance to the individual case manager in the development and maintenance of an environment in which case management practice is conducted ethically. Such an environment is one in which morality prevails and there is support for right (good) decisions and actions.

The statement sets forth ethical principles for case management practice. When applied in practice, these principles underlie right decisions and actions. Thus, they can be utilized by individuals or peers to judge the morality of particular decisions and/or actions.

Ethics is inherently intertwined with morality. In the practice of the healthcare professions, ethics traditionally has dealt with the interpersonal level between provider (e.g. case manager) and client, rather than the policy level which emphasized the good of society. Ethics deals with ferreting out what is appropriate in situations which are labeled "dilemmas" because there are no really good alternatives and/or where none of the alternatives are particularly desirable. Thus, ethics addresses the judgement of right and wrong or good and bad.

### ***Ethical Principles in Case Management Practice***

As professionals emanating from a variety of healthcare disciplines, case managers adhere to the code of ethics for their profession of origin. In all healthcare practices certain principles of ethics apply. Case management is guided by the principles of autonomy, beneficence, nonmaleficence, justice and veracity.

Autonomy is defined as "a form of personal liberty of action when the individual determines his or her own course in accordance with a plan chosen by himself or herself" (Beauchamp and Childress, 1979, p. 56)<sup>1</sup>. This is the fundamental ethical principle of case management practice. The role of case manager as client advocate arises from a commitment to the concept of client autonomy. The needs of the client, as perceived by the client, are preeminent. Thus the client is primary relative to decision making. The case manager collaborates with the autonomous client with the goal of fostering and encouraging the client's independence and self-determination. This leads the case manager to educate and empower the client/family to promote growth and development of the individual and family so that self advocacy and self direction of care is achieved. This implies informing and supporting the client in their options and decisions related to their healthcare.

From application of the principle of autonomy, the practice of case management is concerned with preservation of the dignity of the client and family. The case manager is knowledgeable about and respects the rights of the individual and family which arise from human dignity and worth, including consent and privacy. The case management plan is individualized and constantly changing based on the needs of the specific client and family. The case manager does not discriminate based on social or economic status, personal attributes, or the nature of the health problems of the client. Beneficence is "the obligation or duty to promote good, to further a person's legitimate interests, and to actively prevent or remove harm" (Fromer, 1981, p. 317)<sup>2</sup>. In ethical case management practice the application of beneficence is balanced with the interests of autonomy in order to prevent paternalism

and promote self determination. The definition of the principle of nonmaleficence is related to beneficence. Nonmaleficence means refraining from doing harm to others (Frankena, 1973, p. 5)<sup>3</sup>. The realization of this principle in case management practice involves emphasis on quality outcomes.

Although uniformity of thought about the practical application of the principle within our society does not exist, Frankena (1973) defines justice as maintenance of what is right and fair. The concept of justice raises such public healthcare policy questions as: who should receive services? based on what criteria? who should pay for services for the poor? what services should benefit from government funding?, etc.

Case management practice brings the issue of comparative treatment of individuals into sharp focus because on a daily basis it deals with allocation of healthcare resources on an individual level. Case managers know firsthand the dilemmas related to relative access to care based on such factors as geography and ability to pay.

Decisions regarding such goods and benefits as access to healthcare services within a society with limited resources are initially analyzed based on individual need. Where a fundamental need exists, that is, in situations in which an individual will be harmed if a product or service is not provided, the case manager advocates for the individual to receive it. The case manager applies concepts of fairness so as to maximize the individual's ability to carry out reasonable life plans.

Veracity means truth-telling. This is an essential operational principle for the case manager in order to develop trust. Trust is an essential forerunner of collaborative relationships between case managers and clients/families and between case managers, providers, and payors. Truth telling also is basic to the exercise of self-determination by the autonomous client/family.

### **Conclusion**

The professional case manager strives for a moral environment and practice in which ethical principles can be actualized. Ethical dilemmas are identified and reasonable solutions sought through appropriate consultation and moral action. The ethical case manager is accountable to the client as well as to peers, the employer/payor and to himself/herself and to society for the results of his/her decisions and actions.

CMSA Standards of Practice Committee  
February, 1996

### **DEFINITIONS**

**Client:** The individual who is ill, injured or disabled who collaborates with the case manager to receive services.

**Payor:** The individual or entity which purchases case management services.

**Family:** Family members and/or those significant to the client.

<sup>1</sup> Beauchamp, T. and Childress, J, Principles of Biomedical Ethics, (4<sup>th</sup> Edition), New York: Oxford University Press, 1995.

<sup>2</sup> Fromer, Margot Jane, Ethical Issues In Health Care, Mosby Publishing, 1981.

<sup>3</sup> Frankena, W.K., Ethics, 2<sup>nd</sup> Ed., Englewood Cliff, N.J., Prentice-Hall, 1973.

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Reproduced from Case Management Society of America. (1996). CMSA's statement regarding ethical case management practice. Little Rock, AR: Author.

# **Appendix 12-B**

## **Excerpts from the CCMC Code of Professional Conduct for Case Managers**

### **PREAMBLE**

Case management is a professional, collaborative and inter-disciplinary practice guided by the Code of Professional Conduct (the Code).

The objective of the Code is to protect the public interest. The Code consists of Principles, Rules of Conduct, and Standards for Professional Conduct, as well as the Commission for Case Manager Certification (CCMC) Procedures for Processing Complaints.

The Principles provide normative guidelines and are advisory in nature. The Rules of Conduct and the Standards for Professional Conduct prescribe the level of conduct required of every Board-Certified Case Manager (“CCM<sup>®</sup>”). Compliance with these levels of conduct is mandatory. Board-Certified Case Managers (CCMs) who become aware of unethical behavior of others are obligated to report such alleged infractions. Enforcement will be through the CCMC Procedures for Processing Complaints. In addition, Board-Certified Case Managers (CCMs) who face ethical dilemmas regarding their own practice and/or ethical challenges that arise in the course of professional practice are encouraged to consult the Code frequently for advice. An opinion can be requested from CCMC’s Ethics & Professional Conduct Committee.

In this document, the term, “client,” is used to refer to the individual to whom a Board-Certified Case Manager provides services. Board Certification refers to certification as a Certified Case Manager (CCM<sup>®</sup>). “Payor” is used to refer to the Board-Certified Case Manager’s (CCM) or the Client’s reimbursement source.

Board-Certified Case Managers (CCMs) recognize that their actions or inactions can aid or hinder clients in achieving their objectives. Board-Certified Case Managers (CCMs) accept responsibility for their behavior. Board-Certified Case Managers (CCMs) may be called upon to provide a variety of services and they are obligated to do so in a manner that is consistent with their education, skills, moral character, and within the boundary of their competence and experience. In providing services, Board-Certified Case Managers (CCMs) must adhere to the Code of Professional Conduct for Case Managers as well as the professional code of ethics for their specific professional discipline.

## PRINCIPLES

- Principle 1:** Board-Certified Case Managers (CCMs) will place the public interest above their own at all times.
- Principle 2:** Board-Certified Case Managers (CCMs) will respect the rights and inherent dignity of all of their clients.
- Principle 3:** Board-Certified Case Managers (CCMs) will always maintain objectivity in their relationships with clients.
- Principle 4:** Board-Certified Case Managers (CCMs) will act with integrity and fidelity with clients and others.
- Principle 5:** Board-Certified Case Managers (CCMs) will maintain their competency at a level that ensures their clients will receive the highest quality of service.
- Principle 6:** Board-Certified Case Managers (CCMs) will honor the integrity of the CCM designation and adhere to the requirements for its use.
- Principle 7:** Board-Certified Case Managers (CCMs) will obey all laws and regulations.
- Principle 8:** Board-Certified Case Managers (CCMs) will help maintain the integrity of the Code, by responding to requests for public comments to review and revise the code, thus helping ensure its consistency with current practice.

## CCMC RULES OF CONDUCT

Violation of any of these rules may result in disciplinary action by the Commission up to and including revocation of the individual's certification.

- Rule 1:** A Board-Certified Case Manager (CCM) will not intentionally falsify an application or other documents.
- Rule 2:** A Board-Certified Case Manager (CCM) will not be convicted of a felony.
- Rule 3:** A Board-Certified Case Manager (CCM) will not violate the code of ethics governing the profession upon which the individual's eligibility for the CCM designation is based.
- Rule 4:** A Board-Certified Case Manager (CCM) will not lose the primary professional credential upon which eligibility for the CCM designation is based.
- Rule 5:** A Board-Certified Case Manager (CCM) will not violate or breach the Standards for Professional Conduct
- Rule 6:** A Board-Certified Case Manager (CCM) will not violate the rules and regulations governing the taking of the certification examination and maintenance of CCM Certification.

## SCOPE OF PRACTICE FOR CASE MANAGERS

Case management is a professional, collaborative and inter-disciplinary practice. Board certification indicates that the professional case manager possesses the education, skills, moral character, and experience required to render appropriate services based on sound principles of practice.

Board-Certified Case Managers (CCMs) will practice only within the boundaries of their role or competence, based on their education, skills, and appropriate professional experience. They will not misrepresent their role or competence to clients. They will not represent the possession of the CCM credential to imply a depth of knowledge, skills, and professional capabilities greater than those demonstrated by achievement of certification.

### I. Underlying Values

- Board-Certified Case Managers (CCMs) believe that case management is a means for improving client health, wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.
- Board-Certified Case Managers (CCMs) recognize the dignity, worth and rights of all people.
- Board-Certified Case Managers (CCMs) understand and commit to quality outcomes for clients, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective.
- Board-Certified Case Managers (CCMs) embrace the underlying premise that when the individual(s) reaches the optimum level of wellness and functional capability, everyone benefits: the individual(s) served, their support systems, the healthcare delivery systems and the various reimbursement systems.
- Board-Certified Case Managers (CCMs) understand that case management is guided by the ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity.

### II. Definition of Case Management

The practice of case management is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the "Triple Aim," of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

### III. Ethical Issues

Because case management exists in an environment that may look to it to solve or resolve various problems in the health care delivery and payor systems, case managers may often confront ethical dilemmas. Case managers must abide by the Code as well as by the professional code of ethics for their specific professional discipline for guidance and support in the resolution of these conflicts.

## SELECTED DEFINITIONS

**Advocacy** - The act of recommending, pleading the cause of another; to speak or write in favor of (CMSA Standards of Practice, 2010, p 24).

**Assessment** - The process of collecting in-depth information about a client's situation and functioning to identify individual needs in order to develop a comprehensive case management plan that will address those needs. In addition to client contact, information should be gathered from other relevant sources (patient/client, professional caregivers, nonprofessional caregivers, employers, health records, educational/military records, etc.) (CCMC Certification Guide, p 7).

**Autonomy** - Agreement to respect another's right to self-determine a course of action; support of independent decision making (Beauchamp, T.L. & Childress, J.F. Principles of Biomedical Ethics, 6<sup>th</sup> Ed. 2009, NY, NY; Oxford University Press, p 38–39).

**Beneficence** - Compassion; taking positive action to help others; desire to do good; core principle of client advocacy (Beauchamp, T.L. & Childress, J.F. Principles of Biomedical Ethics, 6<sup>th</sup> Ed. 2009, NY, NY; Oxford University Press, p 38–39).

**Care Coordination** - The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care (CMSA Standards of Practice, 2010, p 24).

**Client** - Individual who is the recipient of case management services. This individual can be a patient, beneficiary, injured worker, claimant, enrollee, member, college student, resident, or health care consumer of any age group. In addition, when *client* is used, it may also infer the inclusion of the client's support (CMSA Standards of Practice, 2010, p 24).

**Coordination** - The process of organizing, securing, integrating, modifying, and documenting the resources necessary to accomplish the goals set forth in the case management plan (CCMC Certification Guide, p 7).

**Evaluation** - The process, repeated at appropriate intervals, of determining and documenting the case management plan's effectiveness in reaching desired outcomes and goals. This might lead to a modification or change in the case management plan in its entirety or in any of its component parts (CCMC Certification Guide, p 7).

**Fidelity** - The ethical principle that directs people to keep commitments or promises (Cottone, R.R. & Tarvydas, V.M., Counseling Ethics and Decision Making, 3<sup>rd</sup> Ed 2007, Pearson Merrill Prentice Hall, New Jersey, p 500).

**Implementation** - The process of executing and documenting specific case management activities and/or interventions that will lead to accomplishing the goals set forth in the case management plan (CCMC Certification Guide, p 7).

**Inter-Disciplinary** - Collaboration occurs among different disciplines that address inter-connected aspects of the client's defined health problem or needs. The members of the team bring their own theories and frameworks to bear on the problem and connections are sought among the disciplines to improve client outcomes (Albrecht, Freeman, & Higginbotham, 1998).

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**Justice** - The ethical principle that involves the idea of fairness and equality in terms of access to resources and treatment by others (Cottone, R.R. & Tarvydas, V.M., *Counseling Ethics and Decision Making*, 3<sup>rd</sup> Ed 2007, Pearson Merrill Prentice Hall, New Jersey, p 501).

**Monitoring** - The ongoing process of gathering sufficient information from all relevant sources and its documentation regarding the case management plan and its activities and/or services to enable the case manager to determine the plan's effectiveness (CCMC Certification Guide, p 7).

**Planning** - The process of determining and documenting specific objectives, goals, and actions designed to meet the client's needs as identified through the assessment process. The plan should be action-oriented and time specific (CCMC Certification Guide, p 7).

**Veracity** - legal principle that states that a health professional should be honest and give full disclosure; abstain from misrepresentation or deceit; report known lapses of the standards of care to the proper agencies (Mosby's Dental Dictionary, 2<sup>nd</sup> Ed, 2008).

# **STANDARDS FOR BOARD-CERTIFIED CASE MANAGER (CCM) CONDUCT**

## **Section 1 - The Client Advocate**

Board-Certified Case Managers (CCMs) will serve as advocates for their clients and perform a comprehensive assessment to identify the client's needs; they will identify options and provide choices, when available and appropriate.

## **Section 2 - Professional Responsibility**

### **S 1 - Representation of Practice**

Board-Certified Case Managers (CCMs) will practice only within the boundaries of their role or competence, based on their education, skills, and professional experience. They will not misrepresent their role or competence to clients.

### **S 2 - Competence**

Case Management competence is the professional responsibility of the Board-Certified Case Manager, and is defined by educational preparation, ongoing professional development, and related work experience.

### **S 3 - Representation of Qualifications**

Board-Certified Case Managers (CCMs) will represent the possession of the CCM credential to imply the depth of knowledge, skills, and professional capabilities as intended and demonstrated by the achievement of board certification.

### **S 4 - Legal and Benefit System Requirements**

Board-Certified Case Managers (CCMs) will obey state and federal laws and the unique requirements of the various reimbursement systems by which clients are covered.

### **S 5 - Use of CCM Designation**

The designation of Certified Case Manager and the initials "CCM" may only be used by individuals currently certified by the Commission for Case Manager Certification. The credential is only to be used by the individual to whom it is granted, and cannot be transferred to another individual or applied to an organization.



## **S 6 - Conflict of Interest**

Board-Certified Case Managers (CCMs) will fully disclose any conflict of interest to all affected parties, and will not take unfair advantage of any professional relationship or exploit others for personal gain. If, after full disclosure, an objection is made by any affected party, the Board-Certified Case Manager (CCM) will withdraw from further participation in the case.

## **S 7 - Reporting Misconduct**

Anyone possessing knowledge not protected as confidential that a Board-Certified Case Manager (CCM) may have committed a violation as to the provisions of this Code is required to promptly report such knowledge to CCMC.

## **S 8 - Compliance with Proceedings**

Board-Certified Case Managers (CCMs) will assist in the process of enforcing the Code by cooperating with inquiries, participating in proceedings, and complying with the directives of the Ethics & Professional Conduct Committee.

## **Section 3 - Case Manager/Client Relationships**

### **S 9 - Description of Services**

Board-Certified Case Managers (CCMs) will provide the necessary information to educate and empower clients to make informed decisions. At a minimum, Board-Certified Case Managers (CCMs) will provide information to clients about case management services, including a description of services, benefits, risks, alternatives and the right to refuse services. Where applicable, Board-Certified Case Managers (CCMs) will also provide the client with information about the cost of case management services prior to initiation of such services.

### **S 10 - Relationships with Clients**

Board-Certified Case Managers (CCMs) will maintain objectivity in their professional relationships, will not impose their values on their clients, and will not enter into a relationship with a client (business, personal, or otherwise) that interferes with that objectivity.

### **S 11 - Termination of Services**

Prior to the discontinuation of case management services, Board-Certified Case Managers (CCMs) will document notification of discontinuation to all relevant parties consistent with applicable statutes and regulations.

## **Section 4 - Confidentiality, Privacy, Security and Recordkeeping**

### **S 12 - Legal Compliance**

Board-Certified Case Managers (CCMs) will be knowledgeable about and act in accordance with federal, state, and local laws and procedures related to the scope of their practice regarding client consent, confidentiality, and the release of information.

### **S 13 - Disclosure**

Board-Certified Case Managers (CCMs) will inform the client that information obtained through the relationship may be disclosed to third parties, as prescribed by law.

### **S 14 - Client Protected Health Information**

As required by law, Board-Certified Case Managers (CCMs) will hold as confidential the client's protected health information, including data used for training, research, publication, and/or marketing unless a lawful, written release regarding this use is obtained from the client/legal representative.

## **332** CHAPTER 12 Ethical Responsibilities of the Case Management Professional

### **S 15 - Records**

Board-Certified Case Managers (CCMs) will maintain client records, whether written, taped, computerized, or stored in any other medium, in a manner designed to ensure confidentiality.

### **S 16 - Electronic Media**

Board-Certified Case Managers (CCMs) will be knowledgeable about, and comply with, the legal requirements for privacy, confidentiality and security of the transmission and use of electronic health information. Board-Certified Case Managers (CCMs) will be accurate, honest, and unbiased in reporting the results of their professional activities to appropriate third parties.

### **S 17 - Records: Maintenance/Storage and Disposal**

Board-Certified Case Managers (CCMs) will maintain the security of records necessary for rendering professional services to their clients and as required by applicable laws, regulations, or agency/institution procedures, (including but not limited to secured or locked files, data encryption, etc.). Subsequent to file closure, records will be maintained for the number of years consistent with jurisdictional requirements or for a longer period during which maintenance of such records is necessary or helpful to provide reasonably anticipated future services to the client. After that time, records will be destroyed in a manner assuring preservation of confidentiality, such as by shredding or other appropriate means of destruction.

## **Section 5 - Professional Relationships**

### **S 18 - Testimony**

Board-Certified Case Managers (CCMs), when providing testimony in a judicial or non-judicial forum, will be impartial and limit testimony to their specific fields of expertise.

### **S 19 - Dual Relationships**

Dual relationships can exist between the Board-Certified Case Manager and the client, payor, employer, friend, relative, research study and/or other entities. All dual relationships and the nature of those relationships must be disclosed by describing the role and responsibilities of the Board-Certified Case Manager (CCM).

### **S 20 - Unprofessional Behavior**

It is unprofessional behavior if the Board-Certified Case Manager (CCM):

- a. commits a criminal act;
- b. engages in conduct involving dishonesty, fraud, deceit, or misrepresentation;
- c. engages in conduct involving discrimination against a client because of race, ethnicity, religion, age, gender, sexual orientation, national origin, marital status, or disability/handicap;
- d. fails to maintain appropriate professional boundaries with the client;
- e. engages in sexually intimate behavior with a client; or accepts as a client an individual with whom the Board-Certified Case Manager (CCM) has been sexually intimate;
- f. inappropriately discloses information about a client via social media or other means.

### **S 21 - Fees**

Board-Certified Case Managers (CCMs) will advise the referral source/payor of their fee structure in advance of the rendering of any services and will also furnish, upon request, detailed, accurate time and expense records. No fee arrangements will be made that could compromise health care for the client.

### **S 22 - Advertising**

Board-Certified Case Managers (CCMs) who describe/advertise services will do so in a manner that accurately informs the public of the skills and expertise being offered. Descriptions/

advertisements by a Board-Certified Case Manager (CCM) will not contain false, inaccurate, misleading, out-of-context, or otherwise deceptive material or statements. If statements from former clients are used, the Board-Certified Case Manager (CCM) will have a written, signed, and dated release from these former clients. All advertising will be factually accurate and will not contain exaggerated claims as to costs and/or results.

### **S 23 - Solicitation**

Board-Certified Case Managers (CCMs) will not reward, pay, or compensate any individual, company, or entity for directing or referring clients, other than as permitted by law and/or corporate policy.

### **S 24 - Research: Legal Compliance**

Board-Certified Case Managers (CCMs) will plan, design, conduct, and report research in a manner that reflects cultural sensitivity; is culturally appropriate; and is consistent with pertinent ethical principles, federal and state laws, host institution regulations, and scientific standards governing research with human participants.

### **S 25 - Research: Subject Privacy**

Board-Certified Case Managers (CCMs) who collect data, aid in research, report research results, or make original data available will protect the identity of the respective subjects unless appropriate authorizations from the subjects have been obtained as required by law.

### **Footnotes:**

1. Beauchamp, T. L., & Childress, J. F. (2009). *Principles of Biomedical Ethics* (6th ed., pp. 38-39). New York, NY: Oxford University Press.
2. Beauchamp, T. L., & Childress, J. F. (2009). *Principles of Biomedical Ethics* (6th ed., pp. 38-39). New York, NY: Oxford University Press.
3. Beauchamp, T. L., & Childress, J. F. (2009). *Principles of Biomedical Ethics* (6th ed., pp. 152-153). New York, NY: Oxford University Press.

