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THE ESSENTIAL GUIDE TO Interprofessional Ethics in Healthcare Case Management

Ellen Fink-Samnick MSW, ACSW, LCSW, CCM, CRP

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For the professional case management workforce: empower toward ethical excellence always

For my father, Dr. Herbert A. Fink: my first ethical mentor

Acknowledgments

Thank you to my ethical hood who consistently ground, mentor, and nurture my soul and sanity. While many of you walk in my chaotic healthcare world, some are employed in other industry sectors. Yet you all share the common bond of valuing the ethical essence that underlies every effort. You know who you are: LJ, LBD, DS, GB, JW, DH, LM, SP, HT, TT, MO, II, JF, CI, JA, MF, and of course, my mother, BF.

To Steven and Kevin, thank you for guiding and inspiring my ethical energies always.

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About the Author

Ellen Fink-Samnick, MSW, ACSW, LCSW, CCM, CRP

Ellen Fink-Samnick empowers healthcare's transdisciplinary workforce through professional speaking, mentoring, and consultation. An award-winning industry thought leader for over 30 years, Ellen is known and respected as "The Ethical Compass of Professional Case Management." She is a popular presenter, with hundreds of offerings to her credit, and the author of well over 100 publications.

Ellen has written content for the industry's top knowledge products for professional case managers and the health and behavioral health workforce, including books, chapters, and educational modules on ethical practice, the ethical use of technology, competency-based case management practice models, and Wholistic Case Management™. Her blog, Ellen's Ethical Lens™, has attained global acclaim, as has her work on the dimensions of both the social determinants of health, plus workplace bullying and violence. She is a contributor to *ICD10 Monitor* and *RAC Monitor* and a popular broadcaster for Talk Ten Tuesdays and Monitor Mondays. Ellen was recently named to the Council of Founders and Advisors for Reverberation 5.0 (a national collective focused on the empowerment of women over 50 in the workplace).

Ellen's passion is evident across her varied roles as professional speaker, industry consultant and subject matter expert, educator, blogger and social media moderator, continuing education content developer, accreditation specialist, clinical social work supervisor, and professional mentor to the case management community.

Her contributions to professional case management, ethics, and clinical social work span the industry's professional associations and credentialing organizations, including roles as an exam item writer and countless leadership positions. In addition, Ellen serves on the Editorial Advisory Board for the *Professional Case Management Journal* and *RAC Monitor* and is moderator of the group Ellen's Ethical Lens™ on LinkedIn. She is a vibrant professional voice.

Continuing Education

Learning Objectives

- Define relevant terms and understand categories and principles of ethics in healthcare case management
- Explain how values and biases impact ethical practice
- Explain how ethical practice standards and codes impact daily practice
- Identify outcomes specific to the fiscal impact of ethical case management practice for organizations
- Identify the six competencies of ethical excellence for case management
- Describe population-based and specialty population considerations that challenge ethical practice in healthcare
- Explain why end-of-life care can pose ethical pitfalls for case managers
- Describe the connection between workplace bullying, quality of care, and client safety
- Identify current ethical technology challenges and resources for accountability for case managers
- Explain ethical considerations for case managing across state lines and how to mitigate risks
- Identify potential ethical concerns of value-based care for case management
- Explain how to implement ethical decision-making models in case management practice

Contact Hours

American Nurses Credentialing Center (ANCC)

HCPro is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This educational activity for 4.5 nursing contact hours is provided by HCPro.

Commission for Case Manager Certification (CCMC)

This program has been pre-approved by the Commission for Case Manager Certification to provide continuing education credit to CCM board certified case managers. The course is approved for 14 CE contact hours.

National Association

This program is approved by the National Association of Social Workers for 4.5 continuing education contact hours.

How to obtain your continuing education certificate

In order to receive your continuing education credits, you must successfully pass a final exam quiz and complete an evaluation. Complete information about how to claim your continuing education credits can be found in the Instructional Guide located on the download page for this book at:

Foreword

Simply speaking, ethics in professional case management (and healthcare) is a set of moral principles, beliefs, values, practices, and strategies. This set constitutes the compass that guides us as professional case managers (or other members of the interprofessional healthcare team) in the provision of health and human services, which most importantly focus on the client and client's support system. Integral to enhancing such an ethical approach to care provision is our sense of "right" and "wrong," and our beliefs about the rights and duties of both the providers and recipients of care. These accountabilities are no small task. They are complex and dynamic as a result of numerous critical factors, such as the following:

- Constantly evolving healthcare practice environment
- Innovative care interventions, which tend to prolong one's life despite the presence of multiple, chronic, and terminal health conditions
- Demand for cost-conscious and quality safe care by consumers, regulators, payers, and other stakeholders
- Pressure for transparency of outcomes and value proposition of care options
- Malpractice litigation with high amounts of damages that are potentially preventable when healthcare providers are comfortable with disclosure, transparency, and "true" shared decision-making
- Balancing what cannot always be balanced while navigating the opposing and conflicting care goals of payers, providers, and clients/support systems

In the center of this complicated healthcare environment and alongside the clients we serve are all of us—the professional case managers and our health professional colleagues. We spend a considerable amount of our day advocating for what is in the best interest of our clients/support systems, remaining attentive to collaboration, and bridging the gaps in communication across diverse care settings and health professionals. At the same time, we face the challenge of meeting the needs of our clients while upholding the purpose, mission, business demands, and strategic goals of the organization where we practice. We think carefully about the ethical aspects of timely communication with our clients/support systems, resolving conflict(s), respecting each client's right for informed decisions regarding care options, or partnering with other health professionals in addressing situations of moral distress and ethical dilemmas. Moreover, we work tirelessly on effecting choices and plans of care that enhance the health of the populations and communities we serve—choices that others will perceive as right, good, beneficial, fair, equitable, just, safe, empowering, authentic, and affordable.

Our ethical obligations in a given situation are most effective when we demonstrate competence in the attentive integration of our roles and responsibilities with the nature of the decisions we make within the complicated context of providing our clients/support systems with the needed health, human, and social services. This reflects "ethics in action" and contributes to achieving desired outcomes. It also helps us honor the autonomy of our clients, upholding their right to choice and self-determination, ensuring safety while preventing harm, and eliminating health disparities while emphasizing equity in receiving compassionate care. As professional case managers, we constantly

face the ethical imperative of making a difference in the lives of our clients and their support systems, enhancing their quality of life, well-being, and self-management, while respecting their self-expressed meaning of these personal outcomes of interest. Additionally, we exhibit our competence in such ethical practice by promoting timely access to healthcare services, acting as a key resource, and advancing social justice, equity, and beneficence for the client population at large. Concurrently for our employers, we demonstrate ethical competence by ensuring cost-conscious care delivery and efficient processes, as well as preventing fragmented, wasted, and duplicative resources.

We are constantly concerned with moral decision-making and the empowering presence of those who contribute to these decisions, including our clients/support systems and fellow health professionals. We have an obligation to enact morally correct decisions that are inclusive of the views and interests of our clients and their support systems. We also must execute care interventions that produce the greatest good for our clients. On the other hand, we are accountable for ensuring that we, and the other healthcare professionals involved in a client situation, demonstrate a character that is "good" and morally "praise-worthy." The codes of ethics and professional conduct of case management practice, jointly with those of our background professional discipline (e.g., nursing, social work, medicine), guide us in understanding and demonstrating professional behavior that is characterized by objectivity, integrity, fidelity, and veracity. Consequently, our preferred behaviors must be free from bias, misrepresentation, conflict of interest, unprofessional actions, and misconduct. As a result, we ultimately protect the privacy and interests of the public we serve—all the time, not just in periods of vulnerability.

Our professional case management practice is rarely simplistic; rather, it will continue to increase in complexity, intensity, and importance. At the same time, it also will require competent, skilled, knowledgeable, and ethically conscientious case managers. Our effectiveness and success are dependent on our ethical compass, including our ability to influence moral decision-making, adhere to ethical practice standards, and maintain our commitment to clients and their support systems first and every time. We can address these demands and challenges and manage existing opportunities to improve the provision of ethical health and social services through the application of essential tacit knowledge and concrete experiences. Ellen Fink-Samnick has done just that.

Fink-Samnick has written a practical book that is dedicated to the ethics in case management practice. In *The Essential Guide to Interprofessional Ethics in Healthcare Case Management*, Fink-Samnick presents a compelling case for the value of ethical case management practice from the perspectives of varied stakeholders. In her argument, she combines the theory with practical applications of ethical principles, concepts, decision-making processes, and both traditional and contemporary models of ethical analysis in case management. Most importantly, however, the book provides professional case managers and their professional colleagues with foundational knowledge, practical tools, and effective strategies for impactful and ethical practice. Being an expert in case management with a track record of publishing and public speaking on relevant and timely topics, Fink-Samnick has shared real-life examples of how to apply ethical standards to specific client situations and one's professional practice to demonstrate moral character and ethical decisions. Other important aspects of the book

are the discussion of ethics based on an interprofessional context of care delivery, understanding the available ethics resources for demonstrating accountability for case management services, differentiating ethical and legal standards, and determining the undesirable effects of workplace bullying on outcomes, including the client experience of care.

We are confident that professional case managers and other members of the healthcare team will find *The Essential Guide to Interprofessional Ethics in Healthcare Case Management* a valuable resource in the provision of ethical and client-centered case management services. It also will guide us in the fair and equitable allocation of resources, advocating for what is in the best interest of our clients/support systems, deploying duty-based ethics that is inclusive of the right course of action, and consistently demonstrating moral character, especially in the context of interprofessional, interdependent, and trustworthy relationships.

Suzanne K. Powell, RN, MBA, CCM, CPHQ

Hussein M. Tahan, PhD, RN, FAAN

Preface

Case managers know that nagging feeling, and I count myself included. Something happens on the job, sending both brains and bodies into a frenzy. Our insides begin to clench and grind, and the sleepless nights begin. Something feels wrong to the point of being untenable. We must take some action but are unsure what that may be or even where to begin. These situations impact the quality of care that case managers advocate to safeguard, while having ethical, if not legal consequences for all involved.

Ethics has transformed from that mundane topic checked off our annual and mandatory orientation "to do" list to one of the hottest issues across the healthcare industry. What began as *that thing professionals do while nobody watches* has evolved into *practitioners having actions scrutinized 24/7 by anyone with internet access*—more than four billion people globally or roughly 51% of the world's population (McDonald, 2018).

While the basic ethical principles of *advocacy, beneficence, fidelity, justice,* and *nonmalfeasance* have remained constant for centuries, they are regularly challenged by ever-evolving disrupters to our practice. This last decade alone has seen an onslaught of these factors. New population demographics mandate innovative practice models to address the social determinants of health and integrated behavioral health. The varied and complex needs of these populations have yielded rapid growth of treatment options across the transitions of care. Client handoffs occur so quickly they pose high stakes for all involved and concern for readmissions. With financial sustainability a high priority for leadership, it can feel like reimbursement, readmission penalties, and satisfaction surveys are often prioritized over treatment efforts.

Technology and the digital health revolution have prompted a ripple effect through every aspect of care, from identification of the need for care, to communications about that care to involved parties, the platform(s) used for delivery of those discussions, and how instantly they occur. Patient rights and advocacy efforts have escalated, at times presenting that clients and caregivers question every stage of treatment and discharge planning. The availability of resources and support through online communities presents as both a blessing and curse to the professional community, with every treatment recommendation questioned by more customer-savvy clients. The opportunity to render care across state lines and via the internet provides moments of pause for practitioners due to the complexity of licensure and reimbursement.

Emphasis on population health initiatives have yielded opportunities to partner with community resources to provide clinical and nonclinical care. A new generation of ICD-10 codes has exploded on the scene to empower reimbursement for the expanded scope of billing options, including the social and environmental factors impacting health and human trafficking. End-of-life care has evolved into an intricate web of treatment alternatives, laws, and initiatives. Workplace bullying has invaded every practice setting, impacting care quality, safety, and workforce attrition and mental health. The increased incidence of violence in healthcare settings has put the workforce on heightened alert.

The aforementioned realities faced by healthcare professionals have contributed to an incidence of workforce stress so pervasive that suicide of frontline professionals is receiving critical attention. The ethical impact of burnout is a high priority, with performance excellence an unwitting side effect. Consequently, another element has joined the Triple Aim's seminal goals of improving population health and the quality and cost of care. Finding the joy and meaning in work is now viewed as both a professional mandate and ethical imperative to ensure the most successful means to the quality end.

There will always be some change that will impact if not disrupt the industry. However, no matter the change, ethics will remain the constant—that universal bond experienced by the interprofessional workforce as a whole, especially case managers. Ethics grounds the practice of every practitioner involved in client care, independent of discipline, setting, or position.

Guiding Thoughts

For the purposes of this text, here are several guiding thoughts for readers:

1. I come from a strengths perspective, whether with clients, students, new staff, or colleagues. From this lens, we all possess foundational knowledge that supports how we each interpret and integrate information into our unique level of practice. However, independent of their level of expertise, I find even the most experienced clinicians are hungry for guidance on how to best handle ethical challenges.

My intent in writing this book is for it to serve as your essential ethical resource, for whatever reason you deem appropriate:

- A solid reference for managing every ethical issue
- A compilation of ethical decision-making tools
- Validation of the current ethical dilemmas and their tough presentations
- A teaching tool for new students or orientation for staff
- A reference to *simply tell you what to do in those most chaotic ethical moments*
- A resource to better understand *why ethics matters* to case managers in your organization
- Guidance on how *addressing ethics supports elimination of unnecessary costs* for your organization (e.g., expanded length of stay, readmissions)

If any of these purposes resonate, which I am confident they do, this book is for you.

2. The term *client(s)* will be used throughout the book as a generic term for all users of the healthcare system. Exceptions may occur for any direct quote or reference using another specific term (e.g., patient, member, consumer, customer).

3. The term *healthcare* will be used as a general industry term to encompass the health and behavioral health sectors, unless these particular settings are otherwise specified. The content is applicable to the industry's ever-expanding practice settings, from community-based and acute, across the transitions of care.

4. This book views case management as transdisciplinary in practice or composed of case managers from assorted disciplines across the health and human services. This listing includes but is not limited to:
   - Nurses
   - Social workers
   - Counselors
   - Rehabilitation and vocational rehabilitation professionals
   - Physicians
   - Pharmacists
   - Respiratory therapists

In addition, case management is interprofessional in scope. Our lens is attentive to care rendered by all disciplines actively engaged in achieving successful treatment outcomes for the populations we serve. While the book is geared primarily to case management professionals, the content will be of interest to any member of the interprofessional care process. This encompasses individuals engaged in direct client intervention and especially those in leadership roles. The industry is faced with some of the most complex populations to date. Moving forward, it will take the collective expertise of every member of the workforce to ensure quality-driven, cost-effective, and ethical care.

5. The book will refer to case management's *ethical principles,* which are the same as *ethical tenets*. For the purposes of this text and in the context of these fundamental pillars of practice, the terms *tenet* and *principle* will be viewed as synonyms.

6. Any student of mine knows my philosophy of the foundation of professional practice. There are three legs to that particular stool: *theory, practice,* and *reality*. I know many cringe when they hear theory is involved, but it serves a key role to define a starting point for validating practice. Theory helps us understand what *should* happen, not that it always does. Yet, the unique nature of our circumstances may leave us quick to judge the evidence-based theories we all learn in school. That is why we often speak to a *disconnect between theory and practice*. However, a powerful and steady foundation is forged when theory, practice, and reality solidify.

To support the building of your own sturdy stool, I will provide a little theory and didactic content (e.g., basic definitions, principles, ethical decision-making models), inform about practice by focusing on specialty topic areas or disrupters (e.g., end-of-life care, bias, transitions of care, treatment adherence), and acknowledge reality through creative case scenarios.

7. The book is divided into three sections:
   - Grounding interprofessional ethical excellence
   - Industry disrupters to impact ethical excellence
   - Models of ethical analysis

Each chapter starts with a main page that details objectives and essential terms. You will be provided practical and relevant knowledge that is thorough yet comprehensive. The concepts presented in earlier chapters will be used to leverage information presented in the later chapters. My goal is to make this text applicable to the reality of your daily work experience. The term *best practice* has always struck me as overused, as well as inappropriate for our fluid healthcare climate; *best practice today will surely be obsolete by tomorrow*. To that end, I provide you a fresh rendering of *ethical excellence*, the weave of my more than 35 years of industry experience aligned with the evidence and established resources of guidance (e.g., regulations, standards of practice, principles, codes).

Innovative case scenarios will furnish you opportunities to engage critical thinking, plus directly apply the content to your practice setting. Original tables, figures, and templates will further promote your efforts to integrate the book content with your distinct perspectives. Finally, the end of each chapter will include contemplation questions to allow you to advance your learning, whether in the classroom, with colleagues, or for solo considerations.

I now invite you to join me on an empowering and educational journey to advance your ethics practice excellence.

Reference

McDonald, N. (2018, January 30). Digital in 2018: World internet users pass the 4 billion mark. *We Are Social*. Retrieved from https://wearesocial.com/us/blog/2018/01/global-digital-report-2018

Section 1

Interprofessional Practice Ethics

Chapter 1

Grounding Ethical Excellence

Chapter 2

Understanding Established Resources of Guidance for Healthcare Case Management

Chapter 3

The Value Proposition of Ethical Case Management Practice

Chapter 1

Grounding Ethical Excellence

Ethics is knowing the difference between what you have a right to do and what is right to do.
—Potter Stewart

Learning Objectives

1. Define relevant terms associated with ethics in healthcare case management
2. Discuss the importance of interprofessional practice to healthcare case management
3. Understand the categories of ethics existing in healthcare
4. Identify distinct types of ethical dilemmas
5. Explore how values impact ethical practice
6. Understand the impact of bias in healthcare case management
7. Understand the relationship between ethics and the law
8. Discuss the concept of morality
9. Distinguish between compliance and adherence
10. Identify principles of ethical practice for case managers
11. Identify why moral distress is an occupational hazard of ethical practice

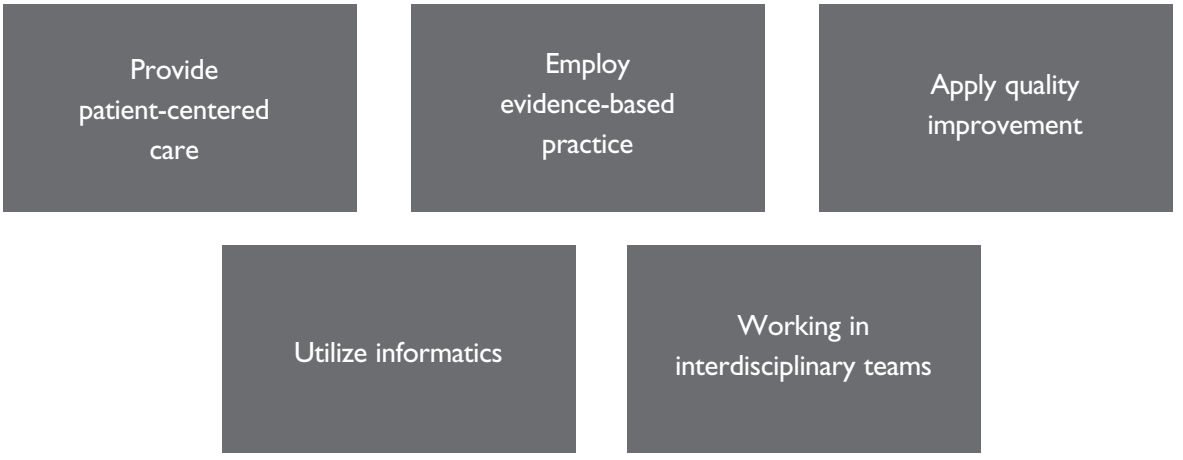
Essential Terms

- Absolute ethical dilemma
- Adherence
- Approximate ethical dilemma
- Bias
- Bioethics
- Compliance
- Conflict of interest
- Dual relationships
- Ethical dilemma
- Ethics
- Interprofessional
- Laws
- Moral distress
- Morality
- Organizational ethics
- Principles
- Professional ethics
- Values

Beginnings

Most case managers have a basic understanding of ethics, gained through their education and work experience. The codes of ethics for each of the disciplines engaged in case management (e.g., nursing, social work, occupational therapy) are taught in academic coursework. Practitioners must then demonstrate their ethical competency when obtaining licensure and case management certification. Once on the job, ethical themes surround every aspect of a professional's practice. Client autonomy and integrity are routine areas of focus. Privacy and confidentiality have reigned supreme, particularly since 1996 and the advent of the Health Information Portability and Accountability Act (HIPAA).

Figure 1.1 Institute of Medicine Competencies



The World Health Organization (2010) subsequently drew a line in the sand for the education of this next generation, aiming to decrease the fragmentation experienced by stakeholders in the care process. It was determined this education would begin at the gateway of the academic journey. The goal was to educate students from two or more professions to learn about, from, and with each other to enable effective collaboration and improve health outcomes. Emerging literature validated the outcome: when students understand how to work interprofessionally, they are far more ready to enter the workplace as members of collaborative practice teams (Canadian Interprofessional Health Collaborative, 2010; World Health Organization, 2010).

Think how valuable this approach becomes when case managers of varied disciplines work together, as in organizations that pair nurse and social work case managers to leverage their combined expertise and perspective. Ponder the most complex client situation you can and how much easier it becomes to compartmentalize the moving parts of family dynamics, psychosocial stressors, and medical acuity. Consider the time saved by engaging teams of case managers who collaboratively explore both domains of clinical care: pathophysiology and psychopathology. It has been impressive to see the industry consensus, evidence, and funding emerge toward development of these interprofessional dyads.

The Interprofessional Education Collaborative

The Interprofessional Education Collaborative (IPEC) (2018) is composed of the majority of academic accrediting entities for the health profession. IPEC has been on the forefront of advancing the competency-based methodology to educational institutions and healthcare organizations. Their work has been supported and endorsed by the Health and Medicine Division (formerly the IOM) (2015) and continues to receive support of accreditation entities across the industry. Along with publishing robust reports and white papers on the various dimensions of interprofessional education and practice, IPEC also provides funding opportunities to entities looking to advance programming toward enhanced team-based care and population health outcomes.

Table 2.3 Scope and Eligibility for Exam-Based Case Management Credentials

American Nurses Credentialing Center (ANCC)	Commission for Case Manager Certification (CMCC)	National Board for Case Management (NBCM)	National Academy of Certified Care Managers (NACCM)
Credential: RN-BC	Credential: CCM®	Credential: ACM	Credential: CMC
Scope: Nurse case managers across health and behavioral health. **Qualifications:** **Education** Hold a current, active RN license in a state or territory of the United States or hold the professional, legally recognized equivalent in another country. **Experience** Have practiced the equivalent of 2 years full-time as a registered nurse. Have a minimum of 2,000 hours of clinical practice in nursing case management within the past 3 years. **Case management experience** Have completed 30 hours of continuing education in nursing case management within the past 3 years.	**Scope:** Board-certified case managers across every practice setting and healthcare sector. **Qualifications:** **Education** Current, active, and unrestricted licensure or certification in a health or human services discipline that within its scope of practice allows the professional to conduct an assessment independently. Licenses or certifications on probationary status will not be considered eligible until documentation has been provided that all terms of the probation have been met. License must be active through the last date of test administration **OR** Baccalaureate or graduate degree in a health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served, *if licensure or certification is not required for your discipline.* The degree must be from an institution fully accredited by a nationally recognized educational accreditation organization, and the individual must have completed a supervised field experience in case management, health, or behavioral health. **Employment experience** **Category 1:** 12 months of acceptable full-time case management employment experience supervised by a board-certified case manager (CCM®) who has been certified for at least 12 months. Supervision is defined as the systematic and periodic evaluation of the quality of the delivery of the applicant's case management services. **Category 2:** 24 months of acceptable full-time case management employment experience. (Supervision by a CCM not required under this category). **Category 3:** 12 months of acceptable full-time case management employment experience as a supervisor of individuals who provide case management services.	**Scope:** Health delivery system and transitions of care (TOC) case management professionals. **Two distinct exams:** ACM Accredited Case Manager Examination for Nurses ACM Accredited Case Manager Examination for Social Workers **Education** **Nursing:** A registered nurse (RN) applicant must possess a valid and current nursing license. RN applicants must provide a nursing license number, state and expiration date. **Social Work:** Social Worker (SW) applicants must have a Bachelor's or Master's degree from an accredited school of social work **OR** a valid social work license. Social worker applicants must provide the degree, name of school, and year of completion **OR** a current social work license number, state, and expiration date. **Paid work experience*** All applicants must have at least one (1) year**, or 2,080 hours, of supervised, paid work experience employed as a case manager, or in a role that falls within the Scope of Services and Standards of Practice of a case manager, by a Health Delivery System. *Candidates with less than two (2) years of experience must provide supervisor contact information and an attestation that they have at least one (1) year of supervised case management experience on the ACM application.	**Scope:** Care managers and health and human services specialists who acts as a guide and advocate for clients and/or families who are caring for older relatives or disabled adults. **Four eligibility options:** **Option A** **Education:** Master's degree or PhD in a field related to care management. **Experience:** 1 year of paid, full-time care management experience during which the case manager received at least 50 hours of supervision. **Option B** **Education:** Bachelor's degree in a field related to care management or Bachelor's, Master's, or PhD in an unrelated field with a university-based certificate in care management or related to care management (gerontology, mental health chemical dependency, guardianship, developmental disabilities). **Experience:** 2 years of paid, full-time care management experience during which the case manager received at least 50 hours of supervision each year. **Option C** **Education:** Associate's degree in a field related to care management OR an RN diploma. **Experience:** 2 years of paid, full-time care management experience during which the care manager received at least 50 hours of supervision each year.

Table 2.3 Scope and Eligibility for Exam-Based Case Management Credentials (cont.)

American Nurses Credentialing Center (ANCC)	Commission for Case Manager Certification (CMCC)	National Board for Case Management (NBCM)	National Academy of Certified Care Managers (NACCM)
Credential: RN-BC	Credential: CCM®	Credential: ACM	Credential: CMC
	Acceptable employment experience MUST meet the following conditions: 1. At least 30% of qualified work time must focus primarily on case management practice. 2. Perform at least four of The Five Core Components of Case Management. Within each of the four of the five core components, you must: • Perform all Eight Essential Activities with Direct Client Contact • Provide services across a continuum of care, beyond a single episode of care that addresses the ongoing needs of the individual being served • Be responsible for interacting with other relevant parties within the client's healthcare system 3. Your qualifying case management experience MUST be obtained in the United States. **Employer verification must be provided	The NBCM recognizes that because case management experience, supervision, and education, some case managers may be qualified to sit for the exam after only one (1) year of experience. If an applicant meets the eligibility requirements of both an RN and SW, they must indicate which exam they wish to take and provide the applicable eligibility documentation. **Paid or unpaid internship experience does not count toward full-time work experience.	**Additional direct client contact:** 1 year of paid, full-time direct experience with clients in fields such as social services, nursing, mental health/counseling, or care management. **Option D** **Education:** Any degree in an unrelated field (Associate's, Bachelor's, or PhD degree). **Experience:** 3 years of paid, full-time care management experience during which the care manager received at least 50 hours of supervision each year. **Additional direct client contact:** 1 year of paid, full-time direct experience with clients in fields such as social services, nursing, mental health/counseling, or care management.

Source: *Data in this table compiled from The American Nurses Credentialing Center. (2018). Nursing case management certification. Retrieved from https://www.nursingworld.org/our-certifications/nursing-case-management/; Commission for Case Manager Certification. (2018). Certification guide to the CCM examination. Retrieved from https://ccmcertification.org/sites/default/files/docs/2018/ccmc-18-guide-certification-update-9.14.pdf; National Academy of Certified Care Managers. (2018). Eligibility. Retrieved from https://www.naccm.net/about-certification/eligibility/; National Board for Case Management. (2018). Accredited case manager candidate handbook. Retrieved from https://www.acmaweb.org/forms/ACMA_ACMhandbook.pdf. Table layout by the author.*

There are an expanding number of certifications across healthcare. Some of these are aligned with a particular professional discipline or background and offered through professional associations, such as the National Association of Social Workers (NASW). Others are aligned with more formal credentialing centers such as the American Nursing Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA).

Several organizations now offer credentials you may purchase, if particular eligibility standards are met, such as those for social work case managers through NASW. Each credential denotes that a practitioner has demonstrated expertise through fulfilling defined requirements. Each of the two credentials offered requires passage of the requisite licensure exam for that level of practice (e.g., BSW, LCSW). While the overall eligibility criteria for this type of certification is not as rigorous as that which is defined for evidence-based exams, the credentials provide another way for interested persons to obtain an industry-acknowledged case management certification.

Table 2.4 displays the scope and criteria for the two case management credentials offered by NASW.

Table 2.4 Specialty Credential Case Management Certifications: National Association of Social Workers

National Association of Social Workers (NASW): Case Management Credentials	
Certified Advanced Social Work Case Manager (C-SWCM) **Scope:** • BSW-level social work case managers with training, experience and commitment to the knowledge, values, theory, and skills used in the service of attaining goals that are established in conjunction with the client and the client's family when appropriate. **Eligibility:** • A Bachelor's degree in social work from a graduate program accredited by the Council on Social Work Education • Documentation of at least three (3) years and 4,500 hours of paid, supervised, post-BSW professional experience in an organization or agency that provides case management services • Current state BSW-level license or an ASWB BSW-level exam passing score. • Adherence to the NASW Code of Ethics and the NASW Standards for Continuing Professional Education **Purchased credential upon confirmed meeting of eligibility requirements**	**Certified Social Work Case Manager (C-ASWCM)** **Scope:** • MSW-level social work case managers represent those social workers with training, experience, and commitment to the knowledge, values, theory, and skills used in the service of attaining goals that are established in conjunction with the client and the client's family when appropriate. **Eligibility:** • A Master's degree in social work from a graduate program accredited by the Council on Social Work Education • Documentation of at least two (2) years (equivalent of 3,000 hours) of paid, supervised, post-MSW case management experience • Current state MSW-level license or an ASWB MSW-level exam passing score • Adherence to the NASW Code of Ethics and the NASW Standards for Continuing Professional Education **Purchased credential upon confirmed meeting of eligibility requirements**

Source: *Data in table compiled from: National Association of Social Workers. (2018). NASW social work credentials. Retrieved from https://www.social-workers.org/Careers/Credentials-Certifications/Apply-for-NASW-Social-Work-Credentials. Table layout by the author.*

Assessment-based certificate programs

Assessment-based certificate programs are educational or training programs with defined learning objectives and subsequent assessment of whether students achieved those objectives. Certificates are awarded to students who meet the performance, proficiency, or passing standard defined for the assessment(s). No specific acronyms or letters are awarded to individuals to use, only a certificate of completion (Institute of Credentialing Excellence, 2018b).

The industry has witnessed an increased number of certificate programs in case management and care coordination available through community colleges and institutions of higher learning. The programs are especially appealing to individuals interested in advancing or changing careers. Course work is provided via a range of models, including distance education, traditional in-person classes, and intensives scheduled over a comprehensive time frame (e.g., single-day event, weekend). These programs provide a certificate upon completion of either the required coursework or fulfillment of a defined number of continuing education units.

Chapter 3

The Value Proposition of Ethical Case Management Practice

Ethics is not definable, is not implementable, because it is not conscious; it involves not only our thinking, but also our feeling.
—Valdemar W. Setzer

Learning Objectives

1. Explore the value proposition of ethics for healthcare case management
2. Discuss outcomes specific to the fiscal impact of ethical case management practice for organizations
3. Identify how adherence to ethical practice enhances case management return on investment for organizations
4. Discuss the fiscal costs of workplace bullying
5. Identify the financial outcomes related to poor quality handoffs and transitions
6. Explore the impact of cost, quality, and workplace stress
7. Discuss the Physician Payments Sunshine Act
8. Identify the Six Ethical Competencies for Case Management
9. Identify conflict-of-interest disclosure tips

Essential Terms

- Absenteeism
- Case Management's Competencies of Ethical Excellence
- Confidentiality
- Dishonesty
- Due diligence
- Handoffs
- Physician Payments Sunshine Act
- Presenteeism
- Quadruple Aim
- Value proposition
- Workplace stress

Introduction

My father was a physician who loved clichés; some he quoted perfectly, while others he adjusted to have an original meaning. One of his favorite clichés was, "Not everyone is as perfect as us." My response would be, "But dad, we are not so perfect." Because my father always needed to have the last word, he would answer, "That's exactly the point. We are not all perfect; we simply expect everyone else to be."

How correct my father was. We tend to view others from our unique lens of expectation. If we view ourselves as ethical, we expect everyone else to be so as well. We then expect our colleagues will know the difference between right and wrong and will hold themselves to the highest ethical standards. However, reality is always different from what we expect it to be.

Box 3.1 Calculating the Costs of Workplace Bullying

Employee turnover: Multiply the combined salaries of departed workers by 1.5.

- For a case manager who earns an $80,000 salary, recruit and replace expenses are $120,000.

Factor in absenteeism and presenteeism: Estimate number/hours per day targets miss work to avoid a bully.

- Absenteeism: Multiply the hours away from employer by hourly rate. For salaried exempt workers, divide annual salary by 2,020 to find the hourly pay rate.
  - $80,000 salary annually equals $39.60 per hour
- Presenteeism: Employees who come to work sick.
  - The trend of bullied workers unable to find another job elsewhere with equivalent pay.
  - As a result, they show up daily but are present in body, not spirit. They are disgruntled, disgusted, and desperate (the "3-Ds") to be somewhere else.
  - Presenteeism counts the number of "3-D" employees, their hourly wage, and number of hours worked during the bullying episode. Then halve that value.
  - The number you get represents paid wages lost to the employer by paying workers rendered unproductive by bullying.
    - Two employees are bullied over one year; each earns $39.60 an hour, or $79.20 combined.
    - Each employee worked a 40-hour workweek over the year they endured bullying; 52 weeks = 2,080 hours
    - Next, multiply $79.20 x 2,080 = $164,736, and halve that value:
    - $82,368 in lost wages to the employer as a result

Finally: Add the employee turnover + both absenteeism and presenteeism costs:

- $240,000 (two case manager recruit and replace) + $82,368 (absenteeism/presenteeism)
- TOTAL: $322,368

Source: *Data in this box compiled from Workplace Bullying Institute. (2017). Estimate the cost of bullying. Retrieved from http://www.workplacebullying.org/individuals/solutions/costs/.*

Imagine the case manager who chronically rolls her eyes when colleagues speak at meetings. This behavior has a toxic influence on team processes. Perhaps you work with a program coordinator who publicly challenges every decision made by staff, presenting as degrading, aggressive, and unsupportive. What about staff who sabotage the work of colleagues and then blame those same colleagues for poor department outcomes? These are just a few of the many workplace bullying manifestations. The impact of each situation is profound, whether experienced directly or as a witness. How long would you stay at your organization dealing with any of them?

Readmissions

Intense expectations are placed on case management to transition clients quickly to maximize reimbursement. Prioritizing length of stay is understood, but too high a length of stay is a symptom of more pervasive problems in the organization (e.g., fragmented communications, bullying behaviors, workplace stress) (Daniels, 2018). Pressures to discharge impact ethical practice and prompt readmissions. Consider the case manager who facilitates client transfers prematurely or discharges in a cursory manner. Inattention to key details is the outcome, like not conveying a needed extra medication dose or forgetting to inform a home health agency of a change in weight-bearing status orders. Beneficence and

nonmaleficence are at issue. Issues of autonomy also emerge when case managers do not communicate effectively with clients and caregivers about their discharge planning preferences. Abrupt dialogues with clients can be perceived as disrespectful. Unethical practice can easily become an unintended outcome in this type of pressure-filled environment. It is imperative that organizations possess a solid understanding of the time, scope, and expertise required for case managers to successfully do the job. Otherwise, a dangerous process is set in motion that hastens errors and readmissions opposed to limiting them.

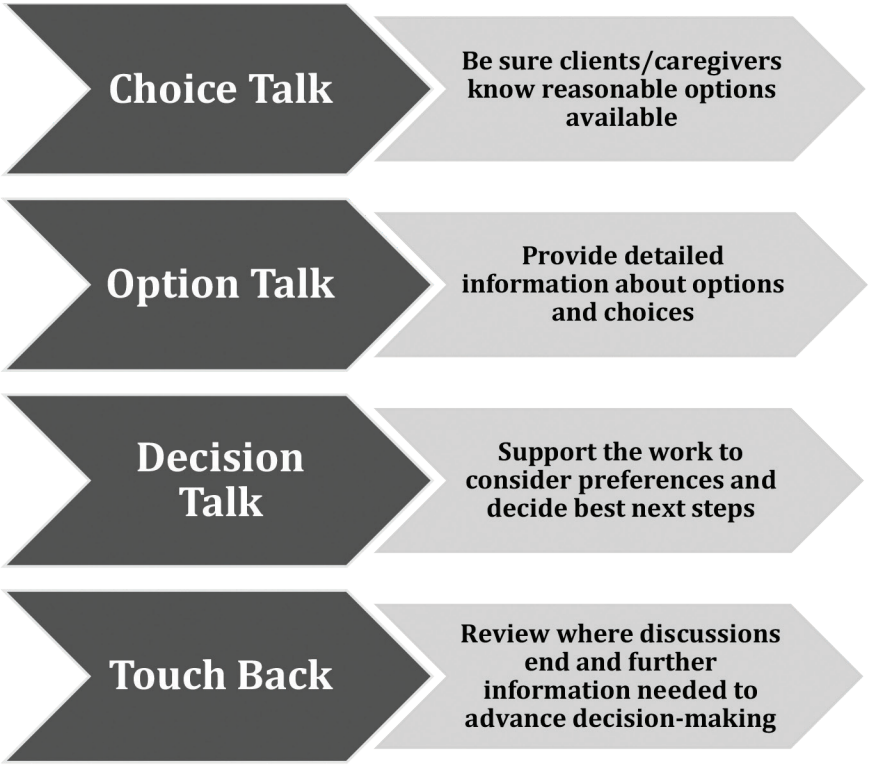
Readmissions across the transitions of care remains a hot topic. Approximately 20% of Medicare hospital discharges resulted in readmissions within 30 days. A total of 75% of these readmissions cost about $12 billion and were considered potentially preventable with improved care transitions (Health Affairs, 2012). Despite rigorous oversight, the industry still wrestles with penalties for unplanned return hospitalizations. More than 50% of U.S. hospitals will have payments docked for fiscal year 2019. Safety net hospitals, the facilities providing care to clients with the lowest incomes, will see a reduction in fines next year, courtesy of a change in how the CMS calculates the penalties for facilities. Yet $566 million in penalties are slated so far for acute care hospitals in 2019 (Rau, 2018). Given the timing of this announcement, who knows what increased penalties await the industry for 2019 and moving forward!

Poor care coordination and transitions

Transitional care planning done well is poetry in motion—quality-attentive, client-centered, cost-savvy, and maximizing wellness for all involved. But the opposite has become the norm. Many readmissions are prompted by discharge planning *handoffs* that fail to meet industry standards, which means errors in the movement of clients between the various transitions of care and providers. Eighty percent of the most serious medical errors are linked to poor communication between clinicians, particularly medication reconciliation issues during discharges and transfers. Referrals to home health agencies are acknowledged to be among the largest threats to client safety. The most common issues identified by CMS inspectors at home health agencies include failures to create and execute care plans, followed by deficient medication reviews. Between January 2010 and July 2015, some 1,591 agencies had defects that inspectors considered so substantial the agencies had to be removed from the Medicare program until the lapses were remedied (Brunken, 2013; Rau, 2016).

The cost of inadequate care coordination, including poor management of care transitions, was responsible for $25–$45 billion in wasteful spending. Lawsuit settlements are in the millions and still rising (Brunken, 2013). Of the $30 billion Congress appropriated to shift the healthcare's antiquated health records system to electronic medical records, none of the monies went to nursing homes, rehabilitation facilities, or providers working with individuals in their homes (Rau, 2016). The industry hoped electronic health records would promote interoperability and enhance coordination of care to reduce

Figure 4.2 Shared Decision-Making for Case Management



Remember the ethical principles, codes, and standards

We discussed in Chapter 1 how important it is for all disciplines to maintain awareness of their personal values and bias, and how easily these dynamics influence how treatment adherence is managed. Case management's professional standards, principles, and ethical codes share consistent language, mandating a case manager's adherence to the ethical principles of autonomy, beneficence, fidelity, justice, and nonmalfeasance. As shown in Box 2.2 in Chapter 2, each ethical standard and code of ethics across case management includes explicit language that promotes attention to:

- Maintaining objectivity
- Respecting the rights and inherent dignity of all clients
- Acting with integrity and fidelity with clients and others
- Placing the public interest above their own

I know this attention can be easier said than done; no magic wand will fix that fact. Although attending to the language of these resources can't force treatment adherence, it does emphasize the significance of where to focus case management intervention (e.g., cultural contexts, health literacy, use of age-appropriate or contextual language).

Table 5.1 Workplace Bullying Terms and Definitions

Term	Definition
Lateral violence (US Legal, 2018)	Persons who are both victims of a situation of dominance turn on each other rather than confronting the system that oppresses them both. These individuals/groups become marginalized and feel oppressed, and they may do the following: • Internalize feelings of anger and rage • Manifest their feelings through behaviors including gossip, jealousy, putdowns, and blaming
Hostile work environment (Heathfield, 2018)	• Actions/behavior must discriminate against a protected classification (e.g., age, religion, disability, race) • Behavior or communication must be pervasive, lasting over time, and not limited to an off-color remark that a coworker found annoying • The problem becomes significant and pervasive if it is all around a worker, continues over time, and is not investigated and addressed effectively enough by the organization to make the behavior stop • The hostile behavior, actions, or communication must be severe – The hostility must seriously disrupt the employee's work – The hostility must interfere with an employee's career progress • Hostile workplaces may include bullying behavior but are not solely defined by the presence of it
Mobbing (Gresham, n.d.)	Bullying by numerous colleagues, superiors, and, in some cases, even subordinates of the victim of the bullying.
Workplace bullying (Workplace Bullying Institute, 2018)	The repeated, health-harming mistreatment of one or more persons (targets) by one or more perpetrators, marked by abusive conduct: • Threatening, humiliating, or intimidating • Work interference or sabotage, which prevents work from getting done • Verbal abuse
Workplace harassment (U.S. Equal Employment Opportunity Commission, 2018)	Unwelcome conduct based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability, or genetic information. Harassment becomes unlawful when the following is true: • Enduring the offensive conduct becomes a condition of continued employment • The conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive

Source: *Data in this table compiled from Gresham, T. (n.d.). What is mobbing at the workplace.* Small Business Chron. *Retrieved from http://small-business.chron.com/mobbing-workplace-43426.html; Heathfield, S. (2018). What makes a work environment hostile. Careers. Retrieved from https://www.thebalancecareers.com/what-makes-a-work-environment-hostile-1919363; US Legal. (2018). Lateral violence, definition. Retrieved from https://definitions.uslegal.com/l/lateral-violence/; U.S. Equal Employment Opportunity Commission. (2018a). Harassment, types of discrimination. Retrieved from https://www.eeoc.gov/laws/types/harassment.cfm; Workplace Bullying Institute. (2018). The WBI definition of workplace bullying, start here. Retrieved from http://www.workplacebullying.org/individuals/problem/definition/. Table layout by the author.*

Here is a common scene that plays out. Perhaps staff members become frustrated by the loss of a critical benefit (e.g., reimbursement for professional fees or case management credentialing examinations) and project their anger onto each other. Lateral violence takes over the atmosphere, with poor morale and decreased camaraderie infecting the department. Staff members call out sick in droves, leading to excessive absences. The remaining case managers struggle to manage the workflow and become more resentful; coverage is subpar at best. Mob mentality manifests as disgruntled staff take their annoyance out on the new manager, who promised to unfreeze positions and hire staff ASAP. Unfortunately, the manager's efforts are unsuccessful. Fifty-eight percent of primary care professionals have been exposed to mobbing on at least one occasion (Erdogan & Yildirim, 2017).

Epilogue

In the final analysis, ethics is less about what we do, and more about who we are.
—Wayne R. Bills

In my efforts to keep the book content of maximum value, this epilogue will be concise and clear-cut. Know that in the context of ethics, there is one given: While the ethical competencies and principles remain constant, they will continue to be tested by a fluid industry. The case management workforce will be tested in tandem.

New "P"s will constantly appear on the healthcare landscape for case management's attention. Emerging *populations* will mandate our expertise, with expanding *programs* and resources to meet their needs. New *products* will be introduced to meet the innovative delivery *platforms* that guide our *practice*. Oh, and of course there will be fresh *policies* to drive the latest laws, reimbursement, and funding. We need to stay informed and savvy of every update and application. How boring our work would be without a *plethora* of change.

For years, colleagues have noted that case managers are the healthcare industry's best-kept secret. The value proposition for case management's ethical practice is significant, with our actions integral to the financial health of the organizations that employ us. We know this but often don't take the time to prove it, getting caught up in other, more pressing tasks. Touting case management expertise includes attention to quality and financial performance metrics and the demonstration of ethical excellence through robust outcomes.

By virtue of a case manager's global perspective to the interprofessional care process, we have the best seat to the care, quality, and cost show. Case management has progressed from best-kept secret to best-utilized resource toward validating client-centric, ethical, and quality-driven care that ensures financial sustainability for the organization.

This book is chock full of grounding ethical content. I have compiled a list of parting thoughts to guide your ethical actions moving forward:

- Ethics is intentional and strategic.
- Ethical situations always have the potential for legal consequences.
- Best intent may not be best, or ethical, practice.

THE ESSENTIAL GUIDE TO **Interprofessional Ethics in Healthcare Case Management**

Ellen Fink-Samnick MSW, ACSW, LCSW, CCM, CRP

Case managers are frequently confronted with ethical dilemmas and tricky situations. Failure to grasp ethics in healthcare case management can negatively impact quality of care, organizational costs, and even a case manager's career. In addition, poor ethical practice can harm an entire organization through financial repercussions, safety concerns, and damage to staff or facility reputation. Understanding and keeping current with ethical, legal, and practice standards is vital for case managers.

The Essential Guide to Interprofessional Ethics in Healthcare Case Management will help case managers navigate the ethical conundrums they face as they interact with one another, the healthcare team, and patients and families. Rather than providing a broad-strokes overview of ethics, author Ellen Fink-Samnick takes a focused approach and considers specific scenarios unique to healthcare and case management. The book covers industry disruptors, including technology and social media; workplace bullying; licensure across state lines; patient care considerations, such as end-of-life care, LGBT patients, and traumatic brain injury; and the impact of ethics on models of care, such as value-based care and population health.

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