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Social Power and Influence of a Case Management Service: Invisible No Longer

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Introduction

Describing Case Management can be very difficult, as one either tries to be comprehensive, or in searching for its essence, too narrow in scope. At times, we point to one or two aspects of Case Management, such as advocacy or denial prevention, that entitle us to use a certain amount of authority in a situation. Justifying Case Management is even more difficult because different constituencies expect a wide range of results from the department, program, or service, and we don't want to promise something we can't deliver. However, if we use the range of social power and influence inherent to the role, Case Management services will be better understood and thus better able to negotiate and meet targets.

When analyzed using the 5 classic bases of social power and influence[1], the authority of a case manager is enormous. Those sources are legitimate authority, referent/representative power, reward/punishment, information, and expert power. This issue of New Definition documents the tradition, laws, regulations, and targets that form the foundation of effective case management practice as well as build positive self-esteem for those involved on case management services. Feel free to add further documentation.

Of course, with authority comes accountability, which can make the full use of these classic sources of power rather daunting. That is why coaching and mentoring beyond an orientation period are so important to the development of case management competencies. The use of a Clinical Narrative for case managers and social workers is also helpful in identifying which power base is being relied on for which interventions that truly create a positive difference for a patient. As one CCM consultant just advised a group of clinical social workers, "You need to Strut your Stuff"; i.e show that you know your information and be proactive in your problem-solving. Future Case Management training programs might be built on these 5 overriding domains. Case Management professionals that always remember that the most important base of power and authority is the patient and family will never abuse their power.

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1 French, JRP and Raven, BH (1959) The bases of social power. In D. Cartwright, Ed. Studies in Social Power (pp 150-167) Ann Arbor, MI: Institute for Social Research. And Raven, BH (1965) Social influence and power. In I.ID Steiner and M. Fishbein (Eds) Current Studies in Social Psychology (pp 399-441) New York: Wiley.

Social Power and Influence of Case Management

Classic Power Base[2]	Sources specific to and justification of a Case Management Service
➤ **Legitimate Power**	***1. Laws that govern all patients*** a) Consent to treat, informed consent (1962-Kefauver-Harris amendment to Food, Drug, Cosmetic Act; process outlined in 1967) b) HIPAA (1996) for insurance portability; includes establishment of fraud and abuse control system; also includes security and privacy rules c) State laws for signed Discharge Info Sheets d) EMTALA (Emergency Medical Treatment and Active Labor Act) ie. No dumping of unstable pts. e) PASSAR (Pre-admission Screening and Annual Resident Review) to assure that each state had screening for Mental Retardation and Mental Illness, and that identified prior to admission to nursing home f) Stark II (1991) No kickbacks to MDs that have financial ties to agencies and labs g) Statutory Bill of Rights (Public Health Law 2803 h) State law governs negligence and malpractice i) Wickline Case-(1987) No physician may shift legal responsibility for a patient's medical welfare to a third party by complying with a cost-containment program[3]
	2. Regulations a) Federal Register b) Balanced Budget Act (1997)—Transfer DRGs, OBS status, expanded PPS and quality expectations to rehab, SNF, Home Health; also requires reporting of % referrals to financially-linked agencies; requires the list, patient choice; bases reimbursement on MDS and OASIS; includes Title XXI SCHIP—State Children's Health Insurance Program c) OPPS (Outpatient Prospective Payment System) included Observation as an outpt procedure; also separate pay for chest pain, asthma, CHF
	3. Delegated UR from commercial payer and government[4] a) SSA (title XVIII and Title XIX) 1965; amendment for PSRO to conduct UR in hospitals and skilled nursing homes, mandated discharge summaries 1972 b) TEFRA—Tax Equity and Fiscal Responsibility Act (DRGs, PPS) c) ERISA (Employment Retirement Insurance Security—1974) impossible to sue Managed Care Organizations that are part of a benefit plan for negligence, denial of treatment, lack of access to specialists, or malpractice[5]
	4. Position in organization

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2 French, JRP and Raven, BH (1959) The bases of social power. In D. Cartwright, Ed. Studies in Social Power (pp 150-167) Ann Arbor, MI: Institute for Social Research. And Raven, BH (1965) Social influence and power. In I.ID Steiner and M. Fishbein (Eds) Current Studies in Social Psychology (pp 399-441) New York: Wiley.

3 Powell, S. (2000) Case Management: A Practical Guide to Success in Managed Care 2nd Ed. Lippincott: PA.

4 Birmingham, J. "Getting Into Case Management", Nursing Spectrum workshops, 2003-4.

5 Cohen, E and DeBack, V (1999) The Outcomes Mandate: Case Management in Health Care Today. Mosby: Missouri, 265-267

Social Power and Influence of Case Management (continued)

Classic Power Base[2]	Sources specific to and justification of a Case Management Service
➤ **Reward/Punishment Power**	*1. Help organization* a) Meet targets b) Pay for Performance c) Beat the Competition
	2. JCAHO compliance (performance improvement, negotiate third-party reimbursement)
	3. "Respondeat superior" (the master is responsible for the acts of his servants) hospitals held liable for the actions of their employees, including case managers[6]
➤ **Referent/Representative Power**	*1. The patient* *2. The family* *3. The physician* *4. The payer* *5. The organization* *6. The community*
➤ **Expert Power**	*1. Knowing PATTERNS!* *2. Clinical trajectory and risk factors* *3. Recovery strategies* *4. Relationships and teamwork* *5. Problem-solving* *6. Conflict resolution* *7. Performance improvement*
➤ **Power of Information**	*1. Patient history and story* *2. Medical record* *3. Resources (internal & external)* *4. Consultation* *5. Criteria*

2 French, JRP and Raven, BH (1959) The bases of social power. In D. Cartwright, Ed. Studies in Social Power (pp 150-167) Ann Arbor, MI: Institute for Social Research. And Raven, BH (1965) Social influence and power. In I.ID Steiner and M. Fishbein (Eds) Current Studies in Social Psychology (pp 399-441) New York: Wiley.

6 Daniels, S. and Ramey, M. (2005) The Leader's Guide to Hospital Case Management. Jones and Bartlett Publishers, MA, 277-284.