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# Role Perceptions of Hospital Based Nurse Case Managers

Kimberly C. Hopey

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ROLE PERCEPTIONS OF HOSPITAL BASED NURSE CASE MANAGERS

A Dissertation

Submitted to the School of Nursing

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctor of Philosophy

By

Kimberly Curran Hopey

December 2008

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2008

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By

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Approved November 18, 2008

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# ABSTRACT

## ROLE PERCEPTIONS OF HOSPITAL BASED NURSE CASE MANAGERS

By

Kimberly Curran Hopey

December 2008

Dissertation Supervised by Gladys L. Husted, PhD, RN, CNE

The purpose of this study was to gain a better understanding of hospital based nurse case managers' perceptions of: (a) their role in today's rapidly changing healthcare environment, (b) practices and other factors that contribute to role success, (c) sources of role frustration, and (d) opportunities to enhance future role success and satisfaction. The study is significant because efficient and effective hospital based nursing case management benefits patients/families, nurse case managers (NCMs), hospitals, insurers, and the community at large. As the emic point of view of participants was highly desired, a qualitative descriptive design using focus groups method was selected, and six research questions were developed to achieve study goals. Because the main objective of the study was to gain an understanding of the NCMs' perspectives of their role, Role Theory was used as the organizing framework. Underlying propositions of Role Theory (Biddle, 1979) supported the use of the focus groups method as the researcher was interested in

the perceptions of a group of NCMs in the context of a particular setting rather than an individual's sole experience or perceptions. Study participants (n=11) were recruited from a purposive convenience sample of NCMs working at a 600+ bed, not-for-profit, inner city academic medical center in a Mid-Atlantic state. The focus groups were conducted using a semi-structured interview guide to stimulate discussion and ensure study goals were achieved. The focus group method was the ideal research methodology for the study. The participants were very open, enthusiastic, and willing to talk about their views and work experiences related to the research questions. The goals of the study were achieved with two focus groups due to saturation of the data. The focus groups were audio-recorded and verbatim transcripts produced. A rigorous transcript-based data analysis strategy was used. The verbatim transcripts, detailed field notes, and debriefing session notes were all used as sources for the data analysis; however, the transcripts were the primary source. Following data analysis procedures outlined by Krueger (1998c), 31 themes and 19 subthemes emerged from the data. Direct quotes from participants were provided to support the study findings.

## DEDICATION

This dissertation is dedicated to my husband, Tom, who has always encouraged me to pursue my professional dreams, and whose loving partnership in childrearing gave me the ability to attain this dream while continuing to work full time in a career I love. It is also dedicated to our children, who have shown much love, patience, and understanding as Mom stayed behind on many a family adventure to work toward achieving this goal.

## ACKNOWLEDGEMENT

Sincere thanks and recognition of their invaluable contributions must be extended to the individuals below. Without their guidance and support, achieving this longstanding professional and academic goal would not have been possible.

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My sister, Cynthia, and brother-in-law, Robert, who have always believed in me, encouraged me, and also supported me in ways too numerous to cite.

My brother, Frank, sister-in-law, Cheryl, and mother-in-law, Judy, who have always cheered me on and provided countless hours of childcare over the years.

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My professional colleagues, who supported me and were particularly flexible and understanding during the final phases of this process.

Finally, the nurse case managers who volunteered to participate in this study. Without their commitment to advancing knowledge within their profession, this would not have been possible.

# TABLE OF CONTENTS

	Page
Abstract.....	iv
Dedication.....	vi
Acknowledgement .....	vii
List of Tables .....	ix
<b>1 Introduction.....</b>	<b>1</b>
1.1. Background of the Study .....	1
1.2. Purpose of the Study .....	4
1.3. Research Questions.....	5
1.4. Definition of Terms.....	6
1.5. Assumptions.....	8
1.6. Limitations .....	8
1.7. Significance.....	9
<b>2 Review of the Literature.....</b>	<b>10</b>
2.1. Introduction.....	10
2.2. Organizing Framework .....	11
2.3. Nursing Case Management.....	14
2.4. Healthcare Demand, Supply, and Workforce Trends .....	29
2.5. Conclusions.....	38
<b>3 Methods.....</b>	<b>41</b>
3.1. Design .....	41
3.2. Setting .....	43

3.3. Participants.....	44
3.4. Instruments.....	46
3.5. Data Collection .....	47
3.6. Protection of Human Subjects .....	50
3.7. Data Analysis.....	52
<b>4 Results and Summary.....</b>	<b>58</b>
4.1. Introduction.....	58
4.2. Description of the Sample.....	59
4.3. Findings.....	60
4.4. Summary .....	97
<b>5 Discussion and Recommendations .....</b>	<b>100</b>
5.1. Introduction.....	100
5.2. Discussion.....	101
5.3. Limitations of the Study.....	114
5.4. Implications of the Study .....	116
5.5. Recommendations for Future Research .....	118
5.6. Summary .....	119

## LIST OF TABLES

	Page
4.1 Description of Participants.....	60
4.2 Themes for Research Question One .....	61
4.3 Themes for Research Question Two.....	68
4.4 Themes and Subthemes for Research Question Three .....	73
4.5 Themes and Subthemes for Research Question Four .....	78
4.6 Themes and Subthemes for Research Question Five.....	87
4.7 Themes for Research Question Six.....	93

# Chapter 1

## INTRODUCTION

### 1.1 Background of the Study

The length of acute hospital stays in the United States has shortened over the past several decades, and will likely continue to shorten (National Center for Health Statistics [NCHS], 2005). This is due to factors such as a shift to prospective payment in federally funded programs, advanced technology, increased availability of outpatient services, and managed care in the commercial sector. The evolution of hospital based nursing case management resulted as hospitals sought efficient and effective ways to coordinate patient care and to address the challenges of a changing health care environment.

The pressure on hospitals and other health care providers has increased dramatically as a result of greater scrutiny on how Medicare and Medicaid health care funds are utilized, including the appropriateness of the setting in which care is delivered. The advent of numerous managed Medicaid, and more recently, managed Medicare plans is the most obvious indicator of this latest trend. There are other indicators though including more stringent eligibility criteria to qualify for state or federally funded programs, reductions and limitations in benefits, and increased medical necessity criteria requirements to utilize benefits. These changes not only impact patients, but also hospitals and other health care providers.

One example of resource utilization controls is the tightened list of eligible patient diagnoses and admission criteria for acute inpatient rehabilitation (IPR) hospitals or units, and the requirements facilities must meet to be designated as an IPR facility/unit. Patients, such as elderly patients with unilateral total hip or knee replacements, who were once eligible for IPR, are no longer qualified. Some hospitals that have IPR units are closing or considering closing their units as a result of these restrictions. Another example is the significant cuts in state Medicaid recipient benefits. Like the changes impacting IPR, Medicaid cuts not only impact patients, but hospitals as well. Case in point, in 2005 Pennsylvania announced a new restriction of one hospital admission per year for Medicaid recipients over the age 18. To be reimbursed for subsequent patient admissions, a hospital must request approval of a waiver form and provide supporting documentation for eligible exclusions to the limitation. How this impacts the long-term health of Medicaid recipients, and the financial health of hospitals remains to be seen. Many are skeptical that the outcome will be good for either.

On another front, the U.S. population is aging and the demand for health care services is anticipated to increase significantly as a result in the ensuing years. Additionally, with the help of the internet and increased consumerism in general, the American healthcare consumer has become more sophisticated, assertive, and in some instances, even more challenging than in years past. These factors are juxtaposed with a well documented shortage of nurses that is projected to continue well into the future. Nurse Administrators charged with recruiting and retaining nurses in general, let alone recruiting those with specialized skills such as in hospital based case management, have been particularly challenged in this endeavor.

Case management has proved to be an effective care delivery system with well documented positive outcomes (Flarey & Blancett, 1996). Further, nursing case management has developed into a valuable specialty within the hospital setting. This is demonstrated in the nursing and healthcare management literature through outcomes measurement and cost analysis reports rather than formal scientific research (Aliotta, 2001; Anonymous, 2005; Cohen & Cesta, 2001a, 2001b; Cook, 1998; Goode, 2001; Harrison, Nolin, & Suero, 2004; Shendell-Falik & Soriano, 1996; Smith, 2003; Tahan, 2001; Zander, 2002).

Hospitals face a difficult road ahead in view of current trends and predictions of continued rising healthcare costs, increased demands by an aging population, and shrinking healthcare benefits and resources. To survive, hospitals will need to provide high quality clinical outcomes and service in the most efficient and effective manner. Given the role nurse case managers (NCMs) played in helping hospitals achieve these goals in the past, it is likely hospitals will rely heavily on NCMs to address future challenges. It is essential that research be conducted to better understand NCMs perceptions about their role and professional practice in the current healthcare environment to enhance their future practice and positively impact patient/family outcomes.

In the face of the limited body of nursing case management research, many of the cited nursing case management experts and leaders stress the critical need for formal research in a wide range of topics important to nursing case management practice. While not limited to those identified, the nursing literature supports the need for research examining the effectiveness of nursing case management in the following areas: (a) the

quality of patient care delivered, (b) patient care resource utilization, (c) patient and provider satisfaction, (d) professional autonomy and decision making of nurses, (e) collaborative practice between nurses and physicians, and (f) the types of nursing case management interventions used and the effects of those interventions on patient outcomes (Aliotta, 2001; Cohen & Cesta, 2001e). This study will begin to address some of these areas.

## 1.2 Purpose of the Study

The purpose of this study was: (a) to gain a better understanding of NCMs' current perceptions of their role in today's rapidly changing healthcare environment, (b) to identify practices and other factors that are perceived to result in role success, (c) to identify sources of role frustration, and (d) to identify perceived opportunities to enhance future role success and satisfaction. It is intended for this study to serve as the foundation for future research studies, and is not an end in itself. For example, will the perceived role enhancements identified in the current study make a measurable difference in future NCM role success and satisfaction?

The researcher used a qualitative descriptive design using focus groups as the data collection methodology to study the NCMs' perceptions noted above. Focus groups have also been referred to as a qualitative research method in itself (Freeman, 2006; Grudens-Schuck, Allen, & Larson, 2004; Kitzinger, 1995; Kitzinger & Barbour, 1999; Mahoney, 1997; Morgan, 1988; Morgan, 1997; Morse & Field, 1995, Webb & Kevern, 2001). Qualitative research is well suited when little is known about a phenomenon, there is suspicion of bias in prior theories, or when the research question relates to a desire to

understand or describe a particular phenomenon or event, especially from the emic point of view (Morse & Field, 1995). It was the emic point of view of NCMs that was particularly valued by the researcher. Further, while there may be articles and books dedicated to the topic of hospital based nursing case management in the nursing literature, research based literature on this topic is scant compared to other areas of nursing practice. It is the researcher's desire to contribute to the advancement of research based knowledge within this specialty area of nursing.

### 1.3 Research Questions

It was the intent of the study to answer the following questions:

1. How do hospital based NCMs describe their current role?
2. What key case management practices do hospital based NCMs perceive as resulting in role success?
3. What do hospital based NCMs describe as the most significant current factors that contribute to their successful role fulfillment?
4. What do hospital based NCMs describe as the most significant challenges, barriers, or frustrations they currently encounter in their role fulfillment?
5. What new interventions, supports, or strategies do hospital based NCMs perceive would enhance the successful fulfillment of their role?
6. How do hospital based NCMs see their role changing in the future?

## 1.4 Definition of Terms

1. The Case Management Society of America (CMSA) defines *case management* as the “collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes” (CMSA, 2006, Definition of Case Management).

In its statement of case management philosophy, CMSA emphasizes the following:

Case management is not a profession in itself, but an area of practice within one’s profession. Its underlying premise is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources.

Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned. (CMSA, 2006, Definition of Case Management)

2. As noted above, case management is not a profession in itself, but an area of practice within one's profession. The Commission on Case Manager Certification (CCMC) defines a *case manager* (CM) as:

A healthcare professional who is responsible for coordinating the care delivered to an assigned group of patients based on diagnosis or need. Other responsibilities include patient/family education, advocacy, delays management, and outcomes monitoring and management. Case managers work with people to get the healthcare and other community services they need, when they need them, and for the best value. (Commission on Case Manager Certification [CCMC], 2005, p. 3)

3. For the purposes of this study, the term *nurse case manager* is defined as a licensed registered nurse performing the functions of case management within the acute care hospital setting.

4. *Case Management Model* is defined as "The organizational structure within which the case manager functions" (Severson, 2001, p. 4).

5. For the purposes of this study *patient/family* is defined as a hospitalized person and their significant other(s) or representative(s) who participates in the development and/or implementation of the patient's plan of care, as well as, assists with decision making processes.

6. *Health Benefit Plan* is defined as "Any written health insurance plan that pays for specific healthcare services on behalf of covered enrollees" (CCMC, 2005, p. 13).

7. *Payer* is defined as "The party responsible for reimbursement of healthcare providers and agencies for services rendered such as the Centers for Medicare and Medicaid Services and managed care organizations" (CCMC, 2005, p.15).

## 1.5 Assumptions

This study was based on the following assumptions:

1. NCMs are a reliable source of rich data regarding their professional practice and experiences.
2. NCMs are genuinely interested in improving patient care outcomes and the advancement of their practice; therefore, will willingly participate in activities aimed at achieving those goals.
3. NCMs can articulate the nuances of their role.
4. A group environment will facilitate disclosure of rich data.
5. Study participants will participate voluntarily without internal fear of coercion or obligation.
6. Study participants will be honest and forthright in their responses.
7. Study participants will treat each other with dignity and respect, adhere to the focus group code of conduct shared with group members, and not use the group environment to advance personal or political agendas.

## 1.6 Limitations

The following limitations of this study were identified:

1. The study is limited to registered nurses and, therefore, the results cannot be generalized to other health care professionals providing case management services.
2. The study is limited to NCMs in one 600+ bed inner city academic medical center in a Mid-Atlantic state. Because case management models, organizational culture,

populations served, health plan practices, and state regulatory requirements vary, generalizability of study findings is limited.

3. The study participants do not report directly to the researcher, nor does the researcher complete study participant performance evaluations. However, the researcher is an administrator in the same work setting as the participants, and the participants' manager reports to the researcher. While the researcher will explicitly reinforce the voluntary nature of study participation in the informed consent and at the beginning of each focus group session, some participants may feel compelled to participate in the study, or choose to participate for reasons other than the stated goals of the study. This could potentially result in inhibited, exaggerated, or distorted responses.

## 1.7 Significance

Efficient and effective hospital based nursing case management benefits patients/families, NCMs, the IDT, hospitals, insurers, and the community at large. The findings from this research study will be useful to nurses, administrators, and educators interested in advancing nursing case management practice, improving NCMs role satisfaction, recruiting and retaining NCMs, improving clinical, service, and financial outcomes, as well as, influencing organizational or public policy. This study also sets the stage for much needed future research in the area of hospital based nursing case management.

# Chapter 2

## Review of the Literature

### 2.1 Introduction

The review of the literature for qualitative research is distinctly different from quantitative research. Qualitative researchers vary in their opinions about the degree to which literature is used to guide a qualitative research study (Holloway & Wheeler, 2002; Morse & Field, 1995; Streubert & Carpenter, 1995). To achieve the goals of this study, the researcher's approach to the review of the literature was a moderate one guided by Morse and Field (1995) who recommend previous research is critically examined and used selectively, and Polit and Hungler (1995) who urge one to strive for relevancy and quality rather than quantity.

Therefore, the literature review for this study was limited to select and relevant research reports, government reports, textbooks, and other reliable resources from individuals considered content experts in the subject under discussion. The review of literature addressed the following topics key to the development of this study: (a) organizing framework, (b) nursing case management, and (c) healthcare demand, supply, and workforce trends and projections.

## 2.2 Organizing Framework

An organizing or conceptual framework in a qualitative study is necessary to link the study with other research and ideas about the topic (Holloway & Wheeler, 1995). A conceptual framework is defined as “interrelated concepts or abstractions that are assembled together in some rational scheme by virtue of their relevance to a common theme” (Polit & Hungler, 1995, p. 638). Theoretical and conceptual frameworks, in addition to summarizing, can guide one’s understanding of the “*what*” and “*why*” of natural phenomena, and serve “as a springboard for scientific advances” (Polit & Hungler, p. 101). As the main objective of this study is to gain an understanding of NCMs’ perspectives of their role, the researcher used Role Theory as an organizing framework for the study.

According to Biddle (1979), “unlike psychoanalysis or field theory, the role field did not begin with the contributions of a single great man. On the contrary, the role orientation has evolved gradually from related interests in several social sciences” (p. 8). The core disciplines involved in the evolution of role theory included anthropology, psychology, and sociology with contributions from those disciplines noted as early as 1890 (Thomas & Biddle, 1966). However, a detailed analysis of the literature conducted by Thomas and Biddle indicate the technical vocabulary now associated with role theory did not appear until the 1930s and later (p. 18). At the time of their analysis, Thomas and Biddle emphasized role theory was not a “single, monolithic theory of the sort that the appellation ‘role theory’ implies,” but rather a body of knowledge that included many hypotheses and theories concerning particular aspects of its domain that had yet to be reviewed and integrated (p. 18).

Biddle (1979) later defined role theory as “a science concerned with the study of behaviors that are characteristic of persons within contexts and with various processes that presumably produce, explain, or are affected by those behaviors” (p. 4). While indicating it was still not a single monolithic theory, Biddle asserted role theory was based on several underlying propositions in which there was informal general agreement (p. 8). The five propositions summarized by Biddle are listed below:

1. Role theorists assert that ‘some’ behaviors are patterned and are characteristic of persons within contexts (i.e., form *roles*).
2. Roles are often associated with sets of persons who share a common identity (i.e., who constitute *social positions*).
3. Persons are often aware of roles, and to some extent roles are governed by the fact of their awareness (i.e., by *expectations*).
4. Roles persist, in part, because of their consequences (*functions*) and because they are often imbedded within larger social systems.
5. Persons must be taught roles (i.e., must be *socialized*) and may find either joy or sorrow in the performances thereof. (p. 8)

Biddle (1979) states that in addition to role theory’s central importance to anthropology, psychology, and sociology, it is also very useful in the “helping professions” such as education, health care professions, community development, and leadership training (p. 12).

Conway (1988), a nurse educator, summarizes two of the major perspectives from which the behavioral sciences have studied roles and role performances, and their relevance for health professionals. The first is the structural-functional perspective which

has an underlying assumption that roles are basically fixed positions within society with little opportunity for change, and are enforced by either positive or negative sanctions (Conway, 1988). An individual's actions, and social interaction in general, is largely prescribed by cultural, societal, and situational norms that are viewed as social facts handed down to the next generation through learned responses and reinforced by either approval or disapproval of significant others (Conway, 1988). Group action is the manifestation of societal demands, as well as, shared social values (Conway, 1988). While this perspective primarily views roles as fixed or stable, it does acknowledge that roles can change over time as the institutions of society evolve (Conway, 1988).

The symbolic interaction perspective is the second major view behavioral scientists have regarding role theory (Conway, 1988). This perspective views human behavior as a response to one's interpretation of the symbolic acts of others, such as speech and gestures (Conway, 1988). In contrast to the structural-functionalist view, the interactionist believes individuals decide what to do and how to do it after considering and interpreting the significance of external and internal cues within one's environment (Conway, 1988). Conway states it is important to note that significant symbols can inhibit or facilitate action and control the actions of both parties in a social interaction. Further, symbols are not equally important to every person, and are selectively identified by an individual in a given situation. Thus, the symbolic interaction perspective contends "one defines a situation as he 'sees it' and acts on this perception," and group action is "the expression of individuals confronting their life situations" (Conway, p. 65). Last, interactionists believe others' attitudes towards an individual strongly influences that

person's actions, development of self-identity, and development of role identity (Conway).

## 2.3 Nursing Case Management

### 2.3.1 *The History and Evolution of Nursing Case Management*

The foundation for case management was laid in the early 1900s by public health nurses, mental health workers, and social workers practicing in the community setting (Cohen & Cesta, 2001b; Severson, 2001). The insurance industry entered the scene during WWII with in-house case management initiated as a cost-containment effort for worker's compensation, and to assist with interdisciplinary care coordination of returning soldiers with complex injuries (Severson, 2001). The insurance industry's use of case management as a cost-containment measure was well established by the 1970s when the inflation rate for health care costs hit the double digits (Severson, 2001). Also in the early 1970s, Medicare & Medicaid demonstration projects rolled out with social workers arranging and coordinating the medical and social services of target patient populations, most notably the frail elderly, those with low income, and the mentally ill (Severson, 2001).

In the mid 1980s, under the leadership of clinical nursing, case management emerged as a distinct strategy to plan and manage the balance of patient care cost and quality in the acute care and post discharge service settings (Zander, 1996). Two organizations in particular, New England Medical Center Hospitals (NEMCH) in Boston Massachusetts, and Carondelet Saint Mary's Hospital (CSMH) in Tucson, Arizona, are credited as bringing hospital case management by nurses to the forefront (Cohen & Cesta,

1997a, 1997b, 1997c, 2001a, 2001f; Conger, 1999; Cook, 1998; Zander, 1996).

NEMCH's case management model, Primary Nurse Case Management, is recognized as the initial structure from which subsequent episode of care models evolved (Zander, 1996). The CSMH model is recognized for its innovative work in linking case management activities between the acute episode of care and the continuum of care in the community (Zander, 1996).

Nursing case management, in these early years, was noted to be the natural progression from the Primary Nursing practice model popularized in the 1970s and early 1980s, and was even referred to as second generation primary nursing by Zander (1996, p. 23-45). Zander (1996) also noted nursing case management was a classic nursing practice model in its own right stating:

As early as 1987, it became clear that nursing case management would be a classic model because it added value, consistency, quality, and accuracy to patient care, was adaptive to the environment, and both enhanced and defined the voluntary differentiation to a newly available professional level of nursing. (p. 38)

Zander further noted "in retrospect, its main strength was that it 'spread' (i.e., could be applied) in a wide variety of settings with no or minimal consultation!" (p. 38). This spread is evident in the multiple nursing case management models that have existed over that past twenty years. Cohen & Cesta (2001c) state nursing case management's strength comes from the philosophy and collaborative practice strategies of both primary and team nursing, noting the care planning and coordination processes of these earlier practice models are reflected in the critical paths and case management plans used to plan and monitor patient care today.

As noted above, there are numerous nursing case management models. The models may vary based on the service setting, patient population/diagnoses served, payer source, or by the type and relationship of care providers involved in direct patient care delivery and the case management process. In addition to episode of care case management, acute care case management has also been referred to as “within-the-walls” case management (Cohen & Cesta, 1997c, 2001f; Newell, 1996; Yamamoto & Lucey, 2005).

### *2.3.2 Role of the Nurse Case Manager*

Tahan, Huber, and Downey (2006a) recently reported the use of role theory to form the conceptual framework for their extensive cross-sectional descriptive study using a practice analysis survey method to describe the role and functions of case managers in a variety of practice settings. The multi-phased research process included the development and validation of the Case Manager’s Role and Functions Survey Instrument (CMRFSI) to collect data for the practice analysis (Tahan et al., 2006a).

The study, conducted in 2004, was sponsored by the Commission for Case Manager Certification (CCMC) and is also referred to as the 2004 CCMC role and function study. Every five years, CCMC sponsors such a study due to “the need to capture information about current status of case management practice and build an evidence base to inform the structure and design of the Certified Case Manager (CCM) examination” (Tahan et al., 2006a, p. 4). Tahan et al. reported the three main research questions for the study were:

1. What are the essential activities/domains of practice of case managers?

2. What are the knowledge areas necessary for effective case management practice?
3. Should there be a need to revise the blueprint of the CCM certification examination? (p. 8)

Tahan et al., maintain such research is needed because the practice and job settings of case managers have evolved rapidly over the last 15 years in response to the changing healthcare environment. They emphasize it is important to accurately identify the current state of practice and document how case management has evolved in responses to these changes. Although expensive to conduct, Tahan et al. emphasize scientific research forms the basis for the CCM's integrity and assures the public that case managers holding this certification have demonstrated knowledge and competence in the core domains essential to current case management practice.

The content of the CMRFSI was developed through a rigorous process that included a review of the literature, review of prior CCMC role and function study instruments, review of findings from a qualitative cluster analysis of 1,000 case managers' job descriptions collected from prior years' CCM examination applicants, and subject-matter experts (Tahan et al., 2006a). The survey was ultimately structured around eight theoretical essential activity domains and six theoretical knowledge domains. The eight theoretical essential activities described by Tahan et al. included: (a) assessment, (b) planning, (c) implementation, (d) coordination, (e) monitoring, (f) evaluation, (g) outcomes, and (h) general (i.e., privacy, confidentiality, etc.). The six theoretical knowledge domains described included: (a) case management principles and concepts, (b) healthcare management and delivery, (c) healthcare reimbursement, (d) community

resources and support, (e) psychosocial and spiritual issues, and (f) outcomes. The final validation of the domains would be determined through analysis of the data collected by the survey tool itself.

Tahan et al. (2006a) used a purposive nonrandomized potential sample of 24,058 case managers that included current CCMs as well as non-CCMs who had expressed interest in participating in the study following advertisement of the study on the CCMC Website and in select case management periodicals. Of the 24,058 case managers who were sent an email invitation to participate in the study, 26.4% responded making the total survey sample size 6,340. The CMRFSI was a five section survey with the first section collecting participants' demographic data. Only case managers who reported they spent a minimum of 50% of their daily time in a direct case management role completed the remaining four sections of the survey, and were included in the final data analysis. Tahan et al. noted this inclusion criterion was selected as it was one of CCMC's eligibility criteria for the CCM examination at the time of data collection for the study. A total of 4,421 (69.7%) of survey participants were able to complete all five sections of the survey and were included in the final data analysis.

Section 2 of the CMRFSI asked participants to rate 103 activity statements on importance and frequency using 5-point Likert scales (Tahan et al., 2006a). Tahan et al. report the importance scale ranged from 4 = very important (*performance of the activity is absolutely essential to job performance*) to 0 = of no importance (*not essential*), and the frequency scale ranged from 4 = very often (*performance of this activity occurs at a maximum frequency*) to 0 = never (*does not happen at all*). In addition, Tahan et al. report the tool asked participants to rate how well the list of activities covered the essential

activities of their practice using a 5-point Likert scale, ranging from 5 (*very well*) to 1 (*very poorly*). Participants were also provided the opportunity to write in any areas of activity they felt were not covered in the tool. Section 3 of the CMRFSI asked participants to rate 64 knowledge statements using the same 5-point Likert importance scale noted above (Tahan et al., 2006a). Like the activities domain, participants were also asked to rate how well the knowledge statements covered the knowledge domain using the same 5-point Likert scale. Again, participants were provided the opportunity to write in other knowledge areas they felt were not covered on the tool.

Section 4 of the CMRFSI asked participants, based on their own perception, the weight or percentage of emphasis on the CCM exam that each of the six knowledge domains should receive (Tahan et al., 2006a). This data helped determine the number of CCM examination questions that should be allocated to each of the knowledge domains. Last, in Section 5 participants were asked to respond to open ended questions about their current professional development and/or continuing education needs, how they expected their role to change in the future, what essential activities they will need to perform, and what knowledge will they need to acquire to be able to meet the changing job demands (Tahan et al., 2006a).

CCMS revised its Fall 2006 CCM examination based on the results of the 2004 CCMS role and function study (Tahan et al., 2006a; Tahan, Downey, & Huber, 2006b). Detailed aspects of the study used to revise the CCM examination are proprietary to the CCMC, and could not be publicly disclosed by Tahan et al. (2006a) in their report. However, they shared the revised exam is organized around six knowledge domains and

six case management activity domains identified by the study. The six knowledge domains identified through the survey data analysis include the following:

- Case management principles and strategies consider knowledge of professional practice behaviors and the impact of internal and external influences upon these behaviors.
- Case management concepts addresses the knowledge of the process(es) associated with case management practice and methods for establishing quality measures and parameters of practice, including adherence to regulatory and accreditation standards.
- Healthcare management and delivery includes knowledge of various healthcare delivery systems and associated collaboration with other providers; case management activities across practice settings and disciplines.
- Healthcare reimbursement addresses knowledge of case management responsibilities in relation to funding for healthcare services and reimbursement methods.
- Psychosocial and support systems discusses knowledge of specific interventions, family dynamics, cultural issues, and resources, which must be integrated into case management practice.
- Vocation concepts and strategies addresses knowledge related to disability, workplace issues, and strategies for work as a life activity.

(Tahan et al., 2006b, p. 79)

The six activity domains identified through analysis of study data include the following categories:

- Case finding and intake focuses on identifying clients requiring case management services, obtaining client's consent for case management services, and communicating clients' needs to other care providers.
- Provision of case management services address clients' health condition, needs, case management plan; facilitation and coordination of care activities; communication among care providers; advocacy; and monitoring of care and progress.
- Outcomes evaluation and case closure includes activities such as data collection, analysis and reporting; evaluation of quality of case management services and effectiveness of the case management plan; and timeliness and access to services.
- Utilization management activities focuses on appropriateness of the level of care, utilization review, communication with payers and insurance companies, resource allocation matching resources with clients' needs, reimbursement denials and appeals management, and review of documentation for completeness.
- Psychosocial and economic issues focuses on client's social, psychologic, cultural, and financial situation. It also addresses community resources and support programs.

- Vocational rehabilitation activities relates to return to work strategies; job modification, accommodation, and analysis; communication with employers; life care planning; and ergonomics. (Tahan et al., 2006b, p. 79)

Tahan et al. (2006b) reported that while their data analysis resulted in the renaming/labeling of the knowledge and essential activity domains, the original knowledge and activity domains delineated by the subject-matter experts “received logical and appropriate support by the survey participants and were evident in the mean importance rating” (p. 85). Tahan et al. also reported the study confirmed the content areas listed under the essential activity and knowledge domains in the survey tool were appropriately and comprehensively covered. Last, the study results supported the conclusion that “the essential activities and knowledge verified as important provided the foundation of information from which to develop test specifications for the CCM certification examination” (p. 85).

It is important to note, the survey participants in Tahan et al.’s quantitative study included current CCMs and non-CCMs from various professional disciplines and practice settings. Most participants (81.4%) were nurses. However, only 18.8% of participants, regardless of professional discipline, worked in a hospital setting. Part II of Tahan et al.’s (2006b) research report provides an in depth discussion on their analysis of findings by participant subgroups using the Index of Agreement Test (IOA). “The IOA is a statistical test that computes the similarity in judgment between groups and is tailored to the purpose of a role delineation or practice analysis” (Tahan, et al., 2006b, p. 72). The agreement scores between the CCM and non-CCM groups were reported to show very close agreement and converging on consensus (Tahan, et al., 2006b). The researchers also

reported they analyzed the results using the IOA for any trends or significant variation between subgroups based on the other demographic variables collected including: (a) job title, (b) work setting, (c) percent of time spent providing direct case management services, (d) years of experience, (e) age, (f) highest educational degree, and (f) ethnicity.

Using the IOA test, Tahan et al. (2006b) found that with the exception of two demographic variables, job title and primary work setting, there tended to be strong agreement among participants regarding the importance level of essential activities and knowledge statements (Tahan et al., 2006b). Rehabilitation counselors and utilization reviewers showed the most consistent difference in mean importance ratings for the essential activity and knowledge domains compared to the other job title groups that included: (a) administrator/manager, (b) care coordinator, (c) case manager, (d) social worker, and (e) other (Tahan et al., 2006b). According to the researchers, this may indicate a difference in the type of work activities and knowledge base required by these two job title categories compared to the others.

In regard to the work setting variable, the subgroup(s) that showed the most consistent differences in mean importance ratings for essential activities compared to the others was the life/disability insurer subgroup, and for the knowledge statements it was the health insurance and hospital subgroups (Tahan et al., 2006b). The remaining subgroups included CMs working in government agency, independent care/case management company, liability insurance carrier, managed care company, private practice, rehabilitation facility, third party administrator, worker's compensation, and home care agency settings.

Tahan et al. (2006b) report when comparing their results to prior CCMC role and functions studies, their study demonstrates the knowledge base required for case management has changed over the past decade as a “direct result of the evolution of the field” (p. 86). In addition to aiding in the development of a valid revised CCM examination, the researchers note their study findings are invaluable for the practice of case management, and may be used to assist in the development of job descriptions, training and educational programs, and competency assessment (2006b). The study also resulted in the development of a valid and reliable instrument that measures the role, functions, and knowledge areas of case managers, and can be used to examine the relationship of case management practice and outcomes (2006b).

### *2.3.3 Nursing Case Management Evaluation and Research*

Formal scientific research in the nursing case management literature is meager compared to other nursing disciplines and even more so when limiting the search to a specific service setting such as the acute care hospital setting. Hospitals operate in a fast paced real world with real patients and real staff which poses particular difficulties for classic experimental research designs with controlled variables (Cohen & Cesta, 2001d, Cook, 1998). Rather than rigorous formal research, efforts are often focused on case management program evaluation over time or following program changes through the collection and analysis of data on outcome indicators such as cost (i.e., length of stay) and quality (i.e., patient satisfaction, readmission rates, etc.) (Cohen & Cesta, 2001d). Outcomes measurement, outcomes research, outcomes management, outcomes effectiveness, evaluation research, evidence based practice, and cost-effectiveness

analysis are terms commonly used to describe these efforts (Aliotta, 2001; Cohen & Cesta, 2001d, Cohen & Cesta, 2001e, Cook, 1998; Goode, 2001; Tahan, 2001).

Tahan (2001) reviewed and critiqued 35 case management evaluation studies published between 1989 and 1998 and reported that “case management programs are rarely appropriately evaluated and, in some instances, variables are loosely defined or used” (p. 504). He spared no words in his assessment of the studies describing them as afterthoughts, retrospective attempts at validating the value of case management programs, of minimal significance for decision-making, weak, and minimally effective in promoting the practice of case management as a patient care delivery model (p. 504). Tahan (2001) emphasizes while one of the most complex tasks is to design a study that evaluates the relationships of process, structure, and outcome variables in any care delivery system, researchers should attempt to do so in order to maximize the significance of their study’s findings.

Aliotta (2001) echoes this sentiment stating “case managers will need to develop a ‘measurement orientation.’ The days of ‘good faith’ belief are rapidly coming to an end” (p. 421). She notes case managers need to incorporate measurement into all key aspects of their practice to prove an action was taken or the desired outcome was observed. Aliotta emphasizes a key implication for practice lies in the ability to link intervention and outcomes, and points out “what is often missing is the knowledge of which intervention or combination of interventions resulted in the positive outcome” (p. 421).

In contrast to Tahan’s (2001) review of the case management research literature, Cook (1998) took a more rigorous approach to evaluate the effectiveness of inpatient case management using a research synthesis approach to conduct his own independent study

of previously reported research data. Cook explains the unique feature of research synthesis is to translate an individual study's data into a quantified format called effect size which can ultimately be used in a meta-analysis. The specific objectives of Cook's research synthesis were to:

- Determine the effects of inpatient case management on provider and consumer satisfaction, quality of care, cost, and LOS;
- Identify the factors that account for variability in effect on outcomes (e.g., patient population, level of implementation, organizational support);
- Distinguish between types of patients that are better served by extant inpatient case management models; and
- Determine how evaluations of case management can be improved. (p. 39)

Out of 2,200 potentially useful titles and abstracts identified through computerized literature searches of studies conducted between 1988 and 1995, Cook identified eighteen inpatient case management studies that met the inclusion criteria for the research synthesis. Cook reported the outcomes data included in the research synthesis included patient and provider satisfaction, quality of care, cost, and length of stay (LOS), and noted only one of the studies examined all of the outcomes.

Cook (1998) reported that due to conflicting or inconsistent findings across the studies, no conclusions could be made about patient satisfaction, provider satisfaction, quality of care, and cost savings. While there were conflicting findings on LOS, the majority of the studies reported positive outcomes (Cook, 1998). Six of the studies had sufficient LOS data for calculation of effect sizes and provided Cook the opportunity to combine the effect sizes using a meta-analysis approach. The combined mean weighted

effect size for the six studies showed a small positive effect size (Cook, 1998). However, upon further testing, dissimilarities among the study populations were found that limit the usefulness of combining effect sizes for LOS, and additional similar studies were recommended in order to statistically combine and interpret the results (Cook, 1998).

Cook (1998) concluded that there was a great deal of rhetoric in the nursing case management literature about its benefits, but there were too few studies reported and the existing studies were often insufficiently designed or had inconsistent findings. However, Cook emphasizes that nursing managers need to make timely improvements in the efficiency and quality of their care delivery systems and cannot just sit waiting for information from formal research studies to guide their decision making. In the interim, he strongly advocates the use of outcomes measurement tools and collection of outcomes measurement data noting "...it is better to begin data collection in a 'rough right' way and make improvements as you move along than wait for the 'exactly right' data collection opportunity or methodology" (p. 45).

Cohen & Cesta (2001b) also note the importance of future research in nursing case management to objectively measure its contributions in quality patient care, its effects on patient care resources, and in assessing patient and provider satisfaction. They advocate additional research in a wide range of topics important to the practice of nursing case management including but not limited to: (a) professional autonomy and decision making, (b) collaborative practice between nurses and physicians, (c) case management staffing and assignment allocation, (d) payment and reimbursement for nursing case management services, (e) identifying the types of nursing case management interventions

used and the effects of those interventions, and (f) the impact of a nursing case management care delivery model on the nursing shortage (p. 501).

A qualitative study of experiences of nurses, who had recently made the role transition from caregiver to case manager, revealed characteristic sources of role strain or tensions among study participants (Schmitt, 2005, 2006). Key topics explored included motivating factors in the role change, expectations about the role of the CM, sources of CM role strain, and CM job satisfaction. Role theory from the symbolic interaction perspective was used as the conceptual framework for the study, and data was collected through individual interviews and focus groups. It is important to note, a purposeful sample limited to the payer environment was used for the study. Further, the data analysis method was poorly described; therefore, the rigor of the analysis was difficult to determine.

Despite these limitations, several of Schmitt's (2006) findings related to participants' motivation for a job change are worth noting. First, Schmitt found the motivation for most participants in making a career change was due to the dissatisfaction with their current work situation. In particular, the hospital setting was described as undesirable for a number of reasons including long hours, inflexible work schedules, excessive workload, and excessive scope of professional responsibilities. Second, two nurses who left the home care setting, identified that burdensome changes in Medicare regulations had negatively impacted their practice and ultimately their job satisfaction (Schmitt, 2006).

## 2.4 Healthcare Demand, Supply, and Workforce Trends

This section of the literature review is provided to help the reader understand the current and forecasted healthcare environment in which the NCM works, and the impact of these factors on the role of the NCM.

### 2.4.1 *Demographic Trends and Projections*

#### 2.4.1.1 *The Aging of the United States*

According to the Institute for the Future (IFTF), by 2010 the average life expectancy in the United States for women will be up to 86 years and for men up to 76 years (The Institute for the Future [IFTF], 2003). IFTF also predicts in 2010 there will be more than 100,000 people over the age of 100 years. IFTF notes the year 2010 is an important marker as it is when the first baby boomers, those born between 1946 and 1964, turn 65 years of age. People age 65 and older are noted to be the fastest-growing segment of the population. Predictions indicate an increase in their numbers from 35 million in 1999 to 40 million in 2010, to over 50 million in 2020, and to greater than 70 million in 2030 (IFTF, 2003). As noted by IFTF, “not until 2030, when the youngest baby boomer has reached 65 and the entire baby boom’s health care is subsidized by Medicare, will the nation’s health and welfare system feel the true social and economic impact of this large age cohort” (p. 17, 2003). They stress this trend points to the urgent need to address the complex issues of financing and delivering health care, social services, and long-term care to this group, as well as, managing their health and health behaviors.

#### 2.4.1.2 *Growing Diversity*

In addition to aging, the United States is growing more and more diverse. While noting 69% of the overall population is white non-Hispanic, IFTF (2003) contends the Hispanic, African American, Asian, and Native American populations are all growing faster than the population as a whole due to higher immigration and birth rates among these groups. IFTF (2003) predicts by 2010, 34% of the population will be comprised of minority ethnic and racial groups, up from 22% in 1980. IFTF emphasizes the “real story of diversity is regional,” noting the western region of the United States followed by the south will be most impacted by this changing landscape (p. 19, 2003). They note several states, such as California, Illinois, New York, Florida and Texas, are already being confronted with the challenge of delivering care to a diverse population (IFTF, 2003).

#### 2.4.1.3 *Income and Poverty Rates*

While various demographic characteristics are correlated with differences in health status, according to IFTF (2003), none is more highly correlated than income. IFTF reports an analysis of United States income distributions from 1970 to 2010 show two significant emerging trends. The first trend is positive and indicates the average per capita income is and will continue to increase. However, the second trend, a widening gap between the richest 25% and the poorest 25% of the population, is very concerning. IFTF predicts “this projected income disparity will have negative consequences on the nation’s overall health status and will remain a significant social and health issue well into the future” (p. 21).

According to U.S. Census Bureau report, released in August 2005 and based on 2004 population survey data, there was no change in real median household income for

the second consecutive year (DeNavas-Walt, Proctor, & Lee, 2005). It was also reported there was no change in real median household incomes between 2003 and 2004 for the various racial and ethnic groups. The report stated black households had the lowest median income at \$30,134, followed by Hispanic, non-Hispanic white, and Asian households at \$34,241, \$48,988, and \$57,518 respectively (DeNavas-Walt, et al., 2005). From a regional perspective, only the Midwest was reported to have a decline, by 2.8%, in real median household income between 2003 and 2004 (DeNavas-Walt, et al.). The South continues to have the lowest median household income at \$40,773, followed by the Midwest, West, and Northeast at \$44,657, \$47,680, and \$47,994 respectively (DeNavas-Walt, et al.).

Despite no reported overall change in median household income in the U.S. Census Bureau report, there was an increase noted in the poverty rate overall and within subgroups. The report noted in 2004 there were 37.0 million people, 12.7% of the population, living in poverty compared to 35.9 million, 12.5% of the population, in 2003 (DeNavas-Walt, et al., 2005). The report states while the 2004 poverty rate is 9.7% lower than rates in 1959, which is the first year such data was available, 2004 marks the fourth consecutive year both the number and rate of poverty has increased since 2000, which was noted to have the lowest rate in recent history (DeNavas-Walt, et al.). The number of people in poverty jumped from 31.6 million in 2000 to 37.0 million in 2004, with a rate increase of 11.3 to 12.7% for the same time periods. The poverty rate for Asians decreased between 2003 and 2004, from 11.8 to 9.8%, the rate remained unchanged for blacks and Hispanics at 24.7 and 21.9% respectively, and the rate increased for non-Hispanic whites from 8.2 to 8.6% (DeNavas-Walt, et al.).

From a regional perspective, the changes in, and rate of, poverty demonstrated a pattern similar to the income findings. Between 2003 and 2004, the Midwest was the only region to change with an increase in the poverty rate from 10.7 to 11.6% (DeNavas-Walt, et al., 2005). Poverty rates in the Northeast, West, and South remained unchanged at 11.6, 12.6, and 14.1% respectively (DeNavas-Walt, et al.). At the state level, Pennsylvania was one of seven states that had an increase in the poverty rate up 0.9% from 2003 to 2004 (DeNavas-Walt, et al.). In a related U.S. Census Bureau report summarizing findings from the American Community Survey, Allegheny County in Pennsylvania was one of seven counties, out of 37 counties with 1 million or more people, that experienced an increased poverty rate, up 0.9% from 2003 to 2004 (Fronczek, 2005). Only two of the 37 counties with 1 million or more people experienced a decreased poverty rate.

#### *2.4.1.4 Health Insurance Coverage*

The number of people with health insurance in 2004 rose to 245.3 million people, 84.3% of the population, which is up 2.0 million from 2003 (DeNavas-Walt, et al., 2005). The number of people without health care insurance also increased from 45.0 million in 2003 to 45.8 million in 2004; however, the rate remained unchanged at 15.7% (DeNavas-Walt, et al.). From an historical perspective, the uninsured rate slowly trended upward from 12.9% in 1987 to a peak rate of 16.3% in 1998 (DeNavas-Walt, et al.). This was followed by a two year decrease to 14.2% in 2000 and subsequent reverse trend upward to 15.7% by 2003, a rate that held steady in 2004 (DeNavas-Walt, et al.). The primary reason for the steady uninsured rate is due to an increase in the number of people being covered by government health insurance. While the rate of people covered by employer

sponsored health insurance decreased from 60.4% in 2003 to 59.8% in 2004, the number and rate of people covered by government health insurance programs increased from 26.6% in 2003 to 27.2% in 2004 (DeNavas-Walt, et al.). The latter was primarily influenced by the increased number and percent of people covered by Medicaid, which went from 35.6 million, 12.4%, in 2003 to 37.5 million, 12.9%, in 2004 (DeNavas-Walt, et al.). The rate of people covered by Medicare held steady at 13.7% in 2003 and 2004. The percent of people covered by the remaining government insurance program, military health care, increased from 3.5% in 2003 to 3.7% in 2004 (DeNavas-Walt, et al.).

While the overall number and rate of uninsured children held steady at 11.2% in 2003 and 2004, in 2004 children living in poverty were more likely to be uninsured than all children (DeNavas-Walt, et al., 2005). The number and rate of uninsured among non-Hispanic whites and blacks did not change between 2003 and 2004, holding a rate of 11.3 and 19.7% respectively. For Asians, the uninsured rate decreased from 18.8 to 16.8%, and while the number of uninsured Hispanics increased to 13.7 million in 2004 from 13.2 million in 2003, their uninsured rate held steady at 32.7% (DeNavas-Walt, et al.). From a regional perspective, the South had the highest uninsured rate at 18.3%, followed by the West, Northeast, and Midwest at 17.4, 13.2, and 11.9% respectively (DeNavas-Walt, et al.). The U.S. Census Bureau report also showed that the income and work status of people influenced whether or not they had health insurance (DeNavas-Walt, et al.). In 2004, 75.7% of households with annual incomes of less than \$25,000 had health insurance compared to 91.6% of those households with annual incomes of \$75,000 or more (DeNavas-Walt, et al.). In 2004, full time employees, age 18 to 64 years, were covered by health insurance at a rate 82.2%, compared to only 75% of part-time workers

(less than 35 hours per week), and 74.2% of non-workers in the same age group (DeNavas-Walt, et al.).

#### *2.4.1.5 Chronic Disease and Health Status Trends*

Due in large part to the aging of the population, according to IFTF (2003), we can expect to see a continued increase in chronic diseases such as cardiovascular disease and cancer. IFTF predicts heart disease will continue to cause the highest morbidity and mortality rates than any other disease, and cancer will continue to rank second in mortality. What IFTF called a surprising finding in their current forecast is that “taking into account the extent to which an illness causes both death and disability---mental illness, especially unipolar major depression, will have a larger impact than cancer by the year 2010” (p. 22). Diseases associated with behavioral causes such as smoking and alcohol abuse were also identified as major areas of concern for the future, and the need for advancement in the areas of health management and disease prevention (IFTF). IFTF notes while there is a current focus on wellness in the United States, the trend is mostly observed in the wealthier and more educated segments of the population, which tend to have a better health status anyway.

In a report on the health status of the Nation presented to the President and Congress annually, the National Center for Health Statistics (NCHS) reported the Nation’s overall health continues to improve partly due to the significant resources invested in public health programs, health care, health education, and research (NCHS, 2005). NCHS reported many diseases have been controlled or their morbidity and mortality have been substantially reduced. Particular areas of achievement over the past century noted were the eradication or control of certain infectious diseases, the reduction

of dental caries, improvements in motor vehicle safety, and decreased mortality from cardiovascular disease. However, the report stresses “yet even as progress is made in improving both the quantity and quality of life, increased longevity is accompanied by increased prevalence of chronic conditions and their associated pain and disability” (NCHS, 2005, p. 3). NCHS also emphasizes, compared to past years, recently progress has slowed or moved in the wrong directions in certain areas such as infant mortality, cause specific mortality, and risk factor reduction (i.e., smoking, lack of exercise, etc.). Consistent with the reports and projections noted earlier, NCHS emphasizes “...it is equally important to keep in mind that these improvements have not been equally distributed by income, race, ethnicity, education, and geography” (p. 3). Further, the report emphasizes “efforts to improve Americans’ health in the 21<sup>st</sup> century will be shaped by important changes in demographics” as we are a Nation that is growing older, is becoming more racially and ethnically diverse, and has “major disparities in health and health care that exist by socioeconomic status, race, ethnicity, and insurance status” (p. 4). The importance of the aging trend in the U.S. is demonstrated by the addition of a new section in the 2005 NCHS report titled “Special Feature: Adults 55-64 Years of Age” (p. 70-85). The new section is dedicated exclusively to the population that is approaching retirement age.

#### *2.4.2 Health Care Expenditures*

According to NCHS (2005), the United States spends more on health per capita than any other country, and spending continues to rise rapidly; in 2003, national health care expenditures (NHE) totaled \$1.7 trillion, a 7.7% increase from 2002. The United States also spends a larger portion of the gross domestic product (GDP) on health

expenditures than any other major industrialized nation; the 2003 rate was 15.3% up from 14.9% in 2002. The NCHS reports most of this spending is for care that reduces or controls the impact of chronic diseases and conditions affecting an aging population, most noteworthy were the costs of prescription drugs and cardiac operations (p. 4). Similar to DeNavas-Walt, et al. (2005), NCHS found, despite a reduced rate of people covered by employer based insurance plans, the uninsured rate has remained steady over the past few years due to shift in the burden of coverage to Medicaid. More recently, Borger et al. (2006) reported the NHE for 2004 was \$1.9 trillion and accounted for 16% of the GDP. Further, they project NHE will continue to grow an average of 7.2% annually over the next decade and 2.1 percentage points faster than projected average annual growth in GDP for the same time period. With the forecast of NHE growth outpacing GDP growth annuals, Borger et al. project NHE as a percent of GDP to rise from 16% in 2004 to 20% in 2015.

### *2.4.3 Registered Nurse Workforce Trends*

Registered nurses (RNs) are the largest single group of health care providers in the U.S., and are primarily employed in hospitals (IFTF, 2003). In their latest forecast, IFTF (2003) acknowledges they and other forecasters were off the mark in their prior projections that future RN supply would meet increasing demands. IFTF explained this was primarily because they failed to anticipate a “rapidly dwindling number of applicants to schools of nursing and a mass exodus of nurses from acute care settings because of poor working conditions” (2003, p. 103). IFTF also notes, by early 2001, the existing and projected nursing shortage was characterized as a national crisis and the number one concern of hospital administrators and health care leaders.

In a report from the Health Resources and Service Administration (HRSA), it is noted “an adequate supply of RNs is essential to achieving the Nation’s goals of ensuring access to affordable, high-quality healthcare” (Health Resources and Service Administration [HRSA], 2004, p. 1). Based on data at the time of their report, HRSA stated there was a moderate shortage of RNs nationally, and they predict, through use of nursing supply and demand models, the RN shortage will continue to grow in severity over the next 20 years if current trends prevail. The data used was collected by the National Center for Health Workforce Analysis (NCHWA), in the Bureau of Health Professions, whose mission is “*to collect, analyze, and disseminate health workforce information and facilitate national, State, and local workforce planning efforts*” (p. 1). NCHWA collects data through its Sample Survey of Registered Nurses and maintains a Nursing Supply Model and Nursing Demand Model to project future RN supply and demand (HSRA, 2004). Based on these models, HRSA predicts by 2020, the Nation will be short 1 million RN full-time equivalents (FTEs), and will only be able to meet 64% of the predicted demand. Based on the same models, HSRA predicts by 2020 Pennsylvania will be short 55 thousand RN FTEs, and will only be able to meet 59% of the predicted demand.

As NCHWA’s mission intended, Pennsylvania has used these, as well as other data, to evaluate the State’s future nurse workforce needs (Pennsylvania Department of Health [PA DOH], 2004). One of three task forces commissioned by the State to study the nurse workforce in Pennsylvania focused exclusively on nurse retention and workplace/care delivery system environments (PA DOH). At the conclusion of the study, this task force strongly recommended nurse employers and leaders acknowledge and

attend to the individual characteristics of nurses and the unique features of the health care environments where nurses work as one of their strategies to improve nurse retention (PA DOH). The goals of this researcher's study include gaining an understanding of NCMs' perspectives of their role and potential opportunities to improve their future role fulfillment and satisfaction.

## 2.5 Conclusions

As previous noted, the purpose of this study was: (a) to gain a better understanding of NCMs' current perceptions of their role within the interdisciplinary team (IDT) and with patients/families in today's rapidly changing healthcare environment, (b) to identify interventions that are perceived to result in positive patient/family outcomes, (c) to identify sources of role frustration, and (d) to identify perceived opportunities to enhance role success and satisfaction. The researcher intends this study to serve as the foundation for future research studies that will link perceived successful case management interventions to objective patient outcome indicators, and to determine if perceived enhancements will make a measurable difference in future role success and satisfaction.

A review of the nursing case management and health care literature clearly supports the need for, and value of, the proposed study. The literature review has assisted one in gaining an historical perspective of nursing case management, in forecasting future health care supply, demands, and workforce trends, and in identifying current gaps in nursing case management research.

To summarize, in response to rapidly changing health care reimbursement methodologies and shrinking resources, nursing case management evolved in the turbulent mid 1980s as a strategy to plan and manage the balance of patient care cost and quality in the acute care hospital and post discharge settings. Unfortunately, the United States health care trends and forecasts for the next 25 years are nothing short of alarming and predict turbulent times ahead again.

These predictions suggest the Nation is facing a future with a population that is aging, more burdened with chronic disease, more culturally diverse and limited in English proficiency, more socio-economically at risk, and more dependent on public sources for health insurance. The NHE is predicted to continue in its steep and steady rise that out paces increases in GDP. Further, while the need for, and cost of, health care will continue to rise, the financial and human resources to pay and deliver the needed care are predicted to be insufficient. In short, there will be a large number of vulnerable Americans who will require a great deal of assistance navigating a complex, resource constrained, and highly competitive health care environment. It will be essential nurse case managers are clear about their roles, and function efficiently and effectively in such an environment.

While the nursing case management literature documents positive cost and quality outcomes in individual outcome measurement reports, nursing case management experts assert there are too few comprehensive and well designed formal nursing case management research studies (Cook, 1998; Tahan, 2001). Experts note formal research is needed in a wide range of nursing case management topics (Aliotta, 2001; Cohen & Cesta, 2001e; Cook, 1998; Tahan, 2001). Aliotta (2001) particularly notes the important

need for research related to case management interventions and the linking of those interventions to defined outcomes.

Government reports, previously discussed, point to an ongoing national nursing shortage. These reports urge nursing leaders to gain an understanding of the challenges facing nurses in their unique work environments, and to seek ways to address those challenges in order to improve nurse retention and recruitment.

Although Tahan et al. (2006a; 2006b) conducted an extensive, well designed and useful case manager role and function study, only 81% of the study participants were nurses and only 19% worked in the hospital setting. Schmitt's (2005; 2006) study is intriguing in that it echoes themes frequently heard anecdotally by this researcher from nurses in various subspecialties within the hospital setting, including NCMs. First, is that the working conditions in the hospital setting are too demanding, and second, similar to the home care arena, the increasing burden of documentation necessary to meet regulatory requirements detracts from a nurse's ability to provide the quality of care she or he desires. However, the NCMs in Schmitt's study were recruited from the payer environment, and one of the purposes of the study was to understand what motivated their move from a caregiver role to a NCM; not why they left a NCM role. While informative, neither of these studies' findings can be generalized to NCMs working in an inner city academic acute care hospital setting. The proposed study will aid in identifying the unique role, challenges, and/or frustrations of NCMs working in the acute care hospital setting, and identify areas for future research to examine job dissatisfaction and turnover.

# Chapter 3

## Methods

### 3.1. Design

The differences between, and contributions of, quantitative and qualitative research methods are well described by Morse and Field (1995). They emphasize “smart researchers, adept at both qualitative and quantitative methods, use the most appropriate method at the appropriate time, according to the type of research question, the goal of the research, and other considerations” (p. 4). Morse and Field note qualitative research is well suited when little is known about a phenomenon, there is suspicion of bias in prior theories, or when the research question relates to a desire to understand or describe a particular phenomenon or event, especially from the emic point of view. It was the emic point of view of the NCMs that was particularly valued by this researcher. Therefore, for this study, the researcher chose a qualitative descriptive design utilizing focus groups method (Freeman, 2006; Grudens-Schuck, Allen, & Larson, 2004; Kitzinger, 1995; Kitzinger & Barbour, 1999; Mahoney, 1997; Morgan, 1988; Morgan, 1997; Morse & Field, 1995, Webb & Kevern, 2001) to study NCMs perceptions.

#### 3.1.1 *Focus Groups*

Morgan (1988, 1998a), an expert in the focus groups research method, defines three basic features of focus groups. He states first and foremost, focus groups are a

method of collecting qualitative research data. Second, focus groups are devoted to gathering targeted data on specific topics using purposive samples of participants. Unlike observing behavior as it naturally occurs, “focus groups create concentrated conversations that might never occur in the ‘real world’” (Morgan, 1998a, p. 31). Third, focus groups use group discussion to generate data. The researcher learns much about the range of experiences and opinions in the group, but little about the individuals within the group.

There are four basic uses of focus groups: (a) problem identification, (b) planning, (c) implementation, and (d) assessment (Morgan, 1998a). “In essence, each of these basic uses corresponds to a stage within a larger project” with subsequent stages building on the knowledge gained from the prior stages (Morgan, 1998a, p. 13). The main objective of the problem identification stage is to define a goal, with a focus on exploration, discovery, and uncovering what matters most to participants on a specific topic (Morgan, 1998a). Academic researchers use focus groups in this stage to generate hypotheses about new areas of investigation (Morgan, 1998a). This is consistent with the objectives of this researcher.

After reflecting on the phenomena to be studied and questions to be asked, and thoroughly investigating the focus group methodology, this researcher concluded a qualitative design utilizing focus groups to collect data was a sound approach to achieve the goals of the study. While the integrity of the study was the primary concern of the researcher, there was an additional attraction to the focus groups method. According to the literature, few published articles reported use of the focus groups methodology in an empirical nursing research study compared to other qualitative methods (Webb &

Kevern, 2001). Therefore, this researcher saw not only an opportunity to add to the body of nursing literature in regard to the stated research questions, but also in regard to a qualitative research method not widely used within the discipline of nursing.

### 3.2 Setting

Krueger (1994), an expert in the focus groups methodology and colleague of Morgan, points out that focus groups have been conducted successfully in a wide variety of locations, such as private homes, restaurants, hotel rooms, and public buildings. A convenient and easily found location is the most important consideration. Other considerations include environmental factors such as the room being free of distractions or interruptions, being free of background noise that could interfere with tape recording, and being located on neutral ground to avoid bias or inhibition.

The setting for this study was a large, comfortable, and aesthetically pleasing conference room in a building, adjacent to the hospital, where outpatient services are provided. The conference room was located in a quiet, low traffic area of the building, which was free of distractions for participants and was ideal for audio recording the focus group sessions. The conference room was conveniently located for participants, and was chosen to increase their willingness to volunteer for the study. While it was adjacent to the hospital, the NCMs do not work in this building, and they had not attended work related meetings or programs in the conference room prior to the focus groups being conducted. Thus, the setting was considered to be neutral territory by the participants.

As refreshments are an important aspect of successful focus groups, an added benefit to this setting was food and beverages were permitted in the room. A refreshment

table was placed by the wall near the entrance door to the room to encourage a small-talk period prior to the start of the session (Krueger, 1998b). The refreshments, among other things included fresh fruit and vegetable platters, chocolate chip cookies, and a variety of beverages, which are considered to be frequent favorites.

Chairs were arranged and equally spaced around a conference table so participants could face each other, as eye contact among all participants was vital (Krueger, 1994). Tables allowed participants to lean forward and to be less self-conscious about their bodies (Krueger, 1994). An audiotape recorder was prominently placed on a stand at the end of the conference table and a microphone was placed in the center of the table to ensure all participants could be adequately recorded.

### 3.3 Participants

Focus groups are often conducted using purposively selected samples in which participants are recruited from a limited number of sources, frequently only one (Morgan, 1997). Participants for this study were recruited from a purposive convenience sample of NCMs working at a 600+ bed, not-for-profit, and inner city academic medical center in a Mid-Atlantic state that provides care to patients from birth to advanced age. The hospital is a Level 1 Trauma Center and major referral facility for complex tertiary and specialty services. It has seven intensive care units including an intensive care nursery. While the hospital has a smaller community campus, participants were only recruited from the main campus of the hospital.

To gain a better understanding of the environment in which the NCMs work, the hospital's patient population is briefly described. The patient population is

demographically diverse as the hospital serves its neighboring inner city residents, metropolitan/suburban residents, regional and tri-state referral patients, as well as, patients from distant states and nations due to its Level 1 Trauma status and specialty services. In 2007, 6.5% of inpatients were under 18 years of age, 56.4% were 18 - 64 years of age, 25.4% were 65 - 79 years of age, and 11.7% were 80 years old and older. Fifty-two percent of the patients were female, and 48% male.

The ideal focus group size is 6 to 10 participants; however, a range of 4 to 12 participants per group is acceptable (Krueger, 1994). The group size must be small enough for all participants to have the ability to share their insights and large enough to elicit a broad range of thoughts, ideas, and opinions (Krueger, 1994). Focus groups are conducted in a series in order to identify patterns and trends across multiple groups that include similar participants (Krueger, 1994). This assists in accounting for focus groups that may have been influenced by internal (e.g., dominant member) or external (e.g., environment distraction) factors that yield extraordinary results. For a project similar in scope to this study, Morgan (1998b) states two to four focus groups are sufficient to achieve the goals of the study.

To be included in the study, participants had to be registered nurses with a minimum of one year of case management experience, and had to have worked for the hospital as a NCM for at least six months. By six months, new employees would have completed their orientation and have worked independently for at least three months. All NCMs meeting the inclusion criteria were invited to participate in the study. This yielded a potential pool of 24 participants. Recruitment efforts included mailing a study invitation/flier (Appendix A) containing the following content: (a) the purpose of the

study, (b) inclusion criteria, (c) the voluntary nature of participation, (d) the right to withdraw participation at any time, (e) when and where the focus groups would be held, (f) that there was no monetary cost of participation, only one to two hours of their time, (g) that light refreshments would be provided, and (h) who to contact for more information on the study. A study invitation response form (Appendix B) and a pre-addressed return envelope were included in the mailing. Additional recruitment efforts included posting of the invitation/flier in the workplace and a second mailing of the study invitation/flier invitation response form to non-responders. In an effort to minimize no shows, responding volunteers received a thank you and confirmation letter that included the date, time, and location of their selected focus group session.

Given the total pool of potential participants and Morgan's recommendation of two to four focus group sessions to achieve the goals of the study, the researcher's goal was to recruit 6 to 8 participants per focus group session for a minimum of two and maximum of four focus group sessions. Ideally, the researcher planned for three focus group sessions. However, if the researcher achieved the higher recruitment goal per session, had a low participant drop out rate, and/or was able to collect sufficient data by the second session, the third session would have been cancelled. Conversely, if there was a high drop out rate or data saturation was not achieved by the third session, a fourth session would have been added.

### 3.4 Instruments

A semi-structured interview guide (Appendix C) was used to stimulate discussion, probe for additional information, and ensure the goals of the study were achieved. The

guide included five categories of questions sequenced in a pattern recommended by Krueger (1998a). First were opening questions that were intended to help participants get acquainted and feel comfortable with each. All members were asked to respond to the icebreaker questions; however, responses were not analyzed. The second category was introductory questions. These questions introduced the topic and allowed participants the opportunity to reflect on their experiences with the topic. Third were transition questions that moved the conversation closer to the key questions under study. These questions helped make the connection between the participants and the topic of investigation. Fourth were key questions that drove the study. These questions were allotted the most time for discussion. The negative questions were strategically sequenced after the more positive questions as Krueger (1998a) warns once participants start discussing more negative topics, it is often difficult to get them refocused back on positive subjects. Last were ending questions that allowed participants to reflect on comments made during the discussion and helped bring closure to the focus group session.

### 3.5 Data Collection

The researcher used audiotape recordings and field notes to record the focus groups discussions. The recording equipment included a Sharp Professional Series, RD-680 AV audiotape recorder, high quality TDK D90 audiotapes, and a cushioned, pressure zoned microphone. The audiotape recorder was placed on an audiovisual stand at the end of the conference table, and the microphone was placed in center of the conference table; both were in plain sight. To verify all members would be heard adequately on the tape and that the equipment was functioning properly, sound checks were recorded with the

researcher sitting at each available chair around the conference room table prior to the focus group sessions beginning. Additionally, audiovisual staff were readily available for backup support should an equipment failure occur. Fortunately, all equipment worked properly without incident. Following each focus group, the audiotapes were labeled and checked to verify the sessions were recorded.

In addition to the researcher, a research assistant was recruited to take detailed notes and assist in the research process. The research assistant signed a confidentiality statement (Appendix D) prior to the beginning of the study. The signed confidentiality statement is locked separately from the data. As recommended by Krueger, a standardized reporting form was used for consistency and clarity of the notes (1998b). The standardized tool had the semi-structured questions preprinted on the form with a table below each question that included the following sections: (a) brief summary and key points, (b) notable quotes, (c) speaker body language/non-verbal behavior, and (d) group observations/body language/non-verbal behavior. The assistant was instructed to capture as many important and poignant direct quotes as possible, as well as, notable nonverbal communication. In addition, the assistant completed a coded seating chart to assist in linking discussion content with the correct participant for data analysis purposes.

Another valuable source of data was debriefing sessions between the researcher and assistant following the focus groups. During the debriefing session, the research assistant's field notes were reviewed to ensure researcher understanding, and immediate impressions from the focus group were shared. During the debriefings, in addition to discussing major themes that emerged in the focus groups, the researcher and research assistant discussed issues including, but not limited to, the level of member participation,

engagement, group interaction, enthusiasm, attitudes, and body language. Notes from these sessions were recorded on a tablet.

The audiotapes were transcribed with the use of a Panasonic Variable Speech Control Transcriber tape player with foot pedal and headphone. A transcriptionist was hired to transcribe the recordings, and signed a confidentiality statement (Appendix E) which is stored separately from the data. After independently listening to the audiotapes several times followed by careful reading of the transcripts, the researcher discovered about one third of the second transcript was missing. Upon further review of the transcripts while listening to the audiotapes at the same time, the researcher identified other areas of each transcript needing to be revised. The researcher, having the benefit of moderating the focus groups, recognizing voices, and understanding the nature and flow of the discussions, chose to personally transcribe (using the equipment noted above) the missing data and edited and corrected the transcripts to produce verbatim final copies. While time consuming, this exercise proved to be beneficial to the researcher as it required repeated and careful listening to the audiotapes. Each participant was alpha coded and labeled in the transcript to aid in the data analysis.

As recommended by Krueger (1998b, 1998c), data collection and analysis began concurrently. To aid in data analysis and ensure the results were a valid reflection of how the participants felt and thought about the topics under discussion, the researcher employed a technique advocated by Krueger (1998c) throughout the focus group sessions. This technique is to provide summary comments on the discussion, and to ask the participants to verify the accuracy of the summary. While Krueger notes one summary at the conclusion of an entire session may be adequate for an experienced

moderator, this researcher, being a new moderator, employed the technique throughout the sessions particularly at key transitions from one research question to the next, or when the discussion became lengthy. For example, the researcher would say, “I believe I heard you say A, B, and C. Is that correct? Did I miss something?” As Krueger also recommends, the field and debriefing notes from the first focus group were used in early analysis, and these early findings and insights were incorporated into the subsequent focus group session for purposes of validation and expansion of the findings. For example, the researcher would say, “In the prior group, the topic of . . . came up. What do you think?” Both of these techniques were found to be very useful and productive in the concurrent data collection and analysis processes.

### 3.6 Protection of Human Subjects

Morgan (1998a) emphasizes, like in medicine, the first rule in focus groups is to do no harm. He notes privacy is one of the key ethical concerns in this type of research. Rather than promise anonymity, that is extremely difficult to achieve in focus groups studies, the researcher should promise confidentiality and careful protection of the information that is gathered. Another aspect of privacy in focus groups research is the risk of over disclosure of highly sensitive personal information that could cause undue stress in participants. Morgan emphasizes the importance of setting boundaries that define the acceptable limits of discussion in advance of the sessions to avoid this potential problem, as well as, the associated stress it could cause in participants.

The researcher took the following preparatory steps to protect the participants of this study. First, the researcher completed all federally mandated and organizationally

required education on the protection of human subjects. Next, permission to conduct the study was obtained from the Duquesne University Institutional Review Board (IRB) (Appendix F) and the hospital's IRB (Appendix G). Verification of completion of the mandatory education was included in the IRB submission packets.

After approvals were obtained, eligible NCMs received the previously described study invitation/flier (Appendix A) that included: (a) the purpose of the study, (b) inclusion criteria, (c) the voluntary nature of participation, (d) the right to withdraw participation at any time, (e) when and where the focus groups would be held, (f) that there was no monetary cost of participation, only one to two hours of their time, (g) that light refreshments would be provided, and (h) who to contact for more information on the study. In addition, a copy of the informed consent was attached to the thank you and focus group confirmation letter sent to volunteers who had scheduled for a focus group. This provided the volunteers an opportunity to thoroughly read the informed consent form in advance of the focus group, and to request additional information if needed. The volunteers were instructed not to sign the informed consent until their last minute questions could be answered, and their signature on the consent form could be witnessed. At the beginning of each focus group, the researcher again explained the purpose of the study, the voluntary nature of the study, how the data would be collected and handled, how study results would be used, and that they could withdraw participation at any time during the session without fear of harm. Participants were also asked to keep all discussions and co-participant identities confidential. Following these explanations, all questions were answered and written informed consent was obtained, including

permission to audio record the group's discussion. Participants were provided with a copy of the informed consent form.

The informed consent form (Appendix H) was the only document that included the identity of the participants. Each participant was assigned a code, and all subsequent documents referenced participants by code alone. Example documents included a demographic questionnaire (Appendix I) that was used to describe the subjects, field notes, seating charts, debriefing notes, and data analysis documents. The audio recordings, informed consents, code key, and all other documents pertaining to the study were secured separately from each other in a locked filing cabinet that was accessible only to the researcher. At the conclusion of the study, all study materials will be stored for five years in a locked filing cabinet as described above and then destroyed.

### 3.7 Data Analysis

Four data analysis strategies for focus group research are described by Krueger (1998c). The first, which was selected by the researcher, is transcript-based analysis. This strategy is considered to be the most rigorous and requires the most time investment as the audiotapes are transcribed verbatim. The transcripts, detailed field notes, and debriefing session notes are all used as sources for the data analysis; however, the transcripts are used as the primary source. The second strategy is tape-based analysis that involves the creation of an abridged transcript following careful listening of the session tapes. A third strategy is note-based analysis. While the focus group is taped, it is not transcribed. The field notes are used as the primary source for the data analysis, and the

tapes are used to verify quotes. The final strategy, memory based analysis, is used primary in market research and is the least rigorous of all the strategies.

As noted above, the researcher used the transcription based analysis strategy due to its rigor. Three sources of data were analyzed for this study, the audiotape transcripts, researcher and research assistant field notes, and the notes from the debriefing sessions following the focus groups. As the emic point of view of the NCMs was highly desired by the researcher and Krueger recommends it, the transcripts were used as the primary source of data in the analysis. Krueger notes though that analysis begins concurrently with data gathering. He also cautions the quality of the analysis is eroded by delay. To guard against this, the researcher conducted post session debriefings with the research assistant as Krueger recommended, and began the data analysis within one to two days of the focus group session from the field and debriefing session notes while the transcripts were being transcribed. The researcher used this preliminary analysis of the first focus group data to verify early impressions of themes and probe for deeper meanings in the subsequent focus group session.

The type of analysis used by this researcher was a thematic analysis. “Thematic analysis involves the search for and identification of common threads that extend throughout an entire interview or set of interviews” (Morse & Field, 1995, p. 139). Themes are usually abstract, but may be come more apparent when the researcher steps back and considers what the participants are trying to tell her (Morse & Field). While initially the themes may appear hidden beneath the surface of the interviews, once discovered, they appear obvious (Morse & Field). Often, themes are concepts derived from the data rather than concrete ideas directly described by the participants (Morse &

Field). Themes are coded from the interview data after careful reading and re-reading of the transcripts in their entirety and reflection on the interviews as a whole (Morse & Field). Coding is defined as the “process of identifying persistent words, phrases, themes, or concepts within the data so that the underlying patterns can be identified and analyzed” (Morse & Field, p. 241). “Once identified, the themes appear to be significant concepts that link substantial portions of the interviews together” (Morse & Field, p. 140).

Krueger (1998c) cautions that focus group analysis is unique, and cautions there is a danger in assuming that focus group transcripts should be analyzed in the same way individual interview transcripts are. He emphasizes that focus group interviews produce data obtained from a group process in a focused manner (Krueger). Focus group participants influence each other and learn from each other, and as a result opinions may change and new insights may surface (Krueger). “The discussion is evolutionary, building on previous comments and points of view” (Krueger, p. 20). Krueger warns that while words are a central element, effective analysis goes beyond words. The analyst should observe all factors in the communication including body language, tone of voice, and gestures when interpreting the data (Krueger).

Another important decision in the data management and analysis was to determine whether to use a manual approach or the use of computer-assisted qualitative data analysis software (CAQDAS). A key factor in this decision identified by focus group method experts and other qualitative research experts is the size and complexity of the study (Krueger, 1998c; Morse & Field, 1995; Webb, 1999). In general, manual approaches are recommended for smaller studies, and the use of CAQDAS with larger studies where the benefit outweighs the costs of their use. Focus group experts note a

study with six or less focus group session transcripts can be adequately managed using a manual data management approach. Potential disadvantages to computer analysis in focus groups research are the dangers of only using partial data, the transcript, and overlooking other data sources, and misinterpretation of data when over emphasis is placed on counting rather than other analysis factors (Krueger). Webb (1999), a nursing educator and researcher, examined the experiences of different approaches to qualitative data analysis used by her former PhD students. She noted when the data set is not large, which she noted was often the case in PhD studies, the additional work of data management using CAQDAS may not be justified. Webb also emphasized the intellectual work of conceptualizing requires the brain of the researcher, and the risks of preoccupation with the technical aspects of using CAQDAS may interfere with the artistic aspects of analysis. Therefore, Webb (1999) recommends beginning qualitative researchers use manual approaches for their first project because the learning and understanding gained through the manual data analysis process sets a solid foundation for any subsequent CAQDAS use.

Because of the uniqueness of focus group data analysis and the smaller data set for this study, the focus groups transcripts were analyzed and coded utilizing the principles and strategies described by Krueger (1998c). The principles provide useful guidance on how to determine what is relevant in the data and what is not. Krueger emphasizes the analyst should consider not only the words in the transcripts and notes, but the meanings of the words, the context of the discussion in which the words were used, and the tone and inflection in which they were said. Additionally, he emphasizes participants may use different words or phrases to describe the same thing and the

researcher needs to ascertain the similarity of these responses. There are three important and distinct factors in data analysis that include frequency, extensiveness, and intensity (Krueger). These factors are not synonymous, and all three must be considered when discerning relevancy. Frequency refers to how often something was said, extensiveness refers to how many people said it, and intensity refers to how strong the opinion or point of view was.

According to Krueger (1998c), there are two general ways to proceed in focus group data analysis. The first is to analyze the data question by question, looking for themes within the questions, and then across questions. The second approach is to organize the analysis around themes that are developed before, during, or after the focus groups. The first approach is noted by Krueger to be the easiest for beginning moderators, therefore, this was the approach selected by the researcher. To perform the analysis, the researcher used some of the classic tools for analysis described by Krueger which included a long table, colored high-lighters, colored marking pens, large sheets of paper, scissors, and tape. These tools were used for marking, cutting, sorting, and arranging the data into categories or themes. Prior to the sorting and arranging the data, the transcripts were read several times carefully and notes were made in the margins on such things as key words used, the meanings of the words or ideas expressed, relevance of the response to the question asked, and emerging themes. This assisted in assessing the frequency, the extensiveness, and the intensity of participant responses.

Once coded, the data from each session was categorized, compared, and contrasted to identify consistent themes that emerged from the data. As a result, a thematic structure that provides a rich description of participants' views relevant to the

research questions was formulated. Krueger (1998c) emphasizes the analysis must be verifiable. Therefore, as recommended, an audit trail of the analysis was kept, and another researcher was asked to independently analyze the data from at least one transcript to see if similar conclusions were drawn.

# Chapter 4

## Results and Summary

### 4.1. Introduction

This chapter describes the study participants and presents the results of the data as gathered from the focus groups. Because the purpose of this study was to gain a better understanding of NCMs' perceptions of their role, and identify perceived factors that contribute to role success, sources of role frustration, and potential opportunities to enhance future role success and satisfaction, a qualitative descriptive design utilizing focus group method was selected. Three sources of data were analyzed for this study, audiotape transcripts, field notes, and debriefing notes from the researcher and research assistant following the focus group sessions. Themes that emerged from the data through a thematic analysis are described for each research question. As the emic point of view of the NCMs was highly desired, the transcripts were the primary source of data, and direct participant quotes are shared to illustrate participant views and support the study findings. To add clarity, and to fairly and accurately present participants' views, some quotes were abridged, minor grammar corrections were made, or words were entered in brackets (Krueger, 1998c). This was necessary when a quote was taken from a larger discussion, or the focus group participants knew what the topic or context of the discussion was, but it may not be evident to the reader of the quote without the insertion. These minor

modifications were only made if the meaning of the quote was unchanged. Additionally, if an individual's name was used in a quote, a pseudonym was used.

## 4.2 Description of the Sample

Study participants (n=11) were selected by purposeful sampling following the stated recruitment protocol. At the time of study recruitment, 24 NCMs met all of the established inclusion criteria. Twelve NCMs volunteered to participate in the study and registered for a focus group session. However, due to illness, one NCM scheduled for the last focus group session called off work and canceled her study participation on that date. Despite scheduled summer vacations, which may have played a role in overall participation, 46% of eligible NCMs participated in the study. The study invitation offered three focus group session dates for participants to select from. Only one of the original 12 volunteers selected the first session date. Following a brief discussion, this volunteer willingly rescheduled for one of the other two focus group dates. Therefore, two focus groups with sufficient numbers of volunteers were established, the first group with six participants and the second with five participants due to the one cancellation. Had it been necessary, additional focus group dates would have been established and a new study invitation sent out to remaining eligible volunteers. Fortunately, all study objectives were achieved with the two focus groups due to data saturation, and additional focus groups were not required.

The participants were predominately female (82%) with an average age of 53 years. The highest degree in nursing completed by participants was most commonly BSN (45.4%), followed equally by MSN (18.1%), AD (18.1%), and Diploma (18.2%). Thirty

six percent of participants held case management certification. The participants' average reported years of RN licensure, hospital based nurse case management experience, and experience in this role at the study hospital averaged 28, 10, and 9 years respectively.

Table 4.1 provides more detail on several key descriptors.

Table 4.1

*Description of Participants*

<b>Descriptor</b>	<b>Range (Years)</b>	<b>Average (Years)</b>
Age	39-60	53
RN Licensure	12-35	28
Hospital Based NCM Experience	3-16	10
NCM Experience at Study Facility	3-14	9

### 4.3 Findings

The findings for the six research questions posed in this study are discussed in this section. The themes and subthemes that emerged from the data relevant to each research question are described, and direct quotes illustrative of the themes are provided to enrich the understanding of the theme.

#### *4.3.1 Research Question One: How Do Hospital Based NCMs Describe Their Role?*

The aim of the first research question was to discover how NCMs describe their current role. Eight themes emerged from the data analysis to answer research question one. The themes are intertwined and often occur in tandem of each other on any given

day in the life of the NCMs. The themes are listed in Table 4.2, and further described below.

Table 4.2

*Themes for Research Question One: How Do Hospital Based NCMs Describe Their Role?*

<b>Number</b>	<b>Theme</b>
One	Hub of Communication
Two	Discharge Planning
Three	Care Coordination
Four	Utilization Management
Five	Patient Advocacy
Six	Resource Person/Problem Solver
Seven	Education on Insurance System and Continuum of Care
Eight	Emotional Support

The first theme, hub of communication, describes a very unique characteristic of the NCM role. These nurses likely communicate with a more diverse group of individuals regarding a patient than any other role in a hospital setting. In addition to the patient and family, they communicate with all disciplines involved in the patient’s clinical care, those involved in the financial aspects of the patient’s hospital stay, and a vast array of individuals outside of the facility, including, but not limited to, insurance reviewers and case managers, insurance medical directors and physician advisors, social service case workers, attorneys, and post acute care providers. This communication is not

unidirectional, but a relaying of information back and forth between the various individuals, thus the concept of the hub. Below are quotes from participants supporting this theme.

Participant D: In a nutshell, what I usually tell is we are kind of like the hub of all the communications. We kind of try to bring all the entities together, the patient, the family, the doctor, the nursing staff, the therapists, and all the other outside entities that are involved in this kind of thing. So everybody is on the same page, in a nutshell that's what I say.

Participant E: . . . But, I think again, go back to the communication skills, because like D said before, because you have to talk to everyone. You're dealing as the hub with everybody.

The second theme, discharge planning, describes an interdisciplinary process involving many of the disciplines and individuals noted in the first theme, but facilitated by the NCM. The term discharge planning was used as an umbrella term, but encompassed the nursing processes of assessment, implementation, and evaluation as well. The participants described these functions as they discussed taking into consideration the patient's current clinical status, input from the patient/family and other disciplines, the patient's ongoing care needs and available support systems, and insurance coverage of post discharge services when they were determining the patient's disposition options. Below are several quotes that support the discharge planning theme.

Participant F: Discharge planning, organizing, you know, if they need home care or hospice, or if they need to go to a skilled nursing facility, or inpatient rehab. Finding out if there is support at home, um, you know, if they do have support, or if they don't – what, you know, they need to be able to go home, or if they do need to go to another, you know, facility in the meantime.

Participant G: The goal is truly, I always tell them [patients], it's to figure out and get together, and get organized whatever you are going to need for your next step, when we don't need to keep you here. And that sort of covers the gamut of that.

Participant J: . . . I usually have my card out and I write discharge planning on my card, because they [patient] will put the card somewhere and not be able to remember what a case manager is. So, I write discharge planning on my card and I pretty much say, close to what I say is, I say that “I am a register nurse and I am responsible for knowing what your insurance is and letting your insurance company know that you are here so you don’t have to worry about that. I am also responsible for your discharge planning.” I usually say “The discharge date is between you and your physician, but I am the one that will be helping you with that.” I almost always say “I’m responsible for assisting you in what your insurance covers so you can make good choices at discharge.”

As noted above, many of the themes that emerged from the data occur in tandem with each other throughout a given day, and the third theme, care coordination is a good example of this. Care coordination interplays with communication, discharge planning, as well as the other themes described below. It relates not only to the coordination of the discharge plan, but also the acute care services needed to progress the patient toward that end point, for example, recommending to physicians that a patient would benefit from physical therapy and occupational therapy (PT/OT), or coordinating their acute and post discharge care with their insurance company. The quotes below demonstrate several of the care coordination functions and its inter-relationship with other aspects of the NCM role.

Participant B: I always try to explain as coordinating between them and their insurance and what their needs are going to be when they are ready to leave to try to set up the best and safest discharge plan, um, for the next step. But, we do truly juggle between working for the hospital, because we do work for the hospital, but we do have to go by the guidelines of the insurance and be a patient advocate.

Participant J: I actually see myself as a UR role [utilization review]. And my first and foremost, when I pick up my caseload, the first thing I do is figure out what my UR responsibility is. Then after that, I think I just bounce to the discharge plan. I try to stay away from bedside nursing with hands on with the patient. But, I try to stay clinically aware. I think I am UR then I guess clinical comes after that for me. But, when I say clinical I mean piecing together the treatment plan . . . Yeah, clinical coordination, not hands on.

Participant J: . . . I have to look at the transfer orders [from ICU to floor], because half of the time, they're not going—they're [the patient is] going to get on the floor and those orders are not going to be what the patient needs to expedite his discharge and the physician's assistant isn't going to know that until the next day and [then] I've got maybe up to two days delay in a physical therapy evaluation . . .

Utilization management was the fourth theme. This theme describes the role the NCM has in demonstrating a patient's medical necessity for being in an acute care hospital, obtaining insurance authorization for the patient's hospital stay and post discharge services, and managing the patient's appropriate length of stay in the hospital. This theme is evident in several of the quotes above, but additional quotes are noted below.

Participant I: . . . "I'm your Case Manager. I'm the nurse that coordinates your insurance coverage and arranges for your after hospital services." Pretty much, that's the open statement, and I usually do [that] the first day I meet them, which is, you know, the day after admission and then I usually tell them "I know you are not ready for discharge now," because usually my patients aren't, "But, I wanted to introduce, show my face, and then I'll be talking to you once we know again what your plan might be" . . .

Participant L: I also give them, I am UR [Utilization Review] – I love UR. So, I always give them the UR, and I always tell people if you can't get it [patient's current clinical status] in InterQual<sup>®</sup> [a standardized medical necessity criteria system], there's a reason. Go in there [into the computerized InterQual<sup>®</sup> program], play around, try and get it in [to meet the acute care criteria guidelines]. If you can't get him in, there's a reason. We have to look at this. We have to make sure we are billing properly. So, I always focus on that.

Participant J: I agree L . . . I was taught to put my [insurance] calls at the top of the list. So, that I know that some time during the day—if those calls are not [at] the top of my paperwork down here, they need to be. So, I definitely, I'm like you L, I definitely look at the little bit of what my UR work is, um, and incorporate that in my day. Because, if I can get that done timely, or know what I have to look for for InterQual<sup>®</sup>. I'm also like (I), I don't hesitate to call physicians ever to say I don't understand why you did this, or why you are not doing this –throw me a bone [referring to acute medical necessity criteria that may not be well documented in the chart] –you know, or let me know what I need for the discharge plan.

The fifth theme that emerged was patient advocacy. This was described in relationship to coordinating patients' care and discharge planning with the insurance companies, as well as, with the hospital interdisciplinary team, particularly as it relates to patients' autonomy and decision making. One of the prior quotes illustrates this, but additional quotes are provided to support the pervasiveness of this theme.

Participant C [following a discussion on discharge planning]: Also working as an advocate with their [the patients'] insurances.

Participant F: I'll hear it from a nurse and this one patient I'm thinking of in particular, he really wasn't safe at home, and she felt that he should be put in a skilled nursing facility, but you cannot force someone – you know.

Participant K: I think, probably, I always tell my families this – if this was my own family, this is the way that we would go through the same process. You know, and just so that they feel like they can identify with you, that you are on their side. A lot of older people don't understand the term liaison. They don't, you just tell them, if you were my family member, you know, I would help you in the same way, and I am here to help you and [pause]. Moderator asks: So, advocacy? Participant K responds: Very much, very much so.

Theme six, resource person/problem solver, describes the NCMs as key and reliable sources of information and help – the “go to people.” The following discussion helps to illustrate this theme.

Participant E: I always tell, if I try to explain to my family why I had a bad day, I can't even articulate it into words. Because, you might have somebody coming to you with a complaint, um, you know, a patient complaint, you are arguing with insurance about something, you have two or three doctors at the door, a nurse at the door. [Participant] D & I have people actually lined up in the hallway. I'm sure we all do. Um, someone calling that they lost their teeth three months ago and could you help them.

Participant D: We are kind of like the catchall.

Participant E: Yeah.

Participant G: Nobody else knows what to do.

Participant B: We wear a lot of hats. Literally, we sort of take on the hat of whatever role it is and whatever you are faced with.

Participant C: Or, if they don't know who to ask, they figure we will tell them the right person or correct one if it is not us.

Participant E: I once had a nurse introduce me in CCU to a new orientee, saying "Oh, this is our Case Manager, E. That's who you call when you don't know who else to call or what else to do." So, I thought that was kind of a good one, because they say we can do everything.

While the NCMs described satisfaction with being able to help others, they also described this as a double-edged sword and source of frustration, which will be discussed later in this chapter.

Education on the insurance system and continuum of care was the seventh theme that emerged from the data relevant to this research question. The education was described as being provided on a continual basis to a wide range of individuals including patients, families, physicians, residents, interns, and nurses. The most frequent topics of education identified were related to insurance and discharge planning issues and barriers.

A few select quotes below illustrate this theme.

Participant C: And, nurses. Because they will say, "Why can't you get this person out of here?" [Discussing educating role regarding patients who are difficult to place post discharge]

Participant E: [In response to C]: Then, if you explain that you can have IV antibiotics in the nursing home, or not at home, or in the hospital, but not –"you mean the government would rather pay you three to keep him in a \$1,000 ICU instead of. . ." So, we hear that all the time, even from the attending.

Participant B: And the residents really don't understand the process, but that's a given. It is really a never-ending education process with them.

Participant G: But, that is also true of attendings . . . I mean they are a little more savvy to it, but we make it happen.

Participant E: If you try to explain the Options Process, especially when it's the target – Oh that's my favorite! Because it's a hard concept, you know, to understand. That's always a tough one. Or, I have had doctors say "Wouldn't it be cheaper for the hospital to pay for that antibiotic or whatever." We hear that a lot as well.

Participant H: . . . I find myself being the educator for both physicians, the families, outside facilities also, because we have to go thru the round. That patient's insurance isn't going to pay for a certain facility because some physicians, especially in our facility here, feel that all they need to do is call one entity and that entity will take care of everything. So, I find that I have to call them back to let them know and educate them this is why, you know, you need to come back to the Case Manager to let us know and then of course, we can go back out. But, I find it really difficult sometimes when physicians do that, no matter how many times I think we all, you know, educate the physicians, but for some reason or another they kind of do the same thing. . . So education, I think, and communication with physicians is a must for me. No matter how many times, I have to repeat it, I think it's important to continue to do that for them. And, no matter how many times you actually talk with families, sometimes it's real difficult. . .

The eighth theme identified from the data was emotional support. This theme was sometimes described as an extension of family education to help family members understand and feel secure with the transition of a loved one to the next level of care, but also to help families deal with serious life crises, such as an unexpected catastrophic illness or eminent death of a loved one. Some participants were at times visibly moved as they shared their experiences. A few notable quotes are provided to illustrate this theme.

Participant H: . . . Especially, if you have a family that's very comfortable in the unit, in the ICU, and they want their family member to stay here. No matter how many times you actually express that to them, and that they [the patients] will be comfortable, they will be fine, they will be taken care of, it's real difficult sometimes, and I can see them probably personally. You know what I mean, if my family member is here, they're on a vent, and I am afraid for them to go outside of here, I need someone else to convince me things are going to be fine. "You need to tour," – so education for the family members is important too.

Participant F: . . . I spend a lot of time with families and patients to talk about the dying process. So, there is a lot of emotional support, a lot of crying on their side and my side, but not in front of them. You know, I remember I was here like a

year and I had two patients and I was sending them both home to die and they were the same ages as both of my daughters. And, I remember I was going out to the shuttle and my daughter called me and I answered my phone . . . and I was crying walking to the shuttle, crying, and she said “What’s wrong with you?” And, I said “I’m losing these two patients.” . . . But, you get to know the patients here. You get to know their families. You get to know the ins and outs and you know what’s going on with them and you are part of their life. And, you know, that’s a big part of the case manager. You know, getting to know these people because they are in and out all the time. I just had a patient who I set up hospice for on Saturday and she died before she even left here, and I was shocked. I mean that just floored me. You know, she was doing so well on Friday. So, you just – your heart aches. So, it is sometimes a hard job for us all to do.

#### 4.3.2 *Research Question Two: What Key Case Management Practices do NCMs Perceive as Resulting in Role Success?*

The second research question was intended to ascertain what key case management practices NCMs perceived as resulting in their role success. There were four themes that emerged from the analysis. The themes are listed in Table 4.3 and described below.

Table 4.3

*Themes for Research Question Two: What Key Case Management Practices do NCMs Perceive as Resulting in Role Success?*

<b>Number</b>	<b>Theme</b>
One	Being Proactive
Two	Prioritize and Organize
Three	Strong Communication/Interpersonal Skills
Four	Creating the Right Atmosphere/Environment

The first theme discovered in the data was that of being proactive. This was described as taking early, typically within a day of a patient's admission, and ongoing action to ensure a patient's treatment plan and discharge plan stay on course. The actions varied, but include things such as communication, assessment, re-assessment, or requesting an order for a referral, such as PT/OT. The following quotes describe some of the proactive strategies NCMs employ and help illustrate this theme.

Participant C: I find one of the biggest things is keeping the bedside nurse really involved in what you are doing as you do it all along. Cause if you don't, you're -- [she hesitates] screwed.

Participant F: And also with the residents too. Keeping them up to date – you know, with what's happening and where you are at.

Participant B: I try to really give as good explanations to patients and their families as I can, in terms that they can understand. So that, we can be on the same page and they don't constantly come back with more questions that I thought I might have answered. I really try to make sense of it and logic of it to them, so I can then - I can move forward and just keep them progressed as the steps go on.

Participant G: I think I like to try to include in the explanation of whatever the discharge plan is going to be, rationale for why you are doing what you are doing and give specific sense to where. Like, if PT/OT is telling someone skilled, you know, I need to tell them what are the potential skilled options for them. Because, inevitably families come back and they want you to send them [the patient] to some personal care home some place. So, if you sort of set it up ahead of time, it works a little easier.

Participant C: I think being proactive on admission too. I mean, you look in the chart and somebody's 84 (years old) and they fell. You know right then we better get a PT/OT order. . . You know they fell, so just kinda know right away I might as well call this family, talk to this person, and it makes you -- it makes you, more successful getting people out earlier. You know -

Participant I: For me to be proactive and know what's going on with my patients, I review every physician's note every day. . . and then I read every nurse's note, at least on Mondays I will read the last nursing note. But, I read the nursing note to see if there is anything clinically that I am missing . . . to read the nursing note, tells me if there is still a foley in, whether that means that patient is going home with that piece of equipment or not and so to me the nursing, and then I read

every therapy note because my discharges are related to the physical therapist's recommendations . . . cause I'm going to have to address it with the family.

The second theme that emerged for this research question was the ability to prioritize and organize. The NCMs described a very fast paced and demanding work environment that often pulled them in multiple directions. In addition to being proactive, these skills were viewed as extremely important to their successful role fulfillment. The participant quotes below provide evidence of this theme.

Participant K: Probably the most important thing is that you prioritize, you know, where you are on a particular day. Um, if anyone on the unit had a question about any patient, it just is amazing to me that you recall every detail of every case at any given time. And, um, but, I think being able to prioritize and be proactive, that's the really most important thing that you can impart to anyone that's new. That's the job as Case Managers that you are being proactive and not reactive, and you know what's going on with your patients.

Participant H: . . . Cause, there are sometimes I have three or four things going at the same time and nurses have come to me and say, "What about this?" and I'll tell them that. Somebody else comes, and I can tell them, I can tell them, what's going right down the line, but I have to write it down for myself too though. You know what I mean? Cause, if I don't write it down for myself at certain times, I'll start at the beginning of the day and there are certain things I write down, and that way I take care of those things first, and then, you know, go from there. But, prioritizing and being organized is the key to getting through your day, and trying to do the best you can. So [when] unexpected things comes up, at least you have taken care of all the important things that you think is on your list and then you can do the rest after that.

Participant G: I think that's the major thing –it doesn't matter what the things are that need to get done. It's how do you juggle it all to make it work right so that you are getting – and it becomes a prioritization issue to me - So that I am getting patient A [discharged] I am focusing on that, [and] letting B & C slide so because that's the one [patient A] that's going to need to go somewhere first.

Strong communication and interpersonal skills was the third theme that answered the second research question. Participants emphasized it was not only what you communicated and how often you communicated it that was important, but also how you communicated it. They noted, if you did not do these things well, processes and

relationships would breakdown and negatively impact the outcome one was trying to achieve. The following quotes have been provided which support this theme.

Participant D: . . . Try to have an open line of communication with as many people as possible. Everyone -- that's, that's the key. Because, everyone has to know, you know, where we are going. And, there's so many people involved, and if you miss one little piece of it, it can break down right then and there. You try to keep everyone in the loop -- that's real good.

Participant I: I'd say if you didn't have strong touchy, feely, interpersonal skills, you couldn't do this job. Because, you have to give people bad news, you have to move them along, you have to encourage them, help them to make decisions they don't want to make.

Participant L: It's not what you say—it's how you say it . . . I've been told that many a time in my . . . days.

The fourth theme that emerged from the data for this research question was creating the right atmosphere or environment. What participants described was a larger concept than interpersonal skills, and was important enough to merit its own theme. The focus group members described how their own attitudes and behaviors not only impacted their success, but also impacted the environment within which they worked. The participant quotes below are several quotes that support this theme.

Participant I: And then the other thing that I do every day, it's corny, but, I greet every patient that I pass in the hall with a "Good morning," and I greet every family member that's walking down the hall that I make eye contact with, with a "Good morning." And I know that patient might not belong to me or that family member may not be relevant to whom I'm seeing, but somehow the appearance of being pleasant creates an atmosphere that people are pleasant back to you. And, I don't feel that people get so defensive, I think. So, even on the days that I don't feel like saying good morning, I still pretend that everything is OK and I create that image of "Everything is fine," "Good morning," "How are you?" "Can I help you with something?"

Participant K [in response to I]: I think also going along with that is, um, and I know that up on my unit everyone gets crazy, but it's maintaining a sense of calmness no matter what. That you are not spinning out of control. That you have a handle on it, there is no need to over react . . . and it's noticed by everyone you come in contact with on that unit. They really rely on you.

Participant E: I think you have to be tolerant and patient in this job. And um, I get discouraged when I see, to be honest, some of our coworkers don't approach things [that way] and that's - we're here to do placements and home care and insurance and talk to families. And, we always make a joke, C, D, & I, that this would be a really good job if it wasn't for placement, home care and insurance. [Lots of laughs]. I mean that's the job. So, if you have someone else come, you know, to say they have another placement, that's what we are being paid to do and I think we have to do it with a good attitude. And you know, it's a two way street then. If we treat the nurses, and the residents, and the physicians that way, respectfully, you know, I think we are treated back the same way.

Participant D [in response to E]: I think E, you know, hit the word there - Attitude too. I think, I think the most successful of us, in whosever eyes that is, have a positive proactive attitude. The cups half full not half empty. And you have to have that, cause if you don't, you start draining yourself and you start draining those around you. It might not be your best day, but you kind of hitch it up and say let's go and put the best foot forward. I would, you know, would say I know everyone in this room, you too, can do that. I have seen it more than one time out of everybody here. And that's, I think, a big plus for all of us.

#### *4.3.3 Research Question Three: What Do Hospital Based NCMs Describe as the Most Significant Factors that Contribute to Their Successful Role Fulfillment?*

The third research question sought to uncover what NCMs perceived as the most significant factors (other than their personal case management practices described above) that contributed to their successful role fulfillment. There were five themes and four sub-themes that emerged from the analysis. The themes and subthemes for the first theme are listed in Table 4.3 and described below. While the data grouped around one central idea for theme one, its scope was broad and included several important components. These components help describe the overall theme more effectively, but did not have sufficient data to be considered themes in their own right. Therefore, the subthemes were included to enhance overall understanding of the core theme.

Table 4.4

*Themes and Subthemes for Research Question Three: What Do Hospital Based NCMs Describe as the Most Significant Factors that Contribute to Their Successful Role Fulfillment?*

<b>Number</b>	<b>Theme</b>	<b>Subtheme</b>
One	Experience	Strong Nursing/Clinical Life Experiences Consulting Peers Knowing Unit Dynamics
Two	Manageable Caseloads	
Three	Good Orientation	
Four	Technology/Clerical Support	
Five	Personal Strength/Resourcefulness	

The first theme that emerged in the data relevant to the third research question was experience. The types of experience described were broad and varied; therefore, to better illustrate this theme, the subthemes noted in Table 4.4 were also included to give the reader a better understanding of the participants' views. The participants shared that their experience enabled them to effectively deal with the complex case management situations they were faced with. The quotes below demonstrate this theme and its subthemes.

Participant J - Well, I'm orienting somebody today and Dr. Welby came up to us and said, we both have been in the hospital a long time, and said "I want to know when the two of you are going to teach?" We laughed and he said "You know, you're moving around here. Why don't you just go teach if you know so much

about what is going on in the clinical area of the hospital?” And I looked at my orientee and I said, “This is kind of what makes, I think, makes a good case manager.” If you have a good clinical background, not necessarily specifics, but you know, enough to know to ask, because a good nurse knows when to ask the questions. Knows when to say “I don’t know about this,” “What do I do now?” “Who do I call now?” “Something’s wrong here with this patient, I don’t know what it is, but what do I do?”

Participant H: I think you just have to look at life experiences. I think that helps me more than anything. I just look at life experiences. You know, what have I personally been through, and what have I learned along the way. You know, I’m always sympathetic with them [patient/family]--I think I’m empathetic. You know what I mean? I know where they’re coming from, and, um, certainly, hopefully, I can help with that - just the fact that I have life experiences that will help me do the things I do, on a day-to-day basis.

Participant J: I don’t know about the other people, but I know in our office, there was three of us . . . and we all three have been here a long time. But, we always, if we had difficult case, we would shut the door and say “Turn around guys. I have to ask you about this.” I mean asking for other people’s expertise in case management can really --“Would you do this differently?” Sometimes, I just do it to be sure I did everything right, because I’m beating myself up.

Participant B: I think knowing each unit, as all of you have assigned units. Knowing the unit and the dynamics of that unit is extremely important. I have certainly found that all units function differently. And, I should think that I am notifying the right people and only to find out on this floor it should have been this other person that I should have gone to first. You know, you learn by making mistakes, but that’s very helpful and it makes everything work better for them as well as you.

The second theme relevant to this research question that emerged from the data was manageable caseloads. The general view was for each unique population there was an upper caseload threshold due to the unique needs of that population. Staying below that threshold resulted in role success, and exceeding that threshold contributed to less success and feelings of frustration. The frustrations related to caseloads will be described later in this chapter. The participant quotes below demonstrate this theme.

Participant J: Caseload numbers. I function much better in [name of service line] with a caseload of 15 patients. I go above 15 or 16 patients, I start to get - that’s a lot of placements. And I think that in a lot of areas, we do crisis intervention.

People have strokes, they're in crisis. When people have heart attacks, they are in crisis. Because I am a nuts and bolts person, for me, if I start to be overwhelmed with the nuts and the bolts, I start to lose it on how much time I can spend with people, and I think that time is important. So for me, case numbers, make a difference.

Participant G: . . . I think the true factor is what is the caseload in terms of the needs that these people have. You know, I can take and baby-sit 25 cases if I only have one or two [patients] that need to go some place. But, you take that [same number] - you can't do home care when you are trying to place into SNF half a dozen [patients] -- and all having to go today, of course.

The third theme that emerged for this research question was a good orientation.

The participants' views relative to this theme was, due to the complexity and breadth of the role, having a solid foundation was critical to ongoing role success. The general view was that recently the orientation process had become fragmented compared to the past, and the focus group members had constructive suggestions on how to improve the orientation for future new hires. The quote below provides evidence of this theme. The strategies for improvement and quotes supporting that theme will be discussed later in this chapter.

Participant B: A good orientation to this job is vital. Um, I was so caught up when I was being oriented into all the technicalities, which you have to be because there are so many things that are new, that large concepts kind of slipped by me for a while. And then, I had to back track and get some of the larger pictures. I mean, I had some idea, but there were things that I needed to fit together. Which, um, I had to go back and do on the back end. But, you know you have to learn so many things initially to be able to move on that that's what you concentrate on initially - it's just those, those things. But as a nurse, there are so many other things that you have to put together – pull together later which -- I felt difficult.

Technology and clerical support was the fourth theme that emerged from the data relative to this research question. The participants noted that again due to the complexity of their role, they would not be successful without technology, such as computers, fax machines, and wireless phones, as well as having clerical support to perform certain tasks

that do not necessarily require a nursing professional to do. Quotes that support this theme are provided below.

Participant I: I know that some of the things that I can't function without in order to do my job is a computer. I keep all my data, my notes, my contacts, um, all existing files and folders in my computer and I don't have access to that information, I'm like screwed. I just can't move anything forward. If I can't print, or if I can't fax, I can't move anything forward, because every facility wants documentation. You know-- that's how you coordinate things. If you are going out of state, you need to send a PASSAR to the state of Ohio or West Virginia. You gotta wait for a response from them by fax before you can move a patient. So, it's the physical hardware that makes my job so unbearable when it doesn't work. When it works, life is good.

Participant J [in response to I]: Ancillary staff, too, I think, you know, when I do have higher numbers, and I have somebody to help me with things that somebody else can do, like faxing, like entering authorization numbers, you know, um, like it's a little bit easier for me to spend time with families, if I don't have to run charts down to medical records --if 8400 is available [8400 is an extension to call for escort staff]. You know, um, I am agreeing with you too on the computer, the adjunct to that is the telephone. You know, it is really frustrating when you cannot get people to call you back. You know, you have left voice mails after voice mails, and your hands are tied if people don't call you back in a timely fashion.

The fifth and final theme that emerged in the data relative to this research question was personal strength and resourcefulness. This theme describes the participants' views that to be successful in this role you need to be hardy, perseverant, resourceful, and rely on internal gratification of the role rather than external gratification, which they shared is in short supply in their fast paced, demanding world. Select participant quotes have been shared to provide evidence of this theme.

Participant C: I think a strong backbone too. Because, even though I cry sometimes, like sometimes it is very hard, very, when one after --when everybody doesn't know that they are about the tenth person that had a problem, and you know that when you get up to this level, it's like OK, you know they're yelling at you about it, but they know it is not your fault but....

Moderator [seeking clarification from C]: So, a strong constitution, perseverance?

All [in response to moderator's question]: Yeah.

Participant E [following a discussion on how she and C built walkers together on a holiday when they could not get them from a Durable Medical Equipment (DME) company]: Yeah, can you believe we did that? I mean, talk about people being resourceful. I found that there was some walkers on [name of nursing unit], but they needed assembled. So, I ran down to get them and brought them back up to [another unit] with wheels under this arm and carrying the walker, and we brought them into the office . . . I remember seeing a physical therapist and I called her to help adjust them and then we had to get a male nurse to pull out the little stoppers. This was about 4:45 on Memorial Day and we still had all kinds of things to do, but....

Participant K: . . . You don't do this job for the external gratification--you do it for your own internal gratification, and you do it, I say despite the support that you're given. I did it, um, even though I don't feel like a lot of times, it's not done for anyone to notice it. But, you do [it] because - and you do it good, and you stay until 6:30 on Friday night, because you know it has to be done.

#### *4.3.4 Research Question Four: What Do Hospital Based NCMs Describe as the Most Significant Challenges, Barriers, or Frustrations They Encounter in Their Role Fulfillment?*

The goal of the fourth research question was to learn what NCMs perceived as the most significant challenges, barriers, or frustrations they encountered in their role. There were five themes and ten subthemes that emerged from the analysis. The themes and subthemes are listed in Table 4.5 and described below.

Table 4.5

*Themes and Subthemes for Research Question Four: What Do Hospital Based NCMs Describe as the Most Significant Challenges, Barriers, or Frustrations They Encounter in Their Role Fulfillment?*

<b>Number</b>	<b>Theme</b>	<b>Subtheme</b>
One	Compensating for Others	Lack of Accountability/Follow Through Inexperience Poor Communication/Direction Incomplete/Inaccurate Information Adding/Shifting of Work
Two	High Caseload/Workload	
Three	Discharge Support Role	
Four	Placement Challenges	PT/OT Referrals Physician Issues Limited Access for Special Populations County Assessments for Level of Care Ethical Dilemmas
Five	Documentation Challenges	

The first theme that emerged from the data was compensating for others. The theme described the frustration participants shared related to an increased workload or rework due to the need to pick up work that is perceived to normally be the responsibility of others. The subthemes listed in table 4.5 categorize the views participants had related

to the various root causes for this increase work and/or rework and characterize the extensive discussions generated around this theme. Examples shared included nurses not forwarding critical messages vital to the patient's care or discharge plan, or new residents or graduate nurses not knowing to take timely action on information they received. Other examples included poor communication and/or direction between attending physicians and their residents or physician extenders. Other scenarios involved the need to track down missing or correct inaccurate essential information such as demographic or insurance information. Last was the perception that new responsibilities often become a requirement for the NCM rather than other applicable roles, and responsibilities that used to be the bedside nurses', particularly related to the discharge of a patient, have shifted to the case manager role. The quotes below demonstrate the overall theme and subthemes.

Participant I: I think the intervention sometimes with your nursing staff is touchy. They're, they're very overwhelmed with the work they have to do, and therefore, expecting them to do anything -- you need to do it yourself, only because you know that they can't follow through. Today's discharges, I know that this patient is going home on Saturday, but I know that this patient is going to a bed that a patient [at the SNF] has to be discharged from on Saturday morning. So, you [referring to the nurse] must call the facility Saturday morning and make sure that patient [at the SNF] is discharged before you send this patient that I set up to go. I leave the message for the discharge resource nurse who's working the weekend. I let the staff nurse know that's the story. I let the charge nurse know that's the story. I happen to be . . . working the next day [Saturday coverage], so I'm going to follow up, and neither the staff nurse nor the charge nurse are aware that's an issue. That [message] does not get passed along. It's just like - and I know I had that conversation with you, and you're the same nurse I talked to on Friday, and you have the patient again on Saturday, and STILL you don't -- "Well, isn't that your job to do it?" [nurse back to NCM]. . .

Participant L: The family is going around asking questions, and nobody knows. You're telling them that they're leaving, and nobody else seems to know what's going on. So now, you got families wondering around like "Wait a minute. You said this and --"

Participant J [in response to I & L]: It's accountability . . . People don't want to be accountable, they want to just dump it back on you because you . . .

Participant H [in response to I, L, & J]: Uh huh, it is accountability.

Participant H: Sometimes, I find that new graduates, for some reason or another, this is their list of things that they can do right now, and they can't go beyond that level, they just can't. [They'll say] ask somebody else the same thing . . . well, this is your patient so you have to deal with it. So, I find that sometimes really difficult, because then when that happens, I find that they're not able to complete their tasks, so therefore, I have to help them do that plus do what I'm doing . . . So, I found that difficult when I have to take care of all these other clinical things, that, I know somebody else should be taking care of . . . It seems like, I have to make sure all these little things are done before I can actually get that patient out. But, if I don't do it, I feel that, that patient is going to sit here, because everybody else doesn't seem to be able to put their name on the dotted line that this is ok.

Participant L: Wishy-washy physicians. Cause, we're trying to direct families, and we have wishy-washy physicians or these fellows haven't spoken with the attendings, so, they're giving you directions that I know the [attending] doctors aren't [going to support]--- I'm saying "Did you talk to Dr. Wellby about that, because I'm not going to get this family all riled up until you spoke with your attending?" So, wishy-washy--

Participant J [ in response to L]: The fact that we're a teaching hospital, and we do have new interns and new residents that come in . . . the nature of a tertiary care hospital lends itself to that.

Participant B: Often times the information we get on the Face Sheet [demographic form] is so wrong. That causes us an unbelievable amount time of to straighten that out. Either we don't have any family, that we have to struggle with, or we have families or next of kin are already dead. Their addresses and phone numbers are incorrect . . . And the insurance, sometimes, it is several days before you actually find out what insurance they have. And--that makes all the difference in the world.

Participant B: You feel like your the victims of it if you want something done ask a busy person ---I feel that we are that busy person that just gets more and more things dumped in our lap, and some how we try to do it. It's amazing.

Participant E: I think when an orientee was with me, and she's been away from the bedside for a long time, she marveled at how many things that we do that the bedside nurse used to do. She'd say, probably six times a day, "Why are you doing that?" Say, getting something for the person's discharge that normally the bedside nurse would have done before.

The second theme that emerged regarding this research question was high caseloads. As noted previously, the participants voiced frustration when caseloads exceeded a perceived threshold for their particular population, and viewed this as a barrier to successful fulfillment of their role. Several participants shared the perception that at times there was an attempt to even out the number of patients each NCM carried on a caseload without taking into consideration the intensity of the work required for a particular population or the number of units the case manager had to travel to. As a result, rather than making the workload equitable across the staff the opposite occurred. Below are participant quotes that provide evidence of this theme.

Participant H: For me personally, if my caseload is high and I can't get to all the things I need to do for that day for myself. It's frustrating for me, because I set a certain amount of things I want to do that day, and if I can't get that done...that, that bothers me more than anything. To get all the things done, that I need to get done that day, and if my caseload is high, I just can't do it all.

Participant C: I think sometimes, I don't mean case load as far as numbers go, patient mix or however you want to say that, and also trying to have everybody in the whole hospital have the same amount of patients. It isn't always to me, the best way to go and it's a barrier. That I have 20 patients and I have to go somewhere three times to just to see two more [patients].

Participant E: When we redesigned the role, and we went offsite and we actually weighed the different...that this floor has this much UR and placement. Now, I think we really [have] drastically gone away from that where we want to even up the numbers and that's all it is.

Participant B: Numbers really don't even begin to give you a picture.

The third theme related to this research question that emerged from the data was a discharge support role was viewed as a source of frustration and barrier to the NCM role. This discharge support role is a second RN (registered nurse) role, within the study hospital's case management department, that supports the NCM role for patients who are in need of post discharge services in the home (e.g., home care, intravenous infusions or

injections, DME, etc.). While the NCM is solely responsible for facilitating the placement of a patient to another level of care setting, she has the option to make a referral to the discharge support role to assist with set up of services in a patient's home. Under normal circumstances the department was staffed with four full time individuals in the discharge support role; however, there had been a recent and prolonged staffing shortage in that role due to vacancies and medical leaves.

Some of the frustrations shared were related to the practice of turning off the flow of referrals to the discharge support role during times of short staffing. During these times the NCM would either need to complete the work herself, or, time permitting, wait for the referral flow to reopen. Ironically, this practice evolved out of a staff brainstorming session on how to deal with the discharge support role staffing crisis. A second source of frustration shared related to individual practices among the support role staff including: a) Leaving work undone that ultimately had to be picked up by the NCM or weekend staff; and b) requesting so much detailed information on a referral, or for so many steps of the process to be completed, that it would be easier for the NCMs to just complete the final step themselves.

A third general perception of participants was the discharge support role was useful and effective when it was established, during a model redesign years ago, but that was no longer the case due to a changing environment. Factors in the current environment compared to prior years that participants identified included things such as the increased number and complexity of patients needing to be placed, increased access to and transmission of electronic clinical data, and an increase number of DME and infusion companies that provide on-site referral services. They perceived the discharge

support role contributed to a broken and outdated case management model that needed to be redesigned. When probed for clarification, the participants conveyed their view of the model was the same regardless of discharge support role staffing level due to the inefficiencies inherent in the role (not the individuals in the role). Most notable was the perception there are significant periods of downtime in that role alternated with significant overload due to the nature of the discharge patterns by day of week and time of day. These periods of referral overload result in process and patient delays that impact service delivery. Participant quotes that demonstrate this theme are provided below. The participants' suggestions for improvement are discussed later in this chapter.

Participant E: I am going to say something, I guess probably won't be very tactful. But for example, on Friday, with the Discharge Resource Nurses (DCRN), we were able to get a call that said that more or less their plates were full, but again as a Case Manager I never get to have anybody say well E's plate is full now. D & I are pretty aggravated when we get that message. And then, you know, because we don't have a quota of placements, or home care, or hospices, or UR reviews to do, or people to talk to. It just -- we have to keep whatever the day has.

Participant E: . . . but then the Discharge Resource Nurses go home, and I feel like the Case Managers are here picking up the work, and that's exactly what happened this past Friday. And, that's a very big negative to me in this job right now.

Participant E: . . . I feel that I have to present it [the referral] on a silver platter. I have to talk to the patient, find out if they have Home care before. I generally am getting the authorization. I'm getting the doctor to write the order/prescription. So, at the time I bring her in, basically she's [only] making a quick phone call and faxing it . . . I also don't like the fact that if my patient wants to go home, I don't want to have to wait until she [DCRN] finishes on a couple of other floors. It's the timing too.

Participant D: Things have changed, I guess over the years in regards to that. There are so many more liaison [DME, infusion] people on the floor and available . . . where as before some years ago, we did it all ourselves. You picked up the phone and you would spend, you know, 2, 3, 4 hours to [infusion provider] faxing off information to them. It was real time consuming. Where now, it's real quick.

Participant F: I do most of my home cares . . . The simple reason I do it is because I'll tell them [DCRN] at 1:00, and at 3:30 they're calling me "Can you do it? I can't get to it." I have gotten burnt too many times, so I just find it easier.

Participant E: And then, our home care [agency], I mentioned that to D this morning, is so much simpler to use, because, they now have access to Sunrise [electronic medical record] and the portal [electronic repository of labs, etc.]. So, you just call [the referral nurse] and it's less than a 30 second conversation.

Participant K: The system has gotten, with the Code Green [a hospital wide patient flow improvement initiative] – it [model] just does not work—it does NOT work.

Participant I: I think K said it really well this morning in the office. That we're working on a model that is seven years old--trying to make it work in a system [and] world [that] has changed. The DCRN are an encumbrance, they're a delay. I can get my patients' needs met sooner, if I do it myself. I'm already having the conversation [with the patient]. I'm already identifying what the needs are. It's one phone call for me then to set up the services, or arrange for the equipment. With rare exceptions, and plus my skills are weaker than they ever were, because the DCRN does IV antibiotics, IV Zosyn, and PO Zyvox. I cannot remember on Saturday, when I'm responsible, how to do that- when I am responsible. When I don't have any resources on Saturday. No references on Saturday and no one to go to on Saturday to ask that question. I'm in charge. It's a bad model—it, it, it's not effective. I have patients looking at me on Saturday. If I get home before my potty chair is delivered and I have to use the bathroom I can't use the toilet. I had a hip repair. I made that referral to the DCRN to set up those services on Thursday, here it's Saturday, we're discharging the patient home, and the patient's looking at me because the equipment isn't set up and delivered. You know, it's breaking my heart and it's ineffective - it's really ineffective.

The fourth theme related to this research question that surfaced from the data was placement challenges. The theme describes participant views regarding issues that delay a timely patient transfer to the next level of care. Participants expressed role frustration related to the challenges and barriers identified. The sources of these challenges were varied and broad in nature; therefore, the subthemes listed in Table 4.5 are provided to assist in characterization of the overall core theme.

The PT/OT subtheme describes participant views on several barriers that result in either a delay in PT/OT services due to staffing shortages and/or lack of orders, or

discharge delays due to PT/OT level of care recommendations that are inconsistent with the medical necessity criteria that Medicare and other insurance companies use to authorize payment for the various care settings. In addition to issues previously described in other themes, this subtheme also describes the problem of physicians setting up unrealistic expectations in patients and/or families relative to a specific level of care (e.g., SNF vs. IPR), or on a specific facility. This frequently results in placement delays and extended length of stay while insurance appeal processes are initiated for a level of care the patient/family now feels entitled to, or re-education of the patient/family is provided relative to in-network insurance coverage and financial responsibility issues. The limited access for special populations' subtheme describes the difficulties participants shared regarding placement of particular populations such as the uninsured or medical/surgical patients who also have a drug/alcohol diagnosis, a behavior health/mental retardation diagnosis, or end stage renal disease. The county assessments for level of care subtheme describes the barriers and frustration shared related to this process which requires the completion of official forms and a formal level of care assessment by a county Area Agency on Aging staff member. This process can be confusing to those involved and may take days to weeks to complete dependent on multiple variables that are involved and mostly out of the control of the case manager. The final subtheme ethical dilemmas describes the challenges NCMs face as they are involved in patient/family decision making relative to patient placement. The participant quotes below illustrate the overall theme and some of the subthemes described above.

Participant I: And their [PT/OT] recommendations – are always, always, always, always the highest level of rehab possible, and because they believe that-- their philosophy is this patient was independent prior to admission, they deserve the BEST SHOT. Yes, and professionally they're probably right. I have to stand

corrected, and say professionally you are probably right, but in the real world I can't make this happen, and you just disappointed a patient, a family, a physician, made me to be the bad guy, cause I say this is all your insurance is going to pay for. Would you like me to make referrals to this level? And, when you can't convince...when it appears that you're leading the family in a direction that they don't want to go, and they are resistant. Then, you make the inpatient rehab [referral], you get them accepted, you refer the information to [insurance company]---[insurance company] laughs at you, they send you to their PA [physician advisor], they have 24 hours to respond to the PA. You've increased the LOS four days while you're working the process out [when occurs on a Friday]. And it's the patient's right to have that process done, and then you explain to the physician that I'm sure the physician [PA] will be calling you to appeal - that you will have to appeal and the physician says nay huh . . . "Well, I guess he could go to a SNF," because the physician won't appeal.

Participant D: I think too like for us there are two clientele types are the drug, uh, the drug people, the homeless people, as well as, the psychiatric people . . . they have ongoing care needs and nobody will touch them with a 10 foot pole, and I don't care how many Options you do. It's all done - the package is all wrapped and no one will take it.

Participant I: The ethics of people asking your advice. For placement, and you cannot support or condone anybody. As a matter of fact, you just need to get them discharged . . . "You [patient/family] just make a choice." "You make a choice, you want to tour, you go ahead tour, but you make that choice." And I'm going to send that patient there. It's very ethically hard for me sometimes to encourage people in go in a direction that meets the institution's needs, but not my moral sense of right and wrong. When someone says [facility name with questionable reputation in the community], I still have a problem keeping a straight face. You know?

Documentation challenges was the fifth and final theme that emerged for this research question. This theme describe the barriers and frustrations related to duplicate and/or redundant documentation, numerous locations of data, the numerous forms to be completed in order to be in compliance with various regulatory, accreditation, or insurance requirements, or the challenges of having a half paper and half electronic medical record (EMR). The participant quotes below support this theme.

Participant C: A big barrier, a big negative is redundant paperwork, and that has always been a need since day one - to discharge somebody-- how many pieces of paper we are responsible for? I can't remember - the last count was six.

Participant I: That is valid [regarding barrier of having a half paper and half electronic chart]. It used to be you just looked at the chart and you were -- cause the orders were there, and now you have to look at the chart [to] read the progress notes, go to Sunrise [EMR] [to] check your orders. But, once you develop that new habit of practice, and that's the reality . . .

4.3.5 Research *Question Five: What New Interventions, Supports, or Strategies do Hospital Based NCMs Perceive Would Enhance the Successful Fulfillment of Their Role?*

The purpose of the fifth research question was to discover what new interventions, supports, or strategies NCMs perceived would enhance their role success. Five themes and five subthemes emerged from the analysis. The themes and subthemes are listed in Table 4.6 and described below.

Table 4.6

*Themes and Subthemes for Research Question Five: What New Interventions, Supports, or Strategies do Hospital Based NCMs Perceive Would Enhance the Successful Fulfillment of Their Role?*

<b>Number</b>	<b>Theme</b>	<b>Subtheme</b>
One	Streamline Work/Documentation	Role Analysis/Reassignment of Tasks Fully Electronic Medical Record
Two	Education	Revise/Enhance NCM Orientation Educate Others on NCM Role Education Consumers/IDT on Insurance
Three	Enhance Accountability in Others	
Four	PT/OT Enhancements	

The first theme that emerged from the data was to streamline work and documentation to increase NCM efficiency and effectiveness. Participants described two aspects of this overall theme that were further categorized by the subthemes. The first subtheme, role analysis/reassignment of tasks, describes the participants' views that there may be opportunities to eliminate or reassign some NCM tasks to others, particularly clerical tasks or parts of the county assessment for level of care process. They recalled this type of analysis had been done in the past with success, and may be helpful again. A second opportunity regarding role analysis/reassignment of tasks identified was related to the set up of services in the home post discharge. Participants viewed the organization would be better served by reallocating the human resources currently dedicated to the DCRN role to the NCM role instead. The general views on the benefits of this were it would improve overall service delivery to patients by eliminating the inefficient referral process for home services previously described, and allow for more manageable NCM caseloads. The participants emphasized they are doing the majority of that process anyway and would easily be able to absorb the work of the final step if their caseloads decreased. The electronic medical record subtheme included not only the integration of the current paper and EMR to aid in the NCM's access to information, but also the hope that some of their forms could be consolidated and automated, and overall data entry requirements would diminish.

Participant B: There are things about the job that could be, um, maybe if you streamlined it, or you looked at all the responsibilities that the case manager has, is there anything that could be pieced out to another individual. Like you did with the faxing, which is done by the clerical staff, which is wonderful. If there is anything else that could be pieced out . . . I feel that the placements are really pretty good coming from the case managers. So, it is really hard for me to say that

would be something you would want to piece out to someone else, but the Options....I would have no problem with that.

Participant E: . . . So, I personally would much rather have those four people be case managers and have less patients than have them [DCRN].

Participant K: . . . I think we're working on a system--I would much rather have them [DCRN] in the numbers [CM staffing], and be case managers and let us do our own [home service referrals].

Participant J: . . . I don't particularly think the model works --it reminds me of when we were PCC [Patient Care Coordinators], when it was PCCs and UR people [these roles were from an old prior model that had separate roles for care coordination and utilization review]. We were just starting to see too that overlap, and it was a waste of man power for the PCC to go in and ask the patient and then the UR person to do it later, and the home care nurse - so we did combine those, and my personal opinion, I agree with K- I'd like to see those positions back in the CM numbers. It is a rare occasion that I use a DCRN. Some body is using them.

Participant I: Uh huh [confirming the view to convert DCRN to CM]...if you can keep our numbers between 15-18, we can do so much [more] effective job. Once it gets over 18, you really have to prioritize what gets done and what doesn't.

Participant K: Well, not only that. I think the accountability, you know, you'd be easily accountable for "Why aren't your discharges out by 11 am?" I mean it's not external things—you're not relying on someone else to do that part of it. You're accountable. You'd prioritize it so that you have them out by 11 AM or there's some valid reason why not.

Participant E: I think once all the charts get on line, because it's actually in many respects takes more time to have to get the orders in Sunrise [EMR]. If there's not something in the portal, you're still going you know...I think usually most of us start with the H & P when we are doing a review, but if there is not an H & P there - but you're already going thru Sunrise to find them, then you're really not piecing the whole thing together, I find it very difficult.

Participant C: Maybe some of the forms I don't like are going to be automated.

The second theme to surface in the data relative to this research question was education. This describes the overarching view that education was needed; however, because the audience and focus of the education varied, three subthemes also emerged. The first subtheme described the participants' views that the NCM orientation could

benefit from several enhancements including: a) Keeping the orientee with an initial preceptor in one service area longer than current practice to establish a better foundation of case management knowledge and processes; b) develop content area experts for complex concepts/processes such as the county assessment for level of care process; and c) provide a classroom experience on the various computer systems for new hires early in the orientation. The second subtheme was more education should be provided to others regarding the NCM role. The audience for this education included patients/families, physicians, residents, and new hires. The third subtheme described the perceptions that more education about insurance should be provided to consumers and the interdisciplinary team members, who, as participants pointed out, are also consumers.

The following participant quotes provide evidence of this theme and its subthemes.

Participant C: I think that that orientation should change also, in that, you know, after 2 weeks you are not 2 days here and 2 days there - you stay with one person for 4 weeks or however long it takes to learn the job, and then [when] you go to the other places [it] is incidental. Cause, if you, if you're already an experienced nurse, you need to learn THIS job - whether you take it to neuro, or ortho, or whatever, it doesn't matter. It seems like the people are coming to you after one week and they don't know the job yet and you are trying to teach them the job and a service line.

Participant J: I don't honestly know what kind of education people, residents, or new employees get, but I want to see a CM talk to people on orientation. I would love to [have] somebody explain the role – one of us who knows it...to residents and to maybe new nurses. The role is confusing enough to families, and you know, how many times have you guys been told “Why don't you do that?” “Well, that's your job.”

Participant J: . . . What about, just more education for the charge nurses? You know, they don't know it and sometimes they just stay ignorant. “Oh, I don't know anything about that insurance stuff.” But, you know, we live in a world now that you need to know about your insurance stuff - even as a consumer. Consumers come in and don't know, and you have to say to them “You know, it's your responsibility to know what you're purchasing.” Just in general, as consumers and health professionals, there should be more...they should know a little bit more.

The third theme to emerge from the data relative to this research question was to enhance accountability in others. The participants viewed that if others would be more accountable to follow through on their responsibilities, the level of NCM frustration and workload would diminish. For example, if the NCM could rely on the people accountable to pass on important information to those that need the information, she would not have to run around telling every possible person who may need to know. Another concern shared was not all nurses fulfill their accountability to get patients out of bed, which causes patients, particularly the frail and elderly, to become de-conditioned. Participants viewed if all nurses were held accountable for getting patients out of bed, the number of debilitated patients needing to be placed would go down. Yet another example was if complete and accurate insurance and demographic data was gathered and recorded, the case manager would not have to spend hours chasing that down that information to avoid discharge delays and reimbursement denials. The following participant quotes demonstrate this theme.

Participant J: . . . We do so many things that are courtesies to make everybody just...so, how many times do you tell people the patient is discharging? I might as well tell the housekeeper. And, I've told the charge nurse, you tell the Manager, you tell the CES....you're going around telling everybody...you know, walking around...you tell the PA. Somebody is going to come to you and say, "I didn't know that." We already touched on this....accountability. If I tell, who do I tell, the bedside nurse, the charge nurse? If I tell the charge nurse, I usually say to her, "Will you please let so & so know. I've already told the PA [physician's assistant], I've already told so & so..." But it's like, you just have to run around like a chicken with your head cut off.

Participant E [following a discussion on getting patients out of bed and physician orders to do so]: And, even at that [physician order to get patient out of bed] they don't. And so, we let the patients that are 85 years old lay in bed. And the next thing - they're de-conditioned.

Participant B [continuing the discussion on patient mobility and de-conditioning]: We place more people than I can believe. . . . I am just amazed by the number of placements that there are here.

Participant C: How many times do you go into a room and the patient is 79 years old and you say “Have you been out of bed?” and they say “No, not yet.” Why? “Well, the nurse didn’t tell me I can get out.” And, they have been there 5 days. And, they were independent before they came in.

The fourth and final theme that was evident for this research question was PT/OT enhancements. This theme describes the participants’ views that more PT/OT staff are required to meet the number of patient PT/OT evaluations and ongoing therapy required prior to transfer to the next level of care, that more appropriate utilization of the existing staff was needed, and PT/OT, as well as, physician recommendations regarding the patient’s level of care needed to be more in synch with Medicare and other payer medical necessity criteria. Below are participant quotes that support this theme.

Participant H: They need more [PT/OT staff]. They’re overwhelmed.

Participant J: They [PT/OT staff] are very overworked.

Participant C: . . . The physicians order PT on wrong people, for instance, I had a 50 year old who was walking in town and had a syncopal episode. PT/OT was ordered. For them to go and review the chart and sign the patient off. As [compared to] an 84 year old who fell at home that you have to call and say can we get it [PT/OT orders] on them? They don’t know who, how to order ---

Participant L: They should be trained to only look at those recommendations when you have a CMS diagnosis that qualifies for inpatient rehab, or at least have a way that we can fight it [justify a patient diagnosis that is not on the list of CMS rehab diagnoses].

Participant I: That’s the part of the story that they don’t get. It’s a Medicare patient ---- I’ll be glad to make a referral to inpatient rehab, but. . . .

*4.3.6 Research Question Six: How Do Hospital Based NCMs See Their Role Changing in the Future?*

The sixth research question’s aim was to explore how NCMs saw their role changing in the future. Five themes were identified from the analysis. The themes are listed in Table 4.7 and described below.

Table 4.7

*Themes for Research Question Six: How Do Hospital Based NCMs See Their Role Changing in the Future?*

<b>Number</b>	<b>Theme</b>
One	More Technology/Electronic
Two	Faster Pace/Time Compression
Three	More Sick/Complex Inpatients
Four	Increased Pre-Hospital/ED CM
Five	Some Things Won’t Change

The first theme that emerged from the data relative to this research question was the perception that there would be more technology and electronic tools. The participants recalled how much things had changed just over the past 10 years.

Participant D: More technical - more electronic - I can see that happening eventually - that is the way of the world . . . Just look how much it has in a short period of time, 10 years.

Participant C: Remember green sheets [manual UR form from 10 years ago]?

Participant E: Yeah.

Participant D: Yeah, green sheets, huh. Yeah, oh boy.

The second theme that surfaced was the view that the hospital would become an even faster paced and time compressed environment than it was now. Below are participant quotes that support this theme.

Participant J: Well, I often times make a joke about, “Why don’t they just discharge them from the Recovery Room?” Because, it’s like, you know, they get the patients up and they’re ready to go, and they’re actually not usually ready to go. They still haven’t even eaten yet.

Participant G: But, I think it’s a compression factor. People are not necessarily sicker or more complex, instead of taking a week to move them you are trying to do it in 3 days. And, if you take 10 people and compress them into 3 days, suddenly, it is much more difficult to do all that activity just to get it done.

The third theme that emerged was that hospital inpatients will be sicker and more complex. The participants viewed more and more patients will be treated as outpatients, and those who make it into the inpatient hospital setting will be extremely ill and likely require long term acute care (LTAC). They also perceived there would be increased barriers to placing special populations such as those previously described. Participants shared they believe increasing gaps in community resources and an increase in the uninsured will contribute to the higher acuity and longer term status of these patients. In addition to an increased utilization of LTACs, the participants believe skilled nursing facilities will be required to take more complex and sicker patients. The participant quotes below illustrate this theme.

Participant C: I think that now that there are so many outpatients than there were in the past, and you know, even more cardiac procedures are bedded outpatients than before - I think that, um, we are just not going to have those easy - they’ll be more long term patients.

Participant J: . . . I mean, there’s going to be mental health diagnosis patients that there aren’t community resources for any longer. Um, I think there’s going to be somebody that falls out of the. . . I don’t know. I just see as a variation, for the most part on mental health diagnosis patients, and the variation is because there is not a lot of support in the community any longer. You know, there’s not group

homes for these people to go to...they closed a lot of that...so much of that is out of our control that a lot of those group homes were closed, a lot of those places were closed. Those people got shifted around, and then they come to us and we try to get them out—trying to find out what their mental health history is almost impossible . . . .

Participant I: There are so many gaps in the community resources that are available to people that eventually it funnels down to us with our placement. The other thing not related to mental health issue, but the amount of people that don't have health care insurance. And that will only continue to worsen, as you know, more people are laid off, as the housing industry crumps more, etc., etc. All those things that externally affect our economy, affect us...

Participant J: This is another barrier, but I see it improving. Remember the day, when you could not get an NG tube [patient with a nasogastric tube] to a nursing home? And, now you can. So, many more nursing homes are. So, the acuity of what people will take post acute hospital seems to be changing . . . Yes --changing for the better. But, it's getting to the point now with the LTACs, we're talking about sending people with . . . .I mean, why even have a critical care? Where are we drawing the line at, with the long term acute care...you know? Which may be fine...maybe that is the future. That ten days of critical, if you're still requiring that kind of nursing care, you go to a different facility. But, it seems senseless to me that you're receiving the same kind of nursing care and your being paid acutely for Medicare when....I don't know. But, that seems to be something that is futuristically changing.

The fourth theme that emerged from the data was the perception there will be more pre-hospital and Emergency Department (ED) case management. The participants felt pre-hospital case management would not only better prepare patients for their subsequent hospital stay, but that this would ensure accurate information about the patients is obtained and that they are gaining access to the appropriate level of care from the get go. They also felt that ED case management would prevent inappropriate admissions into the acute care setting.

Participant J: . . . I really see the need for CM, pre-hospital admission. There's a lot of things could be just - pre-cert did some of that with beds and checking authorization. I'm to the point now, I don't know about [what] anyone else does about the [insurance company name] authorizations - if they don't say inpatient on PM Comments [Patient Management Comment in the hospital financial system] or whatever, even then, because it's such a ridiculous [referring to errors]

- I end up calling [insurance company name] on almost all my patients to see if that's an inpatient authorization . . . I fix [physician] office mistakes all the time, because they don't understand.

Participant I: The other thing is that 10A is opening and that's going to be an elective joint unit, and they [orthopedic service] have talked about having their patients as part of their pre-op evaluation, [provided] the list of SNFs that participate with their insurance and what options are available should they fail to meet their discharge goals before they are discharged. And so in theory, that's what our surgeons want, but God knows if it will actually happen. You know, we have a lot of good plans - they just don't always come to fruition.

Participant H: . . . Of course, I don't want to be the person that does it, but in the ER. . . I think there needs to be a CM in the ER. Because, I think we get a lot of patients [out of network or who don't meet acute care criteria] that are admitted to our facility that should have moved on. . . . I just really feel that we need to have a CM down there. . . I'm not volunteering . . . I'm just throwing that out there. . . There are just certain hours, you know, and it seems to be in the evenings, when we seem to get, or other places too, that we seem to get—I don't want to say any person is a dump, if they need care, they need care, but I think they can certainly be redirected.

The fifth and final theme that emerged from the data was there will be some things, good or bad, that would not change. The first view was that no matter how much technology or automation is put into place, case management will still require a human element to it. Second, unfortunately, participants perceive insurances will be as complex and confusing in the future as it is today. Last, they perceive there will be ongoing consumer ignorance regarding health care insurance. Below are participant quotes that support this theme.

Participant G: I think you can change the how we do what we do, which is, I'll give you, D, technology and all that, that's clearly going to be different, but it doesn't change what we do which is the ability to orchestrate, conduct this insanity, of moving these people, and that is not, it's not automatable. It's literally a conducting art.

Participant B: I think it will be just as confusing as ever. I would think, you know, a lot of issues have to do with the patients really don't understand the kind of insurance they have. So, you have to educate them on their insurance. I just had a family that wanted to meet with me last week and they were both very, very

worried. Their father was a patient and they had no idea what kind of insurance he had. They didn't know how his hospitalization was being paid for. He was a very private person and didn't share things with them. He ended up having [managed Medicare insurance] that had already been verified. They had no idea---they had no idea at all. And, they were very worried until I talked to them. "Oh, you just have lifted a load off of our shoulders." I don't think, even all of us are going to be patients in the future, but the insurances are still changing and that doesn't mean we are going to understand them any better than they do now. I thought at first when they went into all those managed programs, patients just got so confused. I don't see THAT getting much better. I think it changes so often that I think it just lends to be that much more confusing. I used to think we would get through that, and the public would be informed, but I don't see that ever happening, because—

Participant E: People still think-- they don't realize with managed care that they are going to have co-pays, that they can't go to [name of facility] possibly, or wherever they want to go because they do have managed care. Or, that we have that a lot in the ICU, that their Medicare doesn't go on forever. Medicare doesn't cover everything and that you can't get an ambulance to take you home every time you want to go. Those kinds of things are surprising that people haven't....

#### 4.4 Summary

This chapter provided a detailed description of the study findings based on the data analysis for each of the six research questions raised. The goals of the study were achieved with two focus groups due to saturation of the data. The thirty-one themes and 19 subthemes that emerged from the data were thoroughly described and participant quotes from the focus groups transcripts that support the findings were provided. One criticism of published reports on focus groups research is not enough is said about the participants' interaction with each and group dynamics. To address this concern, below, the researcher shares observations made by the researcher and research assistant during the focus group sessions.

The focus group method was the ideal research methodology for this study. The nurses who participated in the study were very open, enthusiastic, and willing to talk about their views and work experiences related to the research questions. The focus groups, as desired, became a true dialogue among the group members and produced an abundance of rich data. The members were clearly interested in both the topic and each other's views. The questions developed for the semi-structured guide were also found to be right on target as the focus members frequently segued on to the next topic naturally without the moderator having to prompt them.

The researcher and research assistant observed good eye contact among the members, and found them to be relaxed, engaged, congenial, and professional throughout the focus group sessions. At one moment, they would be sitting back nodding their heads and actively listening to a member speak. Then in the next, they would suddenly sit forward, lean on the table, and add to the story or provide an example of a similar situation. The members were observed to be supportive of each other when describing frustrations or emotional experiences, and readily joking with each other at other times. The researcher and research assistant also found the group members to have a high level of agreement on the topics of discussion, but when there were differences of opinion there were no reservations to share opposing views in a non-confrontational way. For example, when one member commented that patients on a particular service needed more than the average patient, another quickly responded, "Nay, I can't agree with that . . . they

are typical medical patients.” The whole group began to laugh and quickly chimed in on the discussion.

The researcher found the focus groups to be a very rewarding and beneficial experience. The knowledge and experiences that were shared were invaluable. The members also seemed to benefit from the experience. They shared their appreciation for having the opportunity to talk about their views, frustrations, ideas, and hopes for the future relative to their role. At the conclusion of one focus group, one member joked that the researcher could send her a bill as she felt like she had been to a therapy session with her therapist. Another agreed, saying it felt good to get all that “off my chest.” While the participants shared quite a bit about their role frustrations during the focus groups, many concluded the sessions by stating they had a lot job satisfaction in their role despite the barriers they face. A further discussion of the study’s findings will continue in Chapter 5.

# Chapter 5

## Discussion and Recommendations

### 5.1 Introduction

The purpose of this study was to gain a better understanding of NCMs' perceptions of their role in today's rapidly changing healthcare environment, to identify practices and other factors perceived to result in role success, to identify sources of role frustration, and to identify perceived opportunities to enhance future role success and satisfaction. To achieve the goals of the study, six research questions were developed to uncover these perceptions, and a qualitative descriptive design utilizing a focus group method was selected to obtain the emic point of view of the participants. The following discussion of the study findings is structured around the research questions and the themes that emerged from the data analysis. The relationship of these findings to the previously cited literature, including the organizing framework, is also discussed. This chapter will also address the limitations and implications of the study, recommendations for future research, and concluding thoughts.

## 5.2. Discussion

### 5.2.1 *Organizing Framework*

The main objective of the study was to gain an understanding of the NCMs' perspectives of their role through an inductive research approach. Because the researcher was interested in role perceptions, Role Theory was selected as an organizing framework for the study. It is important to note, the researcher's goal was not to test Role Theory nor use it to guide the study. Once the Role Theory literature was reviewed, that knowledge was set aside, and the researcher proceeded with the inductive approach. As Holloway & Hunger (1995) remark though, organizing frameworks help link study findings to other research and ideas about a topic; therefore, the relationships between the study findings and Role Theory are discussed.

As previously noted, Role Theory is not a monolithic theory as the title implies (Thomas & Biddle, 1966), nor did its origins begin with one great man as many theories do (Biddle, 1979). Rather, it evolved gradually out of the interests of various social sciences beginning as early as the 1890s (Biddle, 1979) into a body of knowledge that included many hypotheses and theories concerning various aspects of its domain that had not be reviewed or integrated as of 1966 (Thomas & Biddle, 1966). Continuing the work that he and Thomas started, Biddle later defined Role Theory as "a science concerned with the study of behaviors that are characteristic of persons within contexts and with various processes that presumably produce, explain, or are affected by those behaviors" (p. 4). While indicating it was still not a single monolithic theory, Biddle asserted role theory was based on several underlying propositions in which there was informal general agreement (p. 8). The five propositions summarized by Biddle were:

6. Role theorists assert that ‘some’ behaviors are patterned and are characteristic of persons within contexts (i.e., form *roles*).
7. Roles are often associated with sets of persons who share a common identity (i.e., who constitute *social positions*).
8. Persons are often aware of roles, and to some extent roles are governed by the fact of their awareness (i.e., by *expectations*).
9. Roles persist, in part, because of their consequences (*functions*) and because they are often imbedded within larger social systems.
10. Persons must be taught roles (i.e., must be *socialized*) and may find either joy or sorrow in the performances thereof. (p. 8)

These propositions supported the use of the focus groups method as the researcher was interested in the perceptions of a group of NCMs in the context of a particular setting rather than an individual’s sole experience or perceptions. As noted in Chapter IV, the focus group method was ideal for this study as it provided a wealth of valuable data due to the dynamic group discussions that took place. As Krueger (1998c) noted, the discussion was evolutionary and built on prior comments, points of view, and experiences. As the scope of the discussion would expand in new directions, the participants often attempted to corroborate their experiences or opinions with other members. For example, a participant might say, “Does that happen in your area?” While there was clearly a comfort level among participants to express divergent views, overall, the researcher and research assistant observed a high level of agreement among participants, and but the richness (wealth) if focus groups is not in what is validated. The themes that emerged from the data supported that the participants shared a common

identity. It was also evident their perceptions of their role was influenced by the larger social system within which they worked which is consistent with the above propositions. These two observations may be due to the amount of time the participants worked together in this setting. The average length of time participants worked as a NCM in this setting was nine years. Last, it is important to note study participants' viewed a good orientation to their role as a key factor to the successful fulfillment of their role, reinforcing the proposition above that roles must be taught and may bring either joy or sorrow in the performances of those roles.

### *5.2.2 Research Question One*

The first research question was how do hospital based nurse case managers describe their role? Eight themes emerged from the data to answer this question: (a) the hub of communication, (b) discharge planning, (c) care coordination, (d) utilization management, (e) patient advocacy, (f) resource person/problem solver, (g) education on the insurance system and continuum of care, and (h) emotional support. The participants were observed to have much agreement when describing their role, and the data supported they shared a common identity which is consistent with Biddle's (1979) second proposition noted above. Detailed descriptions of the themes for this research question and supporting participant quotes were provided in Chapter IV. The participants described these responsibilities and functions as being inter-related and often occurring concurrently with each other. They described at other times one function would take priority over the others depending on the context of the situation and the needs of the patient. This correlates well with Biddle's (1979) first proposition, which states some behaviors are patterned and characteristic within contexts.

The above themes identified in this study are consistent with the Case Management Society of America's (CMSA) definition and philosophy of case management. CMSA defines case management as the "collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes" (CMSA, 2006, Definition of Case Management). The CMSA case management philosophy states:

Case management is not a profession in itself, but an area of practice within one's profession. Its underlying premise is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources.

Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the client and the reimbursement source. Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned. (CMSA, 2006, Philosophy of Case Management)

The themes are also consistent with the Commission on Case Manager Certification's (CCMC) definition of a case manager, which is:

A healthcare professional who is responsible for coordinating the care delivered to an assigned group of patients based on diagnosis or need. Other responsibilities include patient/family education, advocacy, delays management, and outcomes monitoring and management. Case managers work with people to get the healthcare and other community services they need, when they need them, and for the best value. (CCMC, 2005, p. 3)

While the theme of emotional support is not explicitly noted in the above definitions and philosophy statement, it is consistent with the psychosocial and economic

activity domain that was one of the six case manager activity domains identified by Tahan et al. (2006b) in their CCMC sponsored quantitative study on CM role and functions. The identified themes relative to this research question are also consistent with all but one of the remaining five activity domains described by Tahan et al. These five remaining activity domains included: (a) case finding and intake, (b) provision of case management services, (c) outcomes evaluation and case closure, (d) utilization management activities, and (e) vocation rehabilitation activities (Tahan et al., 2006b). It was the last activity domain, vocational rehabilitation activities, that was discrepant with the themes identified in this study. This was not surprising though given the acute care hospital setting that this research study was set in. Tahan et al.'s study included case managers from a wide variety of settings with only 18.8% coming from the acute care setting. They noted that two demographic variables, job title and primary work setting, influenced how participants ranked the level of importance of the activity and knowledge domains in their study. The most notable difference was in the life/disability insurance setting, which would be more consistent with the vocational rehabilitation activities domain.

### *5.2.3 Research Question Two*

The second research question in this study was what key case management practices do hospital based NCMs perceive as resulting in role success? As little was found in the nursing literature on this topic, a qualitative approach was ideal to explore NCMs perceptions of their role. Four themes emerged from the data analysis relative to this research question: (a) being proactive, (b) prioritizing and organizing, (c) strong communication/interpersonal skills, and (d) creating the right atmosphere/environment.

Descriptions of the themes and participants quotes that support the themes were provided in Chapter IV. At a high level, these themes described a variety of strategies, activities, and skills that the participants viewed enabled them to perform the responsibilities and functions (described in Section V.2.2.) in an efficient and effective way, enabled them to attain desired patient outcomes in a timely manner, and maintain personal sanity/control in a challenging role. Biddle's (1979) third proposition states individuals are often aware of roles, and to some extent that awareness sets up role expectations. The NCMs clearly articulated certain role expectations, such as ensuring a timely and safe patient discharge. They also described taking strategic action aimed at meeting those expectations.

When reviewing the nursing case management literature, rather than rigorous formal research, efforts are often focused on case management program evaluation over time or following program changes through the collection and analysis of data on outcome indicators such as cost (i.e., length of stay) and quality (i.e., patient satisfaction, readmission rates, etc.) (Cohen & Cesta, 2001d). In addition to Tahan et al.'s (2006a, 2006b) quantitative role and function study, one qualitative descriptive study exploring the role the nurse case manager was found; however, the study was not in a hospital setting. The aim of the study was to explore the experiences of nurses who recently made the role transition from caregiver to case manager in the insurance setting (Schmitt, 2005, 2006). Key topics Schmitt explored included motivating factors in the role change, expectations about the role of the CM, sources of CM role strain, and CM job satisfaction. As the findings of study related more to role barriers or challenges than role success, this study will be discussed further in Section V.2.5.

### *5.2.4 Research Question Three*

Research question three was what do hospital based NCMs describe as the most significant factors that contribute to their successful role fulfillment? As in research question two, no empirical research was found in the literature relative to question three. Five themes and four subthemes surfaced from the data. The first theme was experience which had four subthemes that included strong nursing/clinical experience, life experiences, consulting peers, and knowing unit dynamics. The remaining four themes included manageable caseloads, a good orientation, technology and clerical support, and personal strength and resourcefulness. Detailed descriptions of the themes and subthemes and participant quotes that support them were provided in Chapter IV. These themes were particularly interesting in that some were driven by external factors such as the caseload size, technology and clerical support, and orientation to the role, and other factors were internal or personal factors such as experience and personal strength and resourcefulness. This illustrates the keen insight participants had into the personal part they played in their professional role success, in addition to factors in their work environment. As previously noted, participants viewed a good orientation vital to successful fulfillment of their role. This supports Biddle's (1979) fifth proposition that roles are taught and individuals find either joy or sorrow in the performance of the role.

### *5.2.5 Research Question Four*

The fourth research question was what do hospital based NCMs describe as the most significant challenges, barriers, or frustrations they encounter in their role fulfillment? As anticipated, this question generated the most discussion of all the research questions.

Five themes and ten subthemes emerged from the data. The five themes were (a) compensating for others, (b) high caseload/workload, (c) discharge support role, (d) placement challenges, and (e) documentation challenges. The first theme, compensating for others, had five subthemes that further describe the scope of the core theme and included: (a) lack of accountability/follow through, (b) inexperience, (c) poor communication/direction, (d) incomplete/inaccurate information, and (e) adding/shifting of work. The fourth theme, placement challenges, also had five subthemes that included: (a) PT/OT referrals, (b) physician issues, (c) limited access for special populations, (d) the County assessment for level of care process, and (e) ethical dilemmas. Detailed descriptions of the themes and subthemes and participant quotes that support them were provided in Chapter IV. Despite the negative nature of the question and the amount of discussion generated, participants communicated their frustrations in a professional manner and never singled out any individual as a source of frustration or barrier.

As noted earlier, one of the key topics explored by Schmitt (2005, 2006) was related to study participants' motivation for a job change, from caregiver to case manager in a payer environment. Schmitt (2006) found the motivation for most participants in making a career change was due to the dissatisfaction with their current work situation. In particular, the hospital setting was described as undesirable for a number of reasons including long hours, inflexible work schedules, excessive workload, and excessive scope of professional responsibilities. Two participants who left the home care setting identified burdensome changes in Medicare regulations had negatively impacted their practice and ultimately their job satisfaction. While the hospital based NCMs are not bedside caregivers, they described some of the same challenges in their role, particularly

excessive workload when caseloads increase and the adding or shifting of work responsibilities onto the NCM role. Likewise, while the NCMs are not care providers in the home care setting, they too noted burdensome documentation to meet regulatory requirements as a major negative in their role.

As previously noted by Biddle (1979), “Roles persist, in part, because of their consequences (*functions*) and because they are often imbedded within larger social systems” (p.8). Because the NCM role provides a valuable and needed service to patients/families, the hospital, and the community at large, their role functions help their role to persist which is a positive effect. However, being part of a larger social system can have its negative effects as well. It is interesting to note that many of the frustrations and barriers the participants shared were related to other roles and factors in the larger social system, both locally, within the hospital setting, and in the community at large. For example, the participants noted an important accountability of the bedside nurse is to mobilize patients. While not all bedside nurses have a problem with that accountability, the participants recognized the negative effects on a patient at risk for rapid de-conditioning when cared for by a nurse who does not sufficiently fulfill this accountability. A patient who becomes de-conditioned may have to be transferred to a skilled nursing facility rather than being able to return to their home for ongoing care. The result is an increased utilization of health care resources and prolonged risk of the patient being exposed to potential iatrogenic complications, such as pneumonia or drug resistant infection, which may have been otherwise avoided.

In regard to the larger community, participants voiced frustration regarding the negative impact of the limited access to the continuum of care for select populations,

such as those with medical/surgical conditions who also have a behavioral health, mental retardation, or a substance abuse diagnosis. An additional challenge expressed by participants was being faced with ethical dilemmas relative to placement of patients in the continuum of care. Per Medicare Conditions of Participation and Freedom of Choice regulations for hospitals, discharge planners cannot specify or direct patients to particular facilities, nor limit or dissuade them from selecting certain facilities. Regulations require the discharge planner to present the patient/family with a list of post discharge providers in the geographic area selected by the patient/family and to document in the medical record that the list was provided. Further, the discharge planner must inform the patient/family of their freedom to choose among participating Medicare providers and respect the patient/family's choice when possible (e.g., the facility has an available bed, the facility accepts the patient, etc.). The participants shared feeling ethically challenged as they fulfilled their obligations to respect a patient's choice and to act quickly on that decision, to ensure a timely discharge, when the choice was a provider that they would not choose for themselves or their own loved ones. The NCMs strongly urge the patients' families to visit the facilities on their lists as early as possible in the hospital stay so they can help their loved ones make informed decisions as once patients are medically cleared for discharge, the NCM must act swiftly to facilitate their transfer to the next level of care. It is important that nurse leaders recognize the ethical challenges NCMs face, and assist them as they work through dilemmas such as this in an effort to minimize role strain.

The healthcare forecasts and government reports previously discussed predict the nursing shortage will continue to worsen over the next several decades (IFTF, 2003;

HRSA, 2004; PA DOH, 2004). It is recognized that an adequate supply of nurses is vital to the Nation achieving its goal of ensuring access to affordable, high-quality healthcare (HSRA, 2004). It is also strongly recommended that nurse employers and leaders acknowledge and attend to the individual characteristics of nurses and the unique features of the health care environments where nurses work as one of their strategies to improve nurse retention (PA DOH). One of the aims of this study was to explore NCMs' perceptions of the challenges, barriers, and frustrations they face as they fulfill their roles in the acute care hospital setting. The study findings provide insight on those perceptions, and provide a foundation for further exploration.

#### *5.2.6 Research Question Five*

Understanding the perceptions of NCMs regarding the barriers and frustrations they encounter is important, but it is equally important to understand what NCMs perceive would enhance their role success. Among other things, this understanding may be used in developing strategies needed to improve nurse retention as recommended by government agencies (PA DOH, 2004). Hence, the fifth research question was what new interventions, supports, or strategies do hospital based NCMs perceive would enhance the successful fulfillment of their role? Four themes and five subthemes surfaced from the data. The first theme was streamline work/documentation which had two subthemes, role analysis/reassignment of tasks and a fully electronic medical record. The second theme, education, had three subthemes which were revise/enhance NCM orientation, educate others on NCM role, and educate consumers and the interdisciplinary team on insurance. The third and fourth themes were enhance accountability in others and PT/OT

enhancements respectively. Descriptions of the themes and subthemes and participant quotes that support them were provided in Chapter IV.

With a worsening nursing shortage and increased need for health care services looming, nurse leaders need to consider how to best use the knowledge, skills, and abilities of nurses to ensure quality patient outcomes in the most efficient, effective, and professionally satisfying manner. This is particularly true for complex and challenging nursing subspecialties such as case management. As the participants in this study shared, this may require more frequent workflow and role redesigns than was necessary in the past due to the increasingly rapid pace of change in the health care arena. For example, while the case management model in the study hospital had undergone model redesigns three times in the past ten years, participants still identified the need for a fresh look because of the changing external environment and the loss of value in processes that had been viewed as effective in the past. Also, as more regulatory, accreditation, or other demands are placed on hospitals, case management leaders must determine whether the unique knowledge and skill set of the NCM is necessary to fulfill the new requirement or if it can be accomplished by other professional or non-professional roles. If these alternate roles lie outside the span of control of the case management leader, this may require intense team building and negotiations with other hospital leaders who may be facing similar resource constraints and challenges. This may be true as well when attempting to address enhanced accountability in others who are outside the span of control of the case management leader. Nevertheless, case management leaders must persevere to remove the barriers the NCMs face in order to improve their role success and satisfaction, and retain them in the nursing work force as long as possible.

The importance of a good orientation to the NCM role surfaced again as a subtheme for this research question. Participants shared several opportunities to enhance the orientation process that they viewed would further contribute to a new NCM's success. They also shared there were times the orientation was not as good as it had been in the past and this led to frustration among the orientees as well as preceptors. This further reinforces Biddle's (1979) fifth proposition that roles are taught and bring either joy or sorrow in the performances of those roles. It is valuable to evaluate the orientation process periodically as with any other educational programs to ensure it is meeting the new employee's learning needs in the current environment. For example, in the past, NCMs may have only had to work with one or two computer systems or programs, and on the job training may have been sufficient. Today, with the proliferation of, and access to, numerous electronic systems (e.g., EMR systems, finance systems, case management systems, discharge referral systems, medical necessity criteria systems, payer systems, etc.), a more structured and intensive training room approach, as recommended by the participants, is worthy of exploration and evaluation.

### *5.2.7 Research Question Six*

The sixth research question was how do hospital based NCMs see their role changing in the future? Five themes emerged from the data relative to this question. The themes included: (a) more technology/electronic, (b) faster pace/time compression, (c) more sick/complex patients, (d) increased pre-hospital/emergency department case management, and (e) some things won't change. Detailed descriptions of the themes and participants quotes that support the themes were provided in Chapter IV.

Many of the perceptions the NCMs have about the future are consistent with what is cited in the literature which forecasts shorter lengths of stay, increases in outpatient services, increases in chronic diseases (including mental illnesses) as the population ages, and increases in the uninsured, just to name a few (DeNavas-Walt, et al., 2005; IFTF, 2003; NCHS, 2005). For example, when discussing future challenges in the placement of special populations, issues of chronic diseases including behavior health, increased unemployment, and the growing number of uninsured were identified. The participants also were noted what effects the external environment also affects them as one participant aptly stated:

There are so many gaps in the community resources that are available to people that eventually it funnels down to us with our placement. The other thing not related to mental health issue, but the amount of people that don't have health care insurance. And that will only continue to worsen, as you know, more people are laid off, as the housing industry crumps more, etc., etc. All those things that externally affect our economy, affect us.

This again reinforces Biddle's (1979) proposition that roles persist, in part, because of their functions and that they are often imbedded within larger social systems. Thus, what affects one affects the other.

### 5.3 Limitations of the Study

Morse and Field (1995) note the question of generalizability of qualitative results is a basic consideration when trying to decide whether to implement or adopt qualitative findings. They emphasize; however, "qualitative research does not have the same standards of replication that quantitative research has for facilitating the decision for adopting research findings" (Morse & Field, p. 190). Rather, the decision should be based on the quality of the research and the relevance of the research to the adoptive setting or

context (Morse & Field, 1995). When deciding whether to adopt focus groups findings, Krueger (1998d) suggests the concept of transferability, noting the individual who wants to use the results should give thought as to whether the findings could transfer into another environment. He suggests the reader consider the research method, procedures, the audience, and the context of the study, and then determine if the situation and conditions are sufficiently similar to the new environment (1998d).

The researcher took every precaution to ensure the quality of this study including the selection of the appropriate method to meet the goals of the study, selection of the most rigorous data analysis strategy (transcript-based), the researcher sought participants' validation of the researcher's understanding of their views, the procedures used to analyze the data were those recommended by focus group experts, an independent review of the data was conducted by another researcher, and an audit trail of the data analysis was kept. There are several important study factors that readers must consider when deciding whether the study findings are transferable to another setting. First, the sample in this study was hospital based nurse case managers. As previously noted, case management is not a profession in itself, but an area of practice within one's profession. For example, social workers provide case management services in some settings. Therefore, the reader must determine whether it is appropriate to transfer these findings to other health care professionals. Second, this study was limited to one acute care hospital in a large inner city academic medical center in a Mid-Atlantic state. Careful consideration must be given when determining whether the finding can be transferred to other hospital settings or non-hospital settings.

One of the potential limitations of this study cited in Chapter 1 was the researcher is an administrator in the study hospital, and the participants' manager reports to the researcher. The researcher thoroughly addressed the protection of human subjects with the Duquesne University IRB and study hospital's IRB. Both IRBs were satisfied with the protective measures in place to prevent harm to the participants, and approved the study. Protective measures included: the acknowledgement that the researcher does not complete NCM performance appraisals; cannot arbitrarily change NCM salaries that are set forth in a union contract; nor has the ability to arbitrarily change NCM working conditions. Because the researcher was an administrator in the study hospital, the researcher also acknowledged the potential for inhibited, exaggerated, or distorted participant responses because of this. Fortunately, the researcher or research assistant did not observe this during the focus group sessions. The participants appeared comfortable, relaxed, and candid in their responses. They presented their views in a balanced and professional manner.

#### 5.4 Implications of the Study

The purpose of this study was to gain a better understanding of NCMs' perceptions of their role in today's rapidly changing healthcare environment, to identify practices and other factors perceived to result in role success, to identify sources of role frustration, and to identify perceived opportunities to enhance future role success and satisfaction. The delivery of efficient and effective hospital based nursing case management services ensures patients get the right services, at the right time, in the right setting, at the least cost. In an era when health care reimbursement is declining and profit

margins are negligible, hospitals also benefit from efficient and effect case management services. When hospitals have sufficient capital to reinvest in their care delivery system and fulfill their missions with the delivery of quality care, the community at large benefits. Payers also gain when there is appropriate utilization of member benefits.

The findings from this research study will be particularly useful to nurse case managers, nursing administrators, and nursing educators, who endeavor to advance nursing case management practice, improve NCM role satisfaction, recruit and retain NCMs, as well as, improve clinical, service, and financial outcomes. The study findings provide insight into what NCMs view as practices and other factors that contribute to their role success. Case management leaders may consider assessing whether these practices are supported in their environment, and create opportunities to foster development of staff in these areas. For example, development of a mentoring program pairing a novice NCM with a more experienced NCM, may assist in developing those skills and abilities noted to contribute to role success. Likewise, leaders need to acknowledge and attend to the global barriers that NCMs are faced with as well as those barriers that may be unique to their specific care delivery environment. Most importantly, because of the rapidly changing environment, NCMs will be faced with new and unforeseen barriers and challenges; therefore, leaders will need to continually assess for and intervene to address these barriers. Last, with a forecast of a worsening nursing shortage, findings from this study suggest case management leaders may need to seriously examine how to use nurses differently in the future to achieve and maintain optimal patient outcomes in a resource constrained environment.

## 5.5 Recommendation for Future Research

Qualitative research is well suited when little is known about a phenomenon, there is suspicion of bias in prior theories, or when the research question relates to a desire to understand or describe a particular phenomenon or event, especially from the emic point of view (Morse & Field, 1995). Because little was known about the role of the NCM from the emic point of view, a qualitative descriptive study using the focus groups method was selected to explore NCMs' perceptions of their role, and identify perceived factors that contribute to role success, sources of role frustration, and potential opportunities to enhance future role success and satisfaction.

According to Morgan (1998a), there are four basic uses of focus groups: (a) problem identification, (b) planning, (c) implementation, and (d) assessment. He emphasizes these basic uses corresponds to a stage within a larger project, with the building and growth of knowledge as the stages progress (Morgan, 1998a, p. 13). The main objective of the problem identification stage is to define a goal, with a focus on exploration, discovery, and uncovering what matters most to participants on a specific topic (Morgan, 1998a). This was consistent with the objectives of this researcher, and the knowledge gained from this focus groups study sets the stage for much needed future research in the area of hospital based nursing case management. Below are several suggestions for future research:

1. The study findings from this study can be used to develop an instrument for measurement of the factors identified in this study.
2. A quantitative study could be designed to evaluate the effectiveness of, and

staff satisfaction with, implementation of one of the identified interventions, supports, or strategies in the practice setting. For example, participants perceived that a role analysis and reassignment of some tasks to clerical support staff would enhance their role success. A quantitative study could be designed that measured certain indicators, such as length of stay and staff satisfaction, before and after implementation of the change to determine if the change actually made a difference.

3. Nurse educators could develop a survey to explore the potential need for increased knowledge in the area of insurance and healthcare reimbursement, and the need for potential adjustments in the nursing curriculum for undergraduates.

4. A study could be designed to examine the differences in defined outcomes between case management models using NCMs differently.

## 5.6 Summary

In summary, the researcher selected a focus groups method to gain an understanding of NCMs perspectives about their role from an emic point of view. The goals of the study were achieved with two focus groups due to data saturation. Thirty-one themes and 19 subthemes emerged from the data through a thematic analysis. Descriptions of the themes and subthemes were provided, and direct participant quotes were shared to illustrate participants' views and the richness of the data. This chapter provided a discussion of the study findings as they related to each of the six research questions. At a high level, the study findings described a complex and dynamic work environment that requires highly skilled and savvy professionals with knowledge based wisdom to navigate it. The

findings also describe multiple workflow barriers and possible solutions participants perceived would enhance their role successful and satisfaction. Last, the study findings demonstrate there is a large knowledge deficit relative to insurance and the continuum of care among health care consumers and health care providers alike. This chapter also discussed the limitations of the study, implications of the study, and recommendations for future research.

Finally, as previously cited, few published articles report the use of focus groups method in an empirical nursing research study compared to other qualitative methods. The researcher found this method to be a useful and meaningful approach to achieve the goals of the study. In many nursing practice settings, the nurse researcher is working with groups rather than individuals, and understanding the views of those groups may be more useful to the researcher than the views of individuals. If that is the case, the nurse researcher may want to explore focus groups method as a viable option.

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## APPENDIX A



### **COME SHARE YOUR VIEWS AT A FOCUS GROUP!**

- What:** You are invited to participate in a research study investigating the role perceptions of hospital based nurse case managers (NCM).
- Who:** RNs with a minimum of one year of case management experience, and who have worked at Allegheny General Hospital as a NCM for at least six months. Participation is voluntary, and participants may withdraw at any time without harmful consequences.
- When:** 12:00 PM on ONE of the following dates July 7, July 14, or July 21, 2008.
- Where:** Prostate Center Conference Room, 4<sup>th</sup> Floor Cancer Center
- Why:** To expand the research based knowledge of nursing case management, AND because you and your views matter!
- Cost:** There is NO monetary cost to you for participation. The only cost is one to two hours of your time. Light refreshments will be provided.
- Contacts:** If you would like to get more information about this research study, please contact Kimberly Hopey at 412-359-3271.

## APPENDIX B

### **Role Perceptions of Hospital Based Nurse Case Managers Focus Group Research Study Invitation Response**

Please complete the requested information below and check the applicable response box.

Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

- I am interested in getting more information about the above research study. Please contact me.
  
- I meet the research study inclusion criteria\* and would like to volunteer to participate in one of the focus group sessions. I have noted my first, second, and third choice of focus group session dates in the space provided. I understand my first choice is not guaranteed and the session will last between one to two hours.

Monday, July 7, 2008 at 12 Noon \_\_\_\_\_

Monday, July 14, 2008 at 12 Noon \_\_\_\_\_

Monday, July 21, 2008 at 12 Noon \_\_\_\_\_

\*Study inclusion criteria: RN with minimum of one year case management experience, and have worked at Allegheny General Hospital as a nurse case manager for at least six months.

## APPENDIX C

### Discussion Questions for Focus Groups

#### Opening Questions (All participants will be asked to respond briefly)

1. How long have you been a registered nurse and a nurse case manager?
2. How long have you worked at this hospital?

#### Introductory, Transition, and Key Questions

1. What does being a case manager mean?
2. What do you see as your role responsibilities?
3. What personal practices contribute most to your role success?
4. What other factors contribute to your role success?
5. What factors make fulfilling your role a challenge?
6. What new interventions, supports, or strategies might enhance your role success?
7. How do you see your role changing in the future?

#### Ending Questions

1. Is there a significant issue or aspect of your role that we have not discussed?
2. What most concerns you about your role?

APPENDIX D

Research Assistant Confidentiality Statement



DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

Statement of Confidentiality

I, \_\_\_\_\_, understand that I may have access to personal information provided by participants, in the study entitled “Role perceptions of hospital based nurse case managers.” As the observer and the second field note recorder for the study, I recognize that I have an obligation to protect the confidentiality of the information acquired in the conduct of the study and that I may disclose information only with the consent of the subject or his/her representative, and of the principal investigator.

My signature below indicates my acceptance of the obligation and restriction on disclosure set forth above and that I realize that a failure on my part to fulfill this obligation can lead to appropriate disciplinary action.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

APPENDIX E

Transcriptionist Confidentiality Statement



DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

Statement of Confidentiality

I, \_\_\_\_\_, understand that I may have access to personal information provided by participants, in the study entitled “Role perceptions of hospital based nurse case managers.” As the transcriptionist of audio recorded data for the study, I recognize that I have an obligation to protect the confidentiality of the information acquired in the conduct of the study and that I may disclose information only with the consent of the subject or his/her representative, and of the principal investigator.

My signature below indicates my acceptance of the obligation and restriction on disclosure set forth above and that I realize that a failure on my part to fulfill this obligation can lead to appropriate disciplinary action.

---

Signature

---

Date

## APPENDIX F



**DUQUESNE UNIVERSITY**  
INSTITUTIONAL REVIEW BOARD  
424 RANGOS BUILDING ♦ PITTSBURGH PA 15282-0202

Dr. Paul Richer  
Chair, Institutional Review Board  
Human Protections Administrator  
Phone (412) 396-6326 Fax (412) 396-5176  
e-mail: [richer@duq.edu](mailto:richer@duq.edu)

February 22, 2008

Ms. Kimberley Hopey  
9889 Moccasin Trail  
Wexford PA 15090

**Re: Role perceptions of hospital based nurse case managers (Protocol # 08-16)**

Dear Ms. Hopey:

Thank you for submitting your research proposal to the IRB.

Based upon the recommendation of IRB member, Dr. Kathleen Sekula, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, the research is approved under 45CFR46.101 and 46.111 on an **expedited** basis under 45CFR46.110.

Attached is the consent form on Allegheny General Hospital letterhead stamped with our approval and expirations dates. You should use it as original for copies that you distribute.

This approval must be renewed in one year as part of the IRB's continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form in one year, you will need to have it renewed. In correspondence please refer to the protocol number shown after the title above.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB of those changes and wait for approval before implementing them. In addition, if any unanticipated problems or adverse effects on subjects are discovered before the annual review, they must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study's Abstract suffices. You should retain a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study's completion.

Thank you for contributing to Duquesne's research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Paul Richer".

Paul Richer, Ph.D.

C: Dr. Kathleen Sekula  
Dr. Gladys Husted  
IRB Records

# APPENDIX G



WEST PENN ALLEGHENY HEALTH SYSTEM

320 EAST NORTH AVENUE, PITTSBURGH, PA 15212-4772

412-359-3156

INSTITUTIONAL REVIEW BOARD #01  
FWA00009149  
(EXPIRES MARCH 14, 2009)

March 4, 2008

Kimberly Hopey, M.S., R.N.  
Department of Case Management

**RE: RC-4475 "Role Perceptions of Hospital Based Nurse Case Managers"**

Dear Ms. Hopey:

The Institutional Review Board (IRB) of Allegheny General Hospital has reviewed the additional information you submitted on February 29, 2008. This protocol was initially reviewed via the "*expedited review*" process, on February 22, 2008.

This protocol has been reviewed via the "*expedited review*" process on its scientific, safety, ethical and socio-economic merits, and **approved** in accordance with Institutional, Federal and State regulations by the IRB. It is the responsibility of the investigator to obtain any other necessary approvals prior to implementation of the research (AGH and/or ASRI). A stamped approved informed consent is attached for your use.

Please be aware of the record keeping responsibilities involved in your protocol. A copy of the *Principal Investigator Responsibilities* is attached for your use. Your approved protocol will be subject to review within one year from the date of initial review by the IRB.

Sincerely,

David S. Parda, M.D., FACP  
Chairman  
Institutional Review Board

DSP/clp

## APPENDIX H

### Informed Consent Form



F-5

320 EAST NORTH AVENUE, PITTSBURGH, PA 15212-4772  
412-359-3131

#### INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

**RC NUMBER AND TITLE:** *4475 Role Perceptions of Hospital Based Nurse Case Managers*

**PRINCIPAL INVESTIGATOR:** *Kimberly Hopey  
Allegheny General Hospital  
320 East North Avenue  
Pittsburgh PA 15212  
412-359-3271*

**ADVISOR (if applicable):** *Gladys L. Husted, PhD, RN  
School of Nursing, Duquesne University  
412-731-0736*

**SPONSOR NAME AND PROTOCOL NUMBER:** *N/A*

#### Introduction/Source of Support

This study is being performed as partial fulfillment of the requirements for the doctoral degree in nursing at Duquesne University.

#### Purpose

You are being asked to participate in a research project that seeks to investigate the Perceptions hospital based nurse case managers have of their role. The number of subjects to be enrolled at Allegheny General Hospital is a maximum of 25.

#### Procedure

Your involvement will require participation in one focus group interview facilitated by me and a research assistant. For your convenience, you will be provided with a list of dates and times of the focus group sessions, and will be asked to note your first, second, and third choice of sessions. Every effort will be made to accommodate your

first choice; however, there is no guarantee. Session slots will be filled on a first come first served basis.

The focus group interview will be taped and transcribed. You will also be asked to complete a demographic questionnaire (excluding your name). Your time commitment will be no more than two hours. These are the only requests that will be made of you.

### **Risks**

Participation in this research study will result in no risks to you greater than those encountered in everyday life.

### **Benefits**

The potential benefit to you is an opportunity to share important perceptions you have about your professional role.

### **Alternative Procedures**

Not participating in the research study is an alternative that you have.

### **Costs to Participate**

Participation in the project will require no monetary cost to you. An envelope is provided for return of your response to the investigator.

### **Compensation**

Light refreshments will be provided at the focus group interview. You will not be compensated in any other way for participating in this research project.

You have been informed and acknowledge that in the unlikely event of your voluntary participation in this research protocol results in the need for you to receive medical care, that no money or free medical care will be made available to you by Allegheny General Hospital or Allegheny-Singer Research Institute.

### **Confidentiality**

Your name will never appear on any survey or research instrument. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file that only the researcher has access to. Your response(s) will only appear in data summaries. All Your identity data related to this study will be kept confidential, except as required by law and except for inspections by regulatory agencies, the Institutional Review Board of Duquesne University, the Institutional Review Board of Allegheny General Hospital (the committee that reviews, approves and oversees

research) and the West Penn Allegheny Health System (WPAHS) Compliance Office. Results of the research may be published for scientific purposes or presented to scientific groups, however, your identity will not be revealed.

By agreeing to participate in the research study, you also agree to keep all focus group discussions and co-participants' identity confidential.

**Summary of Results**

A summary of the results of this research will be supplied to you, at no cost, upon request.

*Inquires/Questions*

Should you have any questions about the study, contact the principle investigator – Kimberly Hopey at (412) 359-3271. If you have any questions regarding your rights as a research participant, you may contact the Institutional Review Board of Allegheny General Hospital at (412) 359-3156, Dr. Gladys Husted at (412) 731-0736, and Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board at (412) 396-6326. You will receive a signed copy of this consent.

**Voluntary Participation and Right to Withdraw From the Study**

I have read the above statements and understand what is being requested of me.

I understand that my participation is voluntary, and refusal to participate will involve no penalty or loss of benefits to which I am otherwise entitled. I also understand I may discontinue participation at any time without penalty or loss of benefits to which I am otherwise entitled.

On these terms, I certify that I am willing to participate in this research project.

_____	_____
<b>Subject Name (please print)</b>	<b>Date</b>
_____	_____
<b>Subject Signature</b>	<b>Date</b>
_____	_____
<b>Witness Signature</b>	<b>Date</b>
_____	_____
<b>Investigator Signature</b>	<b>Date</b>

## APPENDIX I

### Focus Group Participant Demographic Questionnaire

1. Age \_\_\_\_\_
  2. Gender:    Female    Male
  3. Years of RN licensure \_\_\_\_\_
  4. Highest degree in nursing completed:    Diploma    AD    BSN    MSN
  4. Total years of experience as a hospital based case manager \_\_\_\_\_
  5. Total years of experience as a case manager at this hospital \_\_\_\_\_
  6. Do you hold a certification in case management?    Yes    No
- 

To be completed by the researcher:

Participant Code \_\_\_\_\_