

**The American Occupational Therapy Association
Advisory Opinion for the Ethics Commission**

Social Justice and Meeting the Needs of Clients

Introduction

Social justice is an ethical concept related to the equitable division of assets among members of society. In the area of healthcare, it addresses the importance of assuring access to care to all persons in need of it (Beauchamp and Childress, 2009). In an environment of healthcare disparities and limited resources, occupational therapy practitioners can find themselves in ethical dilemmas related to providing appropriate levels of care. Some clients may use their extensive insurance coverage to pressure practitioners into providing more therapy than is needed to meet their occupational performance deficits. Yet others may have considerable needs but little or no coverage to pay for services. Further, employers may pressure practitioners to provide those services based on the reimbursement potential. This advisory opinion discusses the ethical standards that should guide decision making in these challenging situations.

The Issues

Occupational therapy practitioners often face ethical issues involving service delivery because of a complex system of insurance rules and regulations. Practitioners must balance the needs of the individual client, the financial survival of the institution, and the laws regarding appropriate care. In general, clients should get the therapy they need, no more and no less. However, “need” cannot always be clearly defined and may differ in the opinion of different practitioners. In addition, should clients who are motivated and engaged be presumed to derive more benefit and therefore more deserving of services than those who are not?

A reality of healthcare organizations is that they need to be paid for providing services, and health care is a labor-intensive “business.” If organizations do not remain financially viable, they will not be available to provide any services, thereby further limiting access

to resources. Are clients who pay for insurance coverage “entitled” to receive services based on that coverage even if they can no longer continue to benefit from therapy services? If so, how does that affect the resources (e.g., staff, time) that are then available to those with lesser financial means? Three case studies are presented to illustrate the issues.

Case Scenario 1

Jackie was a 39-year-old woman who sustained a right cerebral vascular accident (CVA) due to a previously undiagnosed pancreatic growth that caused severe hypertension. Prior to the CVA, she had been employed in sales at a large home repair chain. She was single, lived alone, and was thus responsible for all home management tasks. Jackie received comprehensive inpatient rehabilitation including occupational, physical, and speech therapy and was referred for further outpatient services after her discharge from the hospital. Jackie received services for approximately 1 month, at which time her former employer notified her by mail that they were cancelling her insurance. Although she had applied for disability and Medicaid, she had not yet been approved. Jackie did not have the financial resources to self-pay for her therapies, and as a result, she discharged herself from outpatient physical, occupational therapy and speech therapy.

Case Scenario 2

Bob was a 62-year-old Vietnam War veteran who had had multiple CVAs and a history of hypertension and diabetes. After his CVAs, he spent a few years in several nursing homes receiving rehabilitation therapies. He was then referred to a day rehabilitation program for 6 weeks of intensive outpatient therapy. After discharge from day rehabilitation, he was referred to the outpatient clinic for continued occupational and physical therapy. Bob lived alone in an accessible apartment, and had an aide who assisted him in all his activities of daily living (ADLs) and home management tasks. Bob’s stated goal for occupational therapy was to “do more for himself.”

Over the course of several months of occupational therapy, it became apparent that Bob was not using the skills he attained in therapy in his home environment. He was

continuing to rely on his aide for dressing, bathing, toileting, and cooking, even though he required only set up or minimal assistance with these tasks. When confronted with the discrepancy between his abilities and his actual performance, Bob admitted that he enjoyed having the aide do these things for him, and did not want to do them himself at this time. The occupational therapist reviewed Bob's goals and progress with him and stated her intention to discharge him from occupational therapy. Bob became irate, stating that he had multiple funding sources including Medicare, Medicaid, and the Veteran's Administration, and that if he wanted to have therapy, then he could have it as long as he wanted.

Case Scenario 3

Ashley was a 12-year-old girl who has cerebral palsy resulting in left hemiplegia. She had been receiving occupational therapy three times a week since a routine screening at age 2 identified her as eligible for related services because of an orthopedic impairment. Ashley was in a regular classroom and was currently on the honor roll. Her occupational therapist determined that "direct services" were no longer necessary and placed her on consult status for occupational therapy. Ashley's mother was fighting this change as she believed that her child still needed occupational therapy to, "fix her left arm." The occupational therapy report stated that, "Ashley has met her goals and gained maximum benefit from occupational therapy in the school environment. Ashley no longer requires the direct support of occupational therapy to benefit from her current educational placement."

Practitioners working in a school setting often encounter difficulty in clarifying the role of occupational therapy in an educational setting versus a rehabilitation or medical setting. Parents, hoping to maximize their child's function, may see services provided in the school as a way to ensure that their child continues to progress when health insurance for therapy is non-existent or exhausted. The occupational therapy practitioner working in the schools has the responsibility to help the parent understand the role of Individuals with Disabilities Education Act and occupational therapy as a related service as well as to direct them to other resources in the community that may be helpful to their child (e.g.,

United Cerebral Palsy, therapeutic recreation). Individualized education program meetings should be conducted in such a manner as to ensure that all parties understand the rationale for changes in the service plan, and have opportunities for discussion and clarification.

Discussion

These case studies provide examples of occupational therapy practitioners who found themselves in a quandary when making decisions regarding service provision or confronting inequities in allocation of available resources. Principle 1 of the *Occupational Therapy Code of Ethics and Ethics Standards* (2010) [referred to as the “Code and Ethics Standards”; American Occupational Therapy Association [AOTA], 2010) calls on occupational therapy practitioners to “demonstrate a concern for the well-being and safety of the recipients of their services,” whereas Principle 5 calls on them to “comply with ... laws and AOTA documents applicable to the profession of occupational therapy”; balancing these two imperatives can sometimes be difficult. Most insurance carriers reimburse for occupational therapy services only when those services are deemed medically necessary, are part of a plan of care that has been developed to improve functional performance and require skilled intervention. If individuals like Bob are no longer progressing toward the stated goals, they must be reassessed to determine whether the goals were unrealistic and need modification or whether they have maximized their functional performance at this time and reached a plateau. Principle 1C of the Code and Ethics Standards, states, “Occupational therapy personnel shall reevaluate and reassess recipients of service in a timely manner to determine if goals are being achieved and whether intervention plans should be revised.”

Principle 1H of the Code and Ethics Standards further instructs the practitioner “terminate occupational therapy services in collaboration with the service recipient or responsible party when the needs and goals of the recipient have been met or when services no longer produce a measurable change or outcome.” The occupational therapy practitioner is ethically bound to be truthful in documentation (Principle 6C) and to not use language in such a way as to deceive the insurance carrier or agency into approving

additional resources for persons when they are not meeting standards for reimbursement of care. Thus, the occupational therapy practitioner could not ethically revise Bob's notes to give the appearance that he was progressing toward his goals when he was not, and she could not omit his conflicting subjective statements regarding his interest in performing his ADLs more independently. Billing codes and documentation must accurately reflect the procedures that were performed and the outcomes that resulted; they should never be modified based on the potential for maximizing reimbursement (see Principles 6B, 6C, and 6D).

Practitioners should "be diligent stewards of human, financial and material resources of their employers" (Principle 7H). Facilities and agencies have limited staffing and financial resources and must allocate those resources carefully to remain viable. Therefore, they may face ethical challenges in prioritizing how therapy is provided. Facilities and agencies must balance the needs of the public with their ability to provide services that are likely to have the greatest positive effect on the life of service recipients. Although Principle 4G holds that occupational therapy practitioners may "consider offering *pro bono* ('for the good') or reduced-fee occupational therapy services for selected individuals," this can be done only "when consistent with guidelines of the employer, third-party payer, and/or government agency." Thus, the occupational therapy practitioner treating Jackie would need to be sure that continuing to treat her for free or at a reduced rate would not be against department policy or law. In fact, because practitioners also have an obligation to, "make efforts to advocate for recipients of occupational therapy services to obtain needed services through available means" (Principle 4E), they should also be aware of sliding scale fees or other assistance that may be available through the facility for clients in need.

The level of reimbursement for services, as in Bob's situation, should not dictate the plan of care. The ethical practitioner does not allow himself or herself to be coerced by administrators or clients or their families into keeping someone on caseload who is no longer progressing toward a functional outcome, or who does not have measurable goals. Clients without reimbursement, and those whose reimbursement has been discontinued or

“maxed out,” as in Jackie’s situation, should be directed to community resources. Such resources can include indigent care and crime victims’ funds, Medicaid, and other resources if financial assistance is not available within the facility. Clients should also be given the option to self-pay for services if their insurance has been exhausted but they are continuing to benefit from services. In addition to an ethical obligation to advocate for clients to receive needed services (Principle 4E), practitioners should educate clients on options other than skilled occupational therapy when their goals have been met, or further progress is unlikely. Transition services to ensure continuity of care are the responsibility of the practitioner. These services may include support groups or community programs such as city therapeutic recreation programs to maintain or advance motor skills, improve endurance, or provide socialization.

Home programs, although generally part of most rehabilitation, can also be an important strategy to continue the client’s progress when further in-clinic therapy is no longer possible or appropriate. These programs should be developed with the needs of the client and their available support network in mind. It is the occupational therapy practitioner’s responsibility to familiarize themselves with the community resources available to their clients and to help them make a smooth transition to the next phase of their rehabilitation or to independent resumption of daily life activities.

It is critical to recognize the social and emotional ties that are created in the therapeutic relationship, which is based on trust and developed during a vulnerable period in a client’s life. Therefore, the practitioner may expect and should acknowledge the client’s feeling of loss when therapy is terminated. The ethical practitioner espouses a “no surprises” approach to discharge, and continuously lays the groundwork for the eventual release from skilled care.

Summary

The increasing number of individuals in need of occupational therapy services and the expanded awareness of the benefits offered by occupational therapy can result in a shortage of practitioners to meet the needs of the population. Skyrocketing medical costs

have led insurance carriers and agencies to limit services for their participants on the basis of strict dollar amounts, number of visits, or progress made. Occupational therapy practitioners often find it difficult to ethically and comfortably balance the needs of the client, the facility or agency, and the payer source. Application of the *Occupational Therapy Code of Ethics and Ethics Standards* (2010) (AOTA, 2010) can assist in managing these challenging situations, permitting this battle between seemingly opposing forces to be resolved in a way that is mutually beneficial and meets the needs of all involved.

References

American Occupational Therapy Association (2010). Occupational therapy code of ethics and ethics standards (2010). *American Journal of Occupational Therapy*, 64 (Suppl.), S17-S26. <http://dx.doi.org/10.5014/ajot.2010.64S17>

Beauchamp, T., & Childress, J. (2009). *Principles of biomedical ethics* (6th ed.). New York: Oxford.

Ann Moody Ashe, MHS, OTR/L
Practice Representative, Ethics Commission (2008-2011, 2011-2014)

Copyright © 2011, by the American Occupational Therapy Association.