Ethics for Professional Case Managers

Author: Nancy R. Kirsch, PT, DPT, PhD, FAPTA; Tracey Long, RN, PhD, APRN; Susan Walters Schmid, PhD

Contact hours: 8

Course price: $59

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This course is approved by the Commission for Case Manager Certification (CCMC).

Course Summary

Ethical behaviors for case managers reflect a foundational requirement to be fair and effective in the profession of healthcare and to promote positive patient outcomes. This course offers a basic knowledge of ethics, including your CCM Code of Ethics and how to implement it in your professional practice. It includes both HIPAA and OSHA requirements.

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80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

- **CCMC Ethics Course**
  This program has been pre-approved by The Commission for Case Manager Certification to provide Ethics continuing education credit to CCM® board certified case managers. The course is approved for 8.0 CE contact hours. Activity code: H00035281. Approval Number: 180004967.

- **Certified Case Managers**
  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 8.0 CE contact hours. Activity code: H00035281. Approval Number: 180004967.

Course Objectives

When you finish this course you will be able to:

- Explain ethical standards of practice.
- Identify the code(s) of ethics that apply to your profession.
- List and define the principles of ethics for healthcare.
- State the relationship between the Rule of Law and ethics and morals.
- Identify 3 legal or regulatory requirements that apply to your practice.
- Be ready to explain the ethical decision-making process with a relevant case.
- Discuss the ways in which HIPAA impacts your daily practice.
- Explain the requirements of OSHA and how they apply to case management.

Ethics in Healthcare Practice

Leonard, a 78-year-old male, lives alone and was admitted to the hospital for failure to thrive after surgery to replace his hip four months ago. The hospital faces a financial challenge to pay for his care because his insurance has run out. Do you downgrade his care to get him discharged even though he has not been doing well in the hospital? What other issues do you need to consider for his failure to thrive? What resources are available to you and to him? How would you even begin to address this dilemma?

Ethical dilemmas are all too common for case managers who must ask hard questions, juggle resources, and make decisions that impact patients and their family members. As a case manager you are in a dilemma as you try to balance the care needed by Leonard with the finances of the hospital.

The Role of Ethical Standards

Ethical violations in government, industry, and the financial world make all-to-common tabloid headlines—and are all too often the cause of grief and even tragedy in work and personal lives. In every area of work, ethical violations make news. Clearly, we need to have a thorough understanding of our own ethical behavior and to avoid the behaviors that become ethical violations. Complying with ethical standards is vitally important because healthcare is a profession that impacts the lives of people, their families, and even our own reputations.

Even though case managers acknowledge their need to make ethical decisions in clinical settings, they may not have received special training for doing so. The case manager is a healthcare professional with an interdisciplinary scope of practice who frequently has to deal with complicated ethical decisions. To be an effective and ethical case manager requires that the professional "possess the education, skills, moral character, and experience required to render appropriate services based on sound principles of practice (CCMC, 2015).

This requires that case managers commit to provide evidence-based advice to clients, coordinate their care, make appropriate use of resources, and empower them to make good decisions regarding their own healthcare. Because case managers deal with patients and family members when they are ill, a very vulnerable stage in life, this compounds the necessity and responsibility for ethically dealing with others.

> Because the role of the case manager inherently deals with challenges in healthcare delivery and payor systems, ethical dilemmas will be encountered. Case managers must abide by their professional code of conduct and use it to guide their professional behavior and decision-making (Airth-Kindree & Kirkhorn, 2016).

The Commission for Case Manager Certification (CCMC) has a formal code of ethics (see below) that can guide you in your role. In addition, case managers are generally nurses or social workers, and each profession has its own a code of ethics as well.

Education and training to manage ethical decision-making is a way to clarify the roles and expectations in professional behavior that is essential to effective moral behavior (Miles, 2016; Brody, 2014; Murrell, 2014). The public's demand for transparency, the growing delivery of care by a variety of healthcare professionals in various roles, and the complicated relationship between healthcare professionals and insurance regulations have increased the pressure to be more accountable for your actions.

A Brief History of Bioethics

In medicine the topic of ethics began with the 2500-year-old Oath of Hippocrates to "First, do no harm"; this implies that, despite best intentions to provide effective care, errors can occur. In a human profession, unfortunately, sometimes those errors can be fatal. Hippocrates, known as the father of modern medicine, outlined the foundational virtues that any present or future physician should pledge to maintain. Virtues included the basics of autonomy, beneficence, justice, and nonmaleficence. He also stressed patient privacy and joining into a partnership with patients to create a health plan that would be best for each individual. (Kantarjian, 2014; Sugarman, 2000).

Medical ethics has evolved for millennia, but the primary four tenants of ethical standards have persisted. As early as 1767 a patient sued and won against his surgeons for breaking his leg as part of a surgical repair without prior consent (Leclercq et al., 2010). In 1914 a woman sued her surgeon for removing a fibroid during an abdominal surgery for another issue, which created the ruling that

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages (Scholendorff v. Society of New York Hospital, 1914).

In 1947, following World War II, discussion of ethical standards turned from physician/patient concerns toward social issues. After awareness had grown of war atrocities such as the Nazi's human experiments in the concentration camps and the Japanese experiments in China, news came of the Tuskegee controversy in the United States (in which medical research was done on black soldiers) and public outrage grew. Human rights cases were widely publicized, creating the need for stronger ethics standards.

Despite the world's becoming more complicated, the original concepts of the Hippocratic Oath of autonomy, **beneficence** (doing good), justice, and **nonmaleficence** (doing no harm), are not outdated. What originally began as the moral principles of patient care evolved into the generally accepted practice of **confidentiality**, and then in 1996 came the legal Health Insurance Portability and Accountability Act, known as HIPAA.

Medical ethics has evolved from theoretical concepts of moral behavior to firm legal standards of practice meant to guide healthcare professionals. Not only do these ethical standards apply in moral issues but also in the ever- advancing use of digital record-keeping to navigating decisions created by new technology (Aicardi, 2016; Means, 2015; Pasztor, 2015; Wells et al., 2015). With the expansion of technology and digital communication, ethical standards have developed rules to use these advances ethically. Hospitals and other healthcare facilities outline the proper and legal use of sharing electronic images and photographs, digital records, and documents. As technology advances, so does the necessity for rules about how to use it.

Healthcare has always demanded impeccable behavior from its practitioners, and today there are renewed expectations of a high level of ethical behavior (Tenery, 2016). Trust is an integral component of the healthcare relationship and patients are generally in a vulnerable position when they encounter a healthcare professional.

As technology and the use of the electronic records have become widely used, healthcare professionals often find themselves facing new challenges as to how to navigate their moral and ethical use. Case managers often find themselves feeling the need for guidance in decision-making. A thorough understanding of the expected standards of practice for healthcare is essential in making good ethical decisions (Marques, 2012; Quigley, 2015).

There are numerous programs to help train healthcare professionals in ethics. Medical and nursing schools, as well as physical therapists, occupational therapists, and pharmacists include it in their training (Kearney & Penque, 2012). Questions related to ethics are found on the licensure exams for these healthcare professionals. Hospitals and healthcare facilities also now include required signatures and strict compliance of students and employees who access their electronic records.

Test Your Knowledge

Ethical decision making has become more complex because:

A. The Hippocratic Oath has long been outdated.
B. Society today is steeped in immorality.
C. Organizational priorities and financial pressures affect everyday decisions.
D. There are more rules today than in earlier times.

At the center of the patient-health professional relationship is:

A. Loyalty
B. Affection
C. Sincerity
D. Trust

Healthcare ethics are unique because:

A. Patients are vulnerable.
B. A lot of money is involved.
C. Healthcare workers care about people.
D. Patients have complete autonomy.

Answers: C,D,A

Ethical Standards of Practice

Professional ethics are incumbent only on those individuals who occupy a professional role. Beyond that, each of us has a **moral threshold**, a bar below which we will not compromise. To compromise below your moral threshold is to compromise your personal integrity.

The corporate scandals of the past decade and the response to them are relevant to the healthcare environment (Xu, 2016, Welsh & Ordonez, 2014). Specialists in ethical leadership have proposed that there is a key element currently missing, which they refer to as *moral potency*. The basis of their work stems from the question: Why do people who know what the ethically correct decision is fail to take action, even when action is clearly necessary? (Hannah, Avolio & May, 2011).

Ethical behavior is not as strongly influenced by judgment as it is by *acting on* a moral judgment. **Moral potency** can be defined as "the capacity to generate responsibility, and motivation to take moral action in the face of adversity and to persevere through challenges."

Moral potency is built on (1) **moral ownership,** a sense of responsibility to take ethical action when faced with ethical issues; (2) **moral efficacy,**the beliefs of individuals that they can organize and mobilize to carry out an ethical action; and (3) **moral courage,** the courage to face threats and overcome fears to act. (Hannah, Avolio, & Walumbwa, 2011).

Apply Your Knowledge

What is the last time you had to make a decision that was ethically difficult? What resources did you have? What support did your employer provide you?

Did you have a template or guideline to help you weigh the issues? Does your facility have an ethics committee? Have you ever attended a meeting with them?

Test Your Knowledge

When you lower your moral threshold, you:

A. Compromise your integrity.
B. Open your mind to new ideas.
C. Increase your awareness of complex issues.
D. Recognize the reality of healthcare.

Moral potency is:

A. Repeating an action until you get the results you want.
B. The capacity to take moral action responsibly in the face of adversity.
C. Being willing to express your religious beliefs across all settings.
D. Doing the right thing.

Answers: A,B

Professional Codes of Ethics

Healthcare providers have a special relationship with their patients that is based on trust; indeed, trust is one of the pillars of the professionalism on which the healthcare relationship rests. When patients have an illness, injury, or disability, their increased vulnerability makes it even more important that we behave ethically.

Research reveals the public has lost trust in professionals in the helping fields; however, it also reveals that this loss of trust can be ameliorated with appropriate education in professional ethics (Sokol, 2015; Sutherland-Smith, 2011). This requires that professionals receive knowledge and training in ethical behavior (deOliveira, 2015; Rawson et al., 2013; Nijhof et al., 2012; Pantic, 2012).

Trust begins with respect and loyalty to your patients, which is the foundation for delivering the best possible care for their unique needs; however, it can sometimes be very difficult to reconcile with the organizational priorities and financial pressures associated within healthcare today.

Healthcare professionals have a fiduciary responsibility to both their employers and their patient and these are often contradictory. Ordering all the necessary laboratory and diagnostic tests to have certainty in a diagnosis and to manage treatment can be costly—and is often prohibited by the insurance company, which requires that the healthcare provider be discriminating when ordering tests. Balancing the two "customers"—the patient and the payor—can be challenging. What is medically appropriate may not be financially prudent.

For example, if we have the technology to save a 20-week pre-term infant who will require NICU attention for at least 4 months, should we?

Most people would emphatically declare Yes! But what if the mother of the premature infant is a young homeless teen who doesn't have insurance and the infant is declared brain damaged from maternal opiate abuse?

Without extraordinary measures the infant would naturally expire. Is it still the best decision to have the hospital or state pay for the infant's care? So, if the state insurance pays the bill for this extensive care for one individual, who else will suffer without state assistance when the money runs out? What if the cost of the brain-damaged infant's care could be used to immunize the entire state's school-aged children instead? Moral and ethical decisions like this are extremely difficult.

Most hospitals and many healthcare facilities have a specially designated ethics committee who can discuss the legal, ethical, medical, and moral issues regarding such difficult and complicated issues. The dynamics of an ethics committee are generally made of a physician, nurse, case manager, social worker, and often a patient legal representative (ombudsman). Each brings a different perspective to expand the group's awareness and increase the number of options and resources.

The responsibility that a profession has to manage its own ethical "house" was identified almost forty years ago. Andrew Guccione (1980) stated: "The need to identify and clarify ethical issues increases as the profession assumes responsibility for those areas of direct care in its domain."

The responsibility to practice ethically goes beyond just the specifics of any one profession:

> The privilege and influence that accompany professional practice obligate healthcare providers to look beyond literal or superficial interpretations of their ethical code, and to consider the complexities of the ethical issues evident in the current practice environment.
>
> Knapp et al., 2013; Sisola, 2013

Certified Case Manager (CCM) Code of Conduct

Case managers have their own established Code of Conduct that was originally adopted in 1996 to ensure quality and protect the public interest (CCMC, 2015). Eight principles are the foundation of the Code and include the following.

The 8 Principles of Case Manager Conduct

Case managers will

1. Place the public interest above their own at all times.
2. Respect the rights and inherent dignity of all of their clients.
3. Act with integrity and fidelity with clients and others.
4. Maintain their competency at a level that ensures their clients receive the highest quality of service.
5. Honor the integrity of the case manager designation.
6. Obey all laws and regulations.
7. Maintain the integrity of the Code.

Source: CM, 2015.

Healthcare ethics are unique. Often patients cannot choose who they want as a healthcare provider. They are vulnerable to variations of assigned providers and must accept whoever is assigned to their care. The result of poor behavior on the part of the practitioner and poor communication between providers can have dire consequences (Caldicott, 2014; Mansbach et al., 2012; Hren, 2011). Public assumption is that the provider is making decisions in their best interest, which should be the standard. Patients also are generally not well educated in medicine and healthcare standards and rely on trained professionals to make healthcare decisions for them.

Not many years ago, physicians could receive a *kickback* (monetary payment for a referral) if they referred patients to other providers or ordered diagnostic tests in which they had a financial stake, which is a conflict of interest and clearly unethical. Equally alarming is that prescriptions often increase after a visit from a pharmaceutical representative who may have treated the physician and his office staff to special gifts, meals, or entertainment. What once started as friendly professional gifts has now required legislation to avoid unethical professional enticements and favoritism.

Professionalism, therefore, is tightly connected to moral and ethical behavior. It is vital that healthcare professionals understand the moral, ethical, and legal issues when making decisions that impact patients.

All case managers are held to these high professional standards. Because in large part case managers oversee the experience of their patients, they may be in a unique position to notice discrepancies and ethical infractions. When this happens, they have the moral and legal obligation to speak up. Thus, they are truly patient advocates.

Although case managers are nurses as well as other health professionals, nurse case managers are also held to the American Nurse Association (ANA) Code of Ethics Provision VIII, which declares

> The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.

Additional Principles for Case Managers Who Are Nurses

- Respect for human dignity
- Appropriate relationships with patients, colleagues and others
- The right to self-determination
- Patient privacy
- Conflicts of interest
- Professional boundaries
- Protection of patient rights
- Human rights in research
- Promoting a culture of safety
- Patient protection and impaired practice
- Accountability for nursing judgements
- Assignments, delegation and patient abandonment
- Duties to self and others
- Maintenance of competence and professional growth
- The environment and ethical obligation
- Contributions through research and scholarly work
- Advocacy for human rights
- Obligation to advance human rights and reduce disparities
- Integrity of the profession
- Integrating social justice and health policy

Source, ANA, 2015.

Apply Your Knowledge

How is the American Nurse Association Code of Ethics different from or similar to the Certified Case Manager Code of Ethics? How is it different from that of any other healthcare professionals, such as Physical Therapists, Occupational Therapists, or Physicians?

Test Your Knowledge

Which of the following are key components to a code of ethics?

A. Respect for human dignity and patient privacy
B. Ability to financially pay for healthcare services rendered.
C. Autonomy to make decisions and transportation resources
D. Compliance to regimens and honesty

What does a case manager agree to abide by in their code of ethics?

A. Confidentiality of personal health information
B. Patient advocacy
C. Obey all laws and regulations
D. All of the above

Answers: A,D

The Principles of Healthcare Ethics

The language of ethics related to healthcare, also commonly called *bioethics*, is applied across all practice settings, and four basic principles are commonly accepted. These principles include (1) **autonomy**, (2) **beneficence**, (3) **nonmaleficence**, and (4) **justice**. For Case managers, and other health professionals, **veracity** (truthfulness) and **fidelity** (trust) are also spoken of as ethical principles but they are not part of the foundational ethical principles identified by bioethicists (Drumwright, 2015).

The Principle of Autonomy

Autonomy is an American value. It is the ability to make decisions for oneself, also known as self-government. We hold great respect for individual rights and equate freedom with autonomy. Our system of democratic law supports autonomy and, as such, upholds the right of individuals to make decisions about their own healthcare.

Respect for autonomy requires that patients be told the truth about their condition and be informed about the risks and benefits of treatment in order for them to make informed decisions. Under the law, they are permitted to refuse treatment even if the best and most reliable information indicates that treatment would be beneficial, unless their action may have a negative impact on the well-being of another individual. These conflicts set the stage for ethical dilemmas.

The concept of autonomy has evolved, from paternalistic physicians who held decision-making authority, to patients empowered to participate in making decisions about their own care, to patients heavily armed with Internet resources who demand their own choice in any decision-making. This transition of authority has been slower to evolve in the geriatric population but, as the baby boomers age, they will assert this standard of independence.

Autonomy, however, does not negate responsibility. Healthcare is a partnership between the provider and the recipient of care. Each owes the other a position of partner and respect in healthcare decision-making (Veatch, 2016). An ethical surety is that the physician, or any other healthcare professional, cannot make a unilateral healthcare decision without the consent of that competent adult, or emancipated minor.

Emancipated minors are persons under the age of 18 who can make legal decisions for themselves without a parent’s consent. Emancipation can occur in several ways, including (1) reaching age of majority [age 18], (2) emancipation by court order, (3) by marriage or parentage, or (4) by active military service. What makes someone an emancipated minor includes being under the age of 18 and legally married, financially independent, a parent, or responsible for his or her own housing, or having been kicked out of a home by abusive parents (Larson, 2018). Healthcare professionals need to be familiar with these legal issues in advocating for patients who fall within the emancipation category. Case managers may need to advocate for emancipated minors in healthcare issues.

Test Your Knowledge

A 15-year-old female presents to a women's clinic requesting an abortion. What are the options and responsibilities of a case manager? Does this require a parent's consent or an ethics committee?

A. She requires parental consent before the abortion can be performed.
B. Only the girl and the father of the unborn baby need to give consent.
C. She can only give consent without a parent if she is an emancipated minor.
D. The abortion can be performed but the parent of the minor still needs to be informed.
E. The minor girl does not need parental consent for this procedure.

Answer: E

Rationale: Even if this girl is not an emancipated minor, she does not require parental consent for an abortion, birth control, or treatment of a sexually transmitted infection per current U.S. law.

Test Your Knowledge

Beneficence means:

A. Being kind.
B. Doing little harm.
C. Ensuring equal services for all.
D. Encouraging independence.

Answer: A

The Principle of Beneficence

The beneficent practitioner provides care that is in the best interest of the patient. **Beneficence** is the act of being kind. The actions of the healthcare provider are designed to bring about a positive outcome. Beneficence always raises the question of subjective and objective determinations, of benefit versus harm. A beneficent decision can only be objective if the same decision would be made regardless of who was making it.

Traditionally the ethical decision-making process and the ultimate decision were the determination of the physician. This is no longer the case; the patient and other healthcare providers, according to their specific expertise, are central to the decision-making process. For example, case managers have expertise in quality-of-life issues, and in this capacity can offer much to the discussions of lifestyle and life-challenging choices, particularly when dealing with terminal diseases and end-of-life dilemmas (Leuwenburgh-Pronk et al., 2015).

The Principle of Nonmaleficence

Nonmaleficence means doing no harm. Providers must ask themselves whether their actions may harm the patient either by omission or commission. The guiding principle of *primum non nocere*, "First of all, do no harm," is found in the Hippocratic Oath. Actions or practices of a healthcare provider are "right" as long as they are in the interest of the patient and avoid negative consequences.

Harm by an act of omission means that some action could have been done to avoid harm but wasn't done. **Omission** would be failing to raise the side rails on the patient's hospital bed, upon which the patient fell out and was injured. An act of **Commission** is something actually done that resulted in harm. An example of an act of commission would be delivering a medication in the wrong dose or to the wrong patient.

Case managers can be accused of **maleficence by omission** if they failed to coordinate a patient's care correctly—for example, discharging a patient to an inappropriate level of care or leaving a patient in a dangerous living situation. A key role for the case manager is to be an advocate for the patient and neglecting this role could be maleficent. An unethical act of commission could be breaking confidentiality by releasing information that becomes harmful to the patient.

Test Your Knowledge

Nonmaleficence means:

A. First of all, assess your patient.
B. Not being malicious.
C. Doing no harm.
D. Avoiding malpractice.

Answer: C

Patients with terminal illnesses are often concerned that technology will maintain their life beyond their wishes; thus, healthcare professionals are challenged to improve care during this end stage of life. Patients may even choose to hasten death if options are available. The right of the individual to choose to "die with dignity" is the ultimate manifestation of autonomy, but it is difficult for healthcare providers to accept death when there may still be viable options. Indeed, in most states it is still illegal to hasten death by any active means.

Here we see the principle of nonmaleficence conflicting with the principle of autonomy as the healthcare providers or case managers desire to be beneficent or, at the least, cause no harm. The active choice to hasten death versus the seemingly passive choice of allowing death to occur requires that we provide patients with all the information necessary to make an informed choice about courses of action available to them.

A complicating factor in end-of-life decisions is patients' concern that, even if they make their wishes clear (such as through an advance directive), their family members or surrogates will not be able to carry out their desires and permit death to occur. Treating against the wishes of the patient can potentially result in mental anguish and subsequent harm to the patient or family members.

Euthanasia can be either active or passive. Currently active euthanasia, which is actively giving a medication to bring about death is illegal under federal law in the United States; however, passive euthanasia may be allowed. Removing ventilation equipment or withholding nutrition, which may cause a natural death, are permissible and currently identified in living wills or advance directives when patients state they desire no *extraordinary* measures be taken to sustain life.

Online Resource

For an update in 2017 on the currently accepted practices, see "Voluntary Euthanasia" in the Stanford Encyclopedia of Philosophy (Young, 2017).

The Principle of Justice

Justice speaks to equity and fairness in treatment. Hippocrates related ethical principles to the individual relationship between the physician and the patient. Ethical practice today must extend beyond individuals to the institutional and societal realms. This means that, in addition to providing fairness in treatment to the patient, the institution and staff must also be treated fairly. For example, it is not fair if a patient cannot make payments and the institution has to pay for the treatments already given for the patient's benefit.

Justice may be seen as having two types: distributive and comparative. **Distributive justice** addresses the degree to which healthcare services are distributed equitably throughout society. Within the logic of distributive justice, we should treat similar cases similarly—but how can we determine if cases are indeed similar? Beauchamp & Childress (2013) identify six material principles that must be considered, while recognizing that there is little likelihood all six principles could be satisfied at the same time (see box).

Looking at the principles of justice as they relate to the delivery of healthcare, it is apparent that they do conflict in many circumstances. For example, a real-life system that attempts to provide an equal share to each person cannot distribute limited resources. There is a finite end to money and resources within the budget of an organization. When good patient care demands more than the system has allocated, there may be a need for adjustments within the marketplace.

Principles of Justice

To each person:

- To each person an equal share
- To each person according to need
- To each person according to effort
- To each person according to contribution
- To each person according to merit
- To each person according to free market exchanges

An example would be when an insurance company has exhausted its allocated and contracted funds to care for a hospitalized patient. The insurance company can then demand that the patient be transferred to another facility of lesser cost. If, however, the acuity of the patient is too high to be transferred, then the patient's healthcare costs continue to exceed the budget, which is unequitable for the insurance company. If the insurance company stops paying for services rendered, then it is unequitable for the hospital. If the hospital discharges the patient home before truly appropriate for the patient, it becomes unequitable for the patient. Clearly, these are unfortunately real-life ethical and moral dilemmas. Who is most important?

Comparative justice determines how healthcare is delivered at the individual level. It looks at disparate treatment of patients on the basis of age, disability, gender, race, ethnicity, and religion. Of particular interest are the disparities that occur because of age. Bias as a result of age compared to gender and race discrimination is referred to the practice as **ageism** (Chrisler et al., 2016). In our society, equal access to healthcare does not exist due to variations in health insurance, third-party payers, socioeconomic levels, and even availability of transportation to care facilities. There is valid concern about the distribution of resources, particularly as the population ages and the demand for services increases.

Currently those age 65 and older receive disproportionate levels of funding in healthcare because the number of individuals in that cohort continues to increase and because people tend to need more healthcare services when they are older. Equitable allocation of resources is an ever-increasing challenge as lives are extended through natural and technological means.

Political trends and changes also impact the principle of justice in healthcare decisions. Democratic President Barack Obama introduced the first government sanctioned healthcare aimed at covering all Americans, nicknamed "Obamacare" or more correctly called the Patient Protection and Affordable Care Act (ACA) (PPACA, 2010). The ACA was an attempt to decrease disparities in healthcare benefits.

All of these factors place greater stress on an already overburdened healthcare system and result in more difficult ethical decisions about workforce allocation and equitable distribution of financial resources.

The Principle of Veracity

Veracity (truthfulness) is not a foundational bioethical principle and is granted just a passing mention in most ethics texts. It is at its core respect for all persons by being truthful. Veracity is the opposite of the concept of paternalism, which assumes patients need to know only what their physicians choose to reveal.

Obviously there has been a dramatic change in attitudes toward veracity because it forms the basis for the autonomy expected by patients today. **Informed consent** is only possible if patients have been well informed of options, which then allows them to exercise autonomy with full knowledge.

Decisions about withholding information involve a conflict between veracity and deception. There are times when the legal system and professional ethics agree that deception is legitimate and legal. **Therapeutic privilege** is invoked when the healthcare team makes the decision to withhold information believed to be detrimental to the patient. Such privilege is by its nature subject to challenge and is taken very seriously by ethics committees.

The Principle of Fidelity

Fidelity is loyalty. It speaks to the special relationship developed between patients and their healthcare professionals. Each owes the other loyalty; although the greater burden is on the provider to be worthy of the patient's trust and loyalty (Beauchamp & Childress, 2013). Fidelity often results in a dilemma, because a commitment made to a patient may not result in the best outcome for that patient (Veatch, 2016). At the root of fidelity is the importance of keeping a promise and being true to your word. Individuals see this differently. Some are able to justify the importance of the promise at almost any cost, and others are able to set aside the promise if an action could be detrimental to the patient.

For example, if a physician promises the patient they will always be there to care for them, yet leaves the organization and joins another healthcare facility, the patient may feel the physician betrayed their loyalty. The same may occur with a case manager who promises the patient and family they will be available to help them, yet leaves the employment, which may make the patient feel abandoned.

Test Your Knowledge

Veracity means:

A. Paternalism.
B. Therapeutic privilege.
C. Legitimacy.
D. Truthfulness founded on a respect for persons.

Answer: D

An Ethical Decision-Making Model

There are many models for ethical decision-making that help to organize the thoughts of the individual. Some are quite simplistic, for example, the tilt factor model.

Tilt Factor Model

The **tilt factor model** looks at the choices confronting the individual, with pros and cons defined and with the factors that would change the decision indicated as "tilt factors." This simple model does not truly guide the practitioners' actions, but it does help to frame the question.

Using this model to make ethical decisions provides the case manager with direction for collecting information about the problem, the facts of the situation, the identification of interested parties, and the nature of their interest: is it professional, personal, business, economic, intellectual, or societal? The healthcare professional then determines if an ethical question is involved and if there could be a violation of the code of ethics, or if there is a potential affront to personal moral, social, or religious values. This model also identifies any potential legal issue (eg, malpractice, a practice-act infringement). The case manager gathers more information if it is needed to make an appropriate decision. In the tilt model, this is the point where the case manager is encouraged to brainstorm potential actions and then analyze the course of the chosen action.

The RIPS Model

A model for ethical decision-making that is popular with case managers and other healthcare professionals is the **Realm, Individual Process, Situation (RIPS) model**. The steps of the RIPS model bring forward many of the aspects of a problem confronting the interdisciplinary team. This method essentially involves four steps (Dale, 2016). To better illustrate the ethical decision-making process, we will work through a case that involves issues of utilization. You will see that the three primary components of the RIPS model are implemented in the case.

Test Your Knowledge

The model of ethical decision making called RIPS means:

A. React intuitively to present solutions.
B. Respect institutional protocols selectively.
C. Rest in peace serenely.
D. Realm, individual process, and situation.

Answer: D

Kenneth Wilson is 82 years old and he has been in relatively good health. He has high blood pressure, and eight years ago he had cardiac bypass surgery. He lives with his 79-year-old wife in the two-story home they have owned for more than forty years. He is retired from an executive position at a large manufacturing company. His primary insurance is Medicare.

Two weeks ago, he awakened disoriented in the middle of the night and fell as he tried to get out of bed to use the bathroom. His wife called 911 and he was taken to the hospital, where it was determined he had sustained a right CVA with resulting left hemiplegia. His course in the hospital was complicated by an unexplained fever. When he had been fever-free for 48 hours it was determined that he could be discharged to a subacute facility to begin rehabilitation.

Mr. Wilson looks forward to being discharged from the acute care hospital but is very tired and finds it difficult to tolerate the 30 minutes of therapy he is receiving in the post-acute rehabilitation hospital. He has only been out of bed for 20 minutes at a time and was exhausted afterward. He and his family are assured by staff that he will continue to get stronger each day.

At the subacute facility he is evaluated by physical therapy (PT), occupational therapy (OT), and speech therapy (ST). He is found to have no speech deficits and no cognitive deficits other than mild confusion, which is steadily clearing. His entire program will consist of physical therapy and occupational therapy. Following evaluation, he is placed on Tim's caseload for PT and Casey's caseload for OT.

Mr. Wilson is assigned a very high-level RUG rehab (Resource Utilization Group, under Medicare Part A) and Tim and Casey plan his program around the required 500 minutes of therapy in seven days required for this RUG level. He is to receive over an hour of service per day, seven days a week.

The first day Tim saw Mr. Wilson, the patient was begging to return to his room after 15 minutes. His blood pressure had dropped, and he had tachycardia. He was diaphoretic and became increasingly lethargic. Tim returned Mr. Wilson to his room, recognizing that he would have to make up the time in the afternoon. Casey sees Mr. Wilson after lunch and, though he wants to cooperate, Mr. Wilson cannot do more than 20 minutes before he has difficulty keeping his head up.

When Tim arrives to take Mr. Wilson to PT in the afternoon he finds him asleep and difficult to rouse. Tim and Casey confer at the end of the day and find that between them they saw Mr. Wilson for 35 minutes. They report the situation to the rehab supervisor, who reminds them of the importance of achieving the full 500 minutes and tells them to be sure to include the missed time over the rest of the week. He reminds them that if Mr. Wilson cannot participate in therapy he may have to be discharged from the subacute facility to a nursing home.

Tim and Casey wonder if Mr. Wilson should be at the assigned RUG level, the second highest level of therapy. They are concerned that, if they push him to achieve the level in which he has been placed, they could compromise his fragile condition. On the other hand, if he cannot do the program they have designed for him and he is sent to a nursing home, there is little chance of his doing well enough to ever return home. Tim and Casey are very uncomfortable with the situation in which they find themselves.

They contact the case manager to discuss options. The case manager understands the dilemma that, if they cannot achieve the approved of physical therapy hours weekly, under Medicare rules the patient would need to be transferred to a nursing home. She also recognizes that the patient's wife has expressed fear of having him placed in a nursing home where she believes he would die. Mrs. Wilson has also expressed to the case manager that she cannot physically care for him at home and prefers the sub-acute facility because the staff is so nice.

The following day Tim and Casey rearrange their schedules, switching a few patients to afford Mr. Wilson more advantageous times of the day. He does a bit better but still cannot achieve even 45 minutes of combined time. The PT supervisor tells them to "make it work" so they can bill appropriately. The lower rehab category does not justify a subacute stay for this patient. Tim and Casey approach the case manager and ask for a decrease in the RUG level for Mr. Wilson.

From experience Tim and Casey recognize that "make it work" means they need to provide the minutes of treatment but they cannot rationalize placing this patient at risk to meet the minutes. The case manager learns that the PT/OT supervisor does not share their concern and believes that their professional values could easily be compromised as they balance their desire to act with nonmaleficence (not harming the patient) while maintaining veracity (being truthful regarding the treatment rendered).

Applying the Model to the Case

Clearly there is an unsettling gap between the outlined course of action for this patient, the legal billing codes and expectations, and the patient's ability to meet the expectations for care. Using the RIPS model, let's go through the steps in the decision-making process to identify the factors to address and potential options and solutions.

Template for Ethical Decision Making Using the RIPS Model

Step 1: Recognize and define the ethical issues	Realm Individual Organizational/ institutional Societal	Individual process Moral sensitivity Moral judgment Moral motivation Moral courage Moral failure	Situation Issue or problem Dilemma Distress Temptation Silence
Step 2: Reflect	1. What are the relevant facts and contextual information? 2. Who are the major stakeholders? 3. What are the possible consequences (intended and unintended)? 4. What are the relevant laws, duties, obligations, and ethical principles? 5. What professional resources speak to this situation? 6. Are any of the five tests for right vs. wrong situation-positive (legal test, stench test, front-page test, Mom test, professional ethics test)?		
Step 3: Decide the right thing to do	Approaches to resolve the issue: **Rule-based**: follow the rules, duties, obligations, or ethical principles already in place **Ends-based**: determine the consequences or outcomes of alternative actions and the good or harm that will result for all of the stakeholders **Care-based**: resolve dilemmas according relationships and concern for others		
Step 4: Implement, evaluate, reassess	▪ What did you as a professional learn from this situation? ▪ What are your strengths and weaknesses in terms of the four individual processes? ▪ Is there a need to plan professional activities to grow in moral sensitivity, judgment, motivation, or courage?		

Source: Nordrum, 2009.

Step 1: Recognize and Define the Ethical Issue

Realm

Into which realm does this case fall—individual, organizational/ institutional, or societal?

This situation falls into mainly the institutional realm. The care of the patient is being dictated by institutional policy. There is also a societal component here, because of the policies dictated by a third-party payer (Medicare). The patient's care is determined largely on payment parameters but a professional must weigh treatment outcomes vs. treatment options. In this case it appears that reimbursement is driving practice, not practice driving reimbursement (Hightower, 2012; Sujdak & Birgitta 2016).

Individual Process

What does the situation require of Tim, Casey, and the case manager? What individual process is most appropriate? There are four components to the individual process. To manage an ethical issue all four components of the process must come into play at some point, although there is no particular order in which the components are handled. The four components are defined as follows.

Moral Sensitivity

This involves recognizing that there is a problematic issue and being aware of its impact. The PT, OT and case manager all recognize that this is an ethical issue. They cannot rationalize treating Mr. Wilson at a level that he cannot tolerate; not only will it not be beneficial, but it also has a high probability of being detrimental to him.

Moral Judgment

The individual considers possible actions and what the effect will be on all parties. Tim and Casey recognize that, while they are right to insist that their patient not be forced into therapy that he cannot tolerate, if Mr. Wilson cannot participate fully in the program at the level it has been set, he risks being discharged to a lower level of care or to home without the benefit of the rehab program he needs. Tim and Casey are torn because they believe that Mr. Wilson just needs some time to build up his endurance, but they cannot document treatment not rendered. Will their honesty result in his loss of services and potential physical decline in a nursing home?

Moral Motivation

This is the force that compels the individual to consider possible courses of action. Casey and Tim are not willing to compromise their integrity or their loyalty to their patient. They want him to get the services to which he is entitled but they also want to protect him. Their supervisor appears to see only the financial ramifications of Mr. Wilson’s lack of treatment. They are faced with falsifying minutes to protect his treatment program, treating him at a level that he cannot tolerate, or risking early discharge by treating him to his tolerance and documenting appropriately. While they support each other in their ethical decision making, they do not feel they are getting much support from their superiors.

Moral Courage

This is a measure of ego strength, the strength to take action to correct a wrong. It is interchangeable with moral character. Tim and Casey feel strongly that Mr. Wilson should be given a lower RUG level—realistically, a rehab evaluation—until he can tolerate more therapy. Administration does not support this view, but the PT, OT and case manager are very emphatic. They cite the literature supporting this more moderate approach and attempt to get their supervisor to understand their discomfort with the treatment protocol. The treatment plan put in place by the administration compromises the autonomy to which they are obligated by the practice acts for each of their disciplines.

Moral Failure

This is a deficiency in any of the four components: (1) the failure to recognize that an issue exists, (2) the inability to plan a course of action, (3) the lack of motivation to take action, and (4) the inability to follow through on the action. The supervisors and administration in the facility are subject to moral failure with deficiencies in multiple areas.

Moral Potency

This is the element that, when absent, results in action not being taken.

Situation

What type of an ethical situation is this: a problem, a distress, a dilemma, a temptation, or a silence?

An ethical problem. An ethical problem exists when healthcare professionals are confronted with challenges or threats to their own moral duties and values. This results in an ethical problem that needs to be resolved.

An ethical distress. The focus is on the practitioner. The practitioner knows what action should be taken but there is a barrier in the way of doing what is right. The individuals experience some discomfort because they are prevented from being the kinds of persons they want to be or doing what they know is right.

An ethical dilemma. This type of problem involves two or more morally correct courses of action where only one can be followed. In choosing one course of action over another the practitioner is doing something right and wrong at the same time.

An ethical temptation. This involves two or more courses of action, one that is morally correct and one that is morally incorrect but, for reasons determined by the practitioner, they consciously choose the incorrect course of action.

Silence. The practitioner chooses to ignore the problem and takes no action.

So, from the above we see that the case manager, PT, and OT are faced with an **ethical distress**. They know the correct action they wish to take but they are unable to take that action because of institutional constraints.

Test Your Knowledge

When case managers act to correct a situation, they are exhibiting:

A. Moral sensitivity.
B. Moral judgment.
C. Moral motivation.
D. Moral courage.

When case managers decide on a line of action, they are exhibiting:

A. Moral sensitivity.
B. Moral judgment.
C. Moral motivation.
D. Moral courage.

When case managers recognize an ethical problem but take no action, it is called:

A. An ethical distress.
B. An ethical dilemma.
C. An ethical temptation.
D. An ethical silence.

Answers: D,B,D

Step 2: Reflect

This is the opportunity to gather the additional information necessary to make a decision.

What else do we need to know about the situation, the patient, and the family? Who are the stakeholders in addition to Mr. Wilson, the patient, the, Tim and Casey, and the case manager? The following people are also stakeholders, or potential stakeholders:

- The patient's wife
- The institution, and the supervisor
- Other healthcare providers
- The insurance company
- The licensing board charged with protecting the public
- The professional association and its code of ethics

What are the consequences of action?

Determining a plan of care is based on the assessment of the patient and available resources for treatment. In this situation, the assessment indicates the need for care and the resources are available to the patient, but the rehab professionals have their plan of care dictated by institution/third-party reimbursement. The professionals find the care to be unreasonable and potentially harmful; however, if they refuse to carry out the care as it is proposed, they may endanger the patient's access to care in their facility.

What are the consequences of inaction?

The members of the rehab team understand that failure to question the plan of care and, instead, attempting to impose the treatment parameters on this patient may place the patient in danger. Mr. Wilson is not stable enough to manage care at the level they are being forced to deliver it. In many cases this is a time-sensitive issue because the patient may be able in the future to benefit from the care, but the current level of recovery is insufficient to tolerate it. Healthcare professionals often find themselves caught between what they have determined is appropriate for the patient and external pressures regarding the delivery of care.

The last step of the reflection phase is associated with a proposal by Rushworth Kidder in *How Good People Make Tough Choices* (Kidder, 1996). Kidder initially proposed a four-standard test. Later, a fifth standard was added because the **Kidder Test** was being applied to professional ethics. The Kidder test asks questions based on five topics of questioning for solutions offered.

Kidder Test Adapted to Mr. Wilson

1. The Legal Test

- Are any laws potentially broken?
- What does the state practice act say about providing inappropriate care?
- What does the practice act demand of licensed professionals as to their autonomy and their individual responsibility to make decisions that are not dictated or controlled by other sources?
- Does the potential exist that the rehab professionals are culpable if they cannot achieve the minutes required, and the care is being billed at the higher level?
- How close do they come to billing in a potentially fraudulent manner?

2. The Stench Test

Does the situation feel "right" or does it stink? The uncomfortable feeling of a professional when integrity is challenged produces a positive response to the stench test. The individual knows that "it stinks." In good conscious, professionals cannot pretend the situation does not exist or is beyond their control.

3. The Front Page Test

Is the potential publicity something you would not like to have on the front page? Healthcare providers generally take pride in the work they do. Positive publicity is welcomed by most professionals, but negative publicity reflects badly on all practitioners and is poorly received by the healthcare community. Negative publicity does considerable harm because it diminishes the public trust. Imagine the headline in our case: "Patient welfare compromised in a revenue enhancement scheme."

4. The Mom Test

The Kidder Test looks at the background of the individual, recognizing that much of our ethical decision-making has strong foundations in our upbringing, reflecting the value system of those who influenced us along the way. Kidder calls this the "mom" test, but it is broader than the values instilled by your mother. It incorporates not just parental guidance but also those mentors, teachers, and colleagues who have influenced your values as a professional. The mom test integrates personal integrity with the professional values that every healthcare professional brings to the situation.

If the action you are contemplating would not be acceptable to those who helped you develop your value system, you must consider other actions more consistent with the values that you hold to be important. If this requires a change in behavior, then you are faced with an ethical challenge to develop a course of action that is different and would be acceptable. In this case, continuing to treat this patient despite Tim's and Casey's concerns about Mr. Wilson's well-being would not pass the mom test.

5. The Professional Values Test

What guidance do we get from professional standards? The physical therapist involved with the care of this patient has access to guidance from his Code of Ethics as well as the case manager's professional Code of Ethics. Codes and other professional documents help individuals determine what their responsibility is to the patient. The Case Manager Code of Ethics sheds light on the responsibilities to serve as a patient advocate with respect.

If the solution to the problem does not pass the Kidder test, there is no need to go any further. The only question remaining is whether the healthcare professional has the moral courage to follow through and take appropriate action. Action in this case must be taken in order to preserve professional integrity. For the therapists and the case manager, taking action to place their patient's needs above those of the institution is more consistent with their professional values.

Step 3: Decide the Right Thing to Do

Step 3 presumes that all the factual material has been investigated and the individual is now ready to make a decision. The adaptation of Kidder questions tests the factual information against the five standards of law: legal, stench, front page, parent/mentor, and professional guidance.

If any of the Kidder tests are positive, action must be taken. Even if the situation passes the Kidder Test there may still be an ethical issue to consider. At that point the information you have gathered must be considered in view of three classical approaches to ethical decision making: rule-based, ends-based, or care-based.

Rule-Based Approach

People who take the rule-based approach follow that which they think everybody else should follow. These are the rules, duties, and obligations already in place. The procedures, techniques, and methods are what would be considered the "standard of care." In addition, objective measurements are available to provide guidance about the ethical dilemma of overtreating a fragile patient in order to qualify for care from which he cannot yet benefit. Standardized assessments—such as those for blood pressure, heart rate, oxygen absorption, reaction to exercise—provide objective measurements that are easily applied and interpreted.

Applying a rules-based approach to our patient situation would ensure that care not be rendered to the patient if he could not tolerate it. Note that this approach does not protect the patient against the situation where care is no longer available because he cannot meet the standard.

Test Your Knowledge

When action is taken based on the standard of care, it is:

A. Care-based.
B. Rule-based.
C. Ends-based.
D. Ethics-based.

Answer: B

Ends-Based Approach

Those using the ends-based approach do whatever produces the greatest good for the most people. The analysis of the action and the resulting outcomes look at the good and harm for all of the stakeholders, not just the patient. An ends-based approach looks more at the general good of society and less at the individual's needs (eg, the PT/OT supervisor). This would be the least likely application in our case. An example would be when to share communicable disease information with a public health authority because the public good is at greater risk if not shared. Currently, public health authorities have clearly outlined what must be reported, and certain diseases take precedence over the rights of privacy of the individual.

Reportable Diseases to the CDC

Diseases that must be reported to the county health district and Centers for Disease Control and prevention (CDC) include communicable illnesses such as:

- Sexually transmitted infections
- HIV/AIDS
- Hepatitis
- Malaria
- Meningitis
- Rabies
- Salmonella
- Smallpox
- Tetanus
- TB
- West Nile Virus
- Yellow Fever
- Zika

Source: Centers for Disease Control and Prevention: https://case.cdc.gov/mmwr/preview/mmwrhtml/00001665.htm.

Apply Your Knowledge

Q: You are the case manager for an emergency department in a 300-bed acute care hospital and have been notified that a 19-year-old female is present with meningitis. She has refused to be admitted because she wants to return to her college dorm for a final exam the next day. What are your options? What would you do?

A: As an adult she cannot be forced to be admitted to the hospital. The physician may discharge her against advice but if she insists on leaving you could call the college and request isolation for the exam because she has a contagious disease.

Test Your Knowledge

When action is taken based on achieving the greatest good, it is:

A. Care-based.
B. Rule-based.
C. Ends-based.
D. Ethics-based.

Answer: C

Care-Based Approach

Those using the care-based approach follow the Golden Rule, which states "Do unto others as you would have them do unto you." Situations are resolved according to relationships and concern for others. It is difficult for healthcare providers to remove themselves from the situation completely, but they can recall a personal experience or another patient-care situation that reminds them how important it is to integrate the ethics of care combined with compassion into the entire patient-care situation.

Step 4: Implement, Evaluate, and Re-assess

Implementing a plan does not end the opportunity to learn more and to develop a workable plan for managing future situations.

It is the responsibility of the professional to reflect on the chosen course of action and consider any steps needed to avoid this type of ethical situation in the future. The responsibility to modify behavior lies not only with the individual but also with the institution. Often after an ethical dilemma arises in an institution, policies and procedures are drafted and put into practice to prevent future controversies and delays in similar experiences.

The situation confronting the case manager and therapists points to the difficulty of implementing plans of care that are not at the discretion of the treating practitioner. The patient's entire team needs to make the treatment a collaborative effort. To effect the most positive outcome, this includes the patient and family. For the team to work as a cohesive unit there must be mutual understanding and respect for the unique contribution of each team member and the way in which that contribution can benefit the approach to the patient (Badawi, 2016; McCarthy 2015).

Test Your Knowledge

The final step of a professional in ethical decision-making is:

A. Implement, evaluate, and reassess.
B. Recognize and reflect.
C. Decide and implement.
D. File a report.

Answer: A

Initially the professional must do some reflection and answer the following questions:

- What was learned from the case involving Mr. Wilson and his plan of care? For the case manager and the therapists, they confirmed their professional responsibility to be autonomous practitioners. They also recognized the constraints they have working in a setting that does not necessarily respect that responsibility.
- What are the strengths and weaknesses of the practitioner with regard to the individual processes? Does the individual exhibit moral sensitivity, judgment, motivation, and courage? They exhibited moral sensitivity, judgment, and motivation. Although we don't know the outcome of this scenario**, we do know that moral courage would require overt action on their part to protect their patient**.
- If the provider needs to develop one or all of these skills, what type of professional activities would help to accomplish this?
- Was the outcome what was expected? Was there any collateral damage? When confronted with an ethical situation we may carry some preconceived concepts about what may result. It is important to look back at the outcome and compare it to what we anticipated. This is particularly important when collateral damage may be worse than the initial situation. Preventing collateral damage is always preferable to trying to address it after the fact. A thorough review of collateral damage—similar to a

risk/benefit ratio—may be enough to suggest mechanisms to prevent them in the future.

Remarks

Case managers may no longer defer ethical decision making to other healthcare providers, such as physicians, with whom they share patient responsibility. They must recognize their responsibility as autonomous practitioners to work on ethical challenges in order to find a reasonable solution that is in the best interest of the patient.

To accomplish this professional mandate, case managers must know ethical principles and be able to apply them effectively to ethical situations and then analyze the outcomes before taking action.

Ethics and the Law

The **rule of law** is expressed by codified legal standards. In the United States, and most other democracies, laws spell out how we will govern ourselves. Over centuries, laws have evolved based on commonly understood societal concepts of right and wrong. Even in the present, the law is evolving to reflect not only our history but also current ideas of how we want to be governed. Knowing we can depend on the law provides stability for the country and for ourselves.

So, what is ethics? **Ethics** is the area of philosophical study that examines values, actions, and choices to determine what is right and wrong. Core principles that have been foundational for ethical behavior were established millennia ago by the great philosophers Aristotle, Plato, and Socrates. In the fourth century B.C. they defined ethics as "the science of morals."

Ethics lays down the *principles* of human behavior. For example, we can debate the principle of the greatest good for the greatest number. ("Should this sweet little girl be given a heart transplant even though many others are ahead on the list?"). Ethics constitutes moral principles, and values are related more to an individual's personal set of standards (Townsville Community Legal Services, 2014).

M**orals,** on the other hand, has to do with day-to-day actions based on these principles. "Should I steal coins from the collection basket?" Virtually every culture forbids stealing, though some give it a wink and a nod. "Should I have sex without a condom?" Morals vary from one society to another. In some parts of Africa the husbands have refused to wear condoms even though they are having extramarital sex, and thus they expose their wives to HIV.

There is an ongoing debate about the relationship of the law and morality. In 1958 the *Harvard Law Review* published the famous Hart Fuller Debate, which addressed the relationship of law and morality (Harvard Law Review, 1958). Hart held that morality and law are separate and Fuller asserted that morality is the source of the law's binding power. Laws bind every citizen to abide by them; however, moral standards depend upon an individual's upbringing, values, religious background, and culture.

Hippocrates defined ethical standards for the practice of medicine. In addition to his famous vow ("First, do no harm"), he underscored the principles of beneficence, nonmaleficence, autonomy, and justice (Entwistle et al., 2016). These standards of doing good, doing no harm, allowing patients to make their own choices, and fairness are the foundations for all professionals in healthcare.

Test Your Knowledge

What are the four foundational values of medical ethics?

A. Beneficence, justice, autonomy, and liberty.
B. Justice, nonmaleficence, autonomy, and peace.
C. Beneficence, justice, autonomy, and equality.
D. Beneficence, nonmaleficence, autonomy, and justice.

Answer: D

There are limits to the law. The law cannot make people honest, caring, or fair. For example, lying, or betraying a confidence, is not illegal but *it is unethical*. While not every healthcare profession requires adherence to a code of ethics, all require adherence to the law. Finally, ethics and the law address similar issues (see box).

Issues Addressed by Both Ethics and Law

- Access to medical care
- Informed consent
- Confidentiality
- Exceptions to confidentiality
- Mandatory reporting
- Privileged communication with healthcare providers
- Advance directives
- Abortion
- Physician-assisted suicide

People have the legal freedom to express themselves; however, their expressions may still be ethically offensive and immoral. On the contrary, some people may express opinions based on their ethical or moral positions; however, the way they express those opinions may actually be illegal.

Did You Know. . .

Not all laws may be ethical and not all ethical decisions are legal! Healthcare professionals may sometimes face a dilemma in balancing the two domains of ethics and law.

Ethics is the aspect of philosophy that addresses questions about human conduct. For healthcare professionals, the professional code of ethics determines the acceptable behavior for that profession, within and supported by the legal standards. The Certified Case Manager Code of Ethics also clearly outlines what is ethical behavior for a case manager when dealing with patients (CCMC, 2015). The American Nurses Association code of ethics for nurses defines ethics as "reasons for decisions about how one ought to act based on principles and virtues" (ANA, 2015).

Certified Case Manager Code of Ethics

The code of professional conduct for case managers is based on the following Principles:

Principle 1: Board-Certified Case Managers (CCMs) will place the public interest above their own at all times.

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

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

Principle 4: CCMs will act with integrity and fidelity with clients and others.

Principle 5: CCMs will maintain their competency at a level that ensures their clients will receive the highest quality of service.

Principle 6: CCMs will honor the integrity of the CCM designation and adhere to the requirements for its use.

Principle 7: CCMs will obey all laws and regulations.

Principle 8: 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.

Source: CCMC, 2015.

In addition to the code's principles of practice, the CCMC also outlines six rules governing professional conduct.

Rules Governing CCM Conduct

Rule 1: A CCM will not intentionally falsify an application or other documents.

Rule 2: A CCM will not be convicted of a felony.

Rule 3: A 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 CCM will not lose the primary professional credential upon which eligibility for the CCM designation is based.

Rule 5: A CCM will not violate or breach the Standards for Professional Conduct.

Rule 6: A CCM will not violate the rules and regulations governing the taking of the certification examination and maintenance of CCM Certification.

Source: CCMC, 2015.

Test Your Knowledge

Which of the following principles is *not* included in the Certified Case manager's code of ethics?

A. CCMS will respect the rights and dignity of clients.
B. CCMS only need to obey all state regulations that control their licensure.
C. CCMS will maintain their competency at the level that ensures high quality for clients.
D. CCMs will always maintain objectivity in their relationships with clients.

Answer: B

The law has several sources, including commonlaw, administrative law, and statutory law. **Commonlaw** has been established over centuries as a result of prior court decisions. **Administrative law,** or regulatory law**,** is passed by executive agencies; for healthcare professionals an example is found in state certification. It is also under administrative law that a state administers its Medicare services. **Statutory law** is written law that is enacted by a legislative body.

Laws governing healthcare professionals reflect the principles of justice, confidentiality, and the right to privacy, as well as informed consent and freedom from abuse (eg, assault and battery by a healthcare worker). Patients also have the legal right to information and accommodation of needs (eg, spouses rooming together). Most hospitals publish and provide all patients the formal patient bill of rights.

Exceptions to the patient's right of privacy include reporting of communicable diseases when the rights of the public to safety outweigh the individual (ie, greater good for the greater number), and also include reporting of violent crimes such as child or elderly abuse. Originally, the rights of privacy and confidentiality were considered ethical principles but since 1996 confidentiality of personal health information is now mandated by the Health Insurance Portability and Accountability Act, known as HIPAA (see Module 7) (US HHS, 2018).

Test Your Knowledge

Which of the following is an example of administrative law?

A. The Case manager must retain legal licensure by the state board where she is practicing.
B. A patient has sued the hospital for malpractice?
C. A client of yours has been raped and wants to press charges against her perpetrator.
D. A client has had a worker's compensation claim against his employer for faulty equipment which caused him to fall and become injured.

Answer: A

Potential ethical dilemmas for case managers can be any of the following:

Type 1: Case manager actions are both ethical and legal.

Type 2: CM actions may be considered ethical but not legal.

Type 3: CM actions may be considered legal but not ethical.

Type 4: CM actions are neither ethical nor legal.

Ethical dilemmas can also be categorized by the following:

1. **Beneficence**: choosing between good vs. harmful
2. **Autonomy**: maximizing a patient's ability to choose for self

3. **Justice**: dividing health resources fairly
4. **Nonmaleficence**: avoidance of harm to the patient vs electing a procedure/treatment that may cause harm though expected to help
5. **Confidentiality**: respecting patient's rights of privacy vs. sharing needed information

Test Your Knowledge

A hospital is about to break ground for a new wing. People chain themselves to a number of old trees that will be lost if the building goes forward. These people are behaving

A. Legally but unethically.
B. Legally and ethically.
C. Unethically and illegally.
D. Ethically but illegally.

Apply Your Knowledge

Who are you allowed to share confidential information with? How would you explain the difference between the principle of confidentiality and the law of HIPAA?

Answer: D

Legal and Regulatory Requirements

It is inherent in the professional role of the case manager to collaborate with multidisciplinary healthcare professionals to promote the health of clients while using resources prudently. Often these two goals conflict, which can bring about an ethical and sometimes legal dilemma. It is therefore vital that a case manager understand the legal and regulatory requirements that impact ethical decision-making.

In addition to the principles and rules that guide case manager conduct, there are CCM standards to help make decisions.

CCM Standards for Decision-Making

Section 1: The Case manager should be a client advocate.

Section 2: The CM has a professional responsibility to maintain professional competence, updated knowledge and skills, disclose conflicts of interest, report misconduct, and comply with any legal proceedings.

Section 3: Client relationship will include explanation of CM services and duties and notification of termination of those services at the appropriate time. CM will withhold sharing personal values and remain objective in services rendered.

Section 4: Confidentiality will be followed including verbal, written, and electronic media and records.

Section 5: Professional relationships will be impartial and legal including disclosure of fees, conflicts of interest, advertising, and research.

Source: CCCM, 2015.

In addition to the CCM codes, principles and standards, all case managers must abide by the state and federal laws in their practice of case management. These include civil law and criminal law. **Civil law** addresses a dispute between private parties. This can be to make restitution for an injury or simply for one party to seek a court judgment against another. **Criminal law** deals with threats to society as a whole or to one or more individuals. It can be categorized as a felony, misdemeanor, or juvenile crime. Criminal law supports the orderly existence of the state.

Test Your Knowledge

Which is an example of criminal law?

A. A nursing assistant forgets to put up the siderails of a bed and the patient falls out and breaks a hip.
B. A Case manager commits a DUI.
C. A neighbor sues the HOA for not putting a stop sign on a busy street, which caused a child to be hit by a speeding car.
D. A Nurse puts on a blood pressure cuff too tightly and causes bruising to a patient's arm.

Answer: B

Generally, decisions on healthcare have been delegated to the individual states, however some legal rulings have been enacted at the federal level and affect all states. These include the **Americans with Disabilities Act of 1990** (and Amendments of 2008), and the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** (see Module 7).

Disability Legislation

This law offers protection against discrimination for individuals who have disabilities. It allows these individuals equal access to employment as well as to public buildings (eg, wheelchair ramps, bathroom accommodations). The categories of disability have broadened to include physical disabilities arising from diseases such as HIV/AIDS, respiratory and musculoskeletal disorders, diabetes, and even mental health issues (ADA, 2014).

Legal violations that affect case managers may include negligent care, as when a case manager fails to act in a prudent manner that causes harm to the client. Any causation of damages must be proven. Professional negligence, also known as **malpractice**, is the failure to meet professional standards of care that result in harm to the client. Individual responsibility demands accountability for one's own actions.

Preventing malpractice or negligence claims include these general practices:

- Delegating and assigning duties carefully within the legal scope of practice
- Being self-aware of your speech and actions
- Following agency policies and procedures
- Documenting clearly and objectively
- Detailing incident reports
- Practicing safely
- Obtaining professional liability insurance
- Maintaining skills and continuing education to stay updated
- Following the chain of command

Documentation and Case Recording

Case managers must document all their actions, phone conversations and people they have communicated with to follow their trail of planning and implementation. Using approved medical abbreviations, writing objectively and thoroughly takes time but can help others identify the actions taken if ever there is a dispute or confusion. Writing out care plans and communications can also help clarify issues that may have originally appeared confusing.

Not only is it ethical to document all of the communications with each case to truthfully record the patient events for other healthcare professionals to coordinate, but it is also a legal responsibility to record all patient encounters correctly and in a timely manner for insurance reimbursement to avoid insurance fraud.

Case managers can help the entire medical team coordinate care with proper case recording and also by addressing legal issues such as obtaining and recording a **Physician Order for Life-Sustaining Treatment** (**POLST**), advance directives, power of medical attorney, and do-not-resuscitate (DNR), mechanical ventilation, artificial nutrition, hospice orders, and even organ donation preferences ((POLST, 2016); Fremgen, 2011).

Test Your Knowledge

What is the meaning of POLST?

A. Provider orientation long statutory testing
B. Physicians on-call late schedule time
C. Physician order for life sustaining treatment
D. Providers or Long-term care service treatment

Answer: C

Meaningful Use and the Electronic Health Record

Under President Obama, the federal government passed The Health Information Technology for Economic and Clinical Health Act (HITECH), authorizing incentive payments through Medicare and Medicaid to clinicians and hospitals when they use electronic health records (EHRs) privately and securely to achieve specified improvements in care delivery.

After a period of gathering data from numerous constituents, **meaningful use** of EHRs was defined as entry of basic data: patients' vital signs and demographics, active medications and allergies, up-to-date problem lists of current and active diagnoses, and smoking status. Over time this list has expanded to include more complete information and software has been created to help providers meet the demands of EHRs.

Case managers intersect with these demands as they record their findings electronically. Merely stating a patient has seen his primary care physician is inadequate. It may be important to say that the patient is in therapeutic range with his anticoagulants. Your system will guide how much information you need to provide. For example, in order to receive reimbursement for services, the case manager often has to document appropriate use of medications, durable medical equipment, home care, and so on.

Test Your Knowledge

Which is an example of meaningful use for a case manager?

A. Documentation of a patient's coagulation lab results in regular time periods to establish correct therapeutic range for the prescription.
B. Documenting the patient attended a Dr.'s appt. as scheduled.
C. Documenting the patient didn't answer the phone call you attempted.
D. Documenting the patient's information from the face sheet.

Answer: A

Applying Ethics to Clinical Practice

We have seen that the code of professional conduct for case managers is established by CCM Certification and outlines formal statements that declare the standards of ethical behavior for the group (CCMC, 2015). Case managers may, however, belong to other healthcare professions, typically nursing or social work. In addition to the Case Manager Code of Ethics, nurses and social workers have their own codes of ethics. None of these standards are contradictory, but rather confirm one another.

A grasp of the basic principles provides the template for sound decision-making. The way in which clinicians actually arrive at ethical decisions continues to be studied and refined. Clearly ethical and clinical decision-making models must overlap significantly to derive a satisfactory outcome (Dale, 2016; Drumwright, 2015; Kearney & Penque, 2012; Sujdak & Birgitta, 2016).

The Ethical Decision-Making Process

Ethical decision-making is a challenge to case manager professionals, who face both an increase in the number of issues and situations that are increasingly complicated (Marfleet & Trueman, 2013). Ethical decision-making skills can be enhanced by studying cases and developing a strategy for facing ethical issues. Practitioners don't always have complete control over the situations that confront them. When the welfare of the patient is compromised, the healthcare provider is challenged to manage the situation in the patient's best interest (Airth-Kindree & Kirkhorn, 2016).

Making decisions is part of everyday living, whether it is deciding when to turn off the stove or how to navigate through heavy traffic. For the most part, these decisions are part of an automatic, and therefore unconscious, process. But there are other decisions, particularly those related to professional practice, that are not automatic. We are often confronted with two equally appropriate choices. Choosing between right and wrong is generally easy and obvious; however, when challenged by choices between two equally good options it becomes more difficult. This is called a **right vs. right dilemma.** When evaluating the alternatives, both courses of action have positive and negative elements. Right vs. right is an *ethical* dilemma, whereas right vs. wrong is identified as a *moral* temptation where the individual knows the right thing to do but consciously chooses the action that is wrong.

Test Your Knowledge

Right vs. wrong may be a moral temptation, but right vs. right is:

A. The best of both worlds.
B. An ethical dilemma.
C. A chance for correct action.
D. A political brawl.

Answer: B

All healthcare providers struggle to establish ethical decision-making standards that provide guidance in a challenging practice environment, and the challenge is not unique to case managers. One threat to ethical practice arises from *within* each profession as a result of materialistic self-interest and from the *outside* in terms of profit motivation. An example of an ethical dilemma that didn't exist decades ago but now does due to technology is the result of scientific advances such as mapping of the human genome. Advances in technology made possible some procedures that raise ethical issues as to whether certain things should be done just because they are possible (eg, cloning of animals or even of people).

A wealth of literature exists on the subject of ethical decision-making. A search of this literature reveals that professionals are inconsistent in ethical decision-making (Singer, 2005). The literature speaks of the "science" of decision-making but cautions that human limitations result in inconsistencies in their decision-making skills that professionals acknowledge.

An additional dilemma is that various healthcare professional groups all have different codes of ethics depending on their perspective. For example, physicians focus on "First, do no harm," while a hospital administrator's code of ethics focuses on fair and judicial allocation of resources. For generations, the code of ethics for anyone in medicine was based on the physician's Hippocratic oath. Gradually, healthcare specialties began to develop their own codes.

While they were helpful to establish guidelines, the wide variety and range of codes often created confusion for interdisciplinary groups. In 2000 a group of multidisciplinary healthcare professionals gathered together at Tavistock, England to create one ethics code for all healthcare professionals. This new code, is a step in the right direction to improve quality of care, collaboration, and continuity of care (Stanford & Conner, 2012).

Decision-making is a complex process that involves time needed to think critically with the goal of decreasing uncertainty. At some point, if action was not taken the decision will be made by default. Note that failure to make a decision may place the patient in a potentially harmful situation.

Ethical decision-making is the integration of ethical principles with practical wisdom. Codes of ethics are generally broadly written. They help to identify issues, but they are not meant to serve as a methodology for ethical decision-making. To recognize an action and decide on that action requires both knowledge and skill in the art of ethical decision making.

Patients have the right to expect that their healthcare providers are involving themselves in thoughtful deliberation of ethical issues, with a commitment to take reasonable and rational action. These steps warrant the trust of the patient and society. Unethical, self-serving behaviors result in a loss of trust by patients and their families.

End-of-life issues, caregiver burnout, and right-to-choose plans often challenge the medical team, patients, and families to make complex ethical decisions. This is made even more challenging when the issues involve more than one generation; they may have the same interests at heart but prefer different expressions of them.

Setting priorities is a strategy for all those who are working together to protect a patient's best interest. Case managers can rely on an ethical decision-making model that is similar to the nursing process, which comprises the steps of collecting data through assessment, defining the problem, identifying possible actions and solutions, implementing the actions, and evaluating the effectiveness and results.

An Ethical Decision-Making Model

Step 1: Recognize and define the ethical issue

Step 2: Collect the Facts

1. Who are the parties involved?
2. Who has the right/responsibility to make the decision?
3. What are the consequences of action?
4. What are the consequences of inaction?

Step 3: Identify possible courses of action.

Step 4: Consult with colleagues and appropriate experts

Step 5: Implement, Evaluate and Reassess

Step 6: Document the decision

Test Your Knowledge

Which step is missing in the 6-step process of decision making?
Document the decision, implement your decision, identify possible courses of action, collect the facts and identify the ethical issue.

A. Recognize the ethical issue.
B. Identify who has the right and responsibility to make the decision.
C. Consult with colleagues and appropriate experts.
D. Document the actions taken.

Answer: C

10 Case Studies

The following case studies illustrate situations encountered by case managers (CMs) and help explain the process for resolving ethical and legal dilemmas.

1. Transitions of Care
2. Home Care
3. Pain Management
4. Pediatrics
5. Perioperative Ethics
6. Perinatal Care
7. Primary Care
8. Professionalism
9. End of Life Care
10. Special Needs Populations

Transitions of Care

Transitions of care is a common issue that CMs deal with as they help patients navigate from acute care facilities, to rehabilitation facilities, to long-term acute, skilled nursing facilities, home and even hospice settings. Knowing when a patient is ready for discharge and that the patient will have adequate resources for recovery and healing is a challenge.

An obese 79-year-old man needs to be discharged from an acute care hospital after a right sided CVA. He lives with his petite 75-year-old wife who he expects to care for him. They are retired on a limited income. She confides in you secretly that she is afraid she won't be able to lift him, and their insurance won't cover additional rehabilitation days, nor do they have savings to pay for in-home care. What is the best, safest, and most economical transition of care choice?

Decision Steps

Step 1: Recognize and define the ethical issue.

It may not be a *legal* dilemma to discharge the husband back to his own home, but it may be *unethical*, considering the limited ability of his wife and her expressed fears. The dilemma illustrates the conflicting principles of autonomy (the husband's) and beneficence (the wife's inability to shoulder the caregiving task).

Step 2: Collect the facts.

Who are the parties involved? The husband and wife may have different interests. He prefers autonomy, but she fears inability to physically care for him.

Who has the right/responsibility to make the decision? The patient has the right to make the decision for his best interest, however the CM has the responsibility for his safety at discharge.

What are the consequences of action? Sending the patient home without assistance may become dangerous, however sending him to a short-term rehabilitation facility without the ability to pay for it harms the facility.

What are the consequences of inaction? There can be no inaction, as the acute hospital will force a discharge because it cannot allow the patient to remain without promise of reimbursement.

Step 3: Identify possible courses of action.

The options are as open as the mind of the CM to think of creative alternatives. Options could be to look for family and friends who may be able to assist; look for additional payor sources from nonprofit organizations and support groups; explore additional insurance options; and so on.

Step 4: Consult with colleagues and appropriate experts.

The CM may need to expand the book of resources and people who may offer additional options.

Step 5: Implement, evaluate and re-assess.

Once a decision is made, it is ethical to follow up with the patient and his wife to assess how they are both doing. Are adjustments to the plan needed?

Step 6: Document the decision.

Throughout any transition of care, documentation is needed to validate the decision.

Home Care

A common setting for case management is with home health patients. Often the CM is in charge of allocating resources, such as durable medical equipment for home use. What could be ethically challenging with that? Remember that the case manager must balance loyalty to several clients and their insurance companies.

You have been the CM for an 82-year-old man who you helped through a recent hospitalization for a broken hip—and then recovery from pneumonia in a long-term acute care setting. He has become one of your favorite patients because of his smile and his endearing personality. He is so pleasant that you check on him regularly. The care facility says he needs to be discharged tomorrow but you know it will be more comfortable for him where he is because he lives alone.

Your company uses several agencies for home care on a rotation system, but your favorite agency is not on the list at this time. Do you schedule him with your preferred agency anyway, knowing you can keep a few more days until the agency will likely be back on the list, if you document that he needs more physical therapy.

Is that unethical or illegal? What are your options?

Being an effective CM means being objective and in control of personal emotions that may sway simple decisions. Sometimes that is easier said than done. Following the checklist for decision-making can help you systematically keep yourself from acting on prejudices and making unethical decisions.

Pain Management

Because pain is so subjective, it is difficult to judge for another person. What one person considers manageable, another will not, requesting narcotics for relief. Always displaying empathy and compassion for a patient who is in pain is the foundation of good practice for pain management. Because of the serious consequences of addiction and overdosing on opiates, careful management of both the pain and the pain medications is needed.

You are the CM for a construction worker who has been receiving medical attention for an on-the-job back injury. Your primary role has been to act as his advocate in helping him navigate the insurance claim process for medical coverage through his employer. In confidence, he admits to you that he has been struggling with alcoholism and had been drinking the morning he fell at work.

Should you notify his employer or insurance company? That might result in denial of his medical claims and his back injury is real. You have met his wife and children and he is the sole source of income for the family.

Is this a legal or ethical dilemma, or both? What are your options?

Although a primary role of the CM is to be a patient advocate, CMs may also need to advocate for the insurance company or hospital that employs them, which can create a conflict of loyalty. Generally, patients do not fully understand the role of the CM and what can be disclosed without repercussions.

Does the employer have the right to know about the additional medical history of alcoholism or is that breaking HIPAA?

Pediatrics

As has been said, when dealing with a pediatric patient the healthcare professional really has three patients, the child and the two parents. Because parents have the legal rights to make decisions on behalf of the child, helping them understand the issues and their rights is the job of the CM. Legal and ethical dilemmas may result when the parents make decisions against the advice of the medical team. Legally, parents have the right to make or deny medical plans for a child.

You are the CM for a refugee family who is receiving food stamps and has limited financial resources. The parents have refused to have their children immunized because they do not believe in the American medical system. The family wants the children to attend public school and the parents want to sign a form refusing immunizations. The developing country from which they came has a high rate of tuberculosis. One of the children consistently coughs but the mother refuses the doctor and prefers their cultural healer. They cannot receive food stamps unless they are seen and cleared by a medical provider.

Is this a legal or ethical dilemma? What are your options? Do they still have the right to refuse treatment?

The CM must first confirm what their legal rights are and what stipulations are placed in order for them to receive food stamps, free immunizations, housing, and so on. Do they understand what the immunizations are for? Who needs to be involved? How do you document your decision?

Perioperative Ethics

Ethical dilemmas in the perioperative setting can be seen frequently in TV's hospital dramas. Case managers may be involved in managing patients transitioning in and out of surgery. Some Affordable Care organizations or MMOs even dedicate CMs within a hospital setting to check on their patients and help navigate a sometimes very confusing perioperative process.

A patient's living will states he does not want mechanical ventilation to sustain his life and it is recorded by his primary care doctor but the document does not make it to the hospital's medical record. During a difficult surgery, the patient has a cardiac arrest and is put on mechanical ventilation. The wife of the patient now wants the patient to remain on life support and ventilation and states she doesn't remember him ever completing an advance directive. She claims she has the right to make the decision as his wife. The prognosis is poor for a quality recovery.

Is this an ethical or legal dilemma? What are the options? You could continue with mechanical ventilation while the patient is in a medically induced coma for recovery, approach the hospital ethics committee for guidance, hold a family meeting to discuss the matter, obtain a court order to ventilate the patient, or simply withdraw the mechanical ventilation support.

According to the law, the advance directive, which clearly states no mechanical ventilation is wanted, would direct the medical team to withdraw support. Generally, the medical team will wait until it is deemed medically clear what the brain function is before they pursue the issue. In the meantime, the CM needs to at least produce a copy of the advance directive from the primary care provider's office.

Perinatal Care

Dealing with pregnant mothers who pose a risk to their unborn child can create both legal and ethical dilemmas.

A 17-year-old pregnant female, married, refuses treatment that is considered medically beneficial to both her and her fetus. Even after medical education regarding the safety of the treatment potential adverse effects and benefits, she still refuses. The CM is called in to help with the case.

What is the most appropriate action? Going through the decision steps can help identify the problem, options, and solutions. Options could include: not initiating treatment because that is the patient's right to refuse; obtaining a court order to initiate treatment because the patient is risking the life of the unborn fetus; calling the baby's father to get him to consent to treatment; submitting a query to the child abuse hotline; approaching the hospital ethics committee for a decision. Is this an ethical or legal issue, or both?

According to the law, the mother has the right to refuse treatment. Period. Yes, the decision can be clouded and difficult when the medical staff disagree with the decision, but the legal standard makes the decision of the medical staff easy—they have to allow the mother to deny the treatment. Legally, although the future mother is a child herself, and not a legal adult, she is considered an emancipated minor based on the following criteria:

- Homeless, or graduated from high school
- Parent
- Married
- Financially independent

Primary Care

Many case managers help manage patients for physicians and advanced health practitioners and physician assistants in large primary care settings. They may be assigned a caseload and asked to follow up with patients having chronic conditions such as congestive heart failure, anticoagulation medication, diabetes, hypertension, COPD, and cancer. Largely, the role of the CM is to be an advocate for patients by explaining procedures, clarifying medical terminology to confused patients, and even helping manage resources for durable medical equipment, doctor's office visits, and transportation. Knowing who the resources are in the patient's community can make a huge difference in the successful outcomes of the patient.

Even small decisions like how much time to spend with one patient over another can create distress for a caring CM who has limited time and resources.

You are the case manager for a patient who has recently been diagnosed with colon cancer and given a poor prognosis. The patient asks you not to say anything to the patient's spouse. The patient calls you daily to discuss feelings and concerns about the diagnosis and proper testing and treatments. You know the spouse cares greatly and would be devastated to not know about the diagnosis. You find yourself taking more time with this patient than the other ones in your caseload this week and worry that it is unfair to the other patients. You also feel you are limiting resources for the patient by not involving the spouse.

Is this an ethical or legal dilemma? What are your options? What are your resources?

Balancing confidentiality and rationing resources is a difficult challenge for case managers. Going through the steps of the ethical decision-making process can help you navigate your own feelings and professional obligations.

Professionalism

Unfortunately, professional and ethical conduct is not innate. Behaving unprofessionally or unethically—even in ignorance—can happen, although it is not tolerated well in the medical profession. How you respond to your own professional or ethical mistakes will define you as either a good or bad case manager. Steps to ethical behavior can be learned, practiced, and improved. The great balance for case managers is to reduce costs, improve patient's health, and deliver a positive experience of healthcare.

You are in the grocery store with your spouse and one of your patients walks by to greet you and wants to discuss issues that you were involved in helping to manage for him. What is your best response?

Is this an ethical or legal dilemma to discuss his case while your spouse is listening? How would you handle the situation? Would you confirm or deny this is your patient? Would you ignore the question of both the patient and your spouse and walk away?

Yes, this could be both an ethical and legal dilemma because it is a HIPAA violation. Your spouse has no need to hear the information, and disclosing anything in front of your spouse puts the patient's private health information at risk. A textbook answer may be to state that you cannot say whether that is your patient and ask to be excused, at the risk of offending the patient.

End of Life Care

When a patient reaches the end of life, it is a difficult passage for everyone involved. Although the primary emphasis is rightfully focused on the patient, it is often the family members that create ethical and legal dilemmas when normal protocols are challenged—such as honoring the patient's advance directives, power of attorney, and financial beneficiaries after the death. Often the death is easier than the weeks or months that precede it. A compassionate and legally savvy CM can help decrease the grief by communicating clearly with the family and patient about expectations, procedures, and legal boundaries.

A 46-year-old woman with stage 4 breast cancer is discussing treatment options with the care team. The patient has chosen to refuse chemotherapy, radiation, or surgery as the first round of chemotherapy several months ago made her extremely ill. She has felt weak, tired, and hopeless. She expresses "Just let me die." She is declared competent by Psychiatry. Her husband wants her to continue with the treatment because they have four children at home.

What is the legal or ethical dilemma? What are the options? You could give the treatment as this is considered life-saving; you do not give the treatment as it is considered active euthanasia; you do not give treatment as that is the patients wish; or you give treatment because if you don't you are legally liable for negligence.

In this case, as with all competent adults, the woman has the right to choose or deny medical treatment. Not giving treatment, although that is considered passive euthanasia, is still the patient's right to choose. Often when our emotions become involved we believe it is an ethical dilemma, when it may truly only be a legal choice. Either way, admittedly it is difficult to allow people to refuse treatment when we believe it can help them. Ultimately the patient's Living Will takes precedence.

Special Needs Populations

Patients with special needs and disabilities can present with many challenging ethical dilemmas as the medical team tries to balance the values of autonomy with helping the patient avoid unintended harm. Mental incompetence poses an additional challenge as legal consent for treatments must come from a parent, spouse, or next of kin. It is often the CM who can help a family navigate the challenges by knowing about resources.

A 30-year-old male patient with Down Syndrome lives on his own in a humble apartment and even has a job that allows him to support himself financially. His parents live nearby and check on him regularly. The patient has type 2 diabetes mellitus and has struggled with foot care and managing new medications on his limited budget. On examination, it is discovered that one of his feet has necrotizing gangrene and needs to be amputated to avoid further injury and infection to the full leg. He insists he is fine and can live on his own and take care of himself. He is refusing medical care and the recommended amputation. You are the CM for this patient and have been called in to assess resources, options, and come up with solutions.

What are your options? You could get a court order for the surgery. You could get consent from the parents. You could allow the patient to make his own decision at the risk of expanding the gangrene. Is this an ethical or legal dilemma?

Legally, if the patient demonstrates complete self-neglect and unawareness, a surrogate decision-maker such as the parent can make the decision for him.

Apply Your Knowledge

How did you respond to each of the case studies? Did you recognize an ethical or legal dilemma in each one? What did you see as resources and options that weren't presented? How would you have handled each case?

Remarks and Resources

Case managers may no longer defer ethical decision making to other healthcare providers, such as physicians, with whom they share patient responsibility. They must recognize their responsibility as autonomous practitioners to work on ethical quandaries in order to find a reasonable solution that is in the best interest of the patient. To accomplish this professional mandate, case managers must know ethical principles and be able to apply the principles effectively to ethical situations and then to analyze the outcomes.

Resources

Certified Case Manager Certification (CCMC). (2017, December). Cultivating moral resilience: Balancing heart and mind for a better practice and better you. Retrieved from https://ccmcertification.org/sites/default/files/issue_brief_pdfs/ccmc-dec2017.web_.pdf.

Certified Case manager Certification (CCMC). (2017, April). Do the right thing: Excellence and ethics in case management webinar. Retrieved from https://ccmcertification.org/archived-webinars/do-right-thing-excellence-and-ethics-case-management.

Certified Case manager Certification (CCMC). (2015, February). Foundational principles: Newly revised Code of Professional Conduct provides a framework for ethical, high-quality care. Retrieved from https://ccmcertification.org/sites/default/files/issue_brief_pdfs/23_-_updated_code_of_conduct.pdf.

Complying with HIPAA

A Commission for Case Manager Certification (CCMC) "Issue Brief" discussing the 2015 update of the Code of Professional Conduct for Case Managers noted that

> Because the revised Code includes updated language calling for knowledge of and compliance with local, state, and federal laws dealing with patient privacy and security, the principles require judgment and assume that case managers possess a certain level of knowledge (CCMC, 2015, 2015a).

Principle 7 of the Code states that "Board-Certified Case Managers (CCMs) will obey all laws and regulations," and Section 4 of the Code's Standards focuses on Confidentiality, Privacy, Security and Recordkeeping, with six guiding steps (CCMC, 2015).

While all healthcare workers need to be familiar with the basics of the **Health Information Portability and Accountability Act of 1996 (HIPAA)**, case managers will benefit from a more detailed and nuanced understanding of HIPAA, and of several critical concepts that underlie it. Case managers frequently must balance the needs of patients and families with the requirements of a variety of healthcare entities and the vagaries of technology, including social media. The more thoroughly case managers have internalized their codes of ethics, the rules and guidelines of their employer(s), and the fundamentals of health information management and HIPAA, the better prepared they will be to manage the complexity and challenge of modern patient information management.

Confidentiality, Privacy, and Security

Confidential, private, and *secure* are terms we hear discussed in relation to many kinds of information, including financial, educational, personal, employment, and medical. The concepts of confidentiality, privacy, and security are related to each other, yet there are differences and they apply somewhat differently depending on the sphere of information we are talking about.

In regard to health information, **confidentiality** refers to the *obligation of professionals* to hold patient information in confidence. **Privacy** is the right of the individual to be left alone and to be allowed to make their own decisions about how their information is shared. **Security** refers to both protection of the privacy of health information, and the means by which that security is accomplished (Prater, 2014; Nass et al., 2009).

Confidentiality "safeguards information that is gathered in the context of an intimate relationship," and also addresses how to keep that information from being disclosed to third parties (Nass et al.2009). The concept is old, going back to Hippocrates in the fourth century B.C., and it is at the root of patient-provider confidentiality; as such, it has been incorporated into the codes of ethics of healthcare professional associations. State laws may provide additional guidance and requirements for confidentiality, especially in more complex situations such as mental health (Prater, 2014).

Privacy may be defined as "who has access to personal information and under what conditions" (Nass et al, 2009). The right to privacy, while not in the U.S. Constitution, has been codified in federal and state law, court decisions, accrediting organization guidelines, and professional codes of ethics. The quintessential privacy example is the federal HIPAA Privacy Rule, which is designed to "define and limit the circumstances in which an individual's protected health information may be used or disclosed" (Prater, 2014).

Security refers to protection of and the means used to protect personal health information and help healthcare professionals to keep that information confidential (Prater, 2014). Proper security prevents unauthorized access to, use of, changes to, or dissemination of health information, and in terms of HIPAA is specifically referring to **electronically stored information**. For example, if someone hacks into your employer's computer system, that is a breach of security and there may also be a breach of confidentiality (Nass et al., 2009).

What Is HIPAA?

When most people hear the term "HIPAA" they likely think of the privacy forms they are always signing at medical offices and perhaps heave a collective sigh of frustration. HIPAA regulations are complex and often not well understood even by those to whom they apply; but there is a great deal more to HIPAA than just those forms. A closer look at HIPAA's origins and purpose, its content, and the subsequent development of rules and enforcement procedures can give case managers the tools to be sure they are HIPAA-compliant as well as the ability to offer better explanations to co-workers and patients.

Originally known in Congress as the Kassebaum-Kennedy or Kennedy-Kassebaum Act, after two of its main sponsors, the **Health Information Portability and Accountability Act of 1996 (HIPAA)**, Public Law 104-191, was enacted by Congress and signed into law by President Bill Clinton on August 21, 1996. It has been described in retrospect as having "two essential goals: making healthcare delivery more efficient and increasing the number of Americans with health insurance coverage" (Nass et al, 2009; Univ of Chicago Med Ctr, 2010). Although correct, this is a deceptively broad and simple description.

What the HIPAA law says:

> To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets; to combat waste, fraud, and abuse in health insurance and healthcare delivery; to promote the use of medical savings accounts; to improve access to long-term care services and coverage; to simplify the administration of health insurance; and for other purposes.

For years, supporters of the legislation had heard repeated complaints from consumers about the very problems outlined in that paragraph, and they believed there were cost savings and efficiencies to be gained from standardization, and electronic storage and transmission, of records. Healthcare reformers had advocated for these changes for a long time, but elements of the healthcare industry had exerted a lot of pushback, and the failure of the industry to make meaningful changes finally led Congress to act (Bowers, 2001). Several years of politicking in Congress among elected representatives, insurers and insurance groups, large employers, state entities, and individuals finally resulted in HIPAA (Atchinson & Fox, 1997).

A primary purpose of the act was to protect health insurance coverage for workers and their families when they change or lose their jobs. This is called **portability** and is covered by Title I of the act (Bowers, 2001; Univ of Chicago Med Ctr, 2010).

Title II, known as Administrative Simplification (AS), required establishing national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans, and employers, with the goal of ensuring security and confidentiality of patient information. This is the "accountability" portion. The law mandated the development of privacy and security **Rules** for these transactions to make the public feel safe (Univ of Chicago Med Ctr, 2010; Bowers, 2001).

The act's three remaining sections (Titles III, IV, and V) are concerned with guidelines for pre-tax medical spending accounts, guidelines for group health plans, and for company-owned life insurance policies, respectively.

Who Does HIPAA Apply To?

HIPAA applies to health plans, healthcare clearinghouses, and healthcare providers who conduct certain healthcare transactions electronically (CDC, 2018; HHS/CMS, 2016; HHS, 2003). These are known as **covered entities**.

Health Plans

Individual and group plans that provide or pay the cost of healthcare are covered entities. Health plans include health insurance companies, company health plans, health maintenance organizations (HMOs), and government programs that pay for healthcare such as Medicare, Medicaid, and the military and veterans' healthcare programs (HHS/CMS, 2016; HHS, 2003).

Healthcare Providers

Every healthcare provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which the Department of Health and Human Services (HHS) has established standards under the HIPAA Transactions Rule (HHS, 2003).

Healthcare providers include any provider of medical or other healthcare services or supplies, including institutional providers such as hospitals and nursing homes; physicians, dentists, chiropractors, and other practitioners; pharmacies; and psychologists (HHS/CMS, 2016; HHS, 2003).

Healthcare Clearinghouses

Healthcare clearinghouses are entities that process nonstandard information they receive from another entity into a standard format, or vice versa. These include billing services, repricing companies, value added networks, and community health management information systems (HHS/CMS, 2016; HHS, 2003).

An additional important entity category is that of **business associate**. In general, a business associate is a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Services provided include accreditation, billing, claims processing, consulting, data analysis, financial services, legal services, management administration, and utilization review. Arrangements are covered by a **business associate contract**. The written contract must detail uses and disclosures of **personal health information (PHI)** that the business associate is allowed to make, and require the safeguarding of that information (HHS/CMS, 2016; HHS, 2003).

Individually Identifiable Health Information (IIHI)

Individually identifiable health information is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of healthcare to the individual, or
- the past, present, or future payment for the provision of healthcare to the individual,

and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (eg, name, address, birth date, SSN#) (HHS/CMS, 2016; HHS, 2003).

Protected Health Information (PHI) is identified in the HIPAA Privacy Rule as "individually identifiable health information" held or transmitted by a covered entity or its business associate, *in any form or media, whether electronic, paper, or oral* (HHS/CMS, 2016; HHS, 2003). Electronic PHI is also now referred to as **e-PHI**.

HIPAA Rules

To improve the efficiency and effectiveness of the healthcare system, HIPAA included Administrative Simplification provisions that required HHS to adopt national standards for electronic healthcare transactions and code sets, unique health identifiers, and security. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information, so it incorporated into HIPAA provisions that mandated the adoption of federal privacy protections for individually identifiable health information (HHS, 2017). Rule revisions have been made several times since HIPAA was enacted and the procedure to do so usually involves preliminary forms, public comment periods, and then final forms, which can be confusing when looking at a history of the rules.

HIPAA Rules address five main areas:

1. Privacy
2. Security
3. Transactions and Code Sets (TCS)
4. Unique Identifiers
5. Enforcement

Case managers will find the details of the Privacy Rule most consistently relevant to their work but each of the other rules will affect them as well. Internal security and IT departments, legal advisors and training officers, and billing departments have all been heavily impacted by HIPAA requirements, as have outside companies and contractors that provide these same services. Understanding more of the details can provide useful insight into the roles others play in HIPAA compliance across the entire healthcare field.

Omnibus and Breach Notification Rules

The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, had a variety of effects on HIPAA rules and enforcement.

In January 2013, HHS enacted a final **Omnibus Rule** that implemented provisions of the HITECH Act to strengthen the privacy and security protection of individuals' health information, modify the **Breach Notification Rule** (Breach Notification for Unsecured Protected Health Information), and strengthen the privacy protections for genetic information (Federal Register, 2013; HHS, 2017).

The six essential modifications were:

1. Make business associates of covered entities directly liable for compliance with certain of the HIPAA Privacy and Security Rules' requirements.

2. Strengthen the limitations on the use and disclosure of protected health information for marketing and fundraising purposes, and prohibit the sale of protected health information without individual authorization.
3. Expand individuals' rights to receive electronic copies of their health information and to restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full.
4. Require modifications to, and redistribution of, a covered entity's notice of privacy practices.
5. Modify the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools, and to enable access to decedent information by family members or others.
6. Adopt the additional HITECH Act enhancements to the Enforcement Rule not previously adopted in the October 30, 2009, interim final rule (referenced immediately below), such as the provisions addressing enforcement of noncompliance with the HIPAA Rules due to willful neglect.

Privacy Rule

HHS published a final Privacy Rule in December 2000, which was modified in August 2002. This Rule set national standards for the protection of individually identifiable health information by the three types of covered entities. Compliance with the Privacy Rule was required as of April 14, 2003 (April 14, 2004, for small health plans) (HHS, 2017; HHS/CMS, 2016). There have been revisions proposed several times since then, most recently in 2013 as part of what is sometimes referred to as the Omnibus Rule (Chesanow, 2013).

The basic principle of the Privacy Rule is to define and limit the circumstances in which an individual's PHI may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either (1) as the Privacy Rule permits or requires, or (2) as the individual who is the subject of the information, or the individual's personal representative, authorizes in writing (HHS, 2003).

The Privacy Rule gives patients the right to view and obtain a copy of their medical records in the form and manner they request, and to ask for corrections to their information (HHS/CMS, 2016).

A major goal of the Privacy Rule is to ensure that individuals' health information is properly protected while allowing the flow of health information needed to promote high quality healthcare and to protect the public's health and well-being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the healthcare marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed (CDC, 2018; HHS, 2013).

The Privacy Rule identifies some 18 items as PHI, ranging from the obvious such as name, address, and social security number, to the not so obvious such as vehicle serial numbers and URLs and IP addresses. All of which must be protected.

As noted by one hospital in its guidelines for employees: "PHI is part of everything you do." It exists in verbal and written communication, interactions with technology, and activities related to the privacy rules. For example, workers come in contact with a patient's health information when they speak to a colleague about a patient's treatment, review a patient's medical record or bill, and when they access information using a computer (Univ of Chicago Med Ctr, 2010).

Disclosure Situations

As noted above, there are situations when HIPAA permits or requires PHI to be disclosed by covered entities:

PHI *must be disclosed* in two cases:

1. when the individual or their representative requests information, or an accounting of disclosures of their PHI;
2. to HHS when it is performing a compliance audit or an enforcement action (CDC, 2018; HHS, 2003).

A covered entity *is permitted, but not required,* to use and disclose PHI, without an individual's authorization, for the following purposes or situations:

1. to the individual (unless it falls under (1) above as required);
2. treatment, payment, and healthcare operations;
3. opportunity to agree or object;
4. incident to an otherwise permitted use and disclosure;
5. public interest and benefit activities; and
6. limited data set for the purposes of research, public health or healthcare operations (CDC, 2018; HHS, 2003).

Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make (HHS, 2003).

HHS provides considerable guidance on its "HIPAA for Professionals" website, including explanations of terminology, up-to-date rule language—in summary and in full, fact sheets with case discussion, and detailed FAQ discussions.

"Treatment, payment, and healthcare operations" are of particular relevance for case managers when they are working with one or more covered entities (or business associates) to coordinate additional care for a patient. Two fact sheets available from the Office of the National Coordinator for Health Information Technology are particularly useful for their case scenarios:
https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf AND
https://www.healthit.gov/sites/default/files/exchange_treatment.pdf.

Business Associates and the Privacy Rule

By law, the HIPAA Privacy Rule applies only to covered entities. But most of them do not carry out all of their healthcare activities and functions by themselves. As noted earlier, a variety of support services may be carried out by contractual arrangements with business associates, and the Privacy Rule allows covered entities to disclose PHI when they have assurances that a business associate will:

- use the information only for the purposes for which it was engaged by the covered entity
- safeguard the information from misuse, and
- help the covered entity comply with some of the covered entity's duties under the Privacy Rule.

Covered entities may disclose PHI to an entity in its role as a business associate only to help the covered entity carry out its healthcare functions—not for the business associate's independent use or purposes, except as needed for the proper management and administration of the business associate (HHS, 2013b).

Security Rule

As noted earlier, Title II of HIPAA—Administrative Simplification—required the Secretary of HHS to issue security regulations regarding measures for protecting the integrity, confidentiality, and availability of e-PHI (not PHI transmitted orally or in writing) that is held or transmitted by covered entities. The final regulation, the Security Rule, was published February 20, 2003. The Rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality, integrity, and availability of e-PHI (CDC, 2018; HHS, 2017, 2017a, 2013).

The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that covered entities must put in place to secure individuals' e-PHI. Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties (HHS, 2013a).

Security measures and procedures include such things as having an assigned chief security officer, workforce training, controlling access to information systems, protections on computer systems, limitations on physical access to computers and servers, appropriate backups and storage, encryption, automated processes, and others (Univ of Chicago Med Ctr, 2010).

Prior to HIPAA, the healthcare industry had no generally accepted set of security standards or general requirements for protecting health information. Yet new technologies were evolving, and the healthcare industry began moving away from paper processes and came to rely more and more on systems such as computerized physician order entry (CPOE), electronic health records (EHR), and radiology, pharmacy, and laboratory systems. Health plans are using self-service programs for members to access claims information and manage care, among other features. This allows the medical workforce to be more mobile and efficient but, as more and more entities adopt these technologies, the potential security risks increase (HHS, 2013a).

A major goal of the Security Rule is to protect the privacy of individuals' health information while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care. Given that the healthcare marketplace is diverse, the Security Rule is designed to be flexible and scalable so a covered entity can implement policies, procedures, and technologies that are appropriate for the entity's particular size, organizational structure, and risks to consumers' e-PHI (HHS, 2013a).

Business Associates and the Security Rule

The HITECH Act of 2009 expanded the responsibilities of business associates under the HIPAA Security Rule. HHS developed regulations to implement and clarify these changes making business associates of covered entities directly liable for compliance with certain of the HIPAA Privacy and Security Rules' requirements.

Transactions (TCS) and Identifiers Rules

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare & Medicaid Services, and include:

- Transactions and Code Sets Standards
- Employer Identifier Standard
- National Provider Identifier Standard

These govern the creation and use of standard codes to identify transactions common to healthcare across the board and for creating unique identifiers for employers and providers to streamline and help secure recordkeeping.

Enforcement Rule

The **Enforcement Rule** provides standards for the enforcement of all the Administrative Simplification Rules. The HIPAA Enforcement Rule contains provisions relating to compliance and investigations, the imposition of civil money penalties for violations of the HIPAA Administrative Simplification Rules, and procedures for hearings (HHS, 2017b).

Since April 2003, OCR has received over 186,453 HIPAA complaints and has initiated over 905 compliance reviews. Ninety-six percent of these cases (178,834) have been resolved. OCR investigated and resolved 26,152 cases by requiring changes to privacy practices and corrective actions or by providing technical assistance, with actions intended to result in systemic changes. As of July 31, 2018, OCR has settled or imposed a civil money penalty in 55 cases for a total dollar amount of $78,829,182.

Early intervention and technical assistance avoided investigation in 29,042 cases. No violation was found in another 11,581 cases after investigation, and the remainder of cases were not eligible for investigation for a variety of reasons. Investigated complaints have involved many different types of entities including: national pharmacy chains, major medical centers, group health plans, hospital chains, and small provider offices (HHS, 2018).

The compliance issues investigated most (cumulatively in order of frequency) are:

- Impermissible uses and disclosures of protected health information;

- Lack of safeguards of protected health information;
- Lack of patient access to their protected health information;
- Lack of administrative safeguards of electronic protected health information;
- Use or disclosure of more than the minimum necessary protected health information.

The most common types of covered entities that have been required to take corrective action to achieve voluntary compliance are (in order of frequency):

- General Hospitals
- Private Practices and Physicians
- Outpatient Facilities
- Pharmacies
- Health Plans (group health plans and health insurance issuers) (HHS, 2018)

Civil Money Penalties

The HITECH Act modified the HHS Secretary's authority to impose civil money penalties for violations occurring after February 18, 2009, significantly increasing the penalty amounts the Secretary could impose for violations of the HIPAA rules and encourage prompt corrective action (HHS, 2011/2009).

Prior to the HITECH Act, the Secretary could not impose a penalty of more than $100 for each violation or $25,000 for all identical violations of the same provision. A covered healthcare provider, health plan, or clearinghouse could also bar the Secretary's imposition of a civil money penalty by demonstrating that it did not know that it violated the HIPAA rules. The HITECH Act strengthened the civil money penalty scheme by establishing tiered ranges of increasing minimum penalty amounts, with a maximum penalty of $1.5 million for all violations of an identical provision. A covered entity can no longer bar the imposition of a civil money penalty for an unknown violation unless it corrects the violation within 30 days of discovery (HHS, 2011/2009).

HIPAA Issues and Concerns

HIPAA's broad goals and complexities have made it the subject of concern and confusion since it was enacted, for everyone involved although not for the same reasons. Those who had waited and worked for change in the healthcare field were happy that the days of open access to individuals' personal health information would be over. The industry was afraid that the cost of compliance would be burdensome. Healthcare providers were concerned that privacy regulations would make it harder to treat patients effectively. One writer observed that no one seemed especially concerned about the issues of data standardization and security, seemingly certain the "technical professionals" could manage all that (Bowers, 2001).

Complacency about security, whether inadvertent and deliberate, looks to have been a mistake. Covered entities that have been careless with the need for security, including everything from insecure passwords and insecure devices to systems poorly protected against hacking and ransomware, continue to be serious issues.

A recent report on multi-industry data breaches found that "58% of incidents involved insiders—healthcare is the only industry in which internal actors are the biggest threat to an organization." That same report noted several other important issues: while stories about medical device hacking may be featured in the media, databases and paper documents are "the assets most often affected in breaches," ransomware infections are the top malware involved in breaches, and even after all these years and all the training "basic security measures are still not being implemented." Unencrypted laptops that are subsequently lost or stolen are a continual problem (Verizon, 2018; Hogue, 2018).

As noted earlier, lack of patient access to their own records is a significant factor in enforcement investigations and actions. A recent study noted that "US hospitals continue to place cost and processing obstacles in the way of patients requesting their personal medical records." Inconsistent information about patient rights to request information and the formats and costs of that information are widespread as is a failure to comply with federal and state regulations and recommendations (Swift, 2018).

The OCR has in recent years proceeded against some large, and not so large, entities and been able to levy considerable fines. The MD Anderson Cancer Center in Houston, Texas, was fined $4.3 million for HIPAA violations involving three separate data breaches involving lost and stolen unencrypted laptops and USB thumb drives. Despite policies in place, the Center had failed to implement encryption in a timely manner and on all devices (Nelson, 2018).

While enforcement cases are important and with the changes from the HITECH Act, OCR now has more teeth in its rules, there are other issues that concern both providers and patients.

Perhaps one of the biggest concerns is the widespread belief that you can't tell anyone anything. This was not the intent of the law and is a routine misunderstanding (Chesanow, 2013). FAQ discussions on the HIPAA website and by other HIPAA experts often involve attempts to clarify these concerns. For example, many doctors believe that they cannot communicate with patients by regular postal service mail or by unsecure email, neither of which is correct. Misunderstanding is also widespread about communications with family and friends regarding a patient's condition and about the penalties for an innocent mistake (Chesanow, 2013).

From another perspective an individual who believes they are the victim of a HIPAA violation has only a complaint to the OCR as recourse. HIPAA does not give a patient the right to sue a doctor, nurse, or hospital. A lawsuit under state law alleging a privacy violation is possible but has nothing to do with HIPAA (Chesanow, 2013).

Other concerns that have been raised about HIPAA involve real problems for mental health patients and their caretakers where information sharing problems can be life threatening; obstacles to research where patient data is needed, and arguments that, especially in the field of mobile health, HIPAA "stifles innovation" (Chesanow, 2013).

Remarks

HIPAA is now more than two decades old and, while it has its problems, few advocate for a return to the old ways. Changes have been made and more will no doubt be made in the future. Case managers with an understanding of how the various parts of HIPAA have evolved and where confusion and misunderstanding are common may find it easier to negotiate solutions to complex problems. A great deal of plain-English, commonsense information on the development of and current operation of the law is available from the HIPAA website for professionals at: https://www.hhs.gov/hipaa/for-professionals/index.html.

Ethics and OSHA

[Unless otherwise cited, all material in this module is from OSHA, 2016.]

On December 29, 1970, President Nixon signed the **Occupational Safety and Health Act of 1970 (OSH Act)** into law, establishing OSHA. Congress created OSHA to ensure safe and healthful conditions for working men and women by setting and enforcing standards and providing training, outreach, education and compliance assistance.

Under OSHA, employers are responsible for providing that safe and healthful workplace. The combined efforts of employers, workers, safety and health professionals, unions and advocates, OSHA and its state partners have reduced work-related deaths and injuries by more than 65% since 1970. At that time, it was estimated that about 38 workers were killed on the job every day. In 2010 that number had fallen to 12 per day. The rate of reported serious workplace injuries and illnesses has also fallen dramatically.

Not only does a safer workplace help individual workers and their families, it saves money for employers in workers' compensation costs and indirect costs for lost work days, training and replacement, and accident investigations.

Who Does OSHA Cover?

The OSH Act covers most private sector employers and their workers, in addition to some public sector employers and workers in the 50 states and certain territories and jurisdictions under federal authority.

OSHA covers most private sector employers and workers in all 50 states, the District of Columbia, and other U.S. jurisdictions either directly through Federal OSHA or through an OSHA-approved state plan.

State plans are OSHA-approved job safety and health programs operated by individual states instead of Federal OSHA. The OSH Act encourages states to develop and operate their own job safety and health programs and precludes state enforcement of OSHA standards unless the state has an approved program. OSHA approves and monitors all state plans and provides as much as fifty percent of the funding for each program. State-run safety and health programs must be at least as effective as the Federal OSHA program.

Federal OSHA provides coverage to certain workers specifically excluded from a state's plan, for example, those in some states who work in maritime industries or on military bases.

Any interested person or group, including individual workers, with a complaint concerning the operation or administration of a state program may submit a complaint to the appropriate federal OSHA regional administrator (regional offices are listed at the end of this guide). This is called a **Complaint About State Program Administration (CASPA)**. The complainant's name will be kept confidential. The OSHA regional administrator will investigate all such complaints, and where complaints are found to be valid, may require appropriate corrective action on the part of the state.

State and Local Government Workers

Workers at state and local government agencies are not covered by Federal OSHA, but have OSH Act protections if they work in those states that have an OSHA-approved state program. OSHA rules also permit states and territories to develop plans that cover only public sector (state and local government) workers.

Federal Government Workers

OSHA's protection applies to all federal agencies. Federal agency heads are responsible for providing safe and healthful working conditions for their workers. Although OSHA does not fine federal agencies, it does monitor these agencies and conducts federal workplace inspections in response to workers' reports of hazards.

Federal agencies must have a safety and health program that meets the same standards as private employers. Under a 1998 amendment, the OSH Act covers the U.S. Postal Service the same as any private sector employer.

Not Covered under the OSH Act are:

- The self-employed;
- Immediate family members of farm employers; and
- Workplace hazards regulated by another federal agency (for example, the Mine Safety and Health Administration, the Department of Energy, or the Coast Guard) (OSHA, 2016).

Rights and Responsibilities Under OSHA Law

Employers MUST provide their workers with a workplace that has no serious hazards and must follow all OSHA safety and health standards.

Employers have the responsibility to provide a safe workplace. Employers must find and correct safety and health problems. OSHA further requires that employers must first try to eliminate or reduce hazards by making feasible changes in working conditions rather than relying on personal protective equipment such as masks, gloves, or earplugs. Switching to safer chemicals, enclosing processes to trap harmful fumes, or using ventilation systems to clean the air are examples of effective ways to eliminate or reduce risks (OSHA, 2016).

Employers **must** also:

- Prominently display the official OSHA Job Safety and Health. It's the Law poster that describes rights and responsibilities under the OSH Act.
- Inform workers about chemical hazards through training, labels, alarms, color-coded systems, chemical information sheets, and other methods.

- Provide safety training to workers in a language and vocabulary they can understand.
- Keep accurate records of work-related injuries and illnesses.
- Perform tests in the workplace, such as air sampling, required by some OSHA standards.
- Provide required personal protective equipment at no cost to workers.*
- Provide hearing exams or other medical tests required by OSHA standards.
- Post OSHA citations and injury and illness data where workers can see them.
- Notify OSHA within 8 hours of a workplace fatality or within 24 hours of any work-related inpatient hospitalization, amputation or loss of an eye (800 321 OSHA [6742]).
- Not retaliate against workers for using their rights under the law, including their right to report a work-related injury or illness.

* Employers must pay for most types of required personal protective equipment.
Source: OSHA, 2016.

Under OSHA law, workers are entitled to working conditions that do not pose a risk of serious harm.

Workers have the right to:

- File a confidential complaint with OSHA to have their workplace inspected.
- Receive information and training about hazards, methods to prevent harm, and the OSHA standards that apply to their workplace. The training must be done in a language and vocabulary workers can understand.
- Receive copies of records of work-related injuries and illnesses that occur in their workplace.
- Receive copies of the results from tests and monitoring done to find and measure hazards in their workplace.
- Receive copies of their workplace medical records.
- Participate in an OSHA inspection and speak in private with the inspector.
- File a complaint with OSHA if they have been retaliated against by their employer as the result of requesting an inspection or using any of their other rights under the OSH Act.
- File a complaint if punished or retaliated against for acting as a "whistleblower" under the 21 additional federal laws for which OSHA has jurisdiction (OSHA, 2016).

OSHA Standards

OSHA's Construction, General Industry, Maritime and Agriculture standards protect workers from a wide range of serious hazards. Examples of OSHA standards include requirements for employers to:

- Provide fall protection;
- Prevent trenching cave-ins;
- Prevent exposure to some infectious diseases;
- Ensure the safety of workers who enter confined spaces;
- Prevent exposure to harmful chemicals;
- Put guards on dangerous machines;
- Provide respirators or other safety equipment; and
- Provide training for certain dangerous jobs in a language and vocabulary workers can understand.

Employers must also comply with the General Duty Clause of the OSH Act. This clause requires employers to keep their workplaces free of serious recognized hazards and is generally cited when no specific OSHA standard applies to the hazard.

OSHA has the authority to issue new or revised occupational safety and health standards. The OSHA standards-setting process involves many steps and provides many opportunities for public engagement. OSHA can begin standards-setting procedures on its own initiative or in response to recommendations or petitions from other parties (OSHA, 2016).

Enforcement: OSHA Inspection Activities

Inspections are initiated without advance notice, conducted using on-site or telephone and facsimile investigations, performed by highly trained compliance officers and scheduled based on the following priorities:

- Imminent danger;
- Catastrophes—fatalities or hospitalizations;
- Worker complaints and referrals;
- Targeted inspections—particular hazards, high injury rates; and
- Follow-up inspections.

Current workers or their representatives may file a written complaint and ask OSHA to inspect their workplace if they believe there is a serious hazard or that their employer is not following OSHA standards. Workers and their representatives have the right to ask for an inspection without OSHA telling their employer who filed the complaint. It is a violation of the OSH Act for an employer to fire, demote, transfer or in any way retaliate against a worker for filing a complaint or using other OSHA rights (OSHA, 2016).

When an inspector finds violations of OSHA standards or serious hazards, OSHA may issue citations and fines. A citation includes methods an employer may use to fix a problem and the date by which the corrective actions must be completed. Employers have the right to contest any part of the citation, including whether a violation actually exists. Workers only have the right to challenge the deadline by which a problem must be resolved. Appeals of citations are heard by the independent Occupational Safety and Health Review Commission (OSHRC) (OSHA, 2016).

General Reporting and Recordkeeping Requirements

OSHA's Reporting Requirements

All employers must report to OSHA:

- The death of any worker from a work-related incident within 8 hours of learning about it;
- All work-related inpatient hospitalizations, amputations and losses of an eye within 24 hours.

In addition, employers must report all fatal heart attacks that occur at work. Deaths from motor vehicle accidents on public streets (except those in a construction work zone) and in accidents on commercial airplanes, trains, subways or buses do not need to be reported.

These reports may be made by telephone or in person to the nearest OSHA area office listed at www.osha.gov or by calling OSHA's toll-free number, 800 321 OSHA (6742) (OSHA, 2016).

OSHA's Recordkeeping Requirements

OSHA requires certain covered employers in high-hazard industries to prepare and maintain records of serious work-related injuries and illnesses. Tracking and investigating workplace injuries and illnesses play an important role in preventing future injuries and illnesses.

Employers with more than ten employees and whose establishments are not classified as a partially exempt industry must record serious work-related injuries and illnesses using OSHA Forms 300, 300A and 301.

A list of partially exempt industries, including establishments in specific low hazard retail, service, finance, insurance or real estate industries is available at from the OSHA website. Employers who are required to keep Form 300, the Injury and Illness log, must also post Form 300A, the Summary of Work-Related Injuries and Illnesses, in the workplace every year from February 1 to April 30.

OSHA is responsible for administering the recordkeeping system established by the OSH Act. OSHA's recordkeeping regulations provide specific recording and reporting requirements which comprise the framework for the nationwide occupational safety and health recordkeeping system (OSHA, 2016).

OSHA's Whistleblower Program

To help ensure that workers are free to participate in safety and health activities, Section 11(c) of the OSH Act prohibits any person from discharging or in any manner retaliating against any worker for exercising rights under the OSH Act. These rights include raising safety and health concerns with an employer, reporting a work-related injury or illness, filing a complaint with OSHA, seeking an OSHA inspection, participating in an OSHA inspection and participating or testifying in any proceeding related to an OSHA inspection system (OSHA, 2016).

Protection from retaliation means that an employer cannot retaliate by taking "adverse action" against workers, such as:

- Firing or laying off;
- Blacklisting;
- Demoting;
- Denying overtime or promotion;
- Disciplining;
- Denying of benefits;
- Failing to hire or rehire;
- Intimidation;
- Making threats;
- Reassignment affecting prospects for promotion; or
- Reducing pay or hours system (OSHA, 2016).

If a worker believes an employer has retaliated against them for exercising their safety and health rights, they should contact their local OSHA office right away. A retaliation complaint must be filed with OSHA within 30 calendar days from the date the retaliatory decision has been both made and communicated to the worker. No form is needed, but workers must call OSHA within 30 days of the alleged retaliation (at 1-800-321-OSHA [6742]) system (OSHA, 2016).

OSHA provides extensive resources on its website, including training requirements, standards for various industries, support available to employers and employees.

OSHA and the Healthcare Industry

Healthcare workers face a number of serious safety and health hazards. They include bloodborne pathogens and biologic hazards, potential chemical and drug exposures, waste anesthetic gas exposures, respiratory hazards, ergonomic hazards from lifting and repetitive tasks, laser hazards, workplace violence, hazards associated with laboratories, and radioactive material and x-ray hazards. Some of the potential chemical exposures include formaldehyde, used for preservation of specimens for pathology; ethylene oxide, glutaraldehyde, and paracetic acid used for sterilization; and numerous other chemicals used in healthcare laboratories (OSHA, n.d.).

More workers are injured in the healthcare and social assistance industry sector than any other. This industry has one of the highest rates of work related injuries and illnesses. In 2010, the healthcare and social assistance industry reported more injury and illness cases than any other private industry sector (653,900 cases). That is 152,000 more cases than the next industry sector: manufacturing. In 2010, the incidence rate for work related nonfatal injuries and illnesses in health care and social assistance was 139.9; the incidence rate for nonfatal injury and illnesses in all private industry was 107.7 (OSHA, n.d.).

Nursing aides, orderlies, and attendants had the highest rates of musculoskeletal disorders of all occupations in 2010. The incidence rate of work related musculoskeletal disorders for these occupations was 249 per 10,000 workers. This compares to the average rate for all workers in 2010 of 34 (OSHA, n.d.).

The OSHA website provides considerable material regarding workplace safety in the healthcare setting at: https://www.osha.gov/SLTC/healthcarefacilities/index.html.

OSHA and HIPAA

Under normal circumstances, an individual must give written consent to disclose his or her health information. However, a covered entity's employees or business associates may disclose protected health information to a public health authority (such as federal OSHA or a state agency operating under a federal OSHA-approved state plan, both of which are hereinafter referred to as "OSHA") that is authorized to investigate a covered entity's conduct, to an attorney retained to deal with a case involving such conduct, or to a health care accrediting organization. These disclosures are permitted as long as the employee believes in good faith that the conditions he is reporting are unlawful or endanger employees, among other things.

Employees who are crime victims may also disclose protected health information to a law enforcement official if the information is about the suspected perpetrator and the information is limited to that listed in the privacy regulation at 45 CFR § 164.512(f)(2)(i). Also, an employee may report a serious and imminent threat to the health and safety of a person if the recipient of the report is reasonably able to prevent or diminish the threat. Such recipients include law enforcement officials, OSHA, and union officials (OSHA, 2018).

Employees are protected from retaliation for making disclosures authorized by HIPAA in connection with an occupational safety or health complaint. They may file whistleblower complaints with OSHA under Section 11(c) of the Occupational Safety and Health Act (OSH Act). The whistleblower complaint must be filed within 30 days of the retaliation (OSHA, 2018).

OSHA is charged with regulating health and safety in the workplace, and is considered both a public health authority and a health oversight agency under HIPAA. The agency sometimes has to use and disclose protected health information to conduct investigations, litigate cases, and engage in other activities. Although OSHA is not a "covered entity" under HIPAA and is not bound by the use and disclosure requirements included in the privacy regulation, it complies with applicable laws and regulations protecting privacy, such as the Privacy Act, 5 U.S.C. § 552a (OSHA, 2018).

Conclusion

Behaving ethically as a case manager is clearly a complex challenge, but the guidelines—codes and principles of practice—stand ready to provide support in your daily work. No doubt you brought much of this with you into your practice; nevertheless, this course is designed to help deepen your commitment to treating both patients and coworkers with the care they deserve. When you come from a base of ethical understanding and behavior, the result is trustworthiness. Everyone will be able to count on you as part of a strong team of professionals.

References

Because of the length of these references and for your convenience, we have presented them in three parts.

References, Part 1: Modules 1 to 3

References, Part 2: Modules 4 and 6

References Part 3: Modules 7 and 8

References Part 1: Modules 1 to 3

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Post Test

Use the answer sheet following the test to record your answers.

1. Ethical decision making has become more complex because:

    a. The Hippocratic Oath has long been outdated.
    b. Society today is steeped in immorality.
    c. Organizational priorities and financial pressures affect everyday decisions.
    d. There are just so many more rules today than in earlier times.

2. At the center of the patient therapist relationship is:

    a. Loyalty
    b. Affection
    c. Sincerity
    d. Trust

3. Healthcare ethics are unique because:

    a. Patients are vulnerable.
    b. A lot of money is involved.
    c. Healthcare workers care about people.
    d. Patients have complete autonomy.

4. When you lower your moral threshold, you:

    a. Compromise your integrity.
    b. Open your mind to new ideas.
    c. Increase your awareness of complex issues.
    d. Recognize the reality of healthcare.

5. Moral potency is:

    a. Repeating an action until you get the results you want.
    b. The capacity to take moral action responsibly in the face of adversity.
    c. Being willing to express your religious beliefs across all settings.
    d. Doing the right thing.

6. Which of the following are key components to a code of ethics:

a. Respect for human dignity and patient privacy
b. Ability to financially pay for healthcare services rendered
c. Autonomy to make decisions and transportation resources
d. Compliance to regimens and honesty

7. What does a Case manager agree to abide by in their code of ethics:

a. Confidentiality of personal health information
b. Patient advocacy
c. Obey all laws and regulations
d. All of the above

8. Beneficence means:

a. Being kind.
b. Doing little harm.
c. Ensuring services for all.
d. Encouraging independence.

9. Nonmaleficence means:

a. First of all, assess your patient.
b. Not being malicious.
c. Doing no harm.
d. Avoiding malpractice.

10. Veracity means:

a. Paternalism.
b. Therapeutic privilege.
c. Legitimacy.
d. Truthfulness founded on a respect for persons.

11. The model of ethical decision making called RIPS means:

a. React intuitively to present solutions.
b. Respect institutional protocols selectively.
c. Rest in peace serenely.
d. Realm, individual process, and situation.

12. When Case managers act to correct a situation, they are exhibiting:

    a. Moral sensitivity.
    b. Moral judgment.
    c. Moral motivation.
    d. Moral courage.

13. When Case managers decide on a line of action, they are exhibiting:

    a. Moral sensitivity.
    b. Moral judgment.
    c. Moral motivation.
    d. Moral courage.

14. When a Case manager recognizes an ethical problem but take no action, it is called:

    a. An ethical distress.
    b. An ethical dilemma.
    c. An ethical temptation.
    d. An ethical silence.

15. When action is taken based on the standard of care, it is:

    a. Care-based.
    b. Rule-based.
    c. Ends-based.
    d. Ethics-based.

16. When action is taken based on achieving the greatest good, it is:

    a. Care-based.
    b. Rule-based.
    c. Ends-based.
    d. Ethics-based.

17. The final step of a professional in ethical decision-making is:

    a. Implement, evaluate, and reassess.
    b. Recognize and reflect.

c. Decide and implement.

d. File a report.

18. What is the meaning of POLST:

a. Provider orientation-long statutory testing

b. Physicians on-call late schedule time

c. Physician order for life sustaining treatment

d. Providers or long-term care service treatment

19. Which is an example of meaningful use for a case manager:

a. Regularly documenting a patient's coagulation to establish therapeutic range for the prescription.

b. Documenting the patient's meeting a physician appointment as scheduled.

c. Documenting that the patient didn't answer the phone call you attempted.

d. Documenting the patient's information from the face sheet.

20. Right vs. wrong may be a moral temptation, but right vs. right is:

a. The best of both worlds.

b. An ethical dilemma.

c. A chance for correct action.

d. A political brawl.

21. Confidentiality and privacy are the same thing:

a. True

b. False

22. HIPAA legislation was intended to:

a. Address, solely, portability of health insurance.

b. Address portability of health insurance, security of insurance information, and other matters.

c. Promulgate rules only about privacy and security of health insurance information.

d. Make it easier and cheaper for everyone to obtain health insurance.

23. Under HIPAA, agencies who develop electronic healthcare records are:

a. Covered entities.

b. Covered businesses.

c. Business associates.

d. Covered contractors.

24. Individually identifiable health information (IIHI) includes information:

a. Relevant only to the current diagnosis.

b. About past treatment only.

c. On past, present, and future health conditions.

d. On physical health conditions only.

25. Protected health information (PHI) is:

a. IIHI transmitted in electronic form only.

b. Not defined in the HIPAA Privacy Rule.

c. IIHI transmitted in any form or media.

d. IIHI transmitted only in paper form.

26. The Privacy Rule gives patients the right to view and obtain:

a. Their medical records in the form and manner they request.

b. Their medical records in person at the covered entity's place of business only.

c. A copy of their medical records in the form the covered entity chooses.

d. A copy of their medical records in electronic form only.

27. The OSH Act covers:

a. Most private sector employers and their workers, in addition to some public sector employers and workers.

b. Only public sector employers and their workers.

c. Only private sector employers and their workers.

d. All private sector employers and their workers.

28. Under OSHA law, workers are:

a. Entitled to damages if proven to work under aesthetically challenged conditions.

b. Entitled to working conditions that pose no risk of serious harm.

c. Guaranteed a completely safe working environment.

d. Not able to file complaints about unsafe working conditions.

Answer Sheet

Ethics for Professional Case Managers

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
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28. _____

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks * are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

* Upon completion of the course, I was able to:

a. Explain ethical standards of practice.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. Identify the code(s) of ethics that apply to your profession.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

c. List and define the principles of ethics for healthcare.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. State the relationship between the Rule of Law and ethics and morals.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. Identify 3 legal or regulatory requirements that apply to your practice.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Be ready to explain the ethical decision-making process with a relevant case.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

g. Discuss the ways in which HIPAA impacts your daily practice.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

h. Explain the requirements of OSHA and how they apply to case management.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

5 4 3 2 1

* The author(s) cited evidence that supported the material presented.

5 4 3 2 1

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satsfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour
- 40-49 minutes per contact hour
- 30-39 minutes per contact hour
- Less than 30 minutes per contact hour

I heard about ATrain Education from:

- Government or Department of Health website.
- State board or professional association.
- Searching the Internet.
- A friend.
- An advertisement.
- I am a returning customer.
- My employer.
- Other
- Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

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Registration Form

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* Professional Credentials/Designations:

_____

Your name and credentials/designations will appear on your certificate.

* License Number and State: _____

* Please email my certificate:

○ Yes ○ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

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8 contact hours: $59

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