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New Definition

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The Overwhelming Moral and Ethical Reality of Care Management Practice

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Introduction

Case or Care Management has existed in some form since the dawn of families; every parent who has juggled the complex lives within a household has an understanding of basic care management processes. It was at one time simple, with rather clear lines of responsibility and authority. But in its translation to health care, and with the growth of professionalization in Social Work and Nursing, coordinating health care and its outcomes have evolved into a complex, professional, advanced practice.

Case Management or Care Management is variously defined in the literature.[1,2,3] The functions of Care Managers are reflected in their multiple roles, including change agent, clinician, consultant, collaborator, coordinator, communicator, facilitator, advocate, educator, manager, negotiator, and leader,[4] as well as goals of their practice: cost containment, managing complex relationships, and providing the highest quality of care in the appropriate setting. The literature speaks of role confusion, ambiguity, and overload, for the very definitions of the Care Management roles are overwhelming, describing some sort of super professional who is capable of suspending the complex reality of health care systems, personalities, and economic constraints while guiding individuals and families through some of the most stressful circumstances the patients have ever known. The physical and emotional implications of Care Management practice are overpowering, even apart from the legal and ethical components of practice.

While nurses and social workers must consider some organizational factors, those who are not Care Managers are bound quite clearly by the relationship with the patient and family, as are physicians. Health care executives are usually most clearly bound to organizational factors. But Care Managers interface with more health care and administrative partners than other professionals and most of those professionals have more authority and fewer responsibilities. In addition, Care Managers are evaluated on outcomes that are only partially under their control. Length of stay may be influenced by a delayed order, unavailability of a receiving bed, or a delay in process within the hospital. Cost of care is always associated with procedures and interventions that are ordered by a physician. Denials are often the result of sketchy or delayed documentation. Yet it all reflects on the professional and personal competency of the Care Manager. Internalizing these "facts" adds to distress.

The legal and ethical implications of Care Management mirror the complexity of practice. Legal responsibility (meeting the standard of care) and ethical accountability (meeting the individual needs of the patient within a family or community) are the moral framework within which each Care Manager functions; each instrumental action is mediated through commitment to an entity such as a person (e.g. a patient) or an organization (e.g. a hospital, payer, or agency) or to a concept (e.g. personal professionalism). With multiple recipients or objects of each action, with each decision affecting a dizzying number of agents, the boundaries between responsibilities and

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loyalties become hopelessly blurred. Within the context of human interaction these conflicting commitments and competing loyalties may not be consciously accessible to the individual Care Manager, but if the professional is aware of the multiple, conflicting roles and responsibilities, confusion and discomfort will necessarily emerge.

Professionalization of Nursing and Social Work gave rise to codes of professional ethical behavior that reflect both the religious roots of the professions and the reality of the activities embodied in practice.[5,6] Professional Care Management has given rise to particular Codes of Ethical Behavior and Codes of Ethics.[7] These codes align, but do not exactly mirror those of the "mother" professions of nursing and social work. Other Codes of Ethics, such as that of the American Health Information Management Association (AHIMA) also inform segments of Care Management.[8]

Moral Distress

The traditional primary ethical duty of every nurse and social worker is to the patient and family; this has been true since the origin of the professions. Yet Care Managers are commonly employed by facilities or organizations in which financial and regulatory constraints limit the resources that are available for provision of care. Additionally, the resources available for care vary according to the financial circumstances (including health care coverage) of the patient, in itself a circumstance that is discordant with the core values of health care. Policies and regulations dictate how much care can be delivered in which setting and by which professional. Clinical decisions must be weighed within community and organizational contexts. The importance of patients' and employees' individual rights must be balanced with the survival of the institution or organization within the community. Preserving one's fundamental belief in patient self-determination within the chaos of conflicting regulatory and organizational demands introduces a sense of dissonance that has been defined as moral distress.

Jameton[9] (1984) described moral distress as being unable to act in an ethically or morally appropriate manner. In an excellent article in 2014, Moffett[10] stated that professionals … "experience moral distress when perceived ethical standards are breeched or unappreciated" (p. 174). She accurately describes the complex environment in which Care Managers' practices insert them into a morass of conflicting opinions, expectations, and standards. Care Managers are not alone in this situation; most health care professionals experience distress when they encounter conflicting ethical situations. But while moral distress is perhaps common in health care professionals, Care Managers may be unusually susceptible to moral conflicts.

Discharge planning involves complex manipulation of constantly shifting criteria. Fraser and colleagues[11] describe an "embedded duality" with conflicting responsibilities to client-centered goals versus system-centered goals. Critical Care Management decisions are made within the context of real world pressures, time constraints, and professional responsibilities within multiple systems (e.g. payers versus providers). Priorities shift unmercifully between patients, families, organizations, and regulatory pressures. For instance, if a patient in the Emergency Department does not "meet criteria" for inpatient admission, but the family cannot assume responsibility for his or her care due to other responsibilities (e.g. a newborn, multiple job responsibilities, lack of adequate housing), and other care settings are not available due to a lack of financial resources, physical condition or behavior of the patient, where do the loyalties of the Care Manager lie? Is a "social admission" a viable option? Can a facility be persuaded to attempt to care for the patient with additional means such as sitters or other creative suggestions? What are the reasonable limits of this patient for self-care, the ultimate goal with each health care recipient? What are the responsibilities of the community in providing a supportive environment for a patient with physical or behavioral limitations?

There is no question that each Care Manager will focus on the patient and family as his or her primary moral responsibility and ethical focus; care for the individual and his or her family is the heart of nursing and social work. Both professions are mediated through the human relationship and traditionally, the tenets of ethics largely centered on that personal relationship. However, the context of the helping relationship, especially within health care, introduces conflicting interests: For instance, an ill individual may require inpatient care but the patient has no financial resources. If resources are spent on the ill patient and not reimbursed, the fiscal needs of the organization might not be met, and the hospital could encounter financial difficulties or regulatory investigation. If the hospital does not survive, the community and its underserved populations could suffer. In the case of a very difficult discharge placement decision, what if a seemingly "perfect solution" seems to exist but the provider will not order the intervention, medication, or admission? Should the Care Manager's responsibilities and ethical decision making focus on the individual, the organization, or the community?

Care Managers no longer have that clear moral compass to guide practice decisions; the context of care introduces as much situational variance as the individual patient at its center. Care Managers are asked to exceed human capabilities. Upon admission and prior to many procedures, the Care Manager must ensure that authorizations and/or pre-certifications are acquired and recorded, which might delay a needed procedure. Since inpatient admission will be short, discharge planning should begin prior to the admission, if possible. Discharge planning must take place while the patient is in pain or in the early stages of recovery; choices of rehabilitation, long-term acute care, or other placement must only include contracted facilities. In other words, Care Managers should be prescient and clairvoyant. Clinical information must be clear to support indications for inpatient admission (or observation) and each day of the inpatient stay. Care Managers must be able to convince others to document promptly, clearly, and communicate without rancor or delay. No measure of education or personality can help a Care Manager accomplish that goal.

Pure concentration on the fidelity of the relationship with the individual is impossible. It becomes impossible to perceive oneself as a competent professional in a context of the impossibility of satisfying conflicting agendas. For the Care Manager, the conflicting ethical reality of practice introduces unrelenting moral distress. The inability to make decisions based on personal values introduces personal suffering. Moral courage is no longer enough in light of multiple conflicting loyalties and responsibilities in the absence of moral and ethical authority.

Five Potential Remedies

1. The first challenge and most important challenge for Care Management professionals is to recognize that what we feel is a *result of our practice circumstance*. It is certainly *not* a personal or professional failure.
2. Second, while we can "own" the feelings, we cannot take personal responsibility for the shortcomings of the system and the impossibilities of practice. We might hear that "Care Management" must solve the financial issues of the organization but those statements must be confronted. Care Managers no more control every outcome than anyone else working within the system. While Care Managers are instrumental in great outcomes, suboptimal outcomes belong to *every individual in the organization*.
3. Third, leaders of Care Management Departments must recognize the inherent moral distress in Care Management practice and signs of it in their staff members. Leaders must discuss and design remediation for the distress prior to the demoralization, which leads to ineffective practice and/or resignation (figurative or literal).
4. Fourth, leadership in Human Resource departments must recognize the realities of Care Management practice and set up performance evaluation criteria that reflect realistic outcomes for its practice.
5. Fifth, organizational leaders must recognize that each financial outcome is the result of uncountable and interdependent processes including multiple professional practices; Care Managers cannot bear responsibility for the collective breakdowns of each system. For with all due respect to Mr. Roosevelt, Care Managers "might fail while daring greatly" with courage that exceeds that of most.

Endnotes

1 NASW *Standards for Social Work Case Management*. Accessed 17 June 2015. https://www.google.com/?gws_rd=ssl#q=definition+of+case+management+for+social+workers

2 Case Management Society of America. *What is a Case Manager?* Accessed 17 June 2015. http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx

3 Commission for Case Management Certification. *Definition of Case Management*. Accessed 17 June 2015. http://ccmcertification.org/about-us/about-case-management/definition-and-philosophy-case-management

4 Cohen EL, Cesta TG. 2005. *Nursing Case Management: From Essentials to Advanced Practice*. St. Louis: Elsevier Mosby.

5 ANA. *Code of Ethics for Nurses*. Accessed 17 June 2015. http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html

6 NASW. *Code of Ethics*. Accessed 17 June 2015.

7 Center for Case Management Certification. *Code of Professional Conduct for Case Managers*. Accessed 17 June 2015. http://ccmcertification.org/content/ccm-exam-portal/code-professional-conduct-case-managers

8 American Health Information Management Association *Code of Ethics*. Accessed 18 June 2015. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_024277.hcsp?dDocName=bok1_024277

9 Jameton A. 1984. *Nursing Practice: The Ethical Issues*. Englewood Cliffs NJ: Prentice-Hall.

10 Moffat M. 2014. Reducing Moral Distress in Case Managers. *Professional Case Management*, 19(4). 173-186.

11 Fraser KD,Estabrooks, C, Allen M, Strang V. (2010) *The Relational Nature of Case Manager Resource Allocation Decision Making: An Illustrated Case*. *Care Management Journals* 11(3). 151-156.