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FROM CAREGIVER TO CASE MANAGER

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ROLE TRANSITIONS FOR NURSES: FROM CARE GIVER TO CASE MANAGER

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ABSTRACT

Role Transitions for Nurses:
From Caregiver To Case Manager

By

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This study describes the experiences of role transition for nurses who made a career move from care giving to case management. How professional nurses experience this type of career move and learn to function in new roles provides a good example of expert to novice transitions that professionals in many disciplines face. Findings suggest that there are factors associated with nurses' experiences of this transition that have implications for the preparation and support of nurses assuming roles as case managers specifically, as well as for preparation and support of professionals in expert to novice transitions in general.

A multi-model framework informs a scope of inquiry and analysis of personal interview and focus group data about nurses' experiences in role transition. Models of the role transition process, situated cognition, and experiential learning contribute to a comprehensive conceptual scheme for inquiry and analysis. Together these models highlight components of the transition process, contextual influences from past and present roles, and learning strategies that help or hinder nurses to function confidently in this new role.

Nurse case managers from three employment settings shared their respective motivations, expectations, sources of role strain and job satisfaction,

and learning experiences associated with this role transition. Data point to specific tensions experienced by nurses in this role transition, which include time -task orientation, interactions and relationships, business culture and objectives, and self-image and professional identity. Data also indicate that, though these professionals are experienced and resourceful learners, as new case managers, they desired and benefited from guidance and support from more experienced and knowledgeable mentors.

Recommendations for preparing and supporting nurses through this role transition emerge from the data. These include orientation and mentoring programs that: (a) help new case managers to assess the difference in past and present performance expectations, (b) alert them to tensions that they may encounter in assuming this new role, (c) inform them about relevant learning resources and how to access them, and (d) guide them in discovering the meaning of new experiences.

Finally, implications of this study that extend beyond this specific role transition are presented. A performance model of continuing professional education holds the most promise for professionals in expert to novice transitions. This model addresses influences on performance, such as past experience, role relationships, and cultural perspectives, that data from this study revealed as significant to professionals transitioning to a new role.

In loving memory of

Phyllis L. Kunath

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Introduction

Novice to expert transitions within specific practice contexts have been explored and described in adult education literature (Benner, 1984; Daley, 1999; Drefus & Dreyfus, 1985; Houle, 1980; Knox, 1992; Mott, 2000; Raelin, 1997; Scribner, 1984; Tennant & Pogson, 1995). Studies and theories addressing this type of transition have provided educators and trainers with conceptual frameworks for assessing performance and designing instructional programs for adult learners at various levels of expertise. Relative little attention has been paid, however, to expert to novice transitions that occur when professionals with considerable experience and skill in one field of practice take on new roles in alternative practice contexts. An increasing trend in the number of occupational changes made by professionals in the course of their careers (Ashforth, 2001; Conger, 1997; Drucker 1994) makes this type of transition ripe for investigation. As organizations respond to societal changes and economic constraints, professionals are finding that traditional employment options are giving way to varied and dynamic roles that often require competencies not achieved through their foundational preparation or practice experiences. Advances in knowledge and technology, changes in consumer awareness and expectations, and resource and market fluctuations precipitate new perspectives, priorities, and problems to be dealt with in professional practice. Those with interests in professional development need to attend to the particular training and

socialization needs of this growing segment of the workforce (Daley, 2001; Eraut, 1994; Ford & Fischer, 1997; Ibarra, 1999).

Whether professionals assume alternative roles voluntarily or by default, the experience of transition and learning can impact job satisfaction and ultimately the speed and ease with which optimal productivity is achieved (Ashforth, 2000; Ibarra, 1999). In order to successfully recruit, retrain, or redirect this talent pool, employers, educators and professional organizations will need to be aware of the nature of expert to novice transitions, and assist professionals to anticipate and deal with the required practice adaptations and gaps in knowledge and skill that quickly need to be filled.

How professional nurses experience this type of career move and learn to function in roles other than caregiver provides a good example of expert to novice transitions. While foundational education and training provide nurses with a knowledge base and procedural skills to care for patients, they do not necessarily prepare nurses for roles that are emerging in the managed care arena ("Adequate Training for New Hires," 2001). Nurses are filling a growing demand by healthcare provider systems and insurance companies for case managers who oversee and coordinate utilization of services ("What's in the Future? More Opportunities, Fewer Case Managers," 2003; Chan, Leahy, McMahon, Mirch & Devinney, 1999). The healthcare and insurance industries are looking to case managers for assistance in containing healthcare costs and improving healthcare outcomes. Fulfilling responsibilities of this role not only requires a familiarity with clinical aspects of healthcare, but also a knowledge

base and skill set for dealing with broader healthcare issues such as service access and utilization, insurance regulations and policy provisions, and cost-containment and quality outcomes. (Chan, et al., 1999; Conti, 1999; Falter, Cesta, Conert & Mason, 1999).

Case management (CM) has emerged over the past twenty years as an area of practice that appears well suited to the nursing profession. The growing number of such positions being filled by nurses provides evidence for this. A recent survey of practicing case managers demonstrated that 60% are registered nurses (American Health Consultants, 2001). Education and training agendas, however, are only beginning to address requisite knowledge and skills for case management in undergraduate and advanced practice nursing curricula and nursing literature (Conti, 1999), and information about the experience of transition for professional nurses entering this field is sparse.

Practicing nurse case mangers have achieved their role understanding and competence primarily through self-directed learning and on-the-job experience (Chan, et. al, 1999; Conti, 1999). This assertion is consistent with my experiences and observations in coaching and supervising nurse case managers. My experience working with nurse case managers, along with my interest in workplace learning and professional development, has fueled a desire to know more comprehensively how these professionals experience this role transition.

This study focuses on the transition and learning experiences of professional nurses in a career change from the role of caregiver to the role of

case manager. In care giving, nursing practice is focused on the patient. Nurses as caregivers provide "hands-on" services such as administering therapeutic agents and procedures, providing comfort measures, monitoring patients' conditions and responses to treatment, and educating and supporting patients in illness, recovery and wellness (Benner, 1984). In CM, the focal point of nursing practice expands to include a number of stakeholders in the recovery or health maintenance process (Meany, 1999; Mullahy 1998; Newell, 1996). Instead of delivering hands-on care, however, case managers provide service though collaboration with patients, healthcare providers and vendors, and third party payers. This collaboration facilitates coordination of healthcare needs with appropriate healthcare services and available payment resources across a continuum of care (Chan, et. al, 1999; Conti, 1996; Falter, et. al, 1999; Meany, 1999).

Clinical nursing preparation and experience are assumed to provide a good background for case management (Flarey & Blancett,1996; Mullahy, 1998; Newell, 1996) which explains why nurses are sought after to fill a growing number of CM positions. Conti (1996) points out, however, that nurses functioning in the role of case manager identified behaviors, (including expediting, negotiating, brokering and researching) essential to case management that received little or no attention in the nurses' foundational education and clinical practice. This illustrates a clear example of an expert to novice transition and provides fertile ground for exploring the nature of such an experience.

Research Questions

The main research question in this study is: How do nurses, primarily trained and experienced as caregivers, transition to and learn in the role of medical case manager?" Sub-questions include:

1. Are there characteristic motivations, expectations, sources of role strain and job satisfaction, and learning experiences associated with the process of this role transition?
2. What elements of contexts associated with past and present roles are influential in this transition?

I developed a semi-structured interview protocol that provided a general aim for the direction of my inquiry yet allowed respondents to explore their experiences and reflections about transition fully and richly.

Theoretical Constructs

Three principal theoretical constructs are utilized in this study of the process of role transition and learning. They are a Model of Role Transition developed by Allen and van de Vliert (1984), situated cognition (Lave, Murtaugh & de la Rocha, 1999; Wenger, 1998; Wilson, 1993), and a Model of Experiential Learning developed by Kolb (1984). These theories form a conceptual scheme that provides a basis for my inquiry into the experiences of transition for new nurse case managers (NCMs).

The Model of Role Transition informed my questions about participants' experiences of making a change from the role of caregiver to that of case

manager. This model provides a conceptual framework for understanding role transition as a dynamic process of change and adaptation, impacted by environmental as well as personal events and attributes. It informed my inquiry of pre- and post- role change factors affecting participants' acclimatization to the role, as well as achievement of their present level of function and professional identity as case managers.

The theory of situated cognition describes the role of context in learning and comprehension. It contributed a focus to my inquiry on the contexts nurses exit and enter during this transition, and the impact of elements associated with those contexts on role learning and the development of expertise.

In order to more fully explore learning in the role of case manager, I used a four-stage model of experiential learning (Kolb 1984). Kolb's Model of Experiential Learning is cyclical. It demonstrates a process that begins with concrete experience and incorporates reflection on that experience, the formation of abstract concepts and generalization that arise from reflection, and the active experimentation that is used to test concepts and generalizations. This model led me to inquire about specific experiences identified by participants as significant in shaping their current understanding of and ability to execute role responsibilities.

Overview of Sample & Methods

I conducted semi-structured interviews with nurse case managers who have had at least three years of clinical experience followed by not more than

three years experience in case management. I chose to limit participants to three years of CM experience in order to harness relatively recent memories of transition and learning experiences in the CM role. The interviews were recorded on audiotapes and transcribed. In the tradition of grounded theory development (Creswell, 1994; Merriam, 2001; Siedman, 1991), transcripts were analyzed for emerging themes associated with the experience of transition and learning for participants as they gained insights and skills as case managers. A more thorough discussion of the methods and sample to be used in this study appears in Chapter Three.

Researcher Perspective and Assumptions

I am currently employed by a financial organization that holds property and casualty insurance lines of business. This organization provides claim services for individuals injured in work- and automobile-related accidents. Nurses are employed here as case managers to assist with the claim process by assessing healthcare needs related to the injury, and facilitating access to appropriate healthcare goods and services. In this role, nurses collaborate with the claimant (injured party), their employer, their healthcare provider, and the claim adjuster. NCMs monitor the injured party's understanding of the prescribed treatment regime and progress toward recovery. NCMs also monitor claimants' responses to prescribed treatment and discuss alternative treatment options with providers if claimants are not progressing as expected. In workers' compensation claims, NCMs work with employers to identify workplace or job

changes that accommodate temporary or permanent functional restrictions of the injured parties.

My role in this organization is within the ranks of management. I provide oversight for the case management program in terms of policy and procedural compliance with a national nonprofit accrediting agency (URAC) and I am responsible for recruiting, training and developing a qualified and competent NCM staff for claims service. I have held a license to practice as a registered nurse (RN) in the state of Michigan since 1972. I have been certified in case management (CCM) from the Commission for Case Management Certification since 1991. I have a background of clinical experience in rehabilitation nursing and also as a nurse consultant and case manager in the insurance industry. I am a member of the Case Management Society of America.

Because of my nursing experience as a caregiver as well as a case manager, there are certain assumptions I have about the transition from caregiver to case manager, as well as the sample of volunteer participants. First, I assume that foundational nursing education and training in providing care contributes significantly to the success of nurses performing the role of case manager. That is, I believe that the stronger the clinical background in terms of exposure to a variety of clinical settings, procedures, and interdisciplinary approaches associated with illness/injury and recovery process, the more resourceful a nurse will potentially be as a case manager. I assume that the longer a nurse has spent in the clinical arena, the more apt he or she is to have had a variety of clinical experiences that can contribute to greater ease in fulfilling

the responsibilities of a case manager. I assume that life experience or maturity in general provides a significant contribution to the success of making a role transition of this type.

However, I believe that the transition from caregiver to case manager involves more than applying clinical knowledge and acute care experience in a different setting. I suspected that the transition and learning experience for nurses as they make this practice-based career change presents some unique challenges that have not been fully explored in the literature. My suspicion in this regard has been raised by interacting with NCMs who have struggled in their transitions and learning in terms of confidence, professional identity, the scope and boundaries of their CM practice, and legal and ethical accountabilities for CM activities and influence.

With regard to volunteer participants, I expected most would be female, as most nurses are female. Based on my experience in recruiting and interviewing nurses for case management positions, I expected that most participants would be over 35 years of age and have had over 10 years of clinical experience.

Value of the Study

The value of this study is two-fold. In a broad sense, it provides data about expert to novice transitions in one field that may have implications for education and training agendas in other fields where similar types of role transitions are taking place. Nurses and other professionals are faced with evolving practice demands and opportunities in traditional as well as non-

traditional work environments. These changes present the need for effective role transition and learning strategies that enable them to accommodate to new performance expectations and to realize job satisfaction.

In a more specific sense, this study provides data about particular issues faced by nurses in transition from caregiver to case manager. The demand for experienced nurses to function as case managers is growing in the wake of a serious nursing shortage. ("What's in the Future? More Opportunities, Fewer Case Managers," 2003; Chan, et al., 1999; Falter, et al.,1999; Feuer, 2002; Howe, 1999). With experienced nurses at a premium, recruitment and retention are foremost concerns for healthcare providers and insurance plans that seek to leverage nurses' familiarity with healthcare systems and processes to control costs and enhance the efficacy of healthcare services.

As the demand for case managers grows, so too does the demand for education and training programs that address specific role requirements and adaptations that professional nurses face in this transition. This study enhances our understanding of the process of role transition and learning for nurses who make this practice–based career change, and contributes to our understanding of what is significant about professionals' experiences of transitions to new roles.

CHAPTER TWO - Literature Review

Introduction

Case management (CM) is an area of practice engaged in by nurses and other healthcare professionals to control healthcare costs though facilitating timely and appropriate use of healthcare resources by patients, providers and payers. Over the past twenty years, employment opportunities for nurses in this area have expanded and continue to grow (Falter, et al. 1999; Howe, 1999). Consequently, many nurses are taking advantage of this career alternative and are making the transition from caregiver to case manager.

As the demand for case managers expands, so too does the need to develop the means to educate and train competent practitioners. In a survey exploring nurse case managers' (NCMs) role behaviors and education (Conti, 1996), 70% of respondents reported that they gained necessary knowledge and skill to perform case management largely on the job and through life experience. In a review of nursing and CM literature from the previous ten years, Falter et al. (1999) found that case management education is diverse and includes not only continuing education courses and on-the-job training, but also some formal undergraduate and graduate course content. The extent to which each of these venues are available, utilized, or effective in preparing nurses for case management responsibilities was not addressed, however. Another study of educational approaches and issues in preparing nurses for case management (Haw, 1996) indicated that while most faculty in academic nursing programs

studied had educational preparation in case management, many lacked experience in the role. This suggests that research on practicing NCMs about transition to and learning that occurs in the role would be a useful contribution to faculty awareness and understanding of issues in CM field experience.

In this study, I examined the processes of learning and transition for experienced nurses who have made a career move from providing hands on care to providing case management services. The focus of this study centers on those experiences and insights that have been significant in the transition to and learning in the role of case manager for nurses whose foundational education and professional nursing experience is in providing direct patient care. Accordingly, the bodies of literature informing my inquiry include nursing, case management, role transition, situated cognition and experiential learning.

In this review of literature, I will first discuss the roles of caregiver and case manager in order to provide a perspective of how these roles, though sharing some foundational knowledge domains, differ in practice in a significant way. This information demonstrates the shift in focus and practice behaviors that needs to occur when nurses move from one role to another. I will then discuss literature on role theory and a model of role transition that helps in examination of this process. I will discuss situated cognition and how contextual factors come to bear on learning and performance. Finally, I will present a model of experiential learning that contributed to a conceptual scheme for my interview protocol and analysis of interview data.

Nurses as Caregivers

In order to approach nurses about their experience in making the transition from caregiver (the traditional role of a nurse) to case manager (a relatively new career alternative for nurses), it is essential to explore and understand specific aspects of each role. In this section I will present a comprehensive survey of behaviors that are characteristically associated with nurses in the role of caregiver.

Benner (1984) identified seven domains of nursing practice. They are: (a) the helping role, (b) the teaching-coaching function, (c) the diagnostic and patient monitoring function, 4) effective management of rapidly changing situations (d) administering and monitoring therapeutic interventions and regimes, (e) monitoring and ensuring quality of health care practices, and (f)) organizational and work role competencies. These domains encompass aspects of work for which nurses are prepared through their professional education programs. Each domain can be viewed as a category of either a hands-on or a facilitating approach. For the purpose of this study, nurses described as caregivers are those that provide a hands-on approach in their practice. Case managers by distinction provide a facilitative approach. Table 1 provides a comparative survey of each approach.

A basic premise of nursing care is the prevention of noxious influences and the provision of life sustaining resources (Newell, 1996). As caregivers in the *helping role*, nurses provide comfort measures and support in coping for patients. Comfort measures include assistance with activities of daily living such

as hygiene, grooming, exercise and positioning. Coping support encompasses creating a climate for healing through control of environmental variables. Caregivers intervene in patients' environments by identifying and removing hazards, taking precautions, and introducing resources that are not only conducive to healing, but stimulate or enhance patients' growth and development. Nursing interventions in this regard encompass the physical as well as psychosocial environment.

Caregivers enact a *teaching-coaching function* that includes such activities as probing to find out patients' interpretation of their illness and their readiness to learn self care activities. "Hands on" teaching and coaching includes providing patient education and counseling on health conditions, giving rationale for procedures and explaining the implications of illness and recovery for patients' lifestyles.

The *diagnostic and monitoring function* engaged in by caregivers includes detection and documentation of significant changes in patents' conditions through direct observations, physical examinations, and attention to patients' concerns about and experience of symptoms. Caregivers record and report patients' responses to various treatment strategies in terms of vital signs such as body temperature, blood pressure, heart rate, and respiration. Monitoring activities include measuring fluid intake and output, assessing changes in skin conditions such as color, texture and integrity, and noting changes in strength and joint mobility, as well as discrepancies in alertness or emotional reactions.

In providing *effective management of rapidly changing situations,* nurses as caregivers recognize emergent physical conditions and respond immediately in an effort to halt or reduce life threatening processes and restore life sustaining processes until physician assistance is available. This requires an immediate grasp of arising problems and the ability to match medical demands with available resources. Skills in cardio-pulmonary resuscitation, and defibrillation, as well as knowledge of the administration of appropriate agents and procedures are essential in this role.

Nurses as caregivers directly *administer and monitor therapeutic interventions and regimes*. This includes dispensing medication, fluids, and nutrition though various means, performing procedures such as wound dressing, bladder catheterization, and tracheal suctioning, facilitating appropriate amounts of rest and exercise, and documenting patients' conditions and responses. Caregivers must therefore be current in knowledge and skill pertaining to advances in pharmacology, medical technology, and various treatment protocols.

Caregivers to varying degrees *monitor and ensure the quality of healthcare practices.* In this domain of nursing practice, caregivers assess the safety or merit of prescribed treatment in light of the patient's condition or response. This entails determining what can be safely omitted or added to the prescribed regime, and getting appropriate and timely responses from physicians.

The practice domain of *organizational and work-role competencies* encompasses the management and administrative responsibilities associated

with providing direct care. Behaviors of caregivers in this domain include setting priorities among multiple demands on time and attention as they pertain to meeting the immediate healthcare needs of assigned patients. Characteristic behaviors may include building and maintaining working relationships with an interdisciplinary team of health professionals that all contribute to the well being of those patients, and whose services require coordination. This domain could also include contingency planning when resources, such as staff, equipment, or supplies, are limited.

Nurses as Case Managers

In this section I will provide background information about case management as an area of practice and about content knowledge that has been identified as foundational for CM. I will then differentiate the practice of case managers from the practice of caregivers using Benner's domains of nursing practice (1984) as an organizing framework.

Evolving from social work and public health models, CM is viewed as an effective strategy for containing healthcare costs and expenditures from both the provider and the payer sides of the healthcare equation. From the patient perspective, case management provides decreased fragmentation of care as well as advocacy (Flarey & Blancett, 1996; Mullahy 1998; Newell, 1996). Through the identification of individuals or populations that present high financial exposure, in terms of actual or potential healthcare needs, and the coordination of timely access and appropriate utilization of healthcare resources in order to meet those

needs, case managers have established their value in the world of managed care (Falter et al., 1999; Howe, 1998; Lamb & Stemple,1994). .The Commission for Case Management Certification, (CCMC) defines CM as "a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's healthcare needs through communication and available resources to promote quality cost effective outcomes" (Mullahy, 1998 p.9).

CM is a multidisciplinary area of practice with representation from the fields of nursing, social work, rehabilitation counseling, and occupational and physical therapy (Mullahy, 1998). A recent survey of working case managers, however, revealed that roughly 63% of respondents had a nursing background (American Health Consultants, 2000). Nurses with strong clinical backgrounds are sought after to practice in this area because of their presumed knowledge of the healthcare system and understanding of care requirements associated disease and disability.

Nursing and CM literatures demonstrate numerous practice models and settings for case management (Chan et al., 1999; Conti,1996; Falter et al 1999; Howe, 1999; Lamb & Stemple, 1994; Mullahy, 1998; Newell, 1996; Nolan, Harris, Kuffa, Opfer & Turner, 1998). Nurse case managers are employed by hospitals and rehabilitation and extended care facilities to provide coordination and oversight of the needed in-patient services and to monitor patient responses to treatment protocols from admission through discharge. .NCMs are employed in ambulatory clinics and health maintenance organizations (HMOs) to

coordinate on-going primary care of patient populations with at-risk and chronic conditions such as high-risk pregnancies, cardiac disease, diabetes, and asthma.

Third party payers (i.e., organizations that provide health care insurance, disability and workers' compensation insurance, and automobile personal injury protection insurance) employ NCMs to identify health care needs associated with illness or injury claims, to coordinate access to appropriate, cost effective resources, and to monitor the recovery process through full recovery or maximum medical improvement. Proprietary case management companies, or CM vendors, who enter into service agreements with insurance companies, attorneys or private individuals to perform case management services, also employ NCMs.

Descriptive terminology associated with models of CM is found throughout the literature. For example, case managers that provide CM services as agents of healthcare provider organizations are commonly referred to as "internal case managers." Those who provide services as agents of third party payers are commonly referred to as "external case managers." Case managers who practice in the field, making personal visits to patients' homes or provider settings to accomplish their tasks, practice what is referred to as "on-site CM." Case managers who accomplish their tasks exclusively by telephone practice "telephonic CM." Some case managers are "independent." They are self-employed and can enter into contractual arrangement for their services with providers, payers, or private individuals.

Five core areas of knowledge have been identified as foundational to all models of case management and are utilized by the CCMC for composition of the case management certification exam. These core areas of knowledge were determined as a result of a national survey of 14,000 certified case managers (Leahy, 1994). .They are (a) coordination and healthcare delivery systems, (b) physical and psychosocial factors, (c) benefit systems and cost benefit analysis, (d) case management concepts, and (e) community resources.

The core knowledge area of *coordination and healthcare service delivery* includes knowledge of the injury or disease and recovery processes, available treatment options, and strategies to access essential and cost effective healthcare services and goods. Knowledge of *physical and psychosocial factors* includes a comprehensive understanding of the interrelationship between influences on states of illness and wellness such as physical condition and functional abilities, psychological state and coping skills, cognitive capacity, family relationships, and community support. .The *benefit systems and cost benefit analysis* area of knowledge relates to familiarity with insurance coverage contracts and benefit provisions as well as cost containment strategies that do not compromise the quality of prescribed healthcare services or goods.

Core knowledge of *case management concepts* refers to basic knowledge and skills necessary to carry out the case management process including assessment, planning , implementing, coordinating, monitoring, and evaluating. The core knowledge area of *community resources* includes disability-related legislation with regard to employment, accessibility in housing and transportation,

medical care, and other services available specifically for persons with chronic illness and disabilities.

Case management has been identified as an area of practice for nurses that utilizes elements of nursing theory (Newell, 1996) and capitalizes on nurses' skills in assessment, outcome oriented interventions, monitoring responses and communication in situations related to healthcare. The role of case manager, however, requires some significant change in the focus and selection of behaviors within Benner's domains of nursing practice as demonstrated in the examples presented in Table 1.

In the *helping role* NCMs facilitate patients' comfort and coping by navigating the healthcare and benefit systems that provide them with essential services and financial support. The *teaching and coaching function* is enacted by NCMs as they identify healthcare service options and resources that patients can choose from and assist patients with making their needs known to those who provide care and financial support. NCMs fulfill a *diagnostic and monitoring function* by assessing patients' healthcare needs, facilitating access to the appropriate providers, and monitoring patients' overall progress in the recovery process.

Although job responsibilities do not require NCMs to manage medical emergencies, changes in health conditions, changes in benefit coverage, even changes in family relationships can present NCMs with the challenge of *effective management of rapidly changing situations* through communication and coordination of alternative services or coverage options. NCMs do not

Table 1. *Comparison of Caregiver and Case Manager Responsibilities*

Domains of Nursing Practice (Benner, 1984)	*Examples of Caregiver Responsibilities*	*Examples of Case Manager Responsibilities*
Helping Role	Assistance with hygiene, grooming, positioning and ambulation. Creating and maintaining an environment free from harm and conducive to healing and well being.	Facilitating access to healthcare resources and available benefits. Creating an environment of open communication and understanding between patient, provider, payer and other stakeholders in the community.
Teaching & Coaching Function	Patient and family education and counseling about health conditions and coaching in self- and supportive care practices.	Patient education about health conditions, care options and benefit coverage. Provider education about benefit system and available financial support. Payer education about patients needs and the cost of necessary care. Community education about patients re-entry needs.
Diagnostic and Monitoring Function	Detection and reporting of significant changes in patients' physical, emotional, cognitive state through physical examination and monitoring laboratory reports.	Detection of changes in patients healthcare needs based on patient, family and provider feedback. Detection of problems with insurance coverage based on payer, provider and patient feedback.
Effective Management of Rapidly Changing Situations	Life saving responses to physical and psychological emergencies.	Responses to situations that threaten continuity of needed care, benefit coverage, or patient adherence to prescribed treatment.
Administering and Monitoring Therapeutic Interventions	Directly dispensing medication, fluids, and nutrition. Performing procedures related to respiration, elimination, mobility, etc.	Facilitation, coordination, and monitoring needed therapeutic interventions.
Monitoring and Ensuring Quality of Healthcare Practices	Assessment of safety and quality of prescribed treatment in light of patients' condition and responses.	Assessment of safety and quality of prescribed treatment in light of established treatment protocols and patients' ability and willingness to participate.
Organizational and Work Competencies	Setting priorities to meet demands on time and attention from multiple patients. Working with interdisciplinary teams. Contingency planning for scarce resources needed for the delivery of care.	Recognition and understanding the needs and interests of multiple stakeholders. Negotiating for the most cost effective healthcare outcomes. Acting as a liaison for effective communication between patients, providers and payers.

administer therapeutic interventions and regimes, rather they indirectly monitor such interventions and regimes. Knowledge of evidence-based treatment protocols and the review of medical records and progress notes put NCMs in a good position to provide input to patients, providers and payers about the appropriate use of therapeutic interventions and regimes.

Perhaps one of the most salient of all the domains of nursing practice for NCMs is the function of *monitoring and ensuring the quality of healthcare practices*. NCMs' activities in this domain include assessing the merit or safety of prescribed treatment in light of the patients' willingness and ability to comply with plans of care, their concurrent healthcare or psychosocial needs, and the availability of healthcare benefits for financial assistance.

The practice domain of *organizational and work-role competencies* for NCMs encompasses a knowledge base of the multiple stakeholders involved, and skill in balancing priorities of patients, providers, and payers in order to render the best healthcare outcome at the most reasonable cost. This entails behaviors such as relationship building, negotiating, coordinating, brokering, and researching.

Conti (1996), by way of a survey study, identified 16 behaviors characteristically engaged in by nurses performing in the role of case manger. These behaviors in order of frequency include monitoring, problem solving, expediting, public relating, communicating, educating, contacting, planning, explaining, recommending, coordinating, documenting, assessing, negotiating, educating, brokering, and researching. She also found the majority of nurses in

her study indicated that the source of learning for this role, with all identified attendant behaviors, was employment and life experience. Conti contends that the majority of these behaviors have received little or no mention in the nursing literature and recommends that the scope of practice of nurse case managers be subjected to substantive examination and discussion.

It is within the past twenty years, and most recently with the proliferation of a "managed care" environment, however, that additional models and CM have developed to suit a variety of practice settings – all with an eye on containing healthcare costs. As such, NCMs have had to deal with competing interests related to cost containment, obligations to employers, and patient advocacy. Mullahy (1999) addresses several ethical issues routinely faced by case managers. They include patient versus payer rights, patient noncompliance, efficacy of treatment, employer involvement, cultural diversity, and under-utilization of services. Litigation, insurance fraud, guardianship, conservatorship, informed consent, confidentiality and other medical–legal issues also pose dilemmas for case managers in the course of practice (Banja, 1998, 1999).

Nurses practicing as caregivers may encounter a number of these issues in providing direct care to patients, however the number of stakeholders to be considered in healthcare scenarios expands for case managers. As a collaborative process, CM necessarily acknowledges and attends to interests of both the individual in need of healthcare and the systems within which healthcare is accessed, provided, and supported (Meany, 1999).

Comparing Roles

Though it appears that Benner's domains of nursing practice (1984) incorporate some of the behaviors identified by Conti (1996) as integral to the case manager role, some significant qualitative differences are apparent. Specifically noteworthy are (a) time perspectives (more immediate for the role of caregiver; more extended timeframe for case management activities), (b) the mode of provision of healthcare goods and services (provided directly by a caregiver; coordinated and facilitated by the case manager), and (c) setting (healthcare provider organization for the caregiver; healthcare provider or payer organization for the case manager). Also though initial formal preparation in nursing, as well as clinical experience in the caregiver role, may provide some foundational knowledge and skill on which to build expertise in case management, according to respondents in Conti's study (1996) there are on-the-job and general life experiences that have helped case managers become functional in their practice.

An appreciation of the foundational knowledge and scope of practice expectations of both the caregiver and case manager roles informed my line of inquiry into the significance of acquired clinical knowledge and experience in transitioning from caregiver to case manager. Exploring how care giving experiences may have or have not contributed to participants' effective case management practices, and the instructive value of specific CM experiences on-the-job provided insight into successful role transition and learning strategies.

Role Transition

Role theory provides a useful conceptual framework for exploration of changes in work practices, relationships and identities. Murray (1997; 1998) used role theory to examine nurses' transitions from hospital–based nursing practice to home care nursing. She relates that although a significant amount of nursing literature exists that addresses the transitional experience and needs of nurses new to the practice setting, literature that addresses the transitional experience and needs of nurses who move from one area of practice to another in the course of their professional career is scarce. She further contends that educators can impact the degree of role strain experienced, and ultimately the success of role transition of nurses making practice-based career changes by incorporating role theory concepts into orientation and continuing education programs. In this section, I will discuss a model of the role transition process that utilizes role theory concepts and language. I will first present a brief overview of the basic assumptions of role theory. I will then explore Allen's and van de Vliert's Model of the Role Transition Process (1982) in depth, and describe how it contributes to the conceptual framework of this study.

Biddel (1979) defines 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." He points out that role theory provides us with a means of studying both the individual and the collective within one conceptual framework, because it is the "theoretical point of articulation between psychology and sociology." He offers

five basic propositions that underlie this science. They are: (a) Roles consist of patterned behaviors that are characteristic of persons within contexts; (b) Roles are associated with sets of persons who share a common identity; (c) To some extent persons performing a role are governed by expectations that exist and are shared about normative performance; (d) Roles persist because of their function and perceived necessity in larger social systems; and (e) Roles are learned through socialization and people may find either joy or sorrow in performing them.

Two basic approaches to role theory have been discussed in literature, those being structuralist and social interactionist perspectives (Ashforth, 2001; Ebaugh, 1988). A debate between these two perspectives is essentially whether a person "takes" or "makes" a role. The structuralist approach views the role, or expected behaviors to be an objective identity or utility that a person takes on by fulfilling certain responsibilities or objectives. The social interactionist approach views the role as an identity or utility that is ultimately negotiated between the person engaging in expected behaviors and the context within which the role resides. The social interactionist view allows that the person transitioning from one role to another brings personal values, goals, meanings and attitudes from previous roles that impact the way the new role is understood and enacted. This study is aligned with this view.

The concepts and propositions of role theory are useful in studying role transition because they offer a lens with which to view issues affecting persons exiting and entering different contexts, trying on new identities, and performing

new behaviors. Through this lens we can identify social, environmental, and individual aspects and processes that produce patterns of behavior, and how and why expectations about these patterns are sustained or are changed.

Allen and van de Vliert (1982) developed a Model of the Role Transition Process that incorporates the social interactionist perspective of concepts and propositions of role theory. This model accommodates a dynamic interplay of social positions, expectations and behaviors that move individuals toward personal growth and adaptation in a role or toward role exit. Figure 1 demonstrates the sequential component parts of the role transition process, which include antecedent conditions, role transition (behavior shift), moderators, role strain, reactions, and consequences.

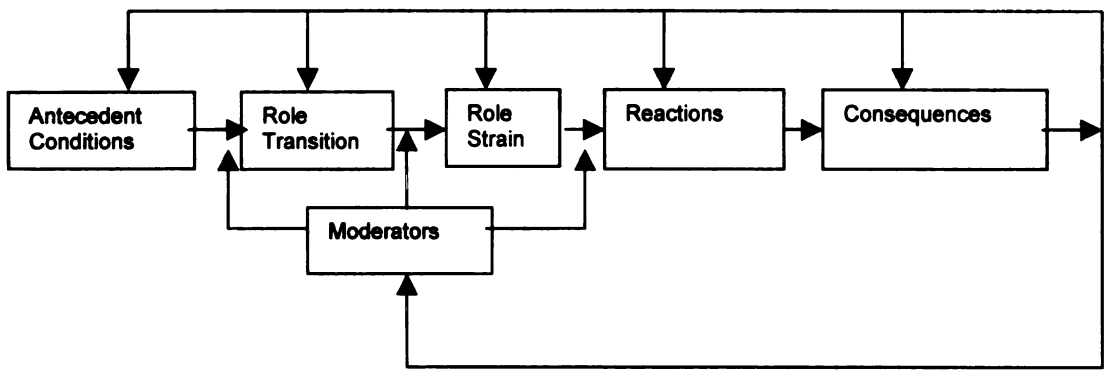

Figure 1. A Model of Role Transition (Allen & Van de Vliert, 1982)

Antecedent conditions are motivating factors that influence individuals to move from one role to another. These motivating factors can operate on various levels. On the level of the individual engaged in transition, for example,

antecedent conditions might be a change in capabilities, values, or financial needs. For nurses making a change from caregiver to case manager, a personal motivation might be more desirable compensation or schedule flexibility. On an organizational level antecedent conditions might include a change in market share, resource availability or mission that either attracts an individual to a new role, or renders the existing role occupied obsolete or no longer acceptable to the individual. Nurses working in clinical settings as caregivers may deal with sustained staff shortages, or threatening hospital closings or mergers, by looking for alternative career options.

The *role transition process* as a component part of the model (as opposed to the model in its entirety) refers to the actual shift in behavior that occurs when individuals exit one role and enter another. According to Allen and van de Vliert (1984), there are three factors that influence this shift in terms of the permeability of old behaviors into the new role. These factors are: (a) the degree of discontinuity between old and new behaviors, or how different the expected behaviors in the new role are from behaviors undertaken in the old role; (b) the accuracy of the transitioning person's anticipation of problems that will be encountered in shifting behaviors; and (c) the extent to which role entry and the assumption of new behaviors and responsibilities is formally structured and governed, as in a formal orientation, apprenticeship or internship program.

Allen and van de Vliert (1982) and others (Ashforth 2001; Nicholson, 1984) point out that the degree of discontinuity in expected behaviors between old and new roles can influence the degree to which old behaviors are carried

into the new role, and the degree to which new behaviors are accepted as more desirable. There is obviously a significant degree of discontinuity between expected behaviors of caregivers and those of case managers in terms of the provision of direct care versus the facilitation of appropriate cost effective care.

Hordijk, Muis and Van de Viler (in Allen & van de Vliert, 1982) found that both overly optimistic and overly pessimistic anticipation of problems associated with a new role caused more role strain than an appropriate anticipation of problems. Nurses entering the role of case manager may be aware of overt differences in expected behaviors, such as the shift from providing direct care to facilitating appropriate, cost effective care. They may not, however, be aware of the nature of the politics involved or ethical dilemmas that case managers face.

The remaining factor significant to the transitional shift in behavior is the extent to which the change is normatively governed; that is, the extent to which the challenges of role learning and socialization in the transitional phase are identified and planned for (Eraut, 1994). Exploring the experiences of NCMs with regard to the nature and effectiveness of their initial orientation to CM and early training agendas add to our understanding about the impact of contextual factors on this role transition.

The component of *role strain* in Allen and van de Vliert's model refers to the subjective experience of the person in the process of transition. Feelings of discomfort, disequilibrium, anxiety, and perplexity are often part of the transition process (Ashforth, 2001; Biddel, 1979; Ebaugh, 1988). Factors affecting the degree of role strain experienced by individuals may include the clarity of

expectations and boundaries associated with the new role and the meaning ascribed to accomplishing the transition – as a loss or gain of function, status, or esteem. Case management expectations and boundaries are not so clearly defined as clinical procedures.

Moderators are individual and environmental variables that can influence the intensity of role strain and ultimately impact other components of the process. On the level of the individual, for example, personality, locus of control, self-confidence, and social identity can modulate the transition experience to produce more or less strain. Contextual or environmental factors such as social networks, support for learning and the availability of resources can also work to exacerbate or diminish the experience of role strain (Carkhuff, M, 1996; Daley, 2001). Moderators in case management may include such things as the amount and kind of clinical and life experience the transitioning nurse has to draw from, the availability of a cohort within and outside of the employing organization, and support from the organization in terms of time and reimbursement for participation in professional organizations and continuing education programs.

Reactions refer to attempts by the individual to reduce role strain. Reactions can be the activation of accommodations in self or the environment to accomplish this. Seeking out more information and working to enhance or gain specific skills are reactions to role strain. Seeking to change behavioral expectations of the new role to comply more with existing skill levels and interests is also a reaction. Exploring how nurses react to strain experienced as beginning and novice NCMs and how effective or ineffective particular reactions

prove to be provide helpful insight for those interested in facilitating effective transitions into this role for nurses.

Consequences are those intended or unintended outcomes resulting from the focal person's attempts to deal with role strain. These outcomes can be an alteration in any of the other components of the process and be short or long term. For example, a nurse making the transition from caregiver to case manager may react to role strain by networking with other case managers to learn more effective practice strategies. The introduction of successful new practice strategies shifts behavior even more (role transition). Performance of new behaviors can either serve to increase or decrease role strain and produce new reactions. If role strain is increased, a subsequent rejection of aspects of the role that are intolerable may become new conditions antecedent to another shift in roles (from case manager back to caregiver, for example). If strain is decreased, the new skills acquired and success experienced may consequently become a moderator, such as a change in professional identity that serves to modulate role strain associated with any subsequent behavior changes. Participant descriptions of consequences of their reactions complete a picture of the process of role transition.

In summary, utilizing Allen's and van de Vliert's Model of the Role Transition Process (1982) provides a conceptual frame within which to examine several dimensions of the experience of change and learning for nurses moving from the role of caregiver to that of case manager. Based on components of this model, my inquiry encompassed individual, environmental and social conditions

that lead nurses to initiate this change in their careers, descriptions of specific behavioral changes involved in assuming a CM role, the nature of discomfort or difficulty associated with making these behavioral changes, and strategies employed and outcomes experienced in dealing with role strain.

Situated Cognition

Research indicates that context, in terms of physical setting, tools, social networks, cultural norms, and personal meaning, is inextricably linked to learning and performance (Daley, 1997; Eraut,1994; Lave,Mutaugh, & de la Rocha, 1999; Merriam & Brockett, 1997; Schön ,1983, Wenger, 1998; Wilson, 1993). Context provides learners with a scope, an aim and a scale of priority for skills and concepts to be learned, and/or tasks to be accomplished. Situated cognition refers to a process of learning and comprehension that is tied to context (Brown, Collins & Dugid, 1989, Wilson, 1993). According to this conceptual frame, learning is a recursive process in which individuals gain knowledge and competence in context through membership in social networks, utilizing tools, and setting and solving problems that are particular to that context. The implication of situated cognition in studying role transition and learning for nurses moving from caregiver to case manager is the need for educators and trainers to appreciate the impact of contextual factors on role learning and performance.

Lave et.al. (1999), for example, demonstrated the role of contextual elements in problem solving in what has been referred to as "the supermarket study." In this study, adult subjects more aptly and accurately solved

mathematical problems in a context of grocery shopping as compared to the outcome of their efforts in solving similar problems offered by way of a paper and pencil test. Researchers noted that the context of grocery shopping offered subjects specific tools and framed solution expectations that differed from the context of traditional academic testing. Shön (1983, p.40) has argued as well that "Problem setting is a process in which, interactively we name the things to which we will attend and frame the context in which we will attend them."

Fundamental nursing education and training is concerned with preparing individuals to be competent caregivers. Foundational preparation in nursing has historically been followed by clinical experience obtained in the context of an acute care setting. In this context, the caregiver's attention is directed quite often at a single episode of illness and medical treatment in a setting that provides distinct tools and expectations for practice. Nurses making a career change to case management, however, move into a new context that holds new expectations, new social structures, new tools, and potential new identities. Inquiry aimed at discovering contextual elements that influence nurses' transition to and learning in the role of case manager was informed by a theory of situated cognition. Figure 2 demonstrates elements of practice settings that influence learning, and accompanies the individual's entry into subsequent practice contexts.

Role identity is associated with context because it is developed through interaction with contextual elements such as technical information, role expectations, organizational structure, appraisal information, cultural norms and

political climate (Ashforth, 2001). The concept of role identity, or how individuals define their rights and responsibilities in relationship to others, becomes an issue in role transition and learning because of its influence on the knowledge and skills selected for learning in the pursuit of competence. Wenger (1994, p. 215) states, "We accumulate skills and information, not in abstract ends in

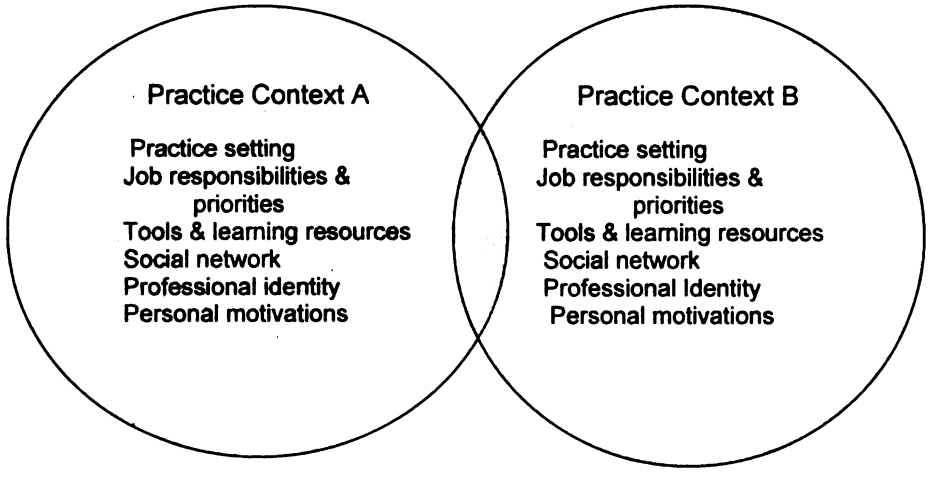

Figure 2. Elements of Practice Contexts that Impact Learning. It also represents how influences from elements of past contexts are brought into and modified by subsequent practice contexts.

themselves, but in service of an identity." For these reasons, it was important to explore how NCMs view differences in relationships to clients, coworkers, colleagues and others with whom they regularly interact from that of relationships they participated in as caregivers.

Experiential Learning

Kolb offers a model that provides a plausible explanation of how learning from experience occurs. It consists of a cycle of concrete experience, reflective

observation, abstract conceptualization, and active experimentation (Kolb, 1994). Figure 3 demonstrates this model.

According to this model, the learner is first engaged in some activity or

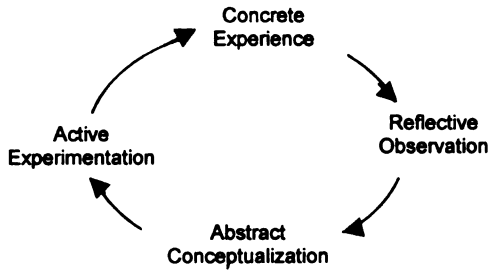

Figure 3. Kolb's Model of Experiential Learning (in Davis, 1993)

encounter. Following this the learner reflects upon the meaning of that experience in terms of personal significance, logic, and value, and then formulates abstract conceptualizations about what has taken place. Testing of the abstract conceptualizations ensues through a process of active experimentation, which returns the learner once again to concrete experience. At this juncture, the cycle repeats.

It is feasible that progressive expertise is accomplished with each successive journey though this cycle (Benner, 1984; Dreyfus & Dreyfus, 1985). It has been argued, however, that learning from experience without guidance is subject to the learner's interpretation of experience. Left to their own interpretations, learners can conceptualize erroneous theories, which then become self-confirming in subsequent experiences (Eraut, 1994).

Conti(1996) indicated that 75 % of NCMs she surveyed reported that they learned case management "on the job." This suggests that experiential learning is an appropriate theoretical frame with which to investigate how nurses learn to function in the role of case manager. Guided by Kolb's model, I formulated interview questions to bring out recollections of specific experiences that participants find instrumental in learning to function as a case managers, and opportunities they have to review or discuss cases and problem solving strategies.

Summary

Case management is a growing field of practice in systems of healthcare delivery and insurance claim payment. Nurses are sought after to fill case management positions because of valued clinical knowledge acquired through nursing education and experience as caregivers. Though foundational nursing education and experience as caregivers provide nurses with valuable insight into issues related to illness and recovery, this background does not necessarily prepare them to assume a role that requires the development of new skills and application of their knowledge base in a different context. This study identified salient characteristics of the processes of role transition and learning that have provided professional nurses with the knowledge and skills to function effectively as case managers.

I assembled a conceptual scheme for studying the nature of role transition and learning for nurses making a practice based career change from that of

caregiver to case manager. This scheme as illustrated in Figure 4 utilizes theories of situated cognition, role transition and experiential learning. The concept of situated cognition directed my attention to the impact of context on learning and comprehension in practice. Understanding the practice

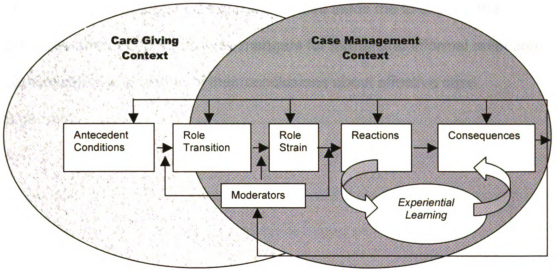

Figure 4. Conceptual Scheme of Study combines the influences of past and present role contexts with Allen & van de Vliert's Model of Role Transition (1982), and Kolb's Model of experiential learning as a reaction to role strain.

contexts that nurses exit and enter in this transition is therefore significant in understanding their experiences of transition and learning. A Model of the Role Transition Process (Allen & van de Vliert ,1982) contributes a structured approach to exploring a dynamic process of change and adaptation. This model provided pathways and milestones for exploring nurse case managers' reflections on experiences associated with role transition. This model includes factors and motivations precipitating role transition as well as experiences of role

strain and the consequences of problem solving strategies to reduce it. Learning in a new role, however requires an emphasis in this study not specifically addressed in Allen's and van de Vliert's model. Kolb's Model of Experiential Learning (1984) provides a format for that emphasis. Kolb's model guides this study toward identification of concrete experiences in CM practice that lead to the development of knowledge and expertise. It also leads me to explore the opportunities afforded to nurse case mangers for formal and informal reflection, conceptualization and testing of their conclusions about effective case management.

CHAPTER THREE - Research Methods

Introduction

Case management is a career opportunity for nurses. Such opportunities are increasing as the healthcare providers and payers seek ways to control costs without sacrificing the quality of care needed by consumers (Chan et al, 1999; Conti, 1996; Falter et al, 1999; Howe, 1999). While current literature addresses foundational knowledge and skills essential for effective case management, there is a gap in information on how nurses learn to apply their foundational education and experience as caregivers and acquire new competencies as case managers. This qualitative study, demonstrating patterns of transition to and learning in the role of case manger for nurses who have been primarily educated and experienced as caregivers, begins to fill that gap.

A qualitative study is appropriate for seeking out this kind of knowledge because it allows for exploration and description of personal experience and meaning in specific contexts (Creswell, 1994). The methods of inquiry and analysis I used are based on the conceptual framework of symbolic interaction, which holds that people create meaning from experiences through interactional responses to situations (Bogdin & Biklin, 1998). These methods accommodate in depth exploration of the interplay of personal meaning and situational factors described in the theories that I have chosen to inform my inquiry and data analysis. Theories of role transition, situated cognition and experiential learning led me to explore phenomena comprised of the interplay between contexts,

motivations, tensions, accommodations and reflections. The investigation of this interplay as it pertains to role transition and learning for NCMs, required detailed descriptions of past experiences and present reflections not accessible through quantitative methods of research.

Participant Recruitment

An explanation of this study along with a call for volunteer participants was presented at two local meetings. One was a local chapter meeting of the Case Management Society of America (CMSA) and the other was a local meeting of the Rehabilitation Insurance Nurse Council (RINC), both in a Midwest metropolitan area. CMSA and RINC are both professional organizations. RINC's membership consists only of NCMs who are specifically associated with insurance carriers either by employment or by contract. CMSA's membership has representation from a variety of disciplines, that is case managers who are nurses as well as others who are social workers, occupational therapists, or physical therapists, and is also inclusive of case mangers associated with healthcare providers as well as payers. These organizations routinely meet on a monthly basis for the purposes of member networking and continuing education on topics of interest to NCMs. Volunteers presented their interest in participating directly to me or indirectly through other NCMs who had attended the meeting. I also contacted supervisors at three CM vendors and requested referrals to any of their staff that fit the desired profile. One supervisor referred me to two of her staff.

I phoned potential subjects and briefed them on the nature of the study and screened them for fit with the desired sample profile. A convenience sample of eleven NCMs was selected from fifteen volunteers to provide data for this study.

Sample Selection

A purposeful sample with consideration to maximum variation in cases was determined to be appropriate for this study. Purposeful sampling is based on the assumption that a criterion-based sample selection serves the need for in-depth study of information-rich cases. Criteria for sample selection reflect the purpose of the study and guide identification of information-rich cases. (Merriam, 2001; Seidman 1991). Maximum variation in cases selected contributes to the identification of the relative strength of shared patterns that emerge from data, even in small samples (Merriam, 2001).

Participants selected were practicing NCMs who had at least three years of hospital or clinic based experience beyond foundational nursing education and training prior to taking on the role of case manager. Because CM is practiced in various settings, an attempt was made to limit participants to those currently practicing in payer environments (insurance companies that are involved in paying health benefits). They also were required to have practiced in the role of case manager from one to three years. Age, gender, or ethnicity was not part of the selection criteria.

While years of experience do not necessarily correspond to a predictable level of role understanding or competency, Dreyfus and Dreyfus (1986) demonstrated that professionals move through progressive stages of competency toward expertise and that these stages roughly correlate to time on task. Based on their study of individuals performing in a number of occupations with varying amounts of experience, they developed a Model of Skill Acquisition and labeled these stages as novice, advanced beginner, competent, efficient, and expert.

According to this model, a professional with up to one year of experience generally functions as a novice. I have chosen to exclude novice NCMs from this study because I do not believe that they would be able to provide the scope of recollection and the degree of insight I am seeking. As Dreyfus & Dreyfus point out, the novice has little to no experience to draw from in analyzing a situation and choosing behaviors appropriate for goal accomplishment. Goals of behavior for this stage are generally short sighted, if present at all. Objective features of tasks are used to gain entry into a situation and consciously attend to "context free" or "text book" rules to help make determinations of the "correct " course of action. Novice NCMs may be able to compare contexts and describe tensions experienced in the transition at hand. I speculated, however, that role understanding and learning strategies may be limited at the novice stage to a degree that is significantly less informative than input from NCMs at the advanced beginner stage (one - two years of experience) or the competent stage (two - three years).

I chose to exclude NCMs with greater than three years of experience in order to capture experiences of role transition and learning with more accuracy. According to Dreyfus & Dreyfus, as professionals' progress through the proficient (three-five years) and expert (greater than 5 years) stages of skill acquisition, they begin to rely more on intuition for problem solving. They develop the ability to zero in on an accurate region of a problem and determine a viable solution almost immediately, and often have difficulty describing this fluid process. I was concerned that NCMs with advanced experience levels may have also found it difficult to recall the impressions, tensions and strategies that were significant in their own processes of role transition and learning.

Sample Description

Table 2 presents the demographic data of the sample of participants for this study. Participants were all female registered nurses (RNs), which is consistent with the most represented gender in the nursing profession and also in the field of medical case management. Although male participants were not excluded from the study by design, no specific attempt was made to insure representation. Six participants were between 41 – 50 years old. Three participants were over the age of 50. The only participant under the age of 40 was 29 years old.

Seven participants earned Bachelor of Science degrees in Nursing (BSN). One of those also completed a Master of Arts (MA) degree in Healthcare Administration and another is completing a Master's degree in Exercise Science.

Table 2. *Sample Summary*

Participants	Age	Education	Years as Caregiver	Clinical Contexts and No. of Participants with Experience	Years as Case manager	Case Management Contexts	Case Mangement Model
N = 11	< 30 y/o: 1	ADN: 5	0-10: 4	Medical /surgical units: 5	1: 2	Workers'	Telephonic: 6
				Home Care: 4		Compensation	
	31-40 y/o: 0	BSN: 5	11-20: 2	Emergency Room: 4	1-2: 6	Carrier: 5	On-site: 4
		MA: 1		Pediatric Clinic: 3			
	41-50 y/o: 7		21-30: 4	Critical Care Units 3	>2: 3	Case	
				Orthopedic Units: 2		Management	
	>51 y/o: 3			Oncology Units 2		Vendor : 3	
				General Practice Clinics: 2			
				Utilization Review* 2		Health	
				Public Health Clinics: 2		Maintenance	
				Obstetrics & Gynecology: 1		Organization: 3	
				Skilled Nursing Facility: 1			
				Occupational Health Clinic: 1			

Note: ADN = Associate Degree in Nursing; BSN = Bachelor Degree in Nursing; MA = Master of Arts Degree; * non- care giving role.

Four participants earned Associate Degrees in Nursing (A.D.N.). One of those is currently enrolled in a BSN program, and another is enrolled in an accelerated Master of Science in Nursing (MSN) program.

Participants' years of experience as caregivers in healthcare provider settings ranged from 5 to 31 years. Five participants had more than 20 years of experience as caregivers. Three participants had between 10 and 20 years of those is currently enrolled in a BSN program, and another is enrolled in an accelerated Master of Science in Nursing (MSN) program.

Participants' years of experience as caregivers in healthcare provider settings ranged from 5 to 31 years. Five participants had more than 20 years of experience as caregivers. Three participants had between 10 and 20 years of experience and three participants had less than 10 years of experience as caregivers.

Clinical contexts where they performed in roles of caregivers were multiple for many participants and included various hospital in-patient units, namely medical surgical units (five participants); orthopedic units (two participants); intensive and critical care units (two participants); pediatric unit (one participant); and obstetric and gynecology units (one participant). Out-patient or ambulatory clinic settings included emergency care (four participants); pediatric clinics (three participants); public health clinics (two participants); general practice clinics (two participants); and occupational health clinics (one participant). Four participants gained care giving experience in the home care context, and one participant provided care in a skilled nursing facility.

Participants' work experience as NCMs ranged from one to three years. The majority of participants (six) fell into the range of one to two years of CM experience. Three participants have worked as NCMs for one year and three have performed in the role for two to three years.

Two national workers' compensation (WC) insurance carriers employ five participants. Four of those are employed by one carrier and practice telephonic CM. One participant is employed by the other WC carrier and practices on-site CM. Three participants are employed by two CM vendors that provided contractual CM services for WC, automobile, and disability insurance carriers. These participants all practice on-site CM. Two of these participants work for the one of the CM vendors. One participant works for the other vendor. The remaining three participants are employed by two health maintenance organizations (HMOs). Two participants work for one of the HMOs and one particpant works for the other.

Data Collection

Data were collected through loosely structured individual and focus group interviews with experienced nurse case managers. Interviewing is a method of inquiry that allows participants to explore their own experience and assign a personal meaning to that experience (Bogdan & Biklen, 1998; Cresswell, 1994; Merriam, 2001; Seidman, 1991). Through dialogue on contextual variables, and reflections on transition and learning experiences, I gained insight into how these

professionals experienced role transition and learned how to function as case managers.

Seidman (1991, p. 3) explains, "At the heart of interviewing research is an interest in other individuals' stories because they are of worth." .NCMs' perceptions of contextual influences and personal accounts of transition and learning are of worth to me specifically because of my responsibilities involved with training and development of nurses as case managers. . believe such accounts and reflections are also of worth to the area of nursing and case management because of the increasing opportunities for nurses to fill this role, and a need to develop education and training programs that comprehensively address learning needs in this area of practice. In addition, these accounts and reflections contribute to out understanding of how professionals in general approach and develop in new roles

Personal interviews began in the phenomenological tradition of the "grand tour" questions. Grand tour questions are posed in a general way so as not to limit respondents in their replies (Bogdan & Biklen, 1998; Cresswell, 1994; Merriam, 2001; Seidman, 1991). vThis approach allowed NCMs to describe personal experiences and observations of phenomena addressed in the theoretical frames of situated cognition, role transition and experiential learning that contribute to the overall conceptual scheme of this study. Taking cues from responses to the grand tour questions I pursued more explicit descriptions of practice contexts and reflections on experiences of transition to and learning in

this role, as well as reflections on how these things have come to bear on their current understanding and practice of case management.

Specific questions associated with situated cognition included: "Tell me about the different contexts in which you have practiced as a professional nurse." "How would you describe the principal differences between the practice context of a caregiver and that of a case manager (e.g. rights, responsibilities, resources, support structure, etc.)?" "How do the resources that were available to you for learning to provide hands-on nursing care compare with the resources that are available for you for learning to function as a case manager?

Questions associated specifically with role transition included: "Describe what the transition from caregiver to case manager was like for you." "What motivated you to make this career change?" "Where does this role fit in your career plan?" "In what ways have your clinical knowledge and care giving experience prepared you to assume the role of case manager?" "Which expectations and responsibilities of a case manager did you feel least prepared to fulfill?" "Describe the sources of conflict or strain that you experience in assuming and developing in the role of case manager." "What environmental or personal accommodations help you to feel more comfortable or confident in the role?" "What do you find satisfying or rewarding about case management?

Questions associated with experiential learning included: "How did you go about learning to practice case management?" "Which experiences do you recall as significant in your learning the core knowledge areas of CM?" " What have you learned essentially through formal means (e.g. pre-service courses, in-

service or continuing education programs?" "What opportunities do you have to review or discuss cases for the purpose of increasing knowledge or improving performance?" "Looking back over your experience of role transition from caregiver to case manger, what was most helpful in terms of socialization and learning?"

Personal interviews were recorded on audiotape and transcribed verbatim. Once I reviewed transcripts and identified themes and nuances, I facilitated two focus group discussions with volunteer participants. This provided additional opportunities for participants to reflect on how their experiences were consistent or inconsistent with themes presented as having emerged from individual interview data. Having NCMs respond to themes emerging from individual interviews with colleagues contributed to my insight into the similarities and differences in the experience of role transition and learning inherent in this practice-based career change. Benner and Wrubel (1982), for example, found that experienced clinicians were able to discover significant aspects of clinical experiences through dialogue with peers.

The focus group method of data collection has found increased acceptance and popularity in social science research. (Morrison & Peoples, 1999) This technique has been utilized to stimulate discussions in homogeneous groups to help determine common and contrasting opinions, perceptions and reflections on specific topics. Underlying assumptions about the validity of this approach include: (a) a homogeneous group can create a milieu in which participants experience freedom to discuss thoughts, feelings and beliefs

candidly; (b) a group's dynamics can generate authentic information; and (c) a facilitator can help people recover forgotten information or form new conceptual connections through focusing the discussion and helping participants explore ideas or impressions in more depth (Morrison & Peoples, 1990).

Data Analysis

Analysis of data was done simultaneously with data collection from individual and group interviews in the tradition of grounded theory development. Characteristic of research in this tradition is the constant comparison of data with emerging categories or themes (Bogdan & Biklen, 1998; Cresswell, 1994; Merriam, 2001; Seidman, 1991). Transcripts and notes from personal interviews were analyzed with components of the research questions in mind to determine emerging common and/or contrasting themes of how participants made the transition from care giver to case manager. I devised a method of coding interview data to decipher themes emerging in association with the research questions I was seeking to answer. For example, I reviewed the first interview transcript and identified general categories of information that were apparent. Most of these categories coincided to the interview questions. I did the same with subsequent transcripts and began to compose a list of categories such as logistics, work experience, caregiver contexts, case management contexts, learning experiences, difficulties, differences, etc. and labeled interview data accordingly. I then assembled data from each participant according to those categories and reviewed them for similarities and differences. I was able to

compose a list of sub categories. For example, from the data associated with "difficulties" sub- categories included "relationships with adjusters," "left alone to learn, " and "business environment."

Following the analysis of transcribed interviews, I created concept and theme listings associated with the research questions that I presented at the beginning of two focus group discussions. All participants were invited to participate. Three attended the first scheduled discussion, and three others attended the second. The meetings were held in the conference room of a centrally located healthcare facility that was made available to us by a professional colleague of mine.

The purpose of this study was reviewed with participants, along with the research questions. My impressions of themes emerging from personal interviews about the nature of role transition for these professionals and how they learned to function in this new role were also presented and discussed. Participants either confirmed or challenged these impressions, and offered more in depth review of some topics. These discussions were recorded on audiotape and reviewed. Added information was then incorporated in concept summaries addressing the research questions.

Data reduction was accomplished by the identification of themes in experiences and reflections described by individual participants and the validation of those themes achieved through focus group discussion. I report my analysis of the data in Chapter Four with descriptions of emergent themes and patterns of experience. I include case examples that illustrate salient factors in

this role transition for participants. Implications of these data in the design and implementation of case management education and training programs are explored and presented in Chapter Five.

Delimitations and Limitations of the Study

This study explored the experience of transition between two unique areas of practice within the profession of nursing by examining interview and focus data from eleven volunteer participants who have recently made the transition from caregiver to case manager. Delimitations set for this study are as follows. Findings reflect the experiences of role transition for nurses with up to three years of experience of case management in one of three work settings. These three settings are workers' compensation insurance carriers, case management vendors, and health maintenance organizations. Data were gathered from self-reports to garner participants' personal experiences and perspectives. There were no intentions in analysis of the data to determine competence of participants in previous or current roles or personality traits that may have influenced their experience of transition.

Limitations of the study associated with sample are the small sample size, limited geographic area (Midwest state) in which participants reside and work, and an absence of male representation. While the common and contrasting themes determined from the data may be useful for educators and trainers in facilitating the transition for nurses in payer or proprietary case management settings, some findings will not necessarily be applicable to nurse case managers

in healthcare provider settings or other professions in this or other areas of practice.

Summary

I conducted a study of role transitions for nurses who have made career changes from the practice of providing hands-on nursing care to the practice of providing case management. My inquiry consisted of individual and focus group interviews of nurse case mangers about their recollections and perceptions of contextual influences, experiences and reflections on the processes of role transition and learning. I utilized the methods of qualitative study because it allowed for in-depth exploration of the interplay between personal, social and environmental factors addressed in the theories of role transition, situated cognition, and experiential learning.

CHAPTER FOUR - Findings

Introduction

Understanding the process of role transition for nurses who make a career change from caregiver to case manger should enable nursing educators and others responsible for developing professionals in this area of practice to design and enhance education and training programs that comprehensively address their learning and socialization needs. This chapter will present an overview of themes emerging from interview data about personal experiences and reflections that are relevant to nurses' experiences of role transition from caregiver to case manager. I will first briefly introduce participants, who were interviewed for this study, to provide a frame of reference for the reader. These introductions will be organized in three groups that illustrate obvious similarities and differences among participants in terms of current work settings and case management practice models.

I will then identify those experiences and reflections shared by participants that address the following research questions:

1. Are there characteristic motivations, expectations, sources of role strain and job satisfaction and learning resources associated the process of this role transition?
2. What elements of contexts associated with past and present roles are influential in this transition?

Introduction to Participants

Eleven nurses from three case management practice settings and with varying clinical backgrounds provided personal recollections and perspectives about their transition from roles of caregivers to roles of case managers. Table 3 provides demographic information about each participant. Following are brief narrative introductions to participants that I have divided into three groupings: (a) participants who practice telephonic CM for a workers' compensation (WC) insurance carrier; (2) participants who practice on-site CM for WC insurance carriers; and (c) participants who practice telephonic CM for health maintenance organizations (HMOs). These groupings are intended to provide the reader with information about CM practice settings and CM models that some participants have in common. (For more detailed information about individual participants, Appendix Three: Participant Profiles.)

Participants Who Practice Telephonic Case Management For A Worker's Compensation Carrier.

The first group of participants that I will introduce includes four nurse case managers (NCMs), Ann, Belinda, Ginger and Irene, who are employed by a national workers compensation (WC) insurance carrier. They work in an office with 8 other NCMs and 25 – 30 claim staff, and carry out their case management (CM) responsibilities telephonically. Ann and Ginger had shared experiences in previous work settings, as did Belinda and Irene. All four currently report to a

Table 3. *Participant Demographics*

NCM	Age	Ed	Yrs as Cgr	Clinical Contexts	Yrs as NCM	CM Contexts	CM Model
Ann	53	BSN, MA	30	Critical Care units Emergency room General Practice clinic	1.5	WC Carrier	Tele-phonic
Belinda	49	ADN	3	Skilled Nursing facility General Practice clinic Pediatric clinic	3	WC Carrier	Tele-phonic
Ginger	53	BSN	30	Critical Care units Emergency room	1.5	WC Carrier	Tele-phonic
Irene	56	BSN	21	Medical Surgical units Pediatric clinic	3	WC Carrier	Tele-phonic
Donna	46	ADN+	21	Emergency room General Practice clinic Occupational health clinic	1	WC Carrier	On-site
Hannah	41	BSN+	14	Orthopedic unit Oncology unit Home Care	1.5	CM Vendor	On-site
Cathy	29	BSN+	5	Medical/surgical units Oncology unit Public Health clinic Home Care	1	CM Vendor	On-site
Judy	43	ADN+	9	Medical /surgical units Home Care	1.5	CM Vendor	On-site
Karen	44	BSN	20	Medical/surgical unit Orthopedic unit Home Care Utilization Review*	1.5	HMO	Tele-phonic
Fran	44	ADN	10	Medical/surgical units Pediatric unit Critical Care units Obstetrics and gynecology unit Emergency room Utilization Review*	2	HMO	Tele-phonic
Evelyn	47	BSN+	29	Pediatric unit Pediatric clinic Public Health clinic	3	HMO	Tele-phonic

Note: Shaded areas indicate coworkers; NCM = Nurse case manager; Ed = Education; ADN = Associate Degree in Nursing; BSN = Bachelor of Science Degree in Nursing; MA = Master of Arts Degree; + = additional coursework; CM = Case management; WC = workers' compensation; HMO = Health maintenance organization; * non care giving role

supervising NCM, as well as a claim department team leader. They share caseload responsibilities with adjusters. All four indicated that the adjuster has the final authority on claim handling decisions.

Ann.

Ann came into her current role as an NCM from 30-year background in emergency and critical care nursing. She made this career move primarily for health reasons. She needed an occupation that was less physically stressful than her role as a caregiver in the hospital. Ann became aware of case management as an employment option through a personal friend who worked for her current employer. When an open position coincided with her health difficulties, Ann made the move. She views case management as "more laid back" than care giving. She notes that CM creates "stress in its own way," for her, but she feels "it's a good way to end a career."

Ann enjoys contact with the employers insured by the company, the patients and the physicians. She struggles at times with her relationships with adjusters, however. She remarks, "[The adjusters] are in that world and [the nurses] are in the medical world and there is a definite distinction." She finds having to relinquish authority to adjusters on medical claim decisions to be very frustrating.

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Ginger.

Ginger also came into the case manager role with significant emergency and critical care nursing experience. Her motivation to make a career change was fueled by dissatisfaction with changes in the hospital setting. Knowing that Ann was satisfied with her change, Ginger asked to be considered when another position was available. Like Ann, Ginger finds this career alternative more laid back than hospital nursing. But unlike Ann, Ginger does not find her role as a telephonic case manger to be a good use of her knowledge and skill. She opines that a nursing background is not really required to accomplish what she understands her job to be.

Her job preference would be to teach in some capacity. She admits, though, that she does have opportunities to provide education about things like treatment options, post-surgery care, and WC coverage issues to claimants. This is when she recognizes the merit of a nursing background in CM.

Irene.

Irene sought alternative employment from a pediatric clinic, where she enjoyed considerable job satisfaction, because of the need to enhance her income. Faced with supporting herself following a divorce, Irene took advantage of an open position made known to her by a personal acquaintance who was employed with this WC insurance carrier. Realizing that her clinical background in pediatrics would most likely be viewed as insignificant in qualifying her for the role of a WC case manager, she was nonetheless determined to secure the

position for the financial advantage it offered over her salary potential at the clinic.

Of all participants, perhaps Irene struggles the most with reconciling her professional identity as a nurse with her role as a WC case manger. Though she believes she has gained significant knowledge, skill, and confidence in her ability to assist injured workers to obtain appropriate and effective healthcare, she resumed her connection with the pediatric clinic on a part-time basis. Every Sunday she provides telephone triage services for patients of the pediatric practice that previously employed her. Irene finds that this keeps her tied to something she finds truly worthwhile. She proudly shares, "I have moms now that only call on Sundays because they know I'm going to be there on Sundays. So you build up that what they expect of you is peace of mind, not so much the actual care giving, but the mentoring shall we say?"

Belinda.

Belinda's clinical background is also primarily in pediatrics, gained in two different clinic settings. Her motivation for making a career change to CM was fear that a change of ownership of the clinic would ultimately result in elimination of her position. She became aware of an open case management position from Irene, who had made this career change earlier and whose employer was seeking to add to the case management staff.

Belinda feels that case management has provided her with opportunities to grow professionally as well as personally. She has learned about a myriad of

injuries and treatment options not encountered in a pediatric practice. She has found a new resourcefulness in looking for information, networking with others and taking advantage of in-service education and training programs. She has gained confidence in questioning or challenging physicians.

She grieves for the "warm, nurturing, [give] me a hug and I'll make you feel better kind of a caregiver" she used to be, and yet she has learned to respond to people from a more realistic, objective perspective where she is able "to pick up the facts and deal with them as they sit there." The more she has learned in the role of case manger, the more interesting it becomes for her.

Participants Who Practice On-Site Case Management For Workers' Compensation Carriers

The second group of participants I will introduce, Donna, Judy, Hannah and Cathy, practice on-site case management for WC insurance carriers. Though many of the contacts they make in the course of their practice are by phone, they routinely make field visits to hospitals, physicians' offices, claimants' homes and job sites in order to establish rapport, make comprehensive assessments, and monitor progress. Donna is employed by a national WC carrier. Judy, Hannah and Cathy are employed by CM vendors that contract with WC, auto and disability insurance carriers for CM services. Cathy and Hannah are coworkers.

Donna.

Donna reflects that her move into case management is the most recent in a series of job opportunities that play out like "stepping stones", each providing her with skill and direction for a logical next move. She gained nursing experience in a variety of clinical settings, including emergency nursing, out-patient clinic administration, and occupational health. She credits each of these experiences with contributing to her interest in and understanding of job related injuries from perspectives of the injured worker, the healthcare provider and the employer.

The major source of role strain for Donna is managing time in the field with time sensitive clerical tasks such as dealing with mail, filing, documentation and time logs for billing. She is most in her element interacting with injured workers, physicians and employers. Though she has been provided with supplies and technology with which she can work from her home, she admits that she continues to struggle with problem solving around that technology and organizing a workspace in her home. She views these expectations of her role to be unnecessary burdens that tax her efficiency and effectiveness in performance of her primary CM responsibilities.

Judy.

Judy is employed by a local CM vendor. She moved into CM from the field of home care where she found dissatisfaction with increasing regulations. Though her experience in home care introduced her to the concept of working in

the field and managing a caseload, she found the transition to CM to be somewhat of a challenge in understanding the NCM/adjuster relationship, that is, knowing what the adjusters expected from her. As an employee of a CM vendor, Judy understood that her case assignments were contractual and that business for her company came from insurance claim adjusters who needed help with managing expenditures on injury claims. She struggled, however, with how to impress claim adjusters with her "helpfulness" in managing medical expenditures when she was not yet confident in her ability to do so. She felt that she lacked a comprehensive understanding of the case management process and that her employer had unrealistic expectations that she should be able to tailor her interactions with adjusters in order to promote her value and garner more referrals while she was learning the job.

Cathy.

At 29 years of age, Cathy is the youngest participant who provided data for this study and also the participant with the least number of years of prior clinical experience as a professional nurse. In addition to hospital and home care experience, Cathy worked for a cancer treatment center providing patient education, and at a county Health Department following patients exposed to or diagnosed with tuberculosis. Cathy chose case management as an employment option in her search for a good way to use her university education. Her initial experience on an oncology unit in a hospital was not sufficiently challenging for her. Responding to a newspaper ad, she was called to interview for this case

management position. Through research on the Internet, and conversation during her interview, Cathy realized she had developed some case management skills in her previous jobs with the Health department and the cancer treatment center. She is pleased with the type of challenge CM has provided. "Here it's more coordination, a lot different. Different time frames to be dealt with, reports to be written, a lot of communication with various people- attorneys, doctors, accounts."

Hannah.

Hannah brings four years of hospital nursing experience on oncology and orthopedic units as well as ten years of home care experience into the role of case manager. Like Judy, Hannah found Medicare regulations to be affecting the way she was able to practice nursing in patients' homes. Disillusioned with the politics and ever increasing paperwork required for home care providers to be reimbursed by Medicare, Hannah followed the lead of a former coworker who found satisfaction in case management. Though she had some preconceptions of the difficulties she might encounter in managing workers' compensation cases in terms of dealing with claimants reluctant to return to work, she found the reality not so grim. She perceives CM as an effective way to bridge the communication gap that occurs frequently in the healthcare system among providers, patients and payers.

Participants Who Practice Telephonic Case Management For A Health Maintenance Organization

The third group of participants includes Fran, Karen and Evelyn, who are employed by health maintenance organizations (HMOs). An HMO is a medical benefit plan that both provides and pays for healthcare. Plan members (patients) are limited to providers within a network, and network providers are expected to practice according to specific care models or protocols. Nurse case mangers are employed to oversee the health care needs and service utilization of members whose medical profile meet certain criteria, like a particular disease entity, or a certain dollar amount of financial exposure for the insurer. These NCMs practice telephonic CM with some occasional on-site opportunities.

Fran and Karen are employed by the same HMO. Both have come into case management with experience as utilization reviewers in addition their respective clinical backgrounds. Utilization review (UR) is a process that certifies the medical necessity of prescribed treatments, procedures, and hospital days, in an attempt to address over or under utilization of services. Initially UR was a method employed by health insurance carriers to hold physicians accountable for what they prescribed for patients and control costs. Hospitals adopted the practice of UR internally to avoid incurring costs for healthcare services that would eventually be denied by third party payers. Fran describes the difference between UR and CM in the following way. "Well, I joke around, but I say a UR person gets them out of the hospital and a case manager keeps them out of the hospital. So really, that's the difference to me..."

Fran.

Fran's clinical background was established on various hospital units over 10 years time. Medical specialties that she became familiar with during that time include internal medicine, general surgery, pediatrics, intensive care, obstetrics and gynecology and emergency medicine. She left bedside nursing for a position in utilization review because it offered an opportunity for growth, to gain some new perspectives. It was this transition that introduced her to the "business part" of healthcare. In the role of case manger, she follows a caseload of members with chronic diseases. Many of the members she follows are senior citizens. Fran practices a combination of telephonic and on-site CM. Her primary source of satisfaction in this role is assisting members navigate through a complex healthcare system in order to gain access to needed services.

Karen.

Karen's clinical background includes 15 years of hospital nursing and home care. A back injury precipitated her search for employment options other than physical care giving. She made the transition to case management after a series of positions including discharge planning and UR in the hospital setting. Her move to case management at the HMO was precipitated by dissatisfaction with the hospital environment. In fact, she increased her commute and took a pay cut in order to escape an environment that was causing her considerable stress.

Karen practices principally telephonic case management, though she has the option of meeting with members either in their homes or during physician appointments. She finds her caseload unwieldy, however, and believes that there is just not enough time for field visits. Her role as case manger has provided Karen with opportunities to become proactively involved with members learning to live with chronic disease. She enjoys the patient interaction and the opportunities to learn new things.

Evelyn.

Evelyn is a pediatric NCM with a different HMO. She is responsible for managing the healthcare of premature babies and children who have illnesses or injuries that are considered catastrophic. Coming from an extensive pediatric clinical background including hospital units and clinic settings, Evelyn feels quite confident in her ability to make considerable impact in helping families deal with significant health issues involving their infants and children, as well as to contain costs for her employer. She came to this position as a result of looking for an alternative to her job as a nursing supervisor at an ambulatory care clinic. Budget cuts and reorganization placed considerable stress on the clinic resources left to carry out work. An ad in the paper for a Pediatric Case Manager caught her eye. Not knowing exactly what the role of case manger entailed, Evelyn knew her background in pediatrics would give her an advantage in securing the position. She feels this has been a good career move, and that she

is supported by her colleagues and supervisors in providing an important service for HMO members.

Characteristics of the Transition from Care Giver to Case Manager

The first research question in exploring the transition experience of nurses who have made a career move from caregiver to case manger addressed here is: Are there characteristic motivations, expectations, conflicts, sources of satisfaction, and learning experiences associated with this transition? This section will demonstrate similarities and differences in each of these areas that emerged from personal interviews and focus group discussions with participants.

Motivations

Most participants shared that the motivation for making this career change stemmed from dissatisfaction with their current work situations. Rather than aspiring to become a case manager with a true appreciation of what the role entailed, most participants explained that a position in case mangement offered them an alternative to work conditions they could no longer tolerate. These conditions included (a) long hours and inflexible work schedules, (b) low staff/high patient ratios, (c) policy and regulation changes that impacted care giving practices, (d) job insecurity (e) inadequate compensation, (f) physically taxing duties, and (g) inadequate intellectual challenge.

The hospital setting was described as undesirable because of the long hours and inflexible work schedules that routinely included weekends and

holidays. While many nurses enjoyed providing care, the low staff/high patient ration prevented them from delivering the kind of care they felt the patients needed. Some participants felt uncomfortable with the excessive volume and scope of their responsibilities while on duty which increased the risk of malpractice and ultimately placed their nursing license in jeopardy.

Ginger and Ann, for example, felt over burdened with professional responsibilities in the hospital setting on the one hand, and yet uncomfortable with the type of tasks being assigned to under-qualified personnel to make up for staff and funding shortages on the other hand.

> It just got so stressful...I really liked what I was doing, and I felt like I was good at it. I really did enjoy the hospital setting and I miss that. I miss that acute care aspect of it. I miss the patient contact. But they started cross training people and eliminating positions. Like first it was the lab techs, and then the nurses did all the blood drawing. Then the next thing was the EKG tech, and slowly but surely adding more and more patient load on you and additional responsibilities. I was working three 12 hour shifts a week on the day shift, 7am to 7pm, and there [were] many, many times when you just weren't getting your breaks and what have you...The situation involved a position where you just could not leave. I mean you were tied to that, and if you didn't have a relief [person], you know, that was it. So it just became more and more stressful to me, not taking breaks and whatever, and that's basically why I got stressed out -not because I got fed up with the job itself. I really liked the emergency nursing. I probably would still be at the hospital if it weren't for that. (Ginger)

> They are letting people do procedures. Like you have aides that are being trained to do things that I don't feel comfortable [with] them doing. And it would be under my license, and I worked too hard to keep my license for thirty years. And that was one of the major reasons too I left. I was having aides telling me what to do, and I'm the nurse. Not that I'm greater than them, but it's my education and my license and it's one of the other reasons I left. (Ann)

Though Karen left her role as a caregiver initially due to a back injury, she left her role in utilization review in a hospital setting because she too felt over-utilized.

> I had had it with hospitals. I want to do something different.... I'm weighing sanity verses less pay, but ...a different outlook, a different something to do. I was putting in 10 to 12 hours on my feet all day no lunch and leaving the hospital exhausted.... We were doing discharge planning and utilization review, so we were reviewing charts. We were on our feet all day. There was nowhere to sit to review ...you could review lots of different units or you work one unit. Now I've learned they're just keeping people on one unit, which I think is a much smarter thing to do. But at that time we weren't. In addition to doing that you would do a discharge plan, so you were trying to get people out the door at the same time... I just wanted a change. I want to do something different. I really felt like I was going to be committed if I didn't do something different. (Karen)

Judy and Hannah cited changes in Medicare regulations as fueling their motivation to leave their positions in home care. They described these what they saw as sudden changes that significantly impacted their practice and ultimately their job satisfaction.

> Pretty much home care was not regulated, and then all of a sudden it became regulated and it caused a lot of turmoil and strain.... It got very political. There were a lot of changes. Medicare made some huge changes that affected things. When I worked at visiting nurse people worked there for years and years. All of a sudden people were starting to leave and go into different roles. They weren't' happy with the environment. (Hannah)

> Home care was different because of the regulations you were under with regard to Medicare. Those were very strict regulations.... When I first started in home care there was quite a bit of leeway to take. It seemed like you were able to do more to make sure things were good for the patient than there is now because the regulations in home care now is you admit them and discharge them as quickly as possible...It's much more geared towards hurrying up, do it as cheaply as possible. (Judy)

Two participants' who left clinic settings for CM positions identified their motivations for making the transition as a need to enhance income and a fear of impending position reductions. Irene and Belinda both had several years of experience in pediatric clinics and enjoyed working with children and providing support and advice for parents. After her divorce, Irene required more income and benefits than a position at a pediatric clinic offered. Though she was very satisfied with her role as a pediatric nurse, she found CM to be a more lucrative alternative.

> It was very emotional for me. I absolutely loved my clinic, and for socio-economic reasons I had to. I was divorced after 30 years and I had no pension or any of those kinds of things available to me so I knew I had to do something else that was going to take me into my retirement. So it was a very, very difficult thing for me to give up my pediatrics and go into case management. I like it now. I don't love it. I like it. I think I'm pretty good at it. I've gotten a confidence and that kind of thing. I've gotten a raise every year. But I'm here because I have to be. (Irene)

Belinda followed Irene into a CM position with a WC insurance carrier because she feared the loss of her job at a pediatric clinic. As a single parent, she found the higher salary to be an added bonus to what she hoped would be job security.

> Basically the whole thing happened because one of the major hospitals in town was experiencing a money problem...They happened to own the practice I worked for, and the rumor came down that anybody who was more than a nurse's aide was being let go because they weren't going to pay the nurses to work in a doctor's office anymore. And that actually did happen to one of the other people that I worked with there and it scared the heck out of me. (Belinda)

Fran and Cathy were the only two participants in search of a more stimulating occupation when they made the transition to CM. Fran explained her

reason for moving from the role of caregiver was a desire for more flexibility in her employment options. She felt that her moves first into UR, then to CM, expanded her capabilities. Cathy, found a CM position in pursuit of a more intellectually stimulating career.

> When I got out of nursing school I was a little bit upset by the fact that when I was in the hospital I felt as though I didn't really need to go to university for doing what I was doing there. You know, I felt that anybody can come here and follow the instructions, follow these orders that the doctors are writing in this little book. And anyone can give this. Anyone with any kind of, you know, because you don't have to be educated to do this. And I was upset by that. (Cathy)

Though participants' motivations to make the transition from caregiver to case manager varied, most shared the characteristic of being fueled more by a desire to find a port in the storm, so to speak, than a desire to advance in their nursing career. Looking to improve the conditions of employment, most participants were willing to take a leap of faith that even the unknown aspects of the case manager role would be more tolerable than the undesirable aspects of previous roles.

Expectations

Participants' expectations about the role of case manager were closely tied to the promise it held for providing relief from the undesirable conditions of the roles they were exiting. These expectations included (a) more flexible work schedule, (b) less physically taxing job responsibilities, (c) manageable workloads, (d) opportunities to utilize nursing knowledge, (e) better

compensation, and (f) job security. These expectations were fed by second hand reports most participants received from personal friends or professional acquaintances that alerted them of open case manager positions while they were contemplating making a career move.

Ann and Belinda and were approached by friends who alerted them to open positions and encouraged them to apply. Irene, Donna, Ginger, Judy and Hannah stumbled on open positions through conversations with professional acquaintances. Evelyn and Cathy saw ads in local newspapers, applied for the positions out of curiosity, and were informed about the role in their job interviews. Fran and Karen, knowing that case management was an employment option that they wanted, submitted resumes to an HMO asking to be considered for an interview when a position opened up.

At 56 years of age, Irene was desperate for employment that offered a suitable compensation package that would help her prepare for retirement. Although she was confident that her current position with a WC insurance carrier would provide her with that, she admitted that she did not have a comprehensive knowledge of what would be expected of her in the case manager role.

> I don't know what I thought it was going to be. I just took it. Somebody told me, "Hey it's not bad. Do it." I mean I feel like I can do just about anything. So I tried it.... I don't think I really knew what I was getting into, but I think just the word case management - I figured I could probably do it cause I'm a pretty good manager. And I'm a good manager of my time and I know I can talk to people and I can relate. (Irene)

Judy was looking to escape the burdensome Medicare regulations she encountered in home care. At the same time, she was enrolled in an accelerated

graduate nursing program and hoping to eventually advance her position within the field of nursing. She acted on an opportunity to move into case mangement with a CM vendor without much prior knowledge of what the job responsibilities were, or how adequately she was prepared to fulfill the expectations of her employer.

> I had no clue what a case manger was, no clue. I had gotten into this nursing administration master's program thinking that I would be in management. And I wasn't sure. I'd considered an acute care nurse practitioner. I ran the gambit of what I was going to do with nursing. I just knew I had to get out of home care and out of that field nurse thing I got tired of that. So anyway what happened is when I was a supervisor in home care, someone, a case manager, called me about one of her clients. And it was a woman I had worked with years before in home care and she started to tell me about what her job was like and what she did. And it just sounded like perfect. (Judy)

She also shared that her graduate nursing program had nothing to offer in the way of scheduled courses or independent study in the field of case management.

Donna had some interaction with NCMs in her role as an occupational health nurse. In this role she gained exposure to work related injuries and often communicated with WC insurance claim staff, some of who were adjusters and others who were NCMs. This provided a basic awareness of the WC claim process and, to a limited extent, the case manager's tasks. Even so, she was not aware of the expectation that as a case manger she would need to log her activities and be held accountable for a certain number of billable hours.

> Well, I knew that case managers went on appointments. And I knew they made calls back to the plant, the employer. And I knew there were forms that they would send me as far as getting the

> information, so there was a communication. I knew about the communication. I knew about the visits. I didn't have a clue about the billing, and that to me is like, what do you mean nurses have to bill? You have to bill your work? That was like "Wait a minute!" I wasn't expecting or prepared for that. (Donna)

Karen and Fran, both having had experience in UR and discharge planning in a hospital, had the most familiarity with the case manger role. They submitted resumes without seeing an ad or having knowledge of a job opening. To them, CM seemed like the next logical step. Karen admits though that her expectations were not entirely consistent with what she is encountering on the job.

> Knowing that discharge planning and UR was part of case management, I thought [I] might have a shot at it - because I knew those were components of case management. But I guess what I expected when I came to [this HMO] is this is what case management is. But I have learned is that case management is a growing body of knowledge that isn't set in stone, and ... We as case managers, along with it , we're learning what it is . And I've got a new case manager who's just come to us a couple of months ago and I said that to her, "We're all learning this together, we really are." (Karen)

Entering the role of case manager with expectations that it would provide relief from undesirable work situations and opportunities to utilize their nursing background, participants were generally not aware of aspects of the case manager role that might prove to be problematic for them or aspects that would provide them with opportunities to grow and develop professionally.

Sources of Role Strain

Hopeful that the role of case manager would fulfill their respective desires for better work situations, participants explained that there were a number of work situations that they did not anticipate and that their knowledge and experience as caregivers did not necessarily prepare them for. Feelings of inadequacy or incompetence associated with these situations contributed to role strain. These situations appeared to center around four major themes: (a) time-task orientation, (b) interactions and relationships, (c) business culture and objectives, and (d) professional identity and self-image.

Nurses entering the field of case management directly from hospital settings did not anticipate the need to accommodate their *time-task orientation* to fit the role of case manager. Managing cases over an extended period of time as opposed to completing care required by assigned patients on an eight or twelve hour shift contributed to role strain for new NCMs. In care giving contexts, the scope of task accomplishment was on administering prescribed care within the timeframe of a daily shift. Patients were assigned or scheduled on a daily basis. This assignment could vary from day to day. Alternate staff was scheduled to work on subsequent shifts or days so that work did not routinely accumulate in their absence.

In contrast, participants described the scope of task accomplishment in the case management context as scheduling and implementing a series of tasks over time to effect longer term objectives. While routine accomplishment of some tasks is expected within certain timeframes, such as initial contacts with

patients, providers or employers, the on-going tasks of case management are seen as more strategic and timeframes more discretionary.

Ann, who had worked for many years as a caregiver in emergency rooms, found the need for a major shift in her inclination to respond and complete task assignments immediately to a planned approach of managing a series of tasks strategically over time.

> I was used to having to do X number of things done before I went home, and here...when I first started, if I had a red number on my [computer diary] screen which meant that these were things that I should have done already, I was like hysterical. "Oh my god! I've got to get these done." Because I was in that mind-set that you don't go home till this is done. You know, you have to get your charting done, and give your meds, and make sure that patient was cleaned up before you went home. Well here it was like "Oh, ok. So I'll just do it tomorrow".... I had to learn that I was setting my own diaries and I could set them for however long I wanted to. So, [if] a person is being evaluated today [by his or her physician].... I was setting diaries for like the next day [to work on the file]. Well no, 'cause nobody's going to know anything [yet]. So set it for next week. (Ann)

Ginger, who had an extensive background in emergency and critical care nursing struggled with the need for a sense of closure and accomplishment as a new NCM. In the hospital she worked long, intense hours, often without breaks. Even so, at the end of her shift, she knew her work was complete and would not carry over to her next scheduled day on duty. As a case manager, she has to deal with a progression of tasks associated with each case assignment that extends over days, weeks and even months. This has forced her to learn new strategies for prioritizing and managing time.

> You know, it's like the kind of job that I do now, it's never done. It's just a continual day-to-day thing where it's not the same kind of

> expectations. I mean you're still a professional. You're still expected to... you know, work according to guidelines. You have expectations given to you, but it's not in the same capacity, I wouldn't say....so once I started doing my own caseload it got more comfortable. Then as the numbers got higher and I got a higher caseload it got very frustrating.... But I had to get over that, feeling like you're not killing anybody here ...you're going to get caught up and if you have to, ask for help. (Ginger)

The autonomy afforded NCMs with designing their own system of managing tasks and time can also contribute to role strain. Donna, an on-site NCM employed by a WC insurance carrier, has an office based in her home. She has to organize her work day to accomplish not only the appointments she has made with claimants at their homes, in hospitals, at physician offices, or with their employers, but also to complete time-sensitive file documentation and manage a number of other clerical tasks without any administrative support. Her background in emergency nursing, occupational health and out-patient clinic administration did not prepare her for this.

> Maybe it's because I'm still new, I feel like there's so much that I didn't get to today. And I don't know if that's typical, whether you've been in it for 4 years or if it's because I'm still trying to sharpen my pencil as a case manager. ...[I'm] starting to eliminate the little things that I don't necessarily need to do. What about working in the field? Just the nature of working in the field and becoming organized, you know, when you have that much flexibility in your day. (Donna)

The care giving experience, particularly for those participants who worked in hospital settings and to a lesser extent clinic settings, created an orientation to time and tasks associated with structure and a sense of urgency. This time-task orientation, which served to focus nurses' attention on immediate healthcare needs of patients, was a necessary part of nursing judgment and clinical skill that

they had developed over many years. The need to change this orientation in their new environment was an aspect of the case manager role that they did not expect and that contributed to a feeling of incompetence.

The second theme associated with sources of role strain in the transition form caregiver to case manager is *interactions and relationships*. Interview and focus group discussion data suggest that new NCMs were confronted with unanticipated dynamics in their interactions and relationships with patients and physicians, and uncharted territory in interactions and relationships with non-medical colleagues, specifically claim adjusters.

In the role of case manager, nurses learn that ill or injured parties are not only patients in the sense that they require healthcare services, they are also "claimants," or in the context of an HMO, "members" of the plan who are also seeking financial support for those services. Available financial benefits associated with illness or injury creates added dimensions to nurse–patient relationships for case managers. The issue of trust in their relationships with patients is one of the first hurdles most participants had to clear.

Dealing with patients who lie to secure financial benefits, or malinger to avoid work responsibilities created discomfort for NCMs who manage WC, disability or automobile injury cases. They reported emotions from surprise to disgust in encounters with patients who would fabricate or embellish an injury. Belinda commented on how naïve she felt after her first few encounters with WC claimants who were less than truthful about circumstances surrounding their

injury or progress in recovery, and how that affected her approach in subsequent contacts with claimants.

> People sounded nice to you on the phone, sounded sincere. You got them into the doctor. You got them everything that you knew they should be getting for this particular thing, and they still weren't better. And then they called me every morning at 7 o'clock. " I'm hurting and I'm in pain." And the first couple of times [I believed them]...and then I find out that they're at the bar with all of their friends and they're dancing ... and this one sees them there, and that one sees them there. And you think, oh my god! I sat on the phone every day for three weeks listening to this lady tell me how awful her life was and putting it in the files. This poor lady has so much trouble. And like I said, then you read the surveillance report and you think, oh god, how could I be so dumb, so dumb? And it was more than one thing like that but I would say within the first 6 months you figured it out - probably the first 3 months. The first time you get somebody who plays you like that, you think, you know, ...I can't do this. Nobody's going to do this to me again. And you go the other way and then you don't trust anybody, and then somebody will come along, "Well you know, ...it really hurts." And you'll think, "Oh come on.... Give me a break!" And you eventually send them to a doctor and they have a broken wrist. And you feel really bad and you say, "Oh gosh, I'm sorry." And you find that middle ground. You find that middle ground where everybody starts out basically the same and until they prove otherwise. (Belinda)

Establishing rapport with patients who are mistrustful was also unexpected and a source of strain for new NCMs. Participants felt that their association with insurance companies often affected patients' perception of them. Judy, whose care giving background was in home care, noted a difference in the ease with which she could initially establish rapport with patients. "[In home care] there wasn't that self protective mode ... in your contact with them. [In CM] they're protecting themselves from you, almost."

Building rapport despite this initial distrust required learning strategies to "get a foot in the door." Evelyn explained how she changed her approach on introductory telephone calls after several encounters with wary parents of the pediatric population she served.

> You can hear it in their voice when I call and I say my name is [Evelyn] and I'm a case manager at [this HMO] and ....[they answer] "....yes?"... You know what they're thinking, "Why is someone from the insurance company calling me?" So I learned a long time ago not to say "I'm calling from [this HMO], a case manager." [I now say] "My name is [Evelyn]. I'm a pediatric nurse. I work for [this HMO] and I've been doing [pediatrics] for twenty something years." Then they loosen right up. (Evelyn)

New NCMs also experienced discomfort around their role in legal issues associated with insurance claims. Not being versed in regulations governing WC, automobile injury protection, disability and health insurance, they were often fearful of making a mistake in handling a case that would contribute to an unintended advantage or disadvantage to either party (the claimant or the insurer) if legal action ensued. This also created another dilemma in their relationships with patients, which is balancing advocacy with prudence. Cathy, who works for a CM vendor, found a surprising need to consider diplomacy in her communications.

> To me it seems that in case management you have to learn diplomacy because of a lot of the things that you're dealing with may be in litigation. There may be litigation going on here, litigation going on there, certain insurance laws that I don't know because I have never worked in insurance. But I find that sometimes I have to be careful in the way I put things. I cannot be as straightforward as I'm used to being. I have to be a little bit sideways. So in that way I'm not very prepared for that. That's something that I'm really trying to work on. For example in situations where there's surveillance going on or when somebody may be doing some

> symptom magnification or something like that... I have to be careful how I should say that or whom I should say that to, ... how I should write it in a report - how I should write things, how I shouldn't write things in this way. (Cathy)

In their role as case manager, nurses encountered added dimensions with their relationships to patients that care giving had not necessarily prepared them for. In this context, patients had the added interest of securing financial benefits, and new NCMs had the added interest of protecting their employers from undo financial exposure. These factors plus the notion that their relationships and interactions with patients could impact any ensuing legal actions associated a claim for benefits were considerable sources of role strain for new NCMs.

Working in a different context with physicians contributed to role strain for some NCMs in their transition from care giving. They were not accustomed to discussing treatment options with physicians or questioning their rationale for continuing treatment. Cathy and Belinda, for example, were uneasy about approaching physicians on a more collegial level, having been socialized to view them as the ultimate authority on all health-related issues or "the boss" in prior jobs.

> I think another difference is in the hospital you're basically...giving a doctor a situation. "Doctor, her blood pressure is elevated," you know, and he will respond by ordering the medication and you will carry it through. Here very often you're not just giving him a situation, but you're also sometimes asking him to justify the reasons behind his treatment, choice of [one] treatment as opposed to another one, you know. If there's an injury and he says, "I'd like to go without this," you might ask, "Doctor, you know, is there a reason why you don't think that this is a good idea?" Which in a way you're asking him to justify that, and that's a very different thing for me to get used to. It was very difficult for me to get used to. (Cathy)

> I've worked for them [in the clinic]. You are an employee and basically you do what you're told. And there is a lot of that old school nursing thing that comes in there. I know that I have friends who have graduated from nursing school 10 or 15 years later who look at me like I'm crazy, you know. "You actually made coffee for them?" And we'd just look at them and go "Well of course you do. God! They're the doctor[s]." So it's perception in your own head and it's just understanding that they have knowledge that you don't. And also that inability, not quite accepting the fact that [a doctor] would order something, be it a surgery or whatever because the patient wanted it, and not because they needed it. And once I realized that that actually does happen, it was a lot easier for me to say [to a doctor] "Well, wait a minute!" (Belinda)

Ann's difficulty in relating to physicians in this new context stemmed not from the need to question or confront them in her role a case manger, but rather how to build rapport and establish credibility over the telephone.

> In the hospital we are directly [relating] with them. You're on a face-to-face most often, or they know you. You know them. In [telephonic CM] you're dealing with physicians all over the nation. I've got them all over the nation, and they don't know you, so you don't have that personal rapport like you do in the hospital. So they have to get to know you and what you're expecting and that when you say "this is black," they have to believe you like in the hospital they do. It was to the point in the hospital, working in the same facility for so many years, that when I would call [the doctor] back ... and say, "Look this patient needs this," he would say, "Oh. OK, [Ann]. Go ahead. Where as these physicians don't know me, and a lot of times they're like, don't want to be bothered because you're just a case manager- what do you know? (Ann)

Approaching physicians with a posture of confidence and credibility and gaining their trust is a tall order for new NCMs whether they practice on-site or telephonic CM. Successful strategies developed and used in relating to physicians as caregivers do not necessarily provide new NCMs with the knowledge and skill required to interact effectively with physicians as case

managers. However, Donna, who had opportunities to relate with physicians in her previous role as manager of an industrial plant health clinic, did not find interacting with physicians on a collegial level to be difficult.

> In the plant setting, when I sought out [an outside] clinic, I wasn't necessarily a nurse. I was more of a manager, and I'm assessing [the services provided by the physician in the clinic], so it was a little different. It wasn't like the hierarchy of a doctor to a nurse. It was more like, "Will you meet our needs?" I think I've always learned to confront the physicians through the roles that I've had, and so in case management when you confront these physicians... I don't know how I even learned it, but I don't feel uneasy, and I don't feel unpolished, and I don't feel insecure. (Donna)

Donna, along with a number of other participants, shared her frustration with interactions and relationships with adjusters. She experiences difficulty at times with convincing adjusters of the merit of her medical perspectives on claims and also has trouble understanding the adjusters' objectives and priorities in claim handling strategies.

> I'm more intimidated by adjusters than I am by physicians... because I don't think [some adjusters] truly understand the situation what goes on in a doctor's office. I don't think they truly appreciate your relationship with your client. I think they are task oriented and less sensitive to the dynamics of a relationship and that includes nurse to client, and nurse to physician, and the dynamics from client to physician there. Only the nurse is sensitive to that. The adjuster doesn't always get a feel for that, what is actually going on. And I think what adjusters don't always know is how much finesse a case manager needs in some situations to make things happen, you know. So I think I feel like I have a harder time trying to communicate what's going on to the adjuster than I have to a physician, to the client. I have, it seems to be a better flow of information here than sometimes with some adjusters. Some adjusters just don't understand. (Donna)

Another source of strain for new NCMs in relationships with adjusters was an authority issue. The NCMs employed by WC insurance carriers believed that

the adjuster had the final say in authorizing benefit payments, and when and how long the NCM was involved with the case. In essence, the NCMs felt that they were expected to submit to the adjuster. Irene and Ann both shared their frustration with what they perceived as a hierarchy in their office that gave adjusters the authority to accept or reject their recommendations on medical claim decisions.

> In the hospital you're the boss generally. Usually it's the nurse who's the [boss]. Aides may not like somebody but the nurse says, "Well this is it. We're going to do [this]." But in this role, the adjuster owns the file and the case manager assists that person. And most of them I get along fine with. And most of them aren't a problem, but when you do get into that situation – [when] I feel confident enough in my case management or my decision that I think I'm right - then they'll dispute the file or something just because they don't like the person... I find that really stressful.... You're working with people who have no idea what they're doing. You have people who are very, very good as adjusters. You have unit managers that support you and you have unit managers who think you're a pain in the neck because they'd really rather do it this way and be done with it. And then you jump in and say "Wait a minute, wait a minute, this is a perfectly relevant thing going on here and we're not just going to close it." (Irene)

> As a nurse in the hospital, when there was a conflict with someone else it was generally a lower discipline and you could say, "I am the nurse you will not do this function." Here we rely on each other more - the nurse and the claims adjuster. I can't do my job unless she does hers or he does his. I can't close out a case if they don't put in dates. And you tell them and you tell them and it doesn't get done. To me, that's very frustrating. You get medical [records] on someone and it's like, "this needs to be done," or "yes, this is a relationship, this [complication] could have occurred from this injury." Well, they don't want to see that. They only want to see the main injury. And then there's a problem further down the road where we could have done something for the secondary [complication] and got the guy back to work. (Ann)

For Judy, an NCM working for a CM vendor, the issue of adjuster relationships took on a different focus. She perceived a need to please the adjuster in order to secure business. She seemed less conflicted over reluctance or non-cooperation from adjusters than her fear of appearing incompetent and therefore losing repeat business.

> What was hard is there was this big fear of making adjusters think you were competent right off the bat, so that they would refer you more cases. Well you're not competent right off the bat, so how to accomplish that feat was just to me, you know, I didn't know how to pretend like I knew what I was doing. And so I would really limit my conversations with adjusters so they wouldn't get the hint that I really didn't know what I was doing - which I think was a mistake, because then I couldn't pull enough information on what maybe they did want. And so there was always this fine line of "Pretend like you really are this, you know, great case manager," but then try and figure out what that means because you don't know.... My mentor case manager projected this idea that I was supposed to really be saving money. "Save money for them." You know, "Hound on the fact that you're saving money for them in this area and that area, yada yada, yada . Really, just let them know how great you are and how good you're going to get things done so quickly, and yada yada yada. (Judy)

Interacting and developing working relationships with claim adjusters proved to be a source of role strain for new NCMs who were accustomed to being surrounded by medical personnel that shared similar experiences and perspectives. Participants felt tentative in arguing their cases with adjusters because of their lack of knowledge in the claim process and the regulations and strategies that drove adjusters decisions. Some struggled with having their judgement circumvented by adjusters and others were intimidated by the "new world" of business that they had entered.

Nurses working for HMOs did not interact regularly with adjusters. In fact the interactions were quite infrequent and dealt mostly with getting or correcting information for the file records. These NCMs interacted more with medical plan directors, physicians employed by the HMO who are responsible for reviewing claim requests for coverage that are outside of benefit package. NCMs in this situation plead a case for approval for extra services, goods, or interventions that they feel are best thing for the member. Working with adjusters was not a source of role strain for these NCMs.

New NCMs found that acclimating to a *business culture and financial objectives* contributed to role strain. Some participants did not anticipate the discomfort they would feel in a payer setting. Nurses who were experienced in the tasks of physical care and who had been entrenched in the norms and perspectives of a healthcare provider setting, found this new business culture somewhat confusing and intimidating. Among a number of environmental differences, participants' perceived significant differences between support structures, work objectives, and tools used in their previous roles as caregivers and their current roles as case mangers.

Participants who work in claim offices with adjusters responded that support for their role in terms of resources specific to their jobs and comradeship is just not the same as in the hospitals or clinics where they had come from. Ginger, for example detected some resentment from adjusters who were used to handling claims without NCMs. It was difficult for her, as a new NCM, to address

this issue with adjusters who didn't seem to understand her role or appreciate her involvement.

> Well I think that at the hospital everybody even though they weren't nurses, it was more medically oriented. Whereas here...I feel that we've had a good rapport [with adjusters] and we work together, but there's not the same trust maybe yet... I feel we should be working together as a team and providing each other with information. Sometimes I feel like I provide them with the information when I get it but I don't always get that in return. And whether that's because they're not used to it... I don't ever feel like it's pointedly not done on purpose, but I don't get that feeling... I mean they just don't seem to be so excited about all the praise that the nurses get this department in the office. Sometimes I notice that. (Ginger)

Ann detected a difference in the amount of collegial support she felt from adjusters in the claim office than she did from personnel she interacted with or depended upon in the hospital.

> Well, [in the hospital] you always had someone you could go to, be it the director of the department, the nursing supervisor, another physician, other nurses. Here you're kind of left alone. We do have our nursing team leader here who's wonderful, but there is that difference between us and the claim adjuster. And there can be...a partition between us. They're looking at something maybe differently than we do and it's hard sometimes to get them to understand what we do. And that support isn't always there. It's kind of sometimes them against us. (Ann)

Coming from clinical settings with a focus on providing patients with the intensity and duration of care prescribed by their physicians, most participants shared that cost containment remains an issue about which they feel some conflict. Though they understood that the main objective of their role is to contain healthcare costs, the patients' welfare is still foremost in guiding their oversight and authorization of payment for healthcare goods and services. This at times

put them at odds with claim adjusters or medical plan directors whose main concern is holding down healthcare expenditures.

Karen remarks that it has been challenging to focus on cost containment in her role as a case manager with an HMO. As is the case presented by most participants, her previous work environments in healthcare provider settings did not require that she attend to that.

> Financial concerns still kind of make me uncomfortable. I'm dealing better with them and well you work for [an HMO] and that is an issue. And if finances aren't contained then people don't have jobs. And you know you really see that there are people that abuse the system.... I guess being raised in a hospital and ... in home care, that's not a concern I mean maybe it is now. It wasn't when I was doing bedside nursing. I mean if [patients] needed a dressing we did a dressing. I mean if they needed medication they got it. If the doctor ordered something he got it. (Karen)

Many participants recognize that the bottom line is paramount in the business world. This influences philosophies about handling insurance claims, which in turn impacts expectations of the case manager's role in the process. Some participants perceive this expectation as potentially confounding to their role as patient advocate. Belinda explained that she feels a tension between her role as patient advocate and the expectation that her influence on a case will result in monetary savings for the WC insurance carrier she works for and ultimately employers who pay premiums.

> In this context your focus is not patient oriented. Your focus is monetarily oriented. You're more involved in following up from the employer's standpoint than you are of taking care of the patient. And for me that's a constant pull between the two - finding a place where I'm happy with that I'm doing the right thing for the employer who ultimately is paying for my services, but as a nurse making sure that patient is getting the care that they need and require. And

> that was a hard place to come to. That took me a while to get there. (Belinda)

Another source of role strain for nurses entering a business environment is learning to use the tools available and necessary to complete tasks associated with their new role. Fran describes her adjustment to business-appropriate communications and the need to collect and compile data and demonstrate trends and outcomes.

> The biggest transition from care giving to the business world ... it's learning to do memos and e-mails and, you know, business-appropriate. It truly is. That was the biggest thing...because you're going from, you know, staff nursing... If you take a staff nurse who's biggest concern is making sure the meds are passed and the bed is made and the IV's are hung to...a position where you really need to produce a statistical report, it is a big transition. You need to show outcome. You know, all these different case management tools that we use are so different than the hospital stuff, it really is. (Fran)

The use of personal computers (PCs) and all the electronic means of communication such as email, voicemail, faxes, and cell phones as necessary tools to complete tasks at work stations were also perceived as a convention of the business culture that took some getting used to.

> I didn't have a lot of computer experience but I don't think that's all it was. I wasn't nervous about that because we used computers at the hospital, but not to the extent that we have to input data here. And of course, that was expected. I mean it's telephonic information. You have to document it. (Ginger)

> I had some computer knowledge, you know. I mean I had taken a class on my own so I knew what a computer [was]. I wasn't a whiz. I had a lot to learn. I still have a lot to learn. 'Cut and paste,' I still have not gotten that down. I'm working on it, but you know I'm a very moving person. I don't like to sit, and sitting just, you know. Ok, I gotta get up and walk. I can't do this, you know . I'm always fidgety, but in the ER we never sat down. (Ann)

Though Donna had experience with the business side of healthcare in roles as nursing director of general practice and occupational health clinics, she struggled with the technical aspects of setting up and managing business from an office in her home.

> Because we work remotely we need to be connected to our organization, to our group, to our supervisor. There [are] all these surveys and expense reports and all this miscellaneous stuff that's much more difficult to do.... in your home office. Whereas if you were in a building you could run over to so and so [and say], "Hey show me how you do this expense report." ... Those things are piling up for me. I don't really have two hours to go through how to do an expense report for this and that. So there [are] things that are piling up because to get the assistance to go through that, even though I've tried, ok it's still like, send an e-mail off to an admin, "Please tell me how to submit my phone bill from December. " [And they reply], "That goes on an expense report." Give me details, exact details. "It goes on an expense report." Ok, back to the pile it goes. (Donna)

Coming from clinical settings where staff were medically oriented and committed to providing patients with the intensity and duration of care prescribed by their physicians, new NCMs found a certain amount of role strain associated with entering a business environment. Interacting with a majority of non-medical coworkers, attending to a business objective of cost containment, and the incorporation of clerical tasks and new tools specific to the business environment all contributed to the experience of role strain for new NCMs.

The forth theme that emerged from interview data and focus group discussions with regard to sources of role strain are experiences and perceptions associated with *professional identity and self mage*. While most participants view CM as a legitimate area of practice within the nursing profession, some assign a

personal value to the case manager role as less important or less significant to their previous role as a caregiver. Ginger, for example refers to case mangement as "another phase of nursing," but does not believe a nursing background is necessary to do the work she is doing.

> I just don't feel like a lot of what I do is nursing decisions. It seems to me that anyone could be trained for what I do, [anyone] that doesn't have a medical background.... I mean there are certainly times when my nursing knowledge has an impact, but I think for the most part it seems like it's basically a lot of things that the claims adjusters did before as far as authorizations, approvals, procedures, what have you, following doctor's visits. That could be done by someone more trained to do it. (Ginger)

Belinda struggled with expanding her notion of nursing to include the role of case manger.

> It's a different job and it's not what you think nursing is going to be and it's not where you thought you would be as a nurse when you graduated from nursing school. The last place I would have expected would be sitting behind a computer at an insurance company and still calling myself a nurse. And I do, and I am. So it's outside my perspective of what a nurse is and what a nurse does. (Belinda)

Because of what she has experienced in her role as a case manger, and the type of problems she has faced in interactions with some WC claimants, Belinda feels a need to hold back on what she held as a characteristic nursing behavior, which is empathizing with and unconditionally supporting the patients she deals with. She also concedes, however that that she is building knowledge and skill that she finds valuable.

> You just can not do that here, because your function here is not to be that person. They're not paying you to be that person. The doctor's office was, and the hospital was, and that's what you did when you were in nursing school. And what you really, really, really

> want to do is just be Florence [Nightingale]. But you have to [put] that aside for other things here. And I don't necessarily think that I have lost anything because I have picked up in knowledge and abilities and different aspects and outlooks that I would not have even given another thought to before. (Belinda)

Irene's difficulty is associated with the lower esteem she affords her role as case manager in comparison with the esteem afforded to her in the role of caregiver. Though she feels that she is becoming more skilled and knowledgeable as a case manger, she is much more aligned with her identity as a pediatric nurse.

> I think when you tell people you are a case manager in an insurance company they think you know it's no big deal I don't think people have a lot of respect for case management.... I think they think you just run around and try to cut money you know I really do and if you say you're a pediatric nurse people go. "Oh wow! That's so good! Oh my little grand baby just fell down the stairs yesterday".... There's definitely a difference for a [pediatric] nurse. Yes, I can honestly say that I would have no doubt about. People say what are you doing now. " Oh." You know it's just not the same. (Irene)

Though all participants reported that their professional identity is that of a nurse, some aspects of the case manger role seem to be in conflict with the unbiased and apolitical image they predominately hold of themselves as nurses. For some, clinical competence and unconditional nurturing care is held in higher esteem than the impact they feel they can make as case managers.

To summarize, characteristic sources of role strain for new NCMs revolved around four themes, (a) time-task orientation, (b) interactions and relationships, (c) business culture and objectives, and (d) professional identity and self image. Participants shared their experiences of confronting the need to

accommodate their assumptions and approaches in several areas of their work. The process of this accommodation contributed to role strain, but also stimulated professional growth and eventually contributed to job satisfaction.

Sources of Job Satisfaction

Despite experiences of role strain in the transition from caregiver to case manager, participants reported sources of job satisfaction that they associate with their role as case manger. These sources fall into five categories: (a) facilitating recovery and impacting healthcare outcomes (b) opportunities to expand knowledge and skill, (c) enhanced professional growth and confidence, (d) appreciation and respect from others, and (e) autonomy.

NCMs involved in WC cases find satisfaction in facilitating the recovery and return to work process for injured workers. This process can be long and complicated. It involves getting to know the claimant, his or her treating physician(s) and employer. For new NCMs it may involve research into an unfamiliar medical specialty to learn about treatment protocols and available resources. It involves determining claimants' ability to cope and follow through with the prescribed treatment plans. It can involve referring claimants to a more appropriate medical specialist, coordinating treatment goals and plans among multiple providers, providing patient education and encouragement, and arranging for work accommodations with employers. It very often involves twists and turns in the form of physical, emotional and interpersonal complications

along the way that the NCM must address and try to problem solve around in order to realize the long-term goal of recovery and return to work for the claimant.

Belinda explains that her satisfaction in facilitating recovery and return to work is often preceded by situations that also cause her a considerable amount of frustration. Being able to impact the outcome, however, provides her with a sense of accomplishment and competence. She also finds that difficult cases provide opportunities for her to expand her knowledge of various medical specialties and the WC claims process.

> What I find rewarding I sometimes have a problem with from other aspects. When I have somebody who has been out there forever on [work] restrictions, [and] you have IME [independent medical examination] after IME saying there's nothing wrong with this person and they keep getting on and on and on, and you eventually get them back to work at a job that you know they can do. You get them out of their house, whether they're happy with you or not. You would've put a productive person back to work, be it at $5 an hour or back at their own job. So I do like that feeling of accomplishment when you get somebody released to work.... I have one lady in particular that I've had open now for ...probably going on 2 years this July. And I got her back to work a little over a year ago. And she's still whining and she's still on restrictions but she's still going everyday. And we're working right now to put her back onto the floor. At this point she's just doing telephones and she's had some problems, but we're working on that. But she's working and otherwise she would have been sitting out there doing nothing. And I don't think that's healthy for anybody. It gets to be a behavior and so I do like getting them to go back to work. I love the nursing part of it. I like the learning part of it, the ability to be involved in more than one specialty, picking up bits and pieces of information that will eventually be put together and we can make what we think is a pretty clear idea of what's going on with somebody. (Belinda)

Cathy describes a sense of satisfaction she gets from producing outcomes that meet the needs of all stakeholders involved in the claim process. Her

understanding of the dynamics of multiple stakeholders in the claim process is part of the expanded knowledge and skill she has realized in enacting her new role as case manger.

> I enjoy working with clients. I know that there are claimants who may malinger, but I think that generally speaking most people want to be well and I enjoy when I can look at someone impartially. Maybe because I'm newer and not [assuming] that they're trying to take advantage of the system, at least not assume until I'm proved otherwise, you know. But when I can resolve a file in a way that I feel good about this, that the claimant feels good about this resolution, the employer feels good, and the adjuster feels good, then I feel good. It feels good. (Cathy)

NCMs who are employed by HMOs find satisfaction in their roles from their capacity to help members gain the most benefit from their health plan or find alternative sources for services or financial support. They have the capacity to identify members who are need of special services and to access them, to influence coverage approval for extraordinary circumstances and to run interference for members in need of immediate assistance.

Fran describes her main source of job satisfaction is in assisting members to navigate through a complex healthcare system that often is over or under-utilized by patients due to the confusion it fosters.

> I truly like navigating someone through this hideous horrible monstrosity called health care... This is the corniest of all. When someone asked me why did you go into managed care and I said, "You know why I went into managed care? I wanted to humanize managed care." And I mean that with all my heart, I really did. It didn't always happen but I want to be able to hold someone's hand and help them through because it's a damned maze you know it is. I mean it's a horrible maze. I don't understand how people who are physically or mentally compromised can make it through the system. They don't. They don't make it through the system. I find it very rewarding to be able to help someone through confusing

[situations] in health care (Fran)

Evelyn finds the personal thanks she gets from families of the pediatric patient population she serves to be quite rewarding. Her capacity as a case manager to influence coverage decisions, and get questions answered for members has also enhanced her confidence.

> What I find satisfying about it is the thanks I get from the families when I put them in touch with other things. Or when I explain to them what their actual contract covers and that I went to the doctor and we discussed it and yes he approved it. So it's just the satisfaction I get from them when they say "Thank you. Thank you for helping me. I'm so glad I have you here to help me. I would have never known, you know. Nobody answers questions" or "I didn't' know how to navigate the system to get these answers." (Evelyn)

In addition to facilitating recovery, and being appreciated by claimants who were helped, many participants find that their roles as case managers affords them more respect for their knowledge and judgment than they experienced in care giving roles. Hannah explained how the patients, physicians and adjusters respect the value of her involvement in the claim process, and that adds to her job satisfaction.

> I think the patient sees you as helping them but they also realize that there's an adjuster and insurance company that oversees what can be done... You're giving the adjuster information. The patient understands that you can help them explain their situation and get approval for certain for certain things. [With] physicians, I see a lot more, even more respect for nurses [in CM than in caregiver roles].... They understand that...workers comp is paying their bills so they try to work with the nurse and you know, try to get a plan that is agreeable to the patient and to me. They always, you know, they deal with the patient. And I always sit back in the beginning because the physician and patient I feel need to establish a rapport. And then a lot of times at the end of the visit I will talk to the physician...or they will ask me, "Do you need anything else?" So I

> feel for the most part you get a lot of respect from the physicians... I think in some ways you get more respect...for your knowledge, especially with an adjuster who doesn't really understand the medical aspect. (Hannah)

Participants identified autonomy as a source of job satisfaction. They explained that the case manager role allows them autonomy in working flexible schedules, in prioritizing and organizing tasks associated with their caseloads and in addressing their own learning needs. Irene demonstrates a common sentiment among participants.

> I like the hours, the flex-time. You know, you can work kind of when you want, anything you want...I guess to a point [CM] gives you a little more, what's the word? Autonomy. You pretty much set it up and this is how you organize it. You set it up and plan it through and hope that it goes. You're definitely on your own more. (Irene)

Though there are specific policies and procedures that NCMs are required to comply with, they feel relatively free from constraints in how they go about the business of managing cases, compared to the rigid structure of hospital or clinic routines. Donna finds satisfaction with the autonomy allowed in creating a work schedule that accommodated her family obligations. She also finds the opportunity this autonomy provides for professional growth and development to be satisfying.

> [CM] works. It works for my family... In the job that I had...I had to work from 7:30 to 4. I couldn't leave to do my taxes. I couldn't leave early to pick up my son if he got sick... And you know you had a doctor that watched every move you made. So ...even though you're a professional there, you couldn't really develop it much because you had limitations of what your job was. You give immunizations for travelers, and flu shots, and little injuries for people who pass out at the [work site]. You know there's not a whole lot going on [there] professionally.... [In my current job]...I can adjust my workdays according to what my family situation is at

> the time... It's a job that I can develop. I can develop this job to whatever I see it as, my vision of the way I want to be as a case manager... There's the autonomy that I can be any kind of case manager that I want and, as I would like to be. (Donna)

While the autonomy associated with the role of case mangager, offers the convenience of flexible schedules, the freedom to exercise personal preferences in work organization, and the challenge to develop professionally, as mentioned previously, it is also a source of role strain for new NCMs. Interview and focus group data suggest that autonomy can become problematic for nurses transitioning from caregiver roles who lack familiarity with effective practice strategies. This will be discussed in more depth in the next section, "Learning Experiences."

Job satisfaction comes from a number of sources for nurses who have made the transition form caregiver to case manager. Participants identified sources of job satisfaction that generally fit into five categories: (a) facilitating recovery and impacting health outcomes, (b) opportunities to expand knowledge and skill, (c) enhanced professional growth and confidence, (d) appreciation and respect from others, and (e) autonomy. Participants, however, have identified autonomy, as contributing to role strain as well, in terms of limited direction for learning effective CM strategies.

Characteristic Learning Experiences

Nurses entering the field of case management require instruction, guidance and socialization in order to effectively accommodate existing

knowledge and skill to a new context and gain professional judgment and confidence in fulfilling the responsibilities of a new role. Many participants explain that, as competent as they felt they were in their respective clinical roles, the experience of moving into this new work environment is challenging and involves more than simply utilizing their clinical knowledge.

Hired for their knowledge of healthcare and their abilities to understand and relate to physicians and patients, most participants lacked knowledge or even awareness about issues in managed care and third party payment systems. They struggle with new concepts, new types of working relationships and new tools. For many, this learning curve is steep. However, through a combination of formal orientation and training programs, on the job experience, guidance and support from colleagues and self–directed learning strategies they manage to function as case managers.

Learning experiences characteristically associated with participants' transitions into case management include: (a) attending employer sponsored orientation and in-service programs, (b) reviewing policy and procedure manuals, (c) shadowing coworkers, (d) reviewing files or discussing cases with supervisors, (e) attending vendor and provider presentations, (f) networking with coworkers and professional colleagues, and (g) learning from successes and errors on the job. Not all participants had access to or participated in all learning experiences listed here. Rather, each had a relative variation consisting of one or more of these experiences. These variations were related to the time and place of

employment of each respective participant, and, I suspect, subject to the accuracy of participants' recollections.

For example, Ann, Belinda, Ginger and Irene are all employed by the same WC carrier, and work in the same branch office. They were hired within the past three years, but they did not have initial learning experiences at the same time. Their descriptions and impressions of their initial learning experiences reflect variations in orientation agendas, as well as, perhaps, variations in what each attended to and recalled.

Ann reported her initial learning experience as a loosely structured orientation that provided her with the opportunity to observe a case manger in action and then gradually take on the responsibilities of her own case load.

> I had two weeks orientation with another nurse case manager.... I sat with her for the first few days, watched her, read over the manual, and then slowly was put into the position by a case to work on, with her coming and checking my work and making sure that I was where I should be, and doing what I should be doing. (Ann)

Belinda recalled that her initial training involved a "formal training program" that her supervisor had designed and presented to her and another new hire. It consisted of reviewing policy and procedure manuals and instruction in specific tasks and duties such as claims data entry, documentation, steps in the case mangement process, and timeframe expectations.

> Case management was a formal training program that my supervisor here had put together to get uniformity in what people were doing. And I found it very easy to follow. We also had a computer program that prompts you to do certain things, and that was a very good resource. But I would say that the training that I

> got here through the program that was put together was very good... We started out with our books and we were given our books to look at and to go home and read. Basically there were two of us that were starting at the same time... I was available before the other person was, and they didn't want to do it a week apart. So they said, "Just take the books home. Look at them and we'll have you both come back on this day." And we went over the books. We went over the screens on the computer that we use, screen for screen. She talked about the codes that needed to be used, the way that notes should be written, the phone calls that we were expected to make, when we were expected to make them, the decisions that we would be asked to make, and what we were expected to do for follow up. (Belinda)

She also indicated that six months later she was sent to an "official" program for a week on the entire claims process that confirmed her understanding, if not introduced her to, how case management fit into the picture.

Ginger described her orientation process as an "in-service" program, review of manuals, computer instructions, and explanations of what was expected. She felt, however "left alone" to learn how to apply the information on the job.

> They provided an in-service when I first started. Basically I felt I was left alone a lot to just learn on my own. I mean they provided the manuals and what have you, but I felt I learned more doing the hands on... [I was] on the computer and following through on what was presented to me in the manuals and during orientation. Until I actually got my own case load and had to deal with what was expected, I think that's when I finally started learning and had more questions.... What I'm saying is when I first started...it was a lot to grasp.... but it was just more or less, you know, this is presented to you, and this is what you're expected to do. And then everyday coming in, and you know, read these procedures and read that procedure. Well until I have to authorize the surgery, I'm not going to remember all these steps, you know, ten steps to do or what have you, and that's the kind of thing... which protocols are approved...what the time element is in approving a surgery from when you get the call, to get the approval for physical therapy or certain procedures that are not going to be covered under work

comp. (Ginger)

Irene recalls a one-week program on "the case management experience." She was disappointed because the program seemed more appropriate for adjusters than NCMs. Coming from a background in pediatrics, and facing the task of managing WC injury cases, she was hoping to learn more about advanced medical issues associated with those types of injuries, treatment protocols and reputable healthcare specialist that she felt would have been more relevant to her learning needs.

> They did send us for some in-service classes...for a week [on] the case management experience. The problem I had with a lot of them was that it was not as medical as I would have liked it.... [They taught us] mostly when, maybe, to deny a case, when was surgery, when was it not appropriate, how to kind of get an idea - which I still have a problem with - suspecting fraud. That was a big part of it. That's why some of the training I didn't think was as medical. It was more, I thought, adjuster oriented, because we don't do that anyway. We don't deny. We don't. But it gave you background into what you are supposed to be doing, and what might give you a hint, because we do often make a better relationship with the workers than the adjusters. And sometimes we pick up things that you think, "Oh, something is not right here," you know. We learned simple things like parts of the body and muscles and things like that. (Irene)

Donna, who works for another WC carrier, described a more intense initial training experience and describes sessions that specifically addressed CM skills and those that addressed company procedures. Like Ginger, she found that too much introductory information without the ability to apply it soon after created some confusion.

> They have a training program ...a two-week training program now...It's very intense... There is so much information that they provide you... Some of it is generic case management, this is how

> you conduct your initial assessment. And they showed us videos on how to meet with the client for the first time, how to meet with the physician for the first time...how to obtain the information you need. Those to me, that's generic. That's not company specific... That's teaching you the skills. What it mostly involved, though, was this is the [company] way. These are the [company's] forms. This is your laptop and this is where you put the information on these forms. So most of it was [company procedures]...and the expectations you'll have this form done in 48 hours, this one done in 7 days, etc. And that part was intense because you're trying to pull it all together to make some sense and you're not if you've never done a 100% case management it seems like a lot of work and a lot of forms and a lot of things that don't mean anything ...until you start doing these things then you understand what they are. (Donna)

Judy, Hannah and Cathy, who work for CM vendors concurred that there was little in the way of a formal introduction to CM for them. They all practice on-site CM, which puts them out of the office and into the field on their own. The element of fieldwork constrained opportunities for impromptu learning from colleagues. When Judy was asked about the learning resources that were initially available for her to learn CM she replied:

> They are not as developed. I have found [that] there's so much diverse ways of understanding what the case manger's role is, and there [are] different personalities. In these past 15 months what I've found is a real hard time getting support from the employer that I was at. They buddied [me] up with a case manager who was very successful in her role, but she had a very different personality than I do and I didn't like calling on her.... They had another woman that was in the office... and she was wonderful. Having someone there to answer those questions was very helpful... but then after six months she started going out in the field, so she was no longer available to me. What was hard is so many of [your coworkers] say, "Oh well you know feel free to call me." Well, you know they're gone during the day. That's when I want to call them. I don't want to call them at 7 o'clock at night when they get home. I don't want to deal with work at that time of day either, so when she was out of the office, that was a real disappointment for me, that there was nobody then... They had a couple of meetings in [these]

> 15 months, and I found them to be extremely irrelevant and very poorly presented, not helpful for someone at my level. They were geared more towards people that maybe had been in case management, talking about maybe specific guidelines in a workers comp thing, while I'm trying to understand the broad basic guidelines. Don't go into one, you know, obscure element of these things and hound on that when I don't know even understand the bigger picture. So that was really frustrating, very frustrating. (Judy)

Hannah and Cathy reported that their employer provided no formal program orientating them to the role of case manger. They had some policy and procedure manuals to read, shadowed another NCM for a few field visits and discussed issues on a case-by-case basis with their supervisor.

> It wasn't really a formal training. It was more you came in they gave you cases and you just asked questions. And that could have been partly my personality because I think I picked it up pretty quick, as my boss said. So it was more a matter of working the cases and constantly going to them to ask questions. I did go there. I took over for another nurse that was leaving, so I went out with her I think it was two or three visits and then...you know, I just then took a case load and started working it.... There was more paperwork, you know, things to read. There [were] a lot of things to read.... like policies, and it wasn't actually a book on case management - just different processes like workers comp process. (Hannah)

> We did some reading, but it was most learning from doing, which I find works best. Like I said, we went to appointments with other nurses to see how they functioned in the appointment and then you learned from doing. And you met with [the supervisor] to talk about your files and how you were progressing with your files. And if you had any questions with your files you were encouraged to speak with some of the more experienced case managers here with any questions. (Cathy)

Fran, Karen, and Evelyn, all employees of HMOs, echoed a report of having no formal training in case management, and basically learning to function

by doing and asking questions. Fran described her learning experience as "on the job training," and shared that "probably three months of it is just getting acclimated to that different environment, to the different expectations." Karen, who works with Fran, responded to a question about what resources were available for her to learn CM by gesturing a zero with her thumb and index finger. She further explained " I really still feel like I'm floating around. I feel like I've gotten more in the past 2 years just by [networking with] other case managers."

Because Evelyn was hired into a position that had not been occupied before, aspects of her role as a pediatric case manager were not yet established. She had considerable leeway to develop the role, but she needed a place to start, some example from which to shape her role.

> Actually looking at the job description, it wasn't that clear. It was so general. When I came here there were two other case mangers who... specialized in a particular area. I specialize in pediatrics. There was one who specialized in oncology and one who specialized in obstetrics. So when I came here, I was put with those two to see what they did and then that's what I was told that I would do... You know we work in cubicles so it wasn't really following them around, I would sit with them at their desk and listen to the conversations they would have with members and doctor's offices and that's how I [learned case management]. (Evelyn)

Though some participants indicated that formal training programs lasted only one or two weeks, all acknowledged that learning occurred on a daily basis in the course of enacting their role and interacting with others. Utilizing other case managers as resources was by far the most common way that participants found answers to their questions. However, participants working in the field voiced frustration with not being able to access their "resources" when needed,

as indicated previously by Judy. Donna related that she is reluctant to call her designated mentor for help for fear of taking up time her mentor needs to handle her own cases.

> [A coworker] has been assigned to me as a mentor. I told my supervisor this and I told [my mentor] this. " [Mentor], you're a case manager. You have to bill for hours. There's no way I'm going to bother you with any of my questions." So I go to my supervisor. I can pick up the phone and call [my mentor] and I've met [her] for lunch, you know. And we'll chat informally about some of the cases, the most interesting cases, good or bad. But I stay away from calling [my mentor]. She's a good resource. She's very experienced. But this billing situation thing, it's like there's no way... I'm not going to call her. I'm not. I'll call my supervisor because she doesn't have to bill for her time, you know. (Donna)

Networking with other NCMs, as previously referred to by Karen, provided participants with a significant amount of informal learning, and contributed to how they understand their role, the tools they used in executing their job responsibilities and the healthcare providers and services they recommended to others. This networking occurred mostly among coworkers, though some participants found local professional meetings or continuing educations programs to be venues for networking with NCMs from other organizations.

Irene, like her coworkers, takes advantage of local professional association meetings, presentations offered by healthcare providers and vendors, and the group of NCMs that work in her office to network. She finds that networking helps her to get answers to specific case-related questions and to fill in the information gaps she identifies in the course of her work.

> I go to every little opportunity [to network], to all these little [professional CM] meetings. I go to everything... Why [I] go to all that stuff, well because I really need it... Not being on top of things

> is very stressful for me, being the dummy, being the new guy. I hated that... I actually formed a group because it was a problem for me to know some of the [healthcare resources], where to send [claimants], what rehabs were good, where they are. I formed a group [of my coworkers]. We all sat together one night till about 9 o'clock and we went through all the card indexes and reviewed [providers we had used for referrals]. (Irene)

All participants share that they are free and even encouraged by supervisors to take advantage of learning opportunities available within and outside the company. They are not, however, necessarily guided or directed in the availability or selection of these opportunities. This facet of the autonomy they otherwise enjoyed about the role contributes to an uneasy vagueness about whether or not they actually "know" what case managers should "know," and how to go about finding out.

Perceived Effectiveness of Learning Experiences

Participants see formal instruction, i.e. classes, manuals, videos, and computer programs on specific company policies, procedures and tasks associated with CM as necessary. These new NCMs came into the role without much prior knowledge, and needed information. Formal orientation and training programs that provide new hires with information about role expectations, tools for the job, and resources for later reference are favorably received. Those who did not receive such instruction suggest that it should be provided for new NCMs. Hannah, who did not receive formal instruction, remarks:

> Things weren't as clear to me in the beginning because it was more of a "Here is your case. Just go out and stumble and ask a lot of questions." I think I would probably do a little bit more bookwork in

> the beginning, or explaining things a little bit in the beginning. One thing that [my supervisor] also did is had you pull charts and read charts. That was very helpful. Just maybe a little more formal education in the beginning rather than that complete "Here's your case load," you know. "Go ahead and do it and let me know if you have any questions" (Hannah)

While training sessions, policy and procedure manuals, and computer tutorials are viewed as necessary, many participants share that they are not sufficient. New NCMs prefer to have opportunities to apply some of what they are learning interspersed with those formal methods of instruction. Ginger, whose employer provided a formal program initially, found the material a bit too much to absorb, and needed a balance between new information and the opportunity to put it to use.

> Starting in a job like this and coming out of the hospital that was the first thing that kind of hit me...it was such dry material. All of a sudden, it's just all this manual thrown at me. Like I'm supposed to remember it all... I'm a hands on person. I guess...the clinical was always easier for me to be able to correlate what I learned in the books you know... I always think it's a little bit easier when you incorporate some hands on or some book learning together. So I think that in the beginning, it may have started out a little dry because of the fact that everything was kind of like presented in book form before being able to apply it. I think that you should be allowed [to apply it]. (Ginger)

Shadowing others is seen as an effective learning as well as socialization experience for new NCMs. Several participants followed experienced NCMs in the course of their duties, which assisted the new hires to formulate questions and observe procedures in context. It also gave them an idea what to anticipate and how they might need to prepare for their own experiences on the job.

Irene's orientation to the job did not include shadowing. Though she practices telephonic CM, and her colleagues are just a cubicle away, she feels that their expertise was not as accessible to her as she would have preferred in the beginning. A dedicated period of shadowing, she speculates, would have been an effective way to learn not only tasks, but also to gain some insight into the type of decision-making expected of a case manager.

> I think if I could have gone through files with someone and watched them - and I realize that this is not always a practical thing - but if I could have watched somebody do their files for two weeks, and have them explain, you know, "Ok I've decided that I'm going to do this and that," that definitely would have been more help to me... If I could have listened to her make that call instead of calling myself... Just saying you have 24 hours to make this contact, oh boy, you know, not that some things weren't written down, but ...I would have preferred to hear it, and have listened to someone actually go through a file explaining it... I know that that's not always practical. But I know it's the biggest complaint of all of those who have come after me. They say you just kind of wing it and then they tell you if you're off.

All participants express the value of having accessible resource persons available to provide on-going feedback and answer questions. Cathy comments about the significance of coworkers and supervisors in her development.

> I've learned from the [NCMs] here. When a situation arises that is complicated, maybe I'll talk to the [NCMs] here, ask them their experiences, things like that. Or just listening to their conversations, or being part of their conversations regarding their cases of things that they've experienced, and things that they've found challenging, and how to handle it. (Cathy)

Having resources available to discuss CM problems and strategies is important, but also having resources provide validation of the meaning new NCMs ascribe to experiences is also valued. Participants share that refection

and discussion about their performance in the context of specific case experiences helps to shape their professional judgment, and serves to sharpen their focus in self-directed learning efforts.

Because CM involves collaboration with a number of stakeholders associated with their assigned cases, NCMs need to learn about the roles and perspectives of those stakeholders. Of significance to new NCMs are not only, for example, what an adjuster or a medical plan director does, but also the extent of a case manager's influence in relationships with them, what they expect from NCMs, and what NCMs can expect from them. Learning and socialization experiences that address these types of things early on would have helped Judy. She speculates that if she could go back and start again, she would attend to this.

> I would try to find out from these adjusters, all this, you know pearly wisdom that they have. You know, what are their expectations and are their guidelines? I think they're kind of very important in this whole [thing], what they expect a case manager to do. I don't have any problem understanding nursing, but I do have a problem understanding the insurance piece... I don't think you could really capture every problem...but if you knew what was appropriate and inappropriate for a case manager to do, you know, what are red flags to adjusters, I think that would be very helpful. (Judy)

Participants also identify specific in-service or continuing professional education topics that they feel would fill in the information gaps in their knowledge base. In addition to updates about various medical diagnoses and treatments, topics such as cost benefit analysis, legal issues in healthcare, workers' compensation and automobile insurance coverage, and community

resources to augment covered benefits are suggested. These topics represent areas in which they feel least prepared.

As previously outlined, participants described seven characteristic learning experiences associated with their transitions from caregivers to case managers. These experiences include (a) attending employer sponsored orientation and in-service programs, (b) reviewing policy and procedure manuals, (c) shadowing coworkers, (d) reviewing files or discussing cases with supervisors, (e) attending vendor and provider presentations, (f) networking with coworkers and professional colleagues, and (g) learning from experience on the job. Though a number of participants had formal or structured training opportunities, many remarked that the initial training they received failed to give them a comprehensive understanding of the CM role or what difficulties they might experience in the transition. Many relied on asking questions of their coworkers and on trial and error. Some sought out opportunities for networking with other NCMs.

Learning and socialization experiences perceived as effective by new NCMs include a combination of hearing, seeing, and doing. The right balance of formal training sessions with opportunities to observe others, and time to try out new tasks and approaches on their own with support, guidance, and validation from those with more expertise enabled new NCMs to expand their knowledge and skill and gain confidence in their professional judgment.

In summary, this section presented data that addressed the research question: Are there characteristic motivations, expectations, sources of role strain

and job satisfaction and learning experiences associated with nurses role transitions from caregiver to case manager? Overall, data from personal interviews and focus group discussions corroborate on a number of characteristic aspects of this transition experience for participants in this study.

A common motivation to enter the field of CM is a desire to find an employment option that eliminates the need to deal with undesirable work conditions. This motivation feeds stronger expectations of relief than expectations of professional challenge, growth or development from new NCMs. In other words, nurses move into case manager roles with little to no knowledge of the scope of CM responsibilities, the problems or struggles they might face in role transition, or the opportunities to grow professionally as a case manager.

Sources of role strain experienced by participants characteristically cluster around four tensions: (a) time-task orientation, (b) interactions and relationships, (c) business culture and objectives, and (c) professional identity and self-image. These tensions reflect the types of accommodations participants struggle with in their transition from caregiver to case manger.

Sources of job satisfaction experienced by participants cluster around five areas: (a) facilitating recovery and impacting health outcomes, (b) opportunities to expand knowledge and skill (c) professional growth and enhanced confidence (d) appreciation and respect from others and (e) autonomy. These areas represent opportunities associated with the case manger role that participants have come to realize are both personally and professionally rewarding.

Learning experiences associated with this transition are characterized by limited formal training programs initially, on-going informal and self-directed learning from actually managing cases. Though opportunities for learning are viewed as a source of job satisfaction for many participants, the formal learning resources that they perceive as available and relevant to novice case managers are sparse. Networking with other case mangers is viewed as extremely helpful.

Despite a number of characteristic aspects of the role transition from caregiver to case manager, data collected also demonstrate some divergent experiences of this transition. Some of those differences most likely can be attributed to personality traits, which are not explored in this study. Some differences, however appear to be associated with past and present practice contexts. The next section will show how data from interviews and focus group discussions demonstrate contextual influences on the role transition from caregiver to case manager.

Contextual Elements that Influence Nurses' Experience of Transition

The second research question addressed here is: What elements of contexts associated with past and present roles are influential in this transition? This section will demonstrate elements of contexts that participants were exposed to as caregivers and those that they are encountering as case managers that either contribute to or moderate role strain. The influence of these elements on nurses may account for experiential differences in this transition.

Contextual Elements Of Past Roles That Contribute To Role Strain

Contextual elements of past roles that seem to contribute to role strain for participants include: (a) physical task requirements, (b) focus on immediate healthcare needs, (c) limited decision making responsibility or opportunity, and (d) specialization. The extent to which these elements of past role contexts were present appeared to influence the amount of role strain experienced by nurses in this transition.

Physical task requirements are significant in the role of caregiver. Though there are other responsibilities and expectations coinciding with that role, most participants agree that providing physical care, or accomplishing physical tasks was a major expectation in their previous roles as caregivers. In contrast, participants shared that the major activities in their current role as case managers-- communication, assessment, planning, coordinating, monitoring and evaluating -- are all done to effect the achievement of longer-term objectives. This required a considerable accommodation for nurses who come into CM directly from care giving roles where accomplishment of physical tasks is the primary method of fulfilling role expectations.

All participants had some experience in care giving contexts where their role involved mostly physical tasks. The hospital setting was a context where this orientation was predominant. Judy's experience was typical of other responses describing this element in a hospital setting.

> [In the hospital] you're more a worker bee. That's how it felt, like I was just this worker bee completing tasks, tasks, tasks. No, it didn't really allow a lot for the art of nursing, on the floor that I was

> on. As far as the holistic type care, you weren't able to really take a whole picture and, you know, see what was going on. You were more, you know, putting out fires. Hang that IV, you know. Do this [admission], and go change that bed, and you know.

However, Judy and a majority of other participants were exposed to care giving contexts subsequent to their early experience in hospital settings. For some, these contexts offered opportunities to adjust a physical task orientation to a more mental task, or management orientation, which served to moderate role strain for them in the transition to case management. For Donna and Evelyn, this was achieved to a significant extent with work experience as supervisors in clinic settings. For Irene and Belinda, this was achieved to a lesser extent with work experience in telephone triage for the pediatric clinics where they were previously employed.

In care giving contexts there is a *focus on meeting immediate healthcare needs*. Participants shared that in these contexts they were often limited in awareness and concern to the episode of illness or injury at hand, and not required to follow or facilitate patients' recovery beyond the acute stage. As new case managers, they have to adjust that focus to extend beyond the acute phase and attend to the recovery and rehabilitation phase as well as deal with chronic conditions. As NCMs they also need to include the interests of stakeholders in the process other than the patient.

Nurses who had worked in out-patient clinics and home care settings explained that these contexts broadened their awareness and understanding of the recovery process as well as the impact of other stakeholders in the process.

This was helpful in their transition to CM. For example, Belinda explained that her clinic experience helped her to expand her focus from meeting the immediate health care needs of patients in one episode of illness to building relationships and arranging for things happen from a distance, over time.

> They had what they called the nurse line there, and I really enjoyed that job. That was basically talking to patients, following up with new babies, answering questions on sick children. You name it, they called us and asked us what was going on. We did some, I hate to use the word diagnosing but patients would call and say, "You know my kid is this, this, and this." And we'd say, "Well, you know it sounds like he could probably stay home another day," or "It sounds like strept throat. You better come in." And so a lot of what I do here [in my current role] is similar, although in many respects it's different. But we were doing what I would say some case management before I came here, because we were given a lot of leeway to make decisions. We contacted doctors, followed up on necessary treatments and x-rays and hospitalizations, things like that. All that was done from the phone... And the [key difference] for me was getting to know my patients and making a difference and being a part of the ongoing saga. And that doesn't happen for you in a hospital. It's right here, right now, we're discharged, we're out of here, and we'll maybe never see you again.

Donna, who currently does on -site CM for a WC carrier, found that her experience in health clinics at industrial plants gave her an appreciation for the interests of other stakeholders in the course of injury and recovery of workers who are injured on the job. This context expanded her awareness to include the perspective of employers and what is involved with returning the injured party back to his or her job.

> [My occupational health background was] most helpful. And this is my perspective in that because I'm so employer oriented, I find that part easy. When I go out as a case manager into these companies and meet with employers and meet with HR people and walk with the supervisor through an environment. I'm loving it... And I'm

> very comfortable with looking at a job, asking questions, and kind of assessing situations. I know terminology [that] some nurses might not. I know pallets and slip-sheets and duct plates and you know, I know those kinds of things, what are pallets, what that means. Where some nurses don't really understand that and it might be more intimidating to go into an environment that's non-medical. I love it.

Nurses in some care giving contexts have *limited decision-making responsibility or opportunity* for suggesting or determining treatment options for patients. They are charged with following physicians' orders for diagnostic and monitoring procedures, and for administration of treatments and medication. Participants noted that coming from such controlled and structured care giving contexts made it difficult for them to transition into a CM context where they are expected to weigh the merit of prescribed treatment options and/or confidently argue their point of view with physicians.

Specifically, participants with hospital experience other than emergency or critical care units commented on how that context offered limited decision-making opportunities, or autonomy. This was true of some clinic experiences where participants were charged principally with assisting physicians in setting up examining rooms, taking vital signs and collecting specimens.

Nurses with home care experience, however felt that this context provided autonomy, which helped them develop self-reliance and ultimately honed decision-making skills. Hannah, Karen, Judy and Cathy all had some home care experience. With the exception of Cathy, they indicated that the autonomy and personal responsibility for a caseload of patients that extended beyond the

hospital served to moderate role strain in their transition to case management. Hannah's remarks are consistent with Karen's and Judy's responses.

> The transition from a hospital to home care is difficult because you've got to be very independent you've got to make decisions on your feet you don't have people around you. That took me a while, I think. I was younger at the time, didn't have a lot of experience. But by the end of my experience I think I was very good at it. And you learn to be very independent, make decisions, know when to call physicians. And you manage a caseload. I mean this one person and all their problems is up to you, how often you see them, that type of thing. (Hannah)

> It was a hard adjustment to go from a hospital where you had another shift behind you to where you were the last person in there and you may be the next person in there in two days a week a month or the next 8 hours, you know depending on what the case was.... [In the hospital] you were in the safe confines of the four walls environmentally and you had another shift behind you and you had educators and you had other people managers and when you do home care, you are mainly it out there.... leaving the hospital scene, it was such a four walls enclosed safe situation. You learn so much more about how people function on their own when you're doing home care out in the community. (Karen)

> The transition [to CM] was difficult in trying to interpret [Automobile Insurance] and WC guidelines. That part was difficult. But one part that was very similar was, you know, assessing the people, interviewing people, developing a plan, setting goals. That was similar. (Judy)

Cathy shared that her role as a visiting nurse in home care was more task oriented. She only made visits to check on patients who required electronic monitors or feeding tubes. Though she felt some autonomy in this role, it was not significant in developing her decisions-making skills.

Care giving contexts are often associated with specific settings and medical specialties, such as hospital units or clinics that deal exclusively with orthopedics, pediatrics, oncology, etc. This type of *specialization*, though

enabling professionals to acquire sophisticated knowledge and skill in specific areas of healthcare, also limits their awareness of the broader healthcare delivery system and the interplay of variables within and without that system. Participants with specialized expertise reported strain associated with learning to deal with a different patient population and with gaining confidence in their interactions with a variety of stakeholders (physicians, adjusters, employers, etc.) in the claim process. Participants with more generalized or varied experiences as caregivers found this to be helpful in their interactions and problem solving strategies as case mangers.

Belinda and Irene provide a good example of how specialization contributed to their struggle in the transition to CM. The majority of Belinda's and Irene's work experience was in pediatric clinics previous to accepting positions as WC case managers. The element of specialization in their past work context created role strain for Belinda and Irene because of the significant change in clientele they deal with as WC case managers. They are now dealing with an adult population, a variety of medical specialties with which they had no interaction in their previous role, and return to work issues, for which they had no frame of reference. In contrast, Cathy and Hannah had exposure and experience in a variety of medical specialties and settings, which they believe eased the transition in dealing with patients and and helping them navigate their way through the healthcare system.

Evelyn, is an exception, however. Her experience and expertise is in pediatric nursing exclusively, but she finds that to be a solid foundation for her in

her role as a pediatric case manager for an HMO. She has maintained essentially the same type of clientele, and understands a variety of healthcare settings that offer pediatric healthcare services. There are more similarities between past and present contexts for Evelyn, so this creates less strain for her than for other participants whose previous field of specialization is quite different than what they encounter in their current roles.

Nurses who transition into the role of case manager bring with them influences of the care giving contexts in which they were trained and socialized. Participants' descriptions about past role contexts that contributed to difficulty in making the transition from care giver to case manager include these four elements: (a) physical task requirements, (b) focus on immediate healthcare needs, (c) limited decision making responsibility or opportunity, and (d) specialization. A predominance of these elements in the previous work experience of new NCMs appeared to contribute to role strain in the transition to their new role.

Contextual Elements Of Present Roles That Moderate Role Strain.

Contextual elements of present roles that seem to moderate role strain for nurses making the transition from caregiver to case manager include: (a) relevant learning resources and reference material, (b) access to colleagues and mentors, (c) manageable caseload. The extent to which these elements are present in CM contexts appear to influence the ability of new NCMs to moderate role strain.

Participants explain that access to what they feel are *relevant learning resources and reference materials* contributes to their ability to deal with role strain. They agree that their current work contexts provide them with access to a number of resources and reference materials. Some of these are relevant to the learning needs of new case managers and some are not. Though they perceive their initial training experiences with varying degrees of satisfaction, they have come to recognize the utility of a number of resources available to them that some were not aware of initially.

Karen, for example, remarks that she didn't realize " how much of a body of knowledge on case mangement was out there." Her initial orientation included more about company polices --as did other participants' -- than specifics about CM as an area of practice. At this stage of her career in CM she is looking for more relevance than procedure and policy manuals, and further adds, " The more you get into it, the more you know what is out there that you don't know about yet."

By and large, participants take advantage of the flexibility that the CM role affords them to pursue their interests in learning about medical as well as insurance related issues. To the extent that participants are aware of relevant resources within and without their respective organizations, this element of the CM contexts serves to reduce role strain.

Interview data suggest that CM contexts generally provide new NCMs with *access to colleagues and mentors.* This moderates role strain by offering formal and/or informal support as they learn from successes and errors their new role.

Participants who regularly met with supervisors or colleagues to discuss cases found the opportunity to exchange stories and ideas invaluable for interpreting their new experiences. Belinda found that the experience of handling her own caseload was made more meaningful with the interactions she had with colleagues. She finds what was most effective in learning to function as a case manger was:

> ...probably a combination of coming in here and doing it everyday - even though I wasn't sure what I was doing - and the constant ability to draw from the people I work with; the nurses and the claim reps and the unit people that I work with. I've picked up an immense amount of knowledge and abilities from them, and that, I think, can make or break a job...If you know nothing about what you're doing, you have got to rely on the people around you who do, and you have to be able to pick out the ones who do know... from the ones who don't. And I have a good group of people. The nurses here have been very willing to share what they know, discuss a file...Everybody here has been willing to tell me, answer my questions, show me the way, point me the way, and I think that's probably the biggest thing that's led me to be able to say, " Yeah, I'm a case manager!"

Some participants who practice on-site CM find it difficult to connect with colleagues and supervisors while working in the field. However, being in the field allows them to network with case managers, healthcare providers and vendors outside of their organizations, which provides some interactions beneficial for learning aspects of their role.

Participants who felt that their work context supported a *manageable caseload* in the beginning of their transition also felt that they were able to confront new situations with sufficient time and support for learning and

reflection. This helped them to accommodate to changes they experienced in focus, tasks, and tools from previous roles as caregivers.

Donna explained how her supervisor's consideration for her need to get acclimated to her office before taking on cases to manage worked for her in the beginning, and speculated that too many cases for fellow trainees seemed to impact their success in the transition.

> I think you need to have enough time to get your office in place before you get overwhelmed with cases, and having not a huge case load to start with out of training. When I was in Florida training before we left, on our laptops you could see cases already listed. Some of the case managers next to me had eight, ten, twelve cases that they knew they were going back to. I didn't have any from...my supervisor, and I'm still on board. Some of those people [I trained with] aren't. So retention might be affected, might be improved [by considering the impact of too heavy a caseload].

Work contexts that offer new NCMs environments that are conducive to effective transitioning from the role of caregiver incorporate elements that are sensitive to their needs as adult learners. Three such elements identified by participants are (a) relevant information and reference material, (b) access to colleagues and mentors for feedback and discussion, and (c) manageable caseloads. The extent to which nurses are exposed to these elements in their new work environment appears to positively impact their success in expanding existing knowledge and skill to accommodate new role expectations.

This section presented data that demonstrate how combinations of nurses' past and present practice contexts may serve to either moderate or contribute to role strain in this transition. Elements of care giving contexts that influence the transition from caregiver to case mangers by contributing to role strain include

those areas of focus and task requirements that are necessary for providing physical care, but do not translate as effective strategies in case management contexts. Elements of case management contexts that influence the transition by moderating role strain include those that are sensitive to individual learning needs of professionals who have knowledge and skills, yet require some guidance and validation. These needs include a balance of new information, practical application and feedback in order to for them to face the discomfort of being novices again. Understanding this dynamic can assist nursing educators and trainers in assessing learning and socialization needs of new NCMs.

Summary

The findings of this study help us to understand how nurses who are primarily trained as caregivers, transition to and learn in the role of case manger. Analysis of collected data reveals information about motivations, expectations, sources of role strain and job satisfaction and learning resources that are characteristic of nurse case managers who participated in this study.

Characteristics of this role transition can be summarized as follows. Nurses who make a practice -based career change from the role of caregiver to the role of case manger are generally motivated by dissatisfaction with aspects of the caregiver role or work conditions in their current employment setting. They enter the role of case manager with expectations of relief from undesirable conditions. They do not, however anticipate aspects of the case manger role that

may cause strain or have a vision of how this role may provide opportunities for them to grow professionally.

Sources of role strain that they encounter are consistent with four major tensions: (a) time -task orientation, (b) interactions and relationships, (c) business culture and objectives, and (d) professional identity and self-image. New NCMs must accommodate assumptions and approaches learned as caregivers to fulfill expectations associated with the role of case manager. The process of accommodating assumptions and approaches from care giving experience not only contributed to role strain, but also stimulated professional growth and eventually contributed to job satisfaction for many.

Five significant sources of job satisfaction are identified by new NCMs: (a) facilitating recovery and impacting health outcomes, (b) opportunities to expand knowledge and skill, (c) enhanced professional growth and confidence, (d) expressions of appreciation from others, and (e) autonomy. Autonomy, though enjoyed by many in this role, was also identified as contributing to stress, particularly if new NCMs felt left alone to learn strategies for efficiency and effectiveness in the role.

Initial learning experiences for new NCMs involve various combinations of formal and informal orientation and training programs, individual instruction and on the job experience. Despite training opportunities offered or allowed by employing organizations new NCMs often feel left to their own ill-informed discretion to seek out and select information and experiences that will help them develop competence. With significant time on the job, however, and access to

more experienced NCMs for observation and dialogue some manage to gain confidence in their ability to facilitate their own professional development.

Data analysis also contributed to an understanding of elements of context associated with past and present roles that are influential in NCMs experience of role transition. Elements of past care giving contexts that influence the transition experience for nurses include (a) physical task requirements, (b) focus on immediate healthcare needs, (c) limited decision-making responsibility or opportunity, and (d) specialization. The extent to which these elements were present in previous work contexts appears to contribute to role strain in the transition to case manger. Elements of present case management contexts that influence the transition experience include (a) provision of relevant job information and reference material, (b) access to colleagues and mentors for feedback and discussion, and (c) manageable caseloads. The extent to which new NCMs appreciated these elements in their present work context appears to moderate role strain in this transition.

Results of this study demonstrate how nurses who make a practice-based career change from caregiver to case manager experience the transition, and identify influences in the process. The implications of this information for designing education and training programs for nurses entering the field of case management will be discussed in Chapter Five.

CHAPTER FIVE - Discussion

Introduction

Nurses' experiences of change from one professional practice context to another provide examples of the type of expert to novice transitions that are becoming more frequent in professional life. This study explored how nurses, who are primarily trained and experienced as caregivers, transition to and learn in the role of case manager. Findings suggest that there are factors associated with nurses' experiences of this transition that have implications for the preparation and support of nurses going into the practice of case management specifically, as well as for those involved or interested in professional development in general.

In this chapter I will revisit the conceptual scheme used to inquire about the process of this expert to novice role transition and discuss the contributions and limitations of each theoretical frame in exploring characteristics of this role transition. I will then identify and discuss themes emerging from the data that are specific to role transitions for nurses entering the role of case manager and how those themes can inform the design of education and training agendas associated with this group of professionals. Finally, I will discuss the significance that findings of this study hold for the practice of professional development and further research in this area.

Revisiting the Conceptual Scheme Used in this Study

There are several lenses with which to view role transitions. For this particular study, a conceptual scheme consisting of multiple theoretical models was used to inform the research questions and guide the scope of inquiry. Findings of the study satisfy theoretical assertions offered by each model, and support the relevance that the application of multiple models, as opposed to one model alone, holds in this type of inquiry.

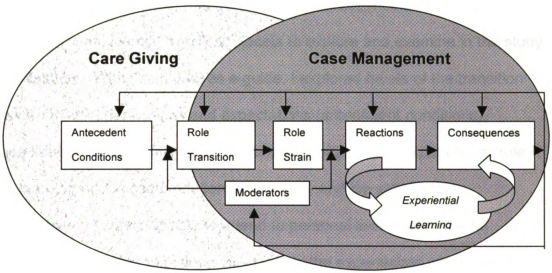

Figure 4. Conceptual Scheme of Study combines the influences of past and present role contexts with Allen & van de Vliert's Model of Role Transition (1982), and Kolb's Model of experiential learning as a reaction to role strain.

The multidimensional conceptual scheme for this study (see Figure 4) incorporated Allen and van de Vliert's Model of the Role Transition Process (1982), the theory of situated cognition (Brown et al, 1989; Lave et. al, 1999; Wenger, 1998; Wilson, 1983), and Kolb's model of Experiential Learning (1984).

Elements of each theory contributed to a comprehensive framework for examining the experience of transition and learning for nurses participating in this study and perhaps for examining the experience of other professionals in practice-based role transitions. This section will discuss specific applications and limitations of each theoretical component of this framework.

Allen and van de Vliert's Model of the Role Transition Process (see Figure 1), served as a useful guide in exploring aspects of the transition process that proved to be significant to participants in this study. Component parts of the model; antecedent conditions, role transition, role strain, moderators, reactions, and consequences, identify significant facets to explore and examine in the study of role transition. With this model as a guide, I explored facets of the transition process from initial motivations and expectations (antecedent conditions), changes in activities (role transition), perceptions of personal experiences (role strain), learning and accommodations (reactions) and job satisfaction (consequences). I was also able to attend to personal and environmental variables (modifiers) that explained variations in the experiences of role strain and job satisfaction for individual participants. Utilized alone, however, Allen and van de Vliert's Model of the Role Transition Process fails to demonstrate roles in unique contexts and therefore does not adequately direct attention to contextual influences of past and present roles that contribute to role strain.

The theory of situated cognition (see Figure 2) adds a dimension to Allen and van de Vliert's model by directing attention to contextual factors associated with past and present roles that can create tension for individuals in transition

between the two. For nurses making the transition from caregiver to case manager, factors associated with the professional contexts they exited and entered demonstrably contributed to tensions or role strain. Though the component of modifiers (personal or environmental factors that impact role strain) in Allen & van de Vliert's model could feasibly handle contextual influences, situating modifiers in particular contexts lends a perspective that tensions may be characteristic of role transitions between specific contexts. Discovery of tensions that are created between specific contexts and modifiers that serve to diminish or escalate these tensions can help facilitate more comprehensive training and socialization agendas.

The incorporation of Kolb's Model of Experiential Learning (see Figure 3) into this conceptual scheme allows for attention to learning as a significant reaction employed by professionals in the face of role strain. This was demonstrated by the data. This model demonstrates a cyclical process of learning from experience that includes concrete experience, reflective observation, abstract conceptualization, and active experimentation.

Though it was difficult to elicit discussion with participants about discreet steps in their learning process, it was clear that they relied on experience, reflection, conceptualization and experimentation to achieve their current levels of role understanding and competence. It was also clear that they sought out experienced NCMs and others to assist them in the processes of reflection and abstract conceptualization, and appreciated structured opportunities, like case

presentations and file reviews to consider new case management strategies, when they were offered.

Alone, Kolb's model does not address motivation to learn. Incorporated with the Model of Role Transition, however, it becomes a reaction to role strain, and demonstrates a process of on-the job learning. It also highlights vantage points for training interventions, like guided reflection, conceptual discussions, and introduction of experimental strategies that educators and trainers can capitalize on when motivating tensions associated with the new role arise for the learner.

Though there are several ways to examine issues associated with professionals making career moves, the conceptual scheme assembled and utilized here provided attention to significant factors and influences in the role transition experience of participants of this study.

Themes Emerging from Data

Literature on role transition suggests that the ease with which new roles are assumed and executed is influenced by three factors: (a) the degree of discontinuity between old and new behaviors, (b) the accuracy of the transitioning person's anticipation of problems that will be encountered by shifting behaviors, and (c) the extent to which role entry and the assumption of new behaviors is formally structured and guided (Allen and van de Vliert, 1982). Themes emerging from this study, which support these assertions, hold

implications for preparing nurses to assume case manager roles, and supporting them in the transition process.

Interview and focus group data suggest that the following themes characterize experiences of transition for professional nurses who enter the role of case manager.

1. Nurses experience varying degrees of discontinuity in performance expectations between care giving and case management contexts.
2. Nurses do not anticipate the nature of problems they will face in fulfilling performance expectations of case managers.
3. Nurses often feel left on their own to determine the significance of new information and experiences.
4. Nurses react to role strain with attempts to enhance their competence through seeking information and examining experience.
5. Nurses are resourceful in getting their learning needs met, yet they benefit from guidance and support from more experienced case managers.

The ensuing discussion will examine each of these themes in light of what is implied for the education and training of nurses entering this field.

1. Nurses experience varying degrees of discontinuity in performance expectations between care giving and case management contexts.

Participants in this study came from various care giving backgrounds, encompassing a variety of medical specialties, physical settings and practice opportunities. This study suggests that nurses bring a knowledge base and

various skills and attitudes from their care giving pasts that can create varying degrees of tension in assuming this new role. In addition to learning new approaches, priorities and operating assumptions, new NCMs face challenges to assumptions and approaches that were effective and supported in previous role contexts. As Ashforth (2001, p. 190) points out, "Part of the challenge of learning a new role is unlearning goals, values, beliefs, and norms that are antithetical to the new role."

Ann and Ginger, for example, found that their approach to work assignments, learned in the context of emergency nursing, carried over into their initial attempts of case management for a worker's compensation (WC) insurance carrier. In some respects, their inclination toward immediate response and task accomplishment actually thwarted their ability to manage a caseload efficiently. They had to change their time-task orientation in order to function efficiently and feel competent.

Nurses entering the role of case manager need to be aware of the degree of discontinuity that exists between performance expectations of past and present roles. Educators, trainers and supervisors can assist them with an assessment of past and present performance expectations in areas of time-task orientation, interactions and relationships, and workplace norms and objectives. This type of assessment will provide educators, trainers, supervisors and new NCMs with a compass for directing learning efforts.

2. *Nurses do not anticipate the nature of problems they will face in fulfilling performance expectations of case mangers.*

This study suggests that nurses moving into case manager roles are seeking relief from undesirable aspects of care giving roles or work settings. This motivation creates expectations for a better employment experience. Without much more than an awareness that their clinical expertise is expected to be useful in case management, participants had little, if any, awareness of the problems they would face in pursuit of competence in this new role. This expectation may belie a need to accommodate certain assumptions and approaches they have utilized effectively in past roles.

Irene, for example, was looking for a more lucrative employment option. Knowing that a NCM position with a WC insurance carrier offered a better compensation package than she realized in her position at a pediatric clinic, she made this career move. Once in the role of case manager, however, she encountered a number of difficulties, including acclimating to a business culture and reconciling her work with her self-image as a caregiver, that she did not anticipate and which negatively impacted her transition experience. In contrast, Fran was more familiar with the role through her interactions with NCMs in the context of her experience in utilization review. She appropriately anticipated her learning curve and was able to adjust without the degree of role strain experienced by Irene.

Being aware of the type of problems characteristically encountered by nurses entering the role of case manager from the role of caregiver enables

educators, trainers and new NCMs to anticipate potential sources of role strain with greater accuracy. This allows for more informed approaches in assessing learning and socialization needs. An assessment of how accurate new nurses' anticipations are with regard to the problems they may face in making the transition to case management will provide educators and trainers with insight into what the learner will perceive as necessary to learn. Confirming, correcting, or informing their expectations will help new NCMs seek out and take advantage of learning opportunities that will best serve their learning needs.

3. Nurses often feel left on their own during this transition to determine the significance of new information and experiences.

Collected data suggests that nurses learning to function as case managers discover various dimensions of this role from unstructured and unplanned experiences. Participants acknowledged that they were provided with ample information from employers about company policy and procedures, specific lines of business (insurance, managed care, etc,) and instruction in computer software programs. They reflected, however, that they felt unguided in determining work priorities and efficiencies, in negotiating relationships, in acclimating to the business norms, and in reconciling their professional identities and self-image to accommodate unfamiliar assumptions and approaches.

Research has advanced the notion that organizational socialization involves transformation of several aspects of newcomers behaviors, values and attitudes. Specifically, these aspects have been identified as (a) development of

work skills, (b) acquisition of appropriate role behaviors and (c) adjustment to group norms and values (Feldman, 1989). Provision of new information about policy and procedures, lines of business, and tools required for task execution, therefore, is not sufficient to facilitate role transition. Issues of group norms and values must be addressed as well.

New NCMs require information about the nature of behavioral changes needed to fulfill performance expectations of this new role. They also require on-going support to acclimate to norms and values of the work place setting in particular, and to case management conventions in general. Educators, trainers and supervisors should address aspects of behaviors and perspectives from previous roles that require adaptation to new role expectations. Facilitated discussions addressing issues of time–task orientation, interactions and relationships, business culture and objectives and professional identity, and self-image will provide new NCMs with a forum to voice their concerns, questions and impressions of their new role. Acknowledging their experiences of role strain as characteristic in this transition should help them to gain a sense of belonging and validation in their progress toward competence.

4. Nurses transitioning from the roles of caregiver to case manager react to role strain with attempts to enhance their competence though seeking information and examining experience.

Allen and van de Vliert (1982) explain that reactions to role strain can be classified as either accommodations to self or accommodations to the

environment. This study suggests that nurses entering the case manger role are intimidated, albeit stimulated, by their new work contexts. As a consequence, they are intent on discovering ways that they can become competent in their new role and take initiatives to learn. That is, participants sought to accommodate themselves through learning in order to fit NCM role expectations, rather than arrange their new role to fit existing competencies or personal desires.

In describing adult learners, Knowles (1980) explains that adults have a characteristic learning orientation toward problems and interests that hold a specific relevance with their obligations and aspirations. That is, adults are ready to learn what they perceive is needed for them to perform necessary tasks, solve practical problems or gain personal satisfaction. Participants in this study portray their learning strategies as two-fold. New NCMs seek out learning opportunities such as formal presentations and published guidelines and explanations to fill information gaps that they perceive as limiting their effectiveness. They also examine their experiences of relative success and failure to gauge their proficiency.

To fill information gaps, Belinda takes advantage of company sponsored programs on insurance-related topics in order to understand adjusters' perspectives. Cathy uses her nursing textbooks and the Internet to research unfamiliar medical issues associated with case assignments. Donna networks with other case managers to find work efficiencies in the way of forms or logs that can help her capture her activities efficiently for recording billable hours.

To gauge their proficiency in their new roles, participants examine their experiences for the amount of discomfort that certain tasks or responsibilities produce for them and the case outcomes in which they feel they have been instrumental. As previously presented, Kolb's Model of Experiential Learning (1984) depicts learning from experience as a cyclical process involving concrete experience, reflective observation, abstract conceptualization and active experimentation. This process is evident in participants' descriptions of learning from experience.

For example, as a result of examining her experience with reluctant parents of pediatric patients, and actively experimenting with her approaches, Evelyn became proficient in establishing rapport with them over the phone by changing how she introduces herself. As a result of examining her experience with judging claimants' trustworthiness, and actively experimenting with her assumptions, Belinda became proficient at collecting facts that contributed to more accurate assessments.

Participants of this study provided ample evidence of their enthusiasm for expanding their knowledge base and gaining new skills. This suggests that the provision of relevant information or resources and encouragement for examining experiences is a sound education and training strategy. Noe & Ford (1992) suggest that two assumptions underlie the recognition of experiential or job–oriented learning as a viable training strategy. The first assumption is that challenges encountered on the job stimulate or force learning to occur. The second is that expansion of knowledge and skill are most likely to occur when

there is a discrepancy between knowledge and skill relied upon in past roles and the knowledge and skill required for competent execution of new role responsibilities. The implication for educators and trainers is to capitalize on new NCMs' enthusiasm for learning by allowing a reasonable amount of tension to stimulate their need to know, and at the same time providing guidance and accessibility to relevant learning resources to help them to satisfy this need.

5. New NCMs are resourceful in getting their learning needs met, yet they benefit from guidance and support from more experienced case managers.

This study suggests that nurses entering the role of case manager have extensive formal and informal learning experience from past roles. Though they pride themselves with being apt learners, they are not confident in their ability to assess their own learning needs or to direct their inquiries to the appropriate resources in this new role.

Their thinking and learning has been situated in care giving contexts, which do not provide perspectives that are altogether useful in situations that they encounter as case managers. In lieu of a comprehensive understanding of the case management process or the business environment in which they now must function, new NCMs draw perspectives and strategies from past experience when they need to expand their knowledge base or enhance their professional skills. This may be problematic because knowledge and learning do not easily transfer across contexts (Lave et. al, 1999; Wenger,1998; Wilson,1983). As Rogoff, asserts, "context is an integral aspect of cognitive events" (1999, p. 3).

Although nurses entering the role of case manager have achieved expertise in care giving roles, and have utilized successful learning strategies to achieve that expertise, it does not necessarily follow that they are aware of what their learning needs are in an alternative practice context or how to effectively go about achieving expertise. This study suggests that new NCMs ascribe significant learning benefits to interactions with and guidance from expert case managers who understand the context in which they are now working. This implies that guidance and support from knowledgeable mentors helps new NCMs align their thinking and develop skilled judgement that meets performance expectations associated with the case manger role. This in turn helps direct their selection and utilization of appropriate learning resources.

Recommendations for Preparing and Supporting Nurses in Transition.

This study illuminated characteristic sources of role strain or tensions experienced by nurses in transition from caregiver to case manager.

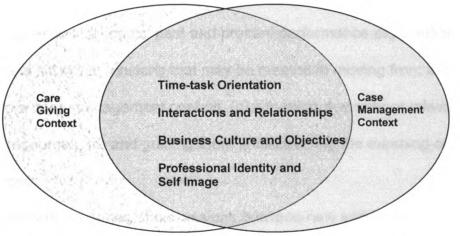

Figure 5. Tensions described by nurses in role transitions from caregiver to case manager.

Collectively, these tensions are associated with time-task orientation, interactions and relationships, business culture and objectives, and professional identity and self-image. Figure 5 illustrates this finding. Though participants experienced varying combinations and degrees of these tensions, data clearly demonstrate common experiences of role strain stemming from expectations and acquired expertise in past role contexts, and expectations and relative inexperience in new role contexts.

These tensions, associated with characteristic sources of role strain, have the potential for motivating growth and development on the one hand, or eroding self-confidence, delaying effective problem solving and negatively impacting job satisfaction on the other. Preparing nurses for these tensions and structuring support for them during the transition process will feasibly help them to better understand their learning needs, take advantage of opportunities for professional growth and development, and expedite their achievement of new competencies.

Those with interests in the performance of NCMs should weave the following items into the fabric of education and training agendas: (a) assessing the differences in individuals' past and present performance expectations, (b) alerting new NCMS to tensions that may be created in moving from a care giving context to a case management context, (c) informing them about relevant learning resources, (d) and guiding them in discovering the meaning of new experiences.

Facilitating a series of discussions between new and experienced NCMs can provide an effective venue for assessing, alerting, informing and guiding new

NCMs in their transition process. This type of forum lends itself to what Brufee (1993) refers to as reacculturation, which is a learning process for individuals who leave one knowledge community and enter another. Nurses entering the role of case manager from the role of case manager need to establish new allegiances, gain new perspectives, and attend to new priorities. Planning conversations about differences in experiences and expectations between past and present roles can expose new NCMs to the perspectives and wisdom of experienced NCMs, allowing them to voice their questions and concerns and assisting them with assigning meaning to their new experiences.

Implications for Professional Development

The need to examine role transition for professionals in today's workforce arises because of the evolution of employment opportunities. Advances in knowledge and technology and changes in resources and consumer expectations have not only precipitated creation and elimination of some roles in the workplace, but have also influenced practice alternatives in traditional roles. Nursing is a profession that has realized practice alternatives and changing employment opportunities for its members. This study of nurses entering the role of case manager provides an example of how professionals experience and learn in transition and offers considerations for effective education, training and socialization strategies that can be applied in other professional role transitions.

As this study demonstrates, role transition actually involves more than changing from one patterned set of behaviors to another. Old and new behaviors

are enacted in contexts that encompass unique expectations, perspectives, priorities, social networks, tools and personal meanings. Professionals who have been educated, trained and extensively socialized through years of experience with particular practices and perspectives face the arduous challenge of letting go or accommodating hard-earned competencies in the wake of evolving practice standards and career directions. Continuing professional education (CPE) needs to address this challenge.

Nowlen (1988) describes three model approaches that characterize current CPE practices; (a) the update model, (b) the competence model, and (c) the performance model. The update model consists of providing the learner with information-intensive resources such as instructional or explanatory reading materials or symposia presentations. Adequate for imparting new or updated information relevant to practice, the update model fails to address the skills required for putting this knowledge to use.

The competence model combines information with skill building in such areas as critical thinking and interpersonal relationships that are necessary for individuals to function competently in a particular role. Adequate for directing attention to the skills required to apply knowledge, the competence model fails to address the larger factors that influence performance like environments and cultures of practice, past experience and life skills, and preparation and support in new roles.

The performance model addresses the shortcomings of the other two models and promotes a process of guiding professionals, as well as

organizations, in self- assessments concerned with a broader range of issues associated with performance. The product of guided self-assessments is personalized,or organization-specific,learning agendas that provide direction toward meaningful learning experiences aimed at enhancing performance. This model offers the most promise for adequately preparing and supporting professionals for and in the process of role transitions.

The promise of the performance model lies in its attention to significant issues associated with role transitions that influence performance. These issues, which include past experience, role relationships, and cultural perspectives, are not traditionally dealt with in CPE or job orientation programs. Findings of this study and the subsequent recommendations for preparing and supporting nurses in role transitions are consistent with this model and, no doubt, have practical applications for other professionals in transition.

Educators, trainers and supervisors should address the experience of expert to novice transitions in job orientation and mentoring programs. Specifically, a guided assessment of the differences in past and present roles and expectations should be explored with professionals in transition. Their anticipation of problems should be discussed and confirmed or corrected. They should be alerted to tensions commonly experienced, as well as opportunities for professional growth, associated with this transition. They should be guided in locating and selecting learning resources that can help them learn to function efficiently and confidently in their new role. They should be supported in dealing with change and the discomfort of expert to novice transition.

Suggestions for Future Research

Some ideas for future research have emerged as a result of studying the experience of role transition for nurses and other professionals. Specific to this professional population, expanding the sample to include a larger number of participants from various geographic areas and case management contexts would certainly serve to validate or add new perspectives about this experience for nurses. Including male representation in the sample might demonstrate some variation in transition experiences between genders. It would also be interesting to examine how the stories of transition are similar or different among people of specific age groups or years of experience.

Additionally, investigation into the assumptions that educators, trainers and supervisors have about experienced nurses coming into the role of case manger and their expectations for how quickly they are expected to function independently would add to our understanding of the transition process from another perspective. It could also contribute to better training of the trainers, by identifying potential disconnects between trainers' assumptions about the transition process and the actual experience of new NCMs.

Pertaining to a broader professional population, this conceptual scheme could be used to explore expert to novice transitions between other professional practice contexts, such as business to academia, private medical practice to public health administration, industrial engineering to corporate leadership, etc. Identifying characteristic tensions between specific role transitions would

certainly provide added value for education and training programs directed at professionals in transition.

Conclusion

I engaged in an inquiry of how nurses, who are primarily trained and experienced as caregivers, transition to and learn in the role of case manager. From observations and conversations with these nurses, I developed a sense of their struggles and rewards in assuming new role responsibilities. While results of this study do not surprise me, this endeavor has helped me to understand the nature of their struggle more comprehensively and to see their journey toward competence more clearly.

It has also informed an approach in educating and training nurses and other professionals who enter alternative fields of practice that extends beyond defining a core knowledge base to be learned. It has identified areas to explore with transitioning professionals that will help them anticipate potential tensions and triumphs that may lie ahead, and develop plans for encountering them. This study highlights an example of professionals in expert to novice transitions and inform the larger field of professional development and those with interests in enhancing professional performance.

APENDICES

APPENDIX ONE

Interview Protocol

INTERVIEW PROTOCOL

Logistical Information:

Age ___
Education ___
Years of practice as a caregiver ___
Years of practice as a case manager ___
Where on a scale of 1-5 (1= novice; 5 = expert) do you rate your level of expertise in CM?
Work experience other than nursing

1. Tell me about the different contexts in which you have practiced as a professional nurse.

    a. How would you describe the principle differences between the practice context of a caregiver and that of a case manager? (ie, rights, responsibilities, resources, support structure, etc.)

b. How do the resources that were available to you for learning to provide hands-on nursing care compare with the resources that are (were) available to you for learning to function as a case manager?.

2. Describe what the transition from caregiver to case manager was like for you.

    a. What motivated you to make this career change?

    b. Where does this role fit in your career plan?
    c. In what ways have your clinical knowledge and care-giving experience prepared you to assume the role of case manager?

    d. Which expectations and responsibilities that you associate with the role of case manager did (do) you feel least prepared to fulfill?

    e. Describe the sources of conflict or strain that you experienced in assuming and developing in the role of case manger? What aspects of this role continue to cause you concern or discomfort?

    f. What types of environmental or personal accommodations make you feel more comfortable or confident in the role of case manager?

    g. What do you find satisfying or rewarding about case management?

3. How did you go about learning to practice case management?

a. Which experiences do you recall as significant in your learning in the following areas described as the core knowledge domains of CM:

1. Coordination and healthcare delivery systems
2. Physical and psychosocial factors
3. Benefit systems and cost analysis
4. Case management concepts
5. Community resources

b. What have you learned essentially through formal means (i.e. pre-service courses, in-service or continuing education programs?)

c. What knowledge and skill have you essentially achieved through experience? Describe how that learning occurred.

d. What opportunities do have to review or discuss cases for the purpose of increasing knowledge or improving performance?

e. How have your conclusions or beliefs about what constitutes effective CM been challenged during your career?

f. In what ways has your practice of CM been impacted by formal and informal learning since assuming this role?

g. Looking back over your experience of role transition from caregiver to case manager, what was most helpful in terms of socialization and learning?

h. What additional or alternative types of support would have more helpful to you in making this transition?

APPENDIX TWO

Participant Consent Form

Role Transitions for Nurses: From Caregiver to Case Manager

Participant Consent Form

The objective of this study is to explore how nurses make the transition from the role caregiver in a provider setting to the role of medical case manager in a payer setting.

As a volunteer participant you will participate in two taped interviews (approximately 60-90 minutes each) about your experiences and perceptions of how you learned to function in your role as a case manager. You may also be asked to participate in a small group discussion with other volunteer subjects on common themes that the investigator gleaned from individual interviews. In total , the amount of your time required over the course of the study should not exceed 3-4 hours. All meeting times will be scheduled at times mutually agreeable to investigator and subject(s).

Your participation is strictly voluntary. You may refuse to answer questions or discuss topics at your discretion. You may withdraw your involvement totally or in part, or withdraw personal data collected at any time prior to the final written report of the study without penalty or loss of benefits to which you are otherwise entitled.

Confidentiality for subjects will be maintained. Your privacy will be protected to the maximum extent allowable by law. Your personal identity will not be made explicit in any written report or commentary that is submitted for publication.

You have the right to review written transcripts of any interview during which you were recorded upon request.

Any or all of the following people are available for you to contact with any questions or concerns that may be raised by participation in this study:

Ashir Kumar, MD,
Chair, University
Committee on
Research Involving
Human Subjects
Michigan State
University
517 355 2180

Ann Austin, PhD
Responsible Project
Investigator
Michigan State
University
517 355 6757

Nancy Schmitt, M.Ed.,
RN, CCM
Project Investigator
Michigan State
University
517 540 4997

I have read the above and volunteer to participate in this study.

_____ _____

Signature Date

APPENDIX THREE

Participant Profiles

Participant Profiles

ANN

Ann is a 53-year-old NCM. She has been doing telephonic CM for a workers' compensation carrier for the past year and a half. She is a coworker of Irene, Ginger, and Belinda. She explains her role in the following way.

> I have a major responsibility in that I have to make the adjuster aware of what is going on with the person...They have no medical background, so I have to be able to relate that to the [claim adjuster]. And also relate to the physician...When the physician orders something I have to be able to relate to the [claims adjuster] why this is appropriate or why not and I have to be able to build my case on it.... -- why we should do it, why we shouldn't. And in turn I have to go back to the physician and say "You know what? This isn't appropriate. Where are you coming up with this?" and have him be responsible to tell me why this is necessary.
>
> I tell [claimants] that I am their nurse case manager, and that my role is to get them back to work and make sure that they get the treatment that they deserve and that they require in order to get back to work.

Ann came into her current role with 30 years of nursing experience, mostly in the emergency room. Though she did some work in hospice and a physician's office, she spent 27 years as a caregiver in critical care and emergency settings. Compared to her care giving experience, Ann finds the CM experience very "laid back."

> No one is going to live or die if you don't do something. If you don't get that report [today], [you can] get it tomorrow. Where as in the hospital, if you didn't give a med [or] answer a light, someone could die or be hurt. So it's a lot less stressful. There's stress in it's own way, but not that emotional stress, that emotional roller coaster that you're on in the hospital. Working in the emergency room, you never knew what was going to come through the door so you had

to be on your toes every minute. In this job you can relax. It's a nice way to end a career.

Ann's friend, an employee of the company Ann currently works for, informed her about an open position for a case manager a few years ago. She considered applying for it, but decided to put that type of a career move on hold. With what she understood of the role, she planned on making a move like this later in her career. The physical nature of emergency nursing became an issue in her health, however, so she took advantage the opportunity when the next NCM position became available. Though she has described CM as more "laid back" than her role in the hospital, the transition for her was "scary".

> I had never been in an office before. I've always been in [healthcare]. I came here and it was very, like I said laid back, and I was used to having to do x number of things before I went home. And here ...when I first started, if I had a red number on my [computer] screen which meant that these were things that I should have done already, I was like hysterical. Oh my God! I've got to get these done!" Because in that [caregiver] mind set, you don't go home till this is done. You know you have to get your charting done and give your meds and make sure that patient was cleaned up before you went home. Well here it was like "oh , ok so I'll just do it tomorrow." So now when I have 50 reds, it's like "Huh! I have 50 reds." I mean not that. I like to do that, but you know.
>
> I guess that was scary, not knowing anyone. How is this job going to affect me? ...I came from working 3 days a week to working 5 days a week. And that was a transition to not be home the extra days. So getting my own personal life in order was a challenge, getting my husband to cook. " Honey, I'm not going to be home." But in the work place it worked out really well for my health. I needed to get to a slower paced job and this was a good alternative.

Sources of satisfaction in this role for Ann include the slower pace, the opportunity to use her knowledge of traumatic injuries and diagnostic tests and

procedures. She has been given the responsibility of handling some of the more serious injury cases and finds this very rewarding. She also enjoys the relationships she's been able to develop with employers, patients and physicians. She enjoys making things happen through conversations - a strategy not often applied in the emergency room.

Despite finding considerable favor with this job, the role of NCM holds certain challenges for her. Working with claim adjusters presents such a challenge.

> As a nurse in the hospital, when there was a conflict with someone else it was generally a lower discipline and you could say, " I am the nurse. You will not do this function." Here we rely on each other more -- the nurse and the claim adjuster. I can't do my job unless she does hers or he does his. I can't close out a case if they don't put in dates. And you tell them and you tell them and it doesn't get done. To me that's very frustrating. You get medical [records] on someone, and it's like this needs to be done. Or yes this is a relationship. This injury could have occurred from this injury. Well, they don't want to see that. They only want to see the main injury. And then there's a problem further down the road where we could have done something for the secondary and got the guy back to work.

Ann considers her clinical background to have provided her with a caring ability in this role. Caregiver experiences like "sitting at the bedside of people, knowing what they're going through, having seen people go through trauma, the stress that it puts on them," motivates her to cut through some of the red tape and run interference for claimants.

Ann does not recall any education specific to the case management process, only bits and pieces of content material on workers' compensation,

specific injuries, etc. The training she was offered for CM consisted of two weeks of "orientation with another NCM."

> I sat with her for the first few days, watched her, read over the manual, and then slowly was put into the position. [I was] given a case to work on with her coming and checking my work and making sure that I was where I should be and doing what I should be doing.

Ann has worked out a new dimension to her identity as a nurse.

> I think I've gained an appreciation of a different type of nursing. Because nursing now is branching out into every aspect of life, you know. We have 5 nurses in our family, and we're all in a different area. And I've learned a lot. I don't think I've lost anything. I did my 30 years of bedside and now it's time.... A caregiver giving baths, giving shots, that I don't see myself in anymore. But a caregiver as directing care, telling people it will be ok, yes, I still do that.

BELINDA

Belinda is a 49-year-old NCM who does telephonic CM for a workers' compensation carrier. She has been in with this employer and in this role for 3 years. She is a coworker of Irene, Ann and Ginger. She has come to understand her role in the following way.

> Effective case management requires a lot of different skills. And when I first came here I figured well, all you've got to do is make the right phone calls and you'll be fine. And that's not the case. There's a lot more. There are a lot more diversified skills in being an effective case manager than just coming in making your phone calls, documenting that you did that and going home. You have to be nice to people you don't want to be nice to. You have to cajole. You have to be observant. You have to search out information. You have to say things that people don't necessarily want to hear, and you have to say it to them with confidence. ...There's just a lot more skill involved than what it looks like. When you say '"manage the case" you think ok, I'll pull the case out. And I'll make all these calls and I'll say "This is what I think should happen," and that will be the end of it. But it's the follow up, making those things happen.

> And what it takes to make those things happen, that really is managing the case. And that's what you didn't know when you first got into it."

Her care giving experience actually started in high school when she worked as a nurses' aide in a nursing home. Belinda earned an associate degree in nursing as a part time student, working all the while in a physician's office. Belinda returned to the nursing home as a graduate nurse for a year after completing her degree. From there she went on to work for in a general practice clinic setting until her daughter was born. After 15 years of raising a family, Belinda returned to work, this time in a pediatric clinic for six years. As she reflects on the various responsibilities she had there she feels she actually did some case management, though at the time would not have identified with the role.

> We were given a lot of leeway to make decisions. We contacted doctors, followed up on necessary treatments and x-rays and hospitalizations, things like that. All that was done from the phone.... We would start the case with the first phone call, especially with new babies. They called us right away and asked us when to make an appointment. And then we were also hand holders in that you know they called us and said, " The baby's screaming and I don't know what to do."...Rather than have the doctor be bothered with all of that stuff that probably moms could handle better anyway, we were on the nurse line and that was a separate line in that office and that was our job all day long we talked to the moms and dads.

The motivation for taking on the role of NCM, Belinda explains as an opportunity that presented itself. While she did not seek out this particular position, she was fearful that her position was in line for elimination as rumors of budget cuts came down. A former coworker, Irene, was now working as an NCM

and her employer was looking to fill another such position. At Irene's suggestion, Belinda applied and was hired. The major attraction, Belinda admits was the salary, which was considerably more than she was being paid at the clinic.

Belinda describes her learning opportunities with this employer as effective in getting her up to speed. Along with a formal orientation program, her caseload was built up gradually and she received regular feedback, which helped her navigate her way through her new responsibilities.

> Case management was a formal training program that my supervisor here had put together to get a uniformity in what people were doing, and I found it very easy to follow. We also had a computer program that prompts you to do certain things, and that was a very good resource. But I would say that the training that I got here through the program that was put together was very good. And along with experience, making mistakes, finding out who's good who isn't, where to follow up, when to ask for this, when not to ask for that.

Though Belinda was happy to have the extra earnings, and found the learning opportunities to be a source of satisfaction, she struggled in her transition from caregiver to case manger.

> In this context your focus is not patient oriented. Your focus is monetarily oriented. You're more involved in following up from the employer's standpoint than you are of taking care of the patient, and for me that's a constant pull between the two. Finding a place where I'm happy with that I'm doing the right thing for the employer who ultimately is paying for my services, but as a nurse making sure that patient is getting the care that they need and require. ...That was a hard place to come to. That took me a while to get there.... It's learning to respond to people from a totally different perspective. You are not their caregiver and you are not responsible for them to be happy and well. You are responsible to put together the medical, to pick up the facts and deal with the facts as they sit there. And that's always been a part of nursing, but to separate yourself from the warm nurturing "give me a hug and I'll

> make you feel better" kind of caregiver that I was, that was a transition. That was the main transition.

Belinda feels that she has learned to be more assertive in this role, and that she has grown in confidence in terms of her knowledge of healthcare and insurance. She admits she has had to loose some of the emotional attachment she was used to having with the patients and families she interacted with as a caregiver.

> Nobody said, "Do not get emotionally involved with these people. It's not what you're supposed to do." And I don't know if it would have mattered anyway even if they had said it, because that's the kind of nurse that I am. That's what I do, and it was trial and error and you learned.... You got pulled under the rug a couple times with people that you had some sympathy for, and then found out later on that they weren't working on the jobs [at the time of injury]. .... And [by] the same token there were people who didn't seem to be sincere at all that turned out to be very sincere. And so trial and error you learn to distance yourself. ...That doesn't stop you from, you know, talking to them about their grandkids or this, that or the other thing. It's just that ...you don't put that emotional attachment that you put with a patient that you are caring for in a sickness setting that you do. Here it's different.

What Belinda finds rewarding is being able to solve problems, to help someone get back to work despite a long and complicated recovery process. She likes the patient contact. She likes to follow up and find out how her clients are doing after surgery. She likes the relationships she has developed with physicians' office staff and her newfound ability to challenge a physician when she doesn't see the rationale of a prescribed treatment plan.

As far as her professional identity, she still feels very strongly that she is a nurse. She has resolved that case management is another opportunity to use her nursing skill, but that it has provided her with an opportunity to grow professionally as well as personally.

> It's a different job and it's not what you think nursing is going to be.... It's not where you thought you would be as a nurse when you graduated from nursing school. The last place I would have expected would be sitting behind a computer at an insurance company and still calling myself a nurse, and I do, and I am. So it's outside my perspective of what a nurse is and what a nurse does.... It's what I learned to do here. I learned to do it here. It's

> where I picked it up and where I'm making it sharper and making it part of who I am, because I'm a lot more aggressive at home now too.

CATHY

Cathy is a 29-year-old nurse who has worked as an on site NCM for a case management company for just under one year. She manages cases from workers' compensation, auto, and disability insurance carriers. She is a coworker of Hannah. She explains her role in the following way:

> There's a lot of demands being put [on] you from a lot of directions. So the adjuster has demands of you. The physician has demands of you in some ways because he wants ... the claimants to do certain things. So basically you're to coordinate it. The claimant has demands of you. Being able to answer to all these demands and sometimes being able to answer to them yesterday... When I go to appointments with claimants and physicians, ...in a way, [I] direct the appointment so that things get addressed. Or in conversations with claimants [I] direct the conversation so that certain things get addressed and don't get lost. ...You're directing the conversation so that the are areas that you need addressed are being addressed... I do a lot of teaching with my clients... I try to make someone understand the processes that they're going through. And I try to encourage people to be active with their choices as opposed to just letting the doctors and the other medical people make the decisions and just following along. I try to encourage them to make active choices regarding their care and to know what those choices, what the implications are.

Cathy holds a Bachelor of Science degree in nursing. Her care giving experience began prior to completion of her formal education in nursing. She worked a home health aid after graduating from high school and continued throughout the time she was completing coursework for her degree. She started her professional nursing career in the hospital on an oncology unit. Within a five-

year timeframe, Cathy had positions in home care, first working for a cancer institute, and then the Visiting Nurse Association. (VNA). Just prior to taking her present position she worked for a county health department.

She explains her role with the cancer institute as more of a health educator. With the VNA her role was task oriented and "high tech". She made field visits to homebound patients, who required special equipment such as monitors, feeding tubes, intravenous lines, etc., and administered treatments, and checked to see if the equipment was working properly. At the health department, Cathy relates the she did a combination of hands on care - administering medication, doing physical examinations and teaching, and some case management- working with a specific caseload of patients, initiating contact, setting up appointments, and following up with them over time.

Her motivation to get into case management was a desire to find an occupation where she could better use her education. The transition, she states, was enjoyable.

> When I was in the hospital I felt as though didn't really need to go to university for doing what I was doing there. You know, I felt that anybody can come here and follow the instructions, follow these orders that the doctors are writing in this little book. And anyone can give this. Anyone with any kind of, you know, because you don't have to be educated to do this... I was upset by that. So I feel that this is a job that I'm using my education for. I feel that it's a job which requires you to be more responsible, which requires you to think through your actions more; which requires you to actually think through the way things are moving; looking at a bigger picture when you're looking at a file; looking at a bigger picture and the progression of this file. So I enjoy the transition a lot. I enjoy being able to do this. Like I said I was upset working at the hospital feeling like I wasn't using my education.

> I enjoy working with clients. I know that there are claimants who may malinger but I think that generally speaking most people want to be well. And I enjoy when I can look at someone impartially, maybe because I'm newer and not assume that they're trying to take advantage of the system, at least not assume until I'm proved otherwise, you know. But when I can resolve a file in a way that I feel good about this, that the claimant feels good about this resolution, the employer feels good, and the adjuster feels good, then I feel good. It feels good.

In terms of her career plan, Cathy speculates that she will most likely stay with this for a while, but go back to school eventually. She is open to entertaining other types of employment.

EVELYN

Evelyn is a 46-year-old nurse who provides telephonic case management for pediatric members of a health maintenance organization (HMO). She has been in her current role and with this company for close to three years. She explains her role in the following way:

> Right now I'm focusing on all the premature babies for the state of MI. And I also have some catastrophic cases; catastrophic illness and long term medical care cases. And what I do is, for the preemie babies in particular, I get in touch with the mom, let them know what's available in the communities, the different programs for premature babies in the communities, and then I also follow them for the first year of their life. I do monthly phone calls depending on how they're doing. Just to make sure they are up to date on their immunizations, keeping their doctor's appointments, and I also coordinate the RSV program...Respiratory Syncytial Virus... It's a vaccine that's been out probably a little over five years now, and its highly recommended for premature babies during this RSV season; which is every year from November to April. So for all the premature babies in the state, I set up the program with the primary care physician so that the babies can get the vaccine... Now the other babies, the other catastrophic cases, I give 'em a call if I'm made aware that they're in the hospital. Sometimes I'll send

Cathy attributes her learning of CM to on the job experience. She relates that she accompanied other nurses on appointments and observed. She received fairly uncomplicated cases to begin with and received feedback form her supervisor who initiated discussions on her assignments. As time went on, the size and complexity of her caseload grew. She utilizes other case managers as resources problem solving and advice.

Sources of role strain for Cathy include gaining a skill in diplomacy, and gaining confidence in her interactions with physicians.

> To me it seems that in case management you have to learn diplomacy because of a lot of the things that you're dealing with may be in litigation.... Certain insurance laws that I don't know because I have never worked in insurance, but I find that sometimes I have to be careful in the way I put things. I cannot be as straightforward as I'm used to being. I have to be a little bit sideways, so in that way I'm not very prepared for that. That's something that I'm really trying to work on. For example, in situations where there's surveillance going on. Or when somebody may be doing some symptom magnification, or something like that. That I have to be careful how I should say that or whom I should say that to type of things or how I should write it in a report, how I should write things, how I shouldn't write thing.
>
> A nurse is taught, ... "Don't question the doctor." ...You're almost taught this. I mean you hear stories about, you know, when the doctor comes you're almost supposed to get up from your seat to offer your seat to him, you know. You're not really, even though they start saying more about now "Don't do things if the doctor says, if you're not comfortable with that treatment plan." Even though you're taught that in nursing school, ...the perception of the doctor being someone you should almost even offer your seat to ... you know, drop what you're doing to find them the chart is still there. And so asking them why they're doing one treatment as opposed to another starts out feeling kind of strange.

Her satisfaction comes from the challenges that the role brings, contact with her clients, and satisfactory outcomes for all stakeholders in a case.

> them a letter, sometimes I won't. Depending on how severe the case is, I'll just jump right in and give them a call. Or contact the doctor and then we'll communicate that way.

Evelyn began her caregiving career at the age of sixteen when she began working part time as a nurses' aide in an urban hospital during high school. She continued this job while she attended college. After completing a Bachelor of Science degree in nursing, she spent 27 years of her professional nursing career in the field of pediatrics. She gained experience working with children and their families in hospital settings, on pediatric medical-surgical and neonatal intensive care units, as well as in health department and HMO pediatric clinics. An ad in the paper for a Pediatric Case Manager caught her eye at a time when she was becoming dissatisfied with her position at an HMO ambulatory care clinic where she was the nursing supervisor.

> I was looking. I wasn't really satisfied with the work I was doing... The clinic there was not only primary pediatric but it was specialty, and we had a lot of specialty and not quite enough staff to handle [specialty cases]. We had staff of13 physicians on that one floor. They were having some layoffs and I was looking for something. I wasn't really looking for case management, or I didn't know what I was looking for. And I saw this position and said, "Hey, I'll apply for this and see what it is." And so I've been here since.

The transition from caregiver to case manager was difficult for Evelyn in the sense that her job duties and responsibilities were not initially well defined. She found, however, that her clinical background prepared her well for the type of cases she would be managing, and the questions she was getting from members as well as coworkers.

> It was difficult at first because I didn't know what it was I was supposed to do and what I was expected to do. Like I said, the job

> description was so general. Management didn't know what they wanted me to do. So that part of it was difficult. Until I learned what it was that I actually should be doing, then I felt comfortable.... It probably took me close to two years to know what I was doing, [to] feel comfortable with what I was doing, and have everybody else feel comfortable with what I was doing. Because whenever somebody said "pediatrics" or "kid".... "[Evelyn, Evelyn, Evelyn!]" ... But that's not what [Evelyn] does. I had to get people used to doing some things on their own and not coming to me with everything.

Evelyn relates that learning to function in the case manager role was a matter of observing two other "specialty" NCMs, finding out what resources were available to help her find answers to her questions, and then developing a role for herself through trial and error. To develop the role of pediatric case manager, she incorporated what she had observed of other NCMs, and made it work for the premature babies and catastrophically ill pediatric members and their families. She developed her own criteria for referrals and strategies for following cases. She also learned to work with parents, physicians and healthcare vendors effectively over the phone instead of face to face as she was accustomed to in the hospital and clinic settings.

She did not attend any training sessions on case management, but she vaguely recalls some print material on the subject provided by her employer. "Now, it was something, I'm trying to think if it was a magazine or something, or if it was actually the company's. I think it was more or less the company's book of what case management involves." This, she says gave her an idea where to start, but not explicit guidelines. Even now, in a Master's program in nursing

When asked about the sources of satisfaction gets from her job, Evelyn cites the gratitude from the families with whom she works.

> What I find satisfying about it is the thanks I get from the families when I put them in touch with other things, or when I explain to them what their actual contract covers and that I went to the doctor and we discussed it and yes he approved it. So it's just the satisfaction I get from them when they say, "Thank you. Thank you for helping me. I'm so glad I have you here to help me I would have never known," you know.

Though Evelyn has experienced significant differences between her roles as caregiver and her role now as an NCM, she does not identify the experience as role strain.

> You know I can't really say that there is anything that I struggle with, that I have difficulty with. There are so many of us here.... I work in the Medical Management Department. Everybody that works in medical management, from the case managers to the patient care coordinators who actually do the utilization review for the hospital to our transitional or comprehensive team, who does home care, are all registered nurses. And so if there's anything that I have a problem with, or I need some more information about, it's 60 something nurses that I can go to for additional resources. But as far as really having something about this job that's difficult, I can't say that there's anything that's difficult.

Some of the differences she cites include empowering parents to care for their seriously ill or injures children at home. She shares that during the time she was providing hands on care, she neither had the time to do the kind of teaching and listening to families that she engages in now, nor was there an expectation that a parent would actually provide on-going care for such children. There were facilities to care for seriously ill or disabled children at one time. She points out, however, " It's different now. They're taking them home because there are no

facilities in the state to care for kids, catastrophic cases. So families have to learn how to care for these children at home."

Evelyn's professional identity is strongly connected to nursing. She feels that case management allows her to utilize her knowledge and skill to help people. Even so, she admits that members are often reluctant to open up to someone associated with an insurance company. However, she is quick to point out that once she identifies herself as a nurse, she is able to establish rapport and make some impact.

> You can hear it in their voice when I call and I say my name is [Evelyn] and I'm a case manager at [this HMO] and [they reply], ..."Yes?".... And you know what they're thinking. "Why is someone from the insurance company calling me?" So I learned a long time ago not to say, "I'm calling from [this HMO], a case manager. [Now I say}, "My name is [Evelyn]. I'm a pediatric nurse I work for [this HMO] and I've been doing peds for twenty something years." .Then they loosen right up.

Though Evelyn is very happy in her current position, and finds it to be a good use for her skills, she shares that she may consider teaching nursing after she finishes her graduate program.

DONNA

Donna is a 46-year-old NCM who practices on site case management for a worker's compensation insurance carrier. She has worked for this company for just under a year. She came into this position having some prior experience in case management as an occupational health nurse in a manufacturing plant.

She explains case management as "a path that you go down with your client together. It's a journey."

Donna's clinical background includes 10 years of emergency nursing, 3 years as director of nursing at an ambulatory care clinic, and 11 years in occupational health. Having earned an Associates' degree in nursing, she is currently enrolled in an RN- to- BSN program at a local university. She sees the various nursing opportunities that she has taken advantage of as "stepping stones" toward her present role of nurse case manager.

> I think they really laid the foundation. I don't think I could have been an occupational health nurse had I not been an emergency room nurse. So the foundation with emergency nursing was the platform that I, what's enabling [me] to perform as an occupational health nurse because you're doing a lot of assessment -- emergency assessment of some situations whether it be an injury or whether it be personal, whether it's a heart attack you have to assess cardiac or you have an amputated foot so you have you need those assessment skills. Not only assessment but treatments. And how to work with an EMS system, etc. So again my emergency nursing was the foundation for occ health. Then I think my occupational health experience was the next layer of my foundation that helped me be or get the job as case manager.

The closing of a plant where she had been employed for nine years forced Donna into working for a temporary agency until she found another suitable full time position. It was while working for this agency, in an employee health clinic at a major automobile manufacturing plant, that Donna was approached by a workers' compensation insurance adjuster about an NCM position with his company. She had become acquainted with this particular adjuster on the job at

her previous employer. Though it was definitely not part of Donna's career plan to become an NCM, she finds that it works for her.

> I think it happened for a reason for what I needed, which is it works for my family situation so much better.... I can adjust my workdays according to what my family situation is at the time.... It's giving me a challenge.... I can develop this job to whatever I see it as my vision of the way I want to be as a case manager.

Donna feels she came into this role with a good understanding of the job responsibilities and the impact a case manager can make. She relates that her company provided a two-week training program that incorporated content of workers' compensation in general as well as the companies policies and procedures associated with the case management process. What was missing, in her estimation was how to work out of a home office and manage her time in the field.

Donna works out of her own home. She has been supplied with a laptop computer, a dedicated business phone line, fax machine, and compensation for travel expenses. While working with claimants, employers and physicians is a good match for the skills she has developed over the course of her career, she identifies balancing time in the field along with managing clerical duties and maintaining office as the main sources of role strain for her. To some extent, working with adjusters contributes to role strain as well.

> I'm more intimidated by adjusters than I am by physicians.... because I don't think [adjusters] truly understand the situation, what goes on in a doctor's office. I don't think they truly appreciate your relationship with your client. I think they are task oriented and less sensitive to the dynamics of a relationship and that includes nurse to client and nurse to physician and the dynamics from client to physician there. And only the nurse is sensitive to that. The

> adjuster doesn't always get a feel for that, what is actually going on. And I think what adjusters don't always know is how much finesse a case manager needs in some situations to make things happen, you know. So I think I feel like I have a harder time trying to communicate what's going on to the adjuster than I have to a physician [or] to the client I have. It seems to be a better flow of information here than sometimes with some adjusters. Some adjusters just don't understand.

Donna's satisfaction with this role is the flexibility and the opportunity to grow professionally.

> It's kind of like there's no limit to me in case management. I see it as a very nebulous. There's no fixed point [where] your job ends, that your description ends. And you can make it as professional or as big as you want to make it, as you have the time for. Case management is the product. It's a search.

FRAN

Fran is a 44-year-old nurse who has worked for a Health Maintenance Organization (HMO) as an on site NCM for 2 years. She explains her role in the following way.

> I feel that as a case manager I need to act as a liaison between the physician and the patient. What you're doing is... you're ensuring that the [HMO member] and the physician are in agreement to the member's treatment and that the member can go ahead and get all that treatment, understands the treatment is the biggy. And then you're acting as a facilitator to make sure they get what they need. You know, like they don't half the time they go in to see the doctor. I take a piece of paper and write it all down for the member...after the visit we sit and [I'll] say, "Well you know he said you've got to decrease your salt intake. He did, you know." [I'm] just reiterating really what the physician's orders are and educating the member because they're so nervous when they go in there."

Fran holds an Associate's Degree in Nursing. Her clinical experience was gained in a hospital setting on a variety of units. Nursing specialties she became

familiar with over the 10 years she spent as a caregiver include internal medicine, surgery, pediatrics, intensive care, obstetrics and emergency nursing. She began a transition away from hands on nursing when she moved into a position within the hospital doing utilization review (UR), and then over to the HMO performing a similar function. She explains UR in the following way:

> Doing UR you're basically moving the patient, the member through the hospital system as an in-patient. It's an isolated part of their care. It's while they're in the hospital that's what you are...making sure the appropriateness of the member's stay, and you're making sure that they're getting the appropriate care, the appropriate tests. They're not over utilizing tests or under utilizing tests.

When asked to comment on the difference between UR and CM, Fran responds "a UR person gets them out of the hospital and a case manager keeps them out of the hospital."

Fran found the transition from giving care to UR more difficult than transitioning from UR to CM. That's when she needed to shift to different focus and begin to look at business aspects of health care.

> The biggest transition from care...it's the business world. It's learning to do memos and e-mails and you know, business appropriate. It truly is. That was the biggest thing... because you're going from you know, staff nursing. And hospital nursing is awfully; I don't what the word is. I don't want to say it's crude, but it's at a base level, you know. You're caring for people's physical needs. You're helping them with their bowel movements. It's a different relationship. Whereas when you come into managed care... it's more of a professional situation. Way more professional, I think.... You're learning the business world. If you take a staff nurse who's biggest concern is making sure the meds are passed and the bed is made and the IV's are hung to someone to a position here you really need to produce a statistical report, it is a big transition. You need to show outcome... you're not really judged on how the patient is doing, how the client is doing. You're really more judged on well how'd that report come out, your know.

> Are you showing that this has been effective? Did you collect enough data? Are the numbers going down? The focus is not the patient... I'm really speaking from the UR piece."

After 2 years of UR, Fran moved into a CM position with the HMO. Her motivation for this was "boredom." She knew she had exhausted her enthusiasm for providing hands on care, and felt that case management was the logical next step. It not only afforded her contact with members (patients), but allows her to develop longer term relationships that can have a significant impact on the healthcare they receive and as a consequence, their health status.

> I truly like navigating someone through this hideous horrible monstrosity called health care. This is the corniest of all. When someone asked me. "Why did you go into managed care?" I said, "You know why I went into managed care? I wanted to humanize managed care." And I mean that with all my heart. I really did. It didn't always happen, but I want to be able to hold someone's hand and help them through. Because it's a damned maze, you know. It is. I mean it's a horrible maze. I don't understand how people who are physically or mentally compromised can make it through the system. They don't they don't make it through the system. I find it very rewarding to be able to help someone through.

Learning to function as a case manger was not difficult for Fran. The understanding of managed care she gained through her UR experience, and exposure to case mangers both in the hospital setting and at the HMO provided a good foundation. She found ample professional resources within the organization to answer her questions, like the physicians and lawyers on staff, as well as her coworkers. Fran also is an active member of the local case management professional organization, which has made her aware of more CM issues, strategies and practices.

Fran describes sources of role strain for her as legal aspects off

Fran describes sources of role strain for her as legal aspects off healthcare coverage (i.e. Medicare & Medicaid) as well as the bureaucracy she encounters when she judges that a member requires something out of the ordinary, something that isn't routinely covered by HMO benefits. When faced with a conflict between what she feels the member really needs and what is expected of her in terms of procedure, she confidently states

> I know it sounds kind of corny to say, but it's the truth. Ultimately, what is going to help that person the most? I might have to also follow my major procedures. I try to do that too. But if I have to choose between following the procedure and doing what's best for the member, and those are my only two choices, I'm going to do what's best for the member.... it's not that much of a struggle for me because I already know the answer I'm going to pick. But it may be for someone whose new to, you know, the employer. Or it's not much of a struggle. But yes, I mean yes it is. I mean its conflict. It's controversy.

Fran's professional identity is closely aligned with the role of NCM. She acknowledges that her care giving background provided her with an understanding of the patient's perspective, what they go through, what they try not to show, what will help them to understand. She feels that her role carries a tremendous responsibility.

> In the hospital what you did then impacted the person directly. But as a case manager I think what you're doing is important because you're impacting the person for not just those three days.... It's different. You're the case manager. That's who they're counting on for the whole time, not just that 8 hours.

GINGER

Ginger is a 53-year-old nurse who does telephonic CM for a workers' compensation insurance carrier. She has been in this role, with this employer for 1 year. She works with Irene, Belinda, and Ann. She explains her role in the following way.

> Well, a lot of times I just don't feel like a lot of what I do is nursing decisions. It seems to be that anyone could be trained for what I do, that doesn't have a medical background...I mean there are certainly times when my nursing knowledge has an impact. But I think for the most part it seems like it's basically a lot of things that the claim adjusters did before as far as authorizations, approvals, procedures, what have you, following doctor's visits, that could be done by someone more trained to do it...I thought that if I left the hospital that I'd go into a teaching position type thing, you know. That's kind of what I liked to do. ...But I guess that this is probably the closest to that if I do see anything really positive about it.... and I feel like I can at least impact that way in doing like pre-op and post-operative type teaching with these people...Also just general education with them as far as work comp and what's expected of them as far as their efforts and their treatment program. And pretty much I think most of them are really responsive to, you know, once you can set up a connection with them.

Ginger holds a Bachelor of Science degree in Nursing. Her clinical background spans 30 years of hospital nursing, the last 24 of which were in the emergency room. She had some limited supervisory experience but found that she much preferred first hand patient care responsibilities. She also became involved as an instructor in various training programs in the hospital associated with critical and emergency care, which she enjoyed. Her motivation to leave her role as a caregiver had more to do with dissatisfaction about changes in the environment than with dissatisfaction with the role of caregiver.

> Within the last, I'd say, three years it just got so stressful. ... I really liked what I was doing and I felt like I was good at it. And I really did enjoy the hospital setting and I miss that. I miss that acute care aspect of it. I miss the patient contact. But they started cross training people and eliminating positions. Like first it was the lab techs, and then the nurses did all the blood drawing. Then the next thing was the EKG tech, and slowly but surely adding more and more patient load on you and additional responsibilities. I was working three 12-hour shifts a week on the day shift 7am to 7pm. And there was many, many times when you just weren't getting your breaks and what have you... just the situation involved a position where you just could not leave. I mean you were tied to that and if you didn't have a relief, you know, that was it. So it just became more and more stressful to me not taking breaks and whatever and that's basically why I got stressed out, not because I got fed up with the job itself. I really liked the emergency nursing. I probably would still be at the hospital if it weren't for that.

She had a friend who had recently accepted a position as an NCM at the insurance company. Looking for an alternative, Ginger asked her friend to contact her when another position became available. When one opened up Ginger applied and was hired.

Ginger describes her orientation to the role of case manager as being presented with a significant amount of "dry material." They provided some formal programs and some reference materials.

> They provided an in-service when I first started. Basically I felt I was left alone a lot to just learn on my own. I mean they provided the manuals and what have you, but I felt I learned more doing the hands on...on the computer and following through on what was presented to me in the manuals and during orientation. Until I actually got my own caseload and had to deal with what was expected, I think that's when I finally started learning and had more questions.

Ginger had anticipated a confrontational experience with the claimants, but found that not to be the case for the most part. She finds satisfaction in

learning more about the long-term treatment course and recovery from injuries. This view of the healthcare system was not apparent from the emergency room. She enjoys feeling influential in positive outcomes – like when an injured worker has a good experience with a physician that she has recommended.

Her sources of role strain are many. In addition to feeling as though this role does not present her with sufficient opportunities to utilize her expertise, she is uncomfortable with the focus on cost containment, quality measures associated with documentation, and working with adjusters who seem resentful of a nurse's involvement in their files. Like Ann, Ginger had to learn to set priorities and organize her work differently than in an emergency situation. She needed to acclimate herself to working a caseload through a diary system, and reconcile to the fact that there is no complimentary shift to back her up as there was in the hospital.

When asked if she thinks the role of case manager in any way compromises her identity as a nurse Ginger replies "-I don't think it compromises, I wouldn't say because it's just a different phase of ...nursing practice for me...I do feel like I'm using my nursing, but not to the extent of my expertise -- to what I was working in the last few years, of course.

Ginger thinks she will stay in this role for another 4 years or so, at which time she is contemplating "semi retirement."

HANNAH

Hannah is 41 years old. She holds a BSN and is currently completing a Master's degree in exercise science. For the past year and a half she has worked as an NCM for a CM vendor. She does onsite CM for a variety of insurance carriers, the majority of which are workers' compensation carriers, but also has cases from automobile insurance and short-term disability carriers. She describes her role as "a coordinator of care." She explains that the most important aspect of her current role is to:

> ...keep the communication going because that's always a problem ....between the physician and the patient and the worker's comp carrier. I think that's a big failing in the health care industry is communication.... You make sure that when you go see that new physician he's got all the information he needs plus you verbally tell him what has gone on in the case. So I think the communication feels a little bit better. And then the physician's focus is not return to work... all you have to do sometimes is sit there and they know why you're there so they'll address that issue where if you're not there it's not addressed and the patient isn't going to always address...that issue.

Prior to assuming the role of NCM, Hannah provided nursing care in a hospital setting for 4 years on orthopedic surgical and oncology units. Following that she worked in home care for 10 years. She relates that her transition from the hospital to home care was far more difficult than her transition from home care to case management.

> The transition from a hospital to home care is difficult because you've got to be very independent you've got to make decisions on your feet you don't have people around you. That took me a while. I think I was younger at the time, didn't have a lot of experience. But by the end of my experience, I think I was very good at it and you learn to be very independent make decisions know when to call physicians. And you manage a caseload. I mean this one person

> and all their problems is up to you, how often you see them, that type of thing.

Describing her experience of transition from Home care to CM she relates:

> That was easy. It was actually easy. The reason it was easy was probably because I was used to working with one person. I mean had I gone from the hospital to home care. That's a little more difficult. But going from home care into this, ...you had different cases that you managed and needed to make phone calls on. And I mean it was something that's always in your mind. These are the people you're responsible for so that aspect of it wasn't easy learning. How the [CM] process [works], that was more difficult.

Hannah sought out employment alternative to home care because of Medicare regulation changes that significantly impacted home care and because it was becoming what she perceived as "too political". She heard about CM from a former coworker who had moved into that role. She thought it would offer her the flexibility of working in the field as well as opportunities to interact with patients and physicians. She had some notion of the possible conflicts that may occur with workers' compensation cases but has found the majority of her interactions with claimants to be not as confrontational as she had imagined.

Hannah describes her opportunities for learning CM much less structured than when she practiced in the hospital or home care. She states

> It wasn't really a formal training. It was more you came in they gave you cases and you just asked questions. And that could have been partly my personality, because I think I picked it up pretty quick as my boss said. So it was more a matter of working the cases and constantly going to them to ask questions. I did go there. I took over for another nurse that was leaving. So I went out with her I think it was 2 or 3 visits and then I think ...I just then took a caseload and started working it.

The main sources of satisfaction in her role as an NCM for Hannah are the job conditions of flexible hours, working in the field and being recognized and respected for her contributions.

> I think in some ways you get more respect in that for your knowledge, especially with an adjuster who doesn't really understand the medical aspect. I think it's very rewarding when you get someone back to work that actually has had an injury and is grateful that you have helped them and realizes that you definitely have added to the process.

The stressors she has encountered include dealing with malingers or being assigned to a claim when the adjuster and claimant don't get along. Also, when she feels that she can no longer impact the outcome of a case, and the patient is not progressing.

She appears to have accepted most of the challenges of this new role in stride. She is not sure where she will go from here career wise. She indicates that she'll cross that bridge when the desire or opportunity presents itself.

IRENE

Irene is a 56-year-old NCM who has been employed by a worker's compensation insurance carrier for three years. In this setting she practices telephonic case management. She explains her role in following way: "I pretty much take a case from beginning to end, make sure that the injured workers are getting the proper care in the shortest amount of time." She further adds, "I'm a mentor for the adjusters ...[I] answer medical questions, answer what drugs do what, why patients might be on certain drugs, a question and answer person."

She gained 8 years of experience as a caregiver on a medical unit in a hospital early in her career. The majority of her nursing experience, however was 13 years in a pediatric clinic where she assisted physicians with medical examinations and procedures and was accessible for phone consultation with parents who had questions or concerns about their children's' health. Significantly invested in her identity as a pediatric nurse, Irene continues to work weekend shifts for the pediatric clinic. This keeps her connected to what she most enjoys doing.

Her experience of transition from care giver to case manager was affected by the fact that she felt she had to move away from a role that she loved and valued to one that served to satisfy only her financial needs. Irene describes her transition experience as "terrible...I hated it"

> It was very emotional for me. I absolutely loved my clinic and for socio-economic reasons I had to. I was divorced after 30 years and I had no pension or any of those kinds of things available to me so I knew I had to do something else that was going to take me into my retirement. So it was a very, very difficult thing for me to give up my pediatrics and go into case management. I like it now. I don't love it. I like it. I think I'm pretty good at it. I've gotten a confidence and that kind of thing. I've gotten a raise every year but I'm here because I have to be.
>
> I was also older and I was terrified that I wouldn't know what to do. I did have some training but not what I would have felt that I needed. I did feel, on the other hand, they don't often hire pediatric nurses to do case management and I sort of accepted that. I sold myself that I could do this job even though they had other offices say, " ... why would you hire pediatric nurses for case management?" ... I think a lot of our skills as pediatric nurses have been a more positive thing than they anticipated.
>
> I think any time you start something new, the older you get...you think you know this. Well, plus I felt I knew pediatrics very well and I didn't

> need this in my life and I didn't want to start over being the bottom.... We've had some young nurses go through that [have said] "This was great. Now I'm done with this. I'm on to the next thing." I'm in a different place. Where maybe if I'd been younger, I might not have been as uncomfortable with the transition. But that's just my own, and you will notice that so many of the nurses who have made this transition we are all middle aged. And everybody has had just as much trouble and just as much stress and I kept saying "You girls worked in the ER for God's sake. What is the matter with you? Talk about pressure. What are you getting upset about?" But it's that not knowing; the feeling that you're at the bottom... when you felt like you knew what you were doing.

An element of the case management context that she finds unfavorable is having to deal with claimants who lie in order to receive workers' compensation benefits, even though she feels she has a good working relationship with most of the claimants whose cases she manages.

Another element that perplexes her is being subject to a legal system that provides what she perceives as incentives for deceitful behavior. Working with adjusters at times causes additional stress when they discount her input about what is needed medically for a claimant, or simply when they are jaded in terms of trust or respect for the injured party or medical providers.

> A lot of the adjusters don't really want us in their face. They really don't want to hear what we have to say. They resent sometimes that we're getting involved in their file when they would rather do it themselves... Sometimes you're kind of fighting, you know. They want to close [the file], or they want to dispute [the claim]. You say [to them] "This is very possible that this [injury or complication] could happen.

Irene describes her source of job satisfaction as being able to arrange for the appropriate healthcare or work accommodations for injured workers and therefore impacting their recovery and return to work. She admits that this role

has provided her with opportunities to learn a lot about other medical specialties, about the insurance field and the legal nuances of workers' compensation - things that she was not even aware of prior to assuming this role. She feels she has perhaps more autonomy here as a case manager than in her role at the pediatric clinic. She explains, " You pretty much set it up and this is how you organize it. You set it up, and plan it through, and hope that it goes... you're definitely on your own more."

In terms of learning how to function as a CM, Irene explains that there is some formal training in the policies and procedures of the organization she works for. Her supervisor, who is also a nurse, oversees the workflow and work products of the case managers. This supervisor is available for questions and offers feedback when asked. Irene owes much of her learning CM to self-directed research through asking questions, networking with coworkers and the healthcare providers and vendors that she interacts with in the course of her workday. She also attends meetings of a local professional organization of case managers, where she is able to get updates on current medical and legal issues and alternate perspectives on case management resources, strategies and practices.

Irene relates that her nursing education and her previous experience in the hospital and at the pediatric clinic contributed to her CM skill set by providing basic knowledge of illness and healthcare. She attributes her organization skills and sensitivity to need to her foundational education and work experience as well as her life experience in raising a family.

With regard to her preparation for assuming and functioning in the role of NCM, Irene felt least prepared to act as a broker of healthcare services. Without a working knowledge of local providers or medical specialties outside of pediatrics, she found the task of making referrals to medical specialists or monitoring medical treatment rather intimidating. She also felt ill at ease with the use of a PC.

Although she feels she has gained considerable confidence through experiential learning on the job, Irene remains reluctant to accommodate her professional identity toward that of a case manager.

> I think when you tell people you are a case manager in an insurance company they think you know it's no big deal. I don't think people have a lot of respect for case management ... I think they think you just run around and try to cut money you know I really do and if you say you're a pediatric nurse people go oh wow that's so good oh my little grand baby just fell down the stairs yesterday you know there's definitely a difference for a hospital nurse. Yes I can honestly say that I would have no doubt about. People say what are you doing now. Oh. You know it's just not the same.

JUDY

Judy is a 43-year-old nurse who is currently "in between" jobs with case management companies. For the past 15 months she worked as an onsite NCM, contracting with automobile and workers' compensation insurance carriers. She will be starting to work with a different CM company within the month. Judy struggled with understanding her role as an NCM, taking cues from multiple sources.

> I didn't know what they wanted exactly.... What did these adjusters really want you to do? ...My mentor case manager projected this idea that I was supposed to really be saving money...for (the insurance companies). You know, 'hound on the fact that you're saving money for them in this area and that area yada, yada, yada. Really, just let them know how great you are, and how good you're going to get things done so quickly and yada, yada, yada.' And then the doctors, he's really guiding what's going to go on so you're just, it was like, "ok, ok.
>
> I think that there is this balance that you have to find in case management, how to get the best care most efficiently. And I think the longer you 're in it, you become more comfortable making those decisions and understanding that what you're doing is that way it is quality and it is efficient. But when you're first starting you're not quite sure.

Having completed an Associate Degree in Nursing (ADN), Judy is currently in an ADN- to- MSN (Master of Science in Nursing) program in nursing administration. Her clinical background consists of 1 and ½ years in a hospital on a general medical surgical unit and 7 and ½ years in home care. Her home care experience included a supervisory role for the last year. In addition her nursing experience, Judy did clerical work, was a dispatcher in a sheriff's office and assisted her husband in running a bakery.

She describes her transition experience to CM as a mixture of ease and difficulty. On the one hand, her clinical knowledge and skills enabled her to understand what patients needed, but on the other hand she struggled with a pressure she felt to appear competent to the insurance companies in order to realize more case assignments.

> The transition was difficult in trying to interpret no- fault and worker's comp guidelines. That part was difficult. But one part that was very similar was, you know, assessing the people, interviewing people, developing a plan, setting goals. That was similar. So

> what was hard is there was this big fear of making adjusters think you were competent right off the bat so that they would refer you more cases. Well you're not competent right off the bat, so how to accomplish that feat was just to me, you know, I didn't know how to pretend like I knew what I was doing. And so I would really limit my conversations with adjusters so they wouldn't get the hint that I really didn't know what I was doing. Which I think was a mistake because then I couldn't pull enough information on what maybe they did want. And so there was always this fine line of pretend like you really are this you know great case manager but then try and figure out what that means, because you don't know.

Judy entered the field of case management as an alternative to home care, which was becoming, in her perception, too regulated. In the course of her home care responsibilities, she had interacted with an NCM who was working with the insurance company involved with the case. In conversations, she learned more about the NCM role and found out that this nurse would soon be leaving and that her employer would be looking for a replacement.

> She started to tell me about what her job was like and what she did and it just sounded like perfect, exactly what I was looking for -- an ability to use your education and you know connect with so many different professionals. That is really interesting to me, the attorneys, the physicians, and I just think it's really cool....So I just kind of figured because I had supervisory experience and home care experience, I figured I might have a good shot at getting in there and I did. I took her spot when she left, which was perfect ...the timing, you know. I don't know if I wouldn't have had that connection I would never be in this case management, never. If she wouldn't have called me about that one position, I would never have made this turn.

Judy found that the resources for learning CM were sparse, and that she depended upon trial and error and finding answers to her questions in the course of case assignments. The training and support she did receive from her employer did not meet her needs as a novice.

> They had a couple of meetings in this 15 months. And I found them to be extremely irrelevant and very poorly presented, very not helpful for someone at my level. They were geared more towards people that maybe had been in case management. Talking about maybe specific guidelines in a workers comp thing, while I'm trying to understand the broad basic guidelines. Don't go into one you know obscure element of these things and hound on that when I don't know even understand the bigger picture. So that was really frustrating, very frustrating.

She explained also that the nursing program that she is currently enrolled in does not provide any course work or practicum in case management.

Judy's sources of job satisfaction include being able to streamline the recovery process for legitimate claimants as well assisting the adjusters weed out questionable claims.

> I think it's really rewarding when you can make things easier for the client. You do a lot of legwork, answer their questions, anticipate what they're going to need, and just facilitate their recovery. That's rewarding to me. And I kind of like sometimes when you do get those...people that are playing games with the insurance company. I like to kind of let the adjuster know other pieces of information.... When you do that initial assessment you can glean little statements from them that are just really telling. I mean they are very telling and I know that if the adjuster wouldn't have called a case manager in the adjuster wouldn't know those little statements that are very helpful to get an overall idea of whether the claimant's playing a game or not.

Like other participants in this study, Judy finds dealing with secondary gain issues associated with some workers compensation claims disturbing. Also, the mistrust she has encountered from claimants who view her as a representing the interests of the insurance company in lieu of theirs is surprising. This is an issue she had not encountered prior to taking on the role of NCM. Perhaps the more disturbing, however, was the pressure she felt from her previous employer to

market her services to adjusters, when she was unsure of her ability to meet their expectations.

Despite her frustrations in learning the role and marketing her services, Judy finds the opportunities to learn in case management worth the struggle.

> I want to expand my knowledge in it. I want to understand the legal aspects. There's a lot of it that I find really interesting and challenging, and I like that in a career. There's, you know, the physician contact, and learning all about these, you know, different injuries...I just find it all fascinating because of the variety. I guess I can see myself doing this. I would like to do this for say the next five years for sure. And then where I'll go from there I'm not sure I don't know. But I would like to become I guess more comfortable in case management.

KAREN

Karen is a 44-year-old nurse who has been working as a telephonic case manager for a health maintenance organization (HMO) for about two years. She describes her role in the following way:

> With managed care you have the primary care [physicians'] support, you have home care you can call on to allow these people to learn to take care of themselves better. Maybe a diabetic doesn't check their blood sugar, [I can arrange for home care] to teach them how to do that, to provide a glucometer for them, to...provide home care so they can learn how to do that. Then maybe we won't have tons of diabetics uncontrolled. And one big thing right now is our morbidly obese people. You know if we can get people when they're 200 lbs. instead of 500 lbs. you have a better chance of helping them...[like] calling the primary care people-- the doctors-- and saying "This looks like a weight management issue. Can I help you? Are you doing anything about it? Have you talked to the member?"

Karen was originally trained as nurse in a hospital-based diploma program and the completed a Bachelor of Science degree in nursing seven years later.

Her care giving experience was obtained in the hospital and home care setting for the first 15 years of her career. The following seven years were spent in discharge planning and utilization review at the hospital. She feels that case management positions in hospitals today are evolved from those two functions and finds that her experience in these two areas of managed care has helped her confidence in assuming the role of case manger with the HMO.

Her motivation to join the case management staff at the HMO came from dissatisfaction with the hospital setting.

> I had had it with hospitals. I want to do something different... I'm weighing sanity verses less pay. But a different a different outlook, a different something to do...[In the] hospital setting I was putting in 10 to 12 hours on my feet all day, no lunch and leaving the hospital exhausted...We were doing discharge planning and utilization review so we were reviewing charts. We were on our feet all day. There was nowhere to sit to review ...you could review lots of different units or you work one unit. Now I've learned there just keeping people on one unit, which I think is a much smarter thing to do. But at that time we weren't. In addition to doing that, you would do a discharge plan so you were trying to get people out the door at the same time. And I just wanted a change. I want to do something different. I really felt like I was going to be committed if I didn't do something different.

Karen's source of job satisfaction is her ability to help members maintain their health. She likes the proactive, preventative aspect of her role. She also likes the opportunities she has to learn about things she had never even considered. She is currently doing a self-study program on managed care concepts in order to earn a certification that will enhance her standing and salary in her department. She finds her present situation a very supportive learning environment.

> There's a whole body of knowledge within managed care that I didn't even know existed, like point of service, benefit packages, how a primary care physician works differently than a specialist, works differently than a plan medical director, what plan medical groups are. All these were Greek to me. I mean we had a 6-month orientation just to stay here and I feel like I needed a year of orientation. And it's only been in the past probably 6 months that I feel kind of comfortable in some areas. And I'm still learning, especially in the case management aspect. It's growing and changing and things are being added and we're all learning together. That's why I kind of like about my coworkers, that we're all in this boat together leaning. And my managers seem to understand that.

There are sources of role strain for Karen as well. Dealing with the financial side of healthcare continues to be difficult.

> I guess being raised in a hospital and at home care that's not a concern. I mean maybe it is now, and it wasn't when I was doing bedside nursing. I mean if [patients] needed a dressing, we did a dressing. I mean if they needed medication they got it. If the doctor ordered something, he got it... Financial concerns still kind of make me uncomfortable. I'm dealing better with them. And well you work [an HMO] and that is an issue. And if finances aren't contained then people don't have jobs. And you know you really see that there are people that abuse the system.

With regard to her professional identity, Karen offers:

> A nurse giving care is very important. A nurse doing case management is also important. It's two ends of the spectrum, I guess. I wouldn't say one's better or not better than the other one... I did bedside nursing. As much as I enjoyed helping somebody out of bed or you know all the basic nursing stuff, I'm enjoying helping people in this way as much as I did.... I don't think I'll ever not feel like a nurse I'd be doing different kinds of nursing.

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