There have been numerous studies attempting to define case management roles, responsibilities, and “essential” functions (Tahan & Campagna, 2010). Given the diversity of settings, case management models, and organizational idiosyncrasies, most studies tend to produce vague, overgeneralized findings and one-size-fits-all assertions. Responses to survey questions often reflect research bias, given the tendency to provide “socially desirable” responses. The American Nurses Credentialing Center (ANCC) conducted an extensive Nursing Case Management Role Delineation Study, identifying 66 work activities ranked hierarchically by “overall criticality” (ANCC, 2011, p. 6). The ANCC (2011) states, “Role delineation or job analysis studies are typically carried out at the national level with the goal of describing current practice expectations, performance requirements, and environments. ANCC has a current goal of conducting a study of each specialty approximately every three years in order to capture changes in work activities and the knowledge and skill areas required to perform those activities. The findings are used to update the content of its respective certification examination” (p. 5). But do role and function studies actually capture the day-to-day involvement, interests, and struggles of hospital case managers?

Hospital case managers have been described as “professionals in the hospital setting who ensure that patients are admitted and transitioned to the appropriate level of care, have an effective plan of care and are receiving prescribed treatment, and have an advocate for services and plans needed during and after their stay” (Wikipedia, n.d., para. 3). Key roles associated with hospital case management include variance analysis, care coordination, optimal patient and hospital outcomes, quality of care, efficient resource utilization, and reimbursement for services (Wikipedia, n.d., para. 3). Phaneuf (2008) provides an extensive overview of the nursing case management role. However, the overview fails to capture the present inordinate emphasis on Centers for Medicare and Medicaid Services (CMS) compliance and utilization review. One study reports, “Almost two thirds of case managers say that patient satisfaction is the number one factor they consider when evaluating a case manager's performance” (Health Law and Regulation, 2010, para. 3). Others stress, “Case managers freed from the need to perform routine chart reviews can work with physicians to manage progression of care and adherence to treatment plans” (Health Law and Regulation, 2010, para. 3). The data suggest that hospital case managers’ time is inordinately leveraged by issues related to observation status/leveling of patients and the Centers for Medicare and Medicaid Services compliance. The data also suggest that hospital case management has taken a conceptual trajectory that has deviated significantly from what was initially conceived (quality, advocacy, and care coordination) and what is publicly purported. Case management education and practical orientation will need to be commensurate with this emerging emphasis. Case management leadership will need to be adept at mitigating the stresses of role confusion, role conflict, and role ambiguity.

**ABSTRACT**

**Purpose of the Study:** The purpose of this study was to identify the roles, functions, and types of activities that hospital case managers engage in on a day-to-day basis and that leverage the most amounts of time. Previous studies superimpose a priori categories on research tools.

**Methodology and Sample:** This study analyzes 4,064 spontaneous, unstructured list serve postings from the American Case Management Association Learning Link list serve from August 15, 2011, to August 18, 2012. The study group was a cross section of 415 case management professionals.

**Implications for Practice:** The data suggest that hospital case managers’ time is inordinately leveraged by issues related to observation status/leveling of patients and the Centers for Medicare and Medicaid Services compliance. The data also suggest that hospital case management has taken a conceptual trajectory that has deviated significantly from what was initially conceived (quality, advocacy, and care coordination) and what is publicly purported. Case management education and practical orientation will need to be commensurate with this emerging emphasis. Case management leadership will need to be adept at mitigating the stresses of role confusion, role conflict, and role ambiguity.

**Key words:** compliance, functions, role conflict, roles

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care from hospital to community” (Daniels & Frater, 2011, para. 3). In “The Gestalt of Case Management,” Powell (2012) notes the following job titles encompassing case management: care coordinator; case manager; care manager; clinical resource coordinator; guided care nurse; health coach; medical home care coordinator; patient navigator; patient motivator; resource coordinator; resource manager; transition coach; utilization manager; and discharge planner.

The Case Management Society of America (2010) promulgates the following standard for case management: “Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost effective outcomes” (p. 8).

The Case Management Society of America 2010 standards (p. 7) assert that their standards reflect many changes in the industry, which resonate with current practice today. Some of these changes include the following:

- Minimizing fragmentation in the health care system
- Incorporating adherence guidelines and other standardized practice tools
- Using evidence-based guidelines in practice
- Expanding the interdisciplinary team in planning care for individuals
- Navigating transitions of care
- Improving patient safety

The underlying premise of case management is based in the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems, and the various reimbursement sources. Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation. … Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned. (Case Management Society of America, 2010, p. 9)

Although laudatory, do these high-level rhetorical statements of standards resonate with actual hospital case management activity?

**Methodology**

In an attempt to cast light on the actual day-to-day roles, tasks, functions, and issues that hospital case managers are immersed in, the author conducted a content analysis of 4,064 list serve postings on the American Case Management Association (ACMA) Learning Link, from August 18, 2011, to August 18, 2012. ACMA’s Learning Link is described as a “vast electronic network that connects members through an e-mail list serve. Members ask questions and share their experiences, tools, resources, successes, and perspectives. When you have a question or challenge, over 2,500 case management professionals are only an e-mail away. … Learning Link is provided as a Member benefit of the American Case Management Association” (ACMA website, n.d.; Learning Link: Who’s in Your Network? para. 2 and 3). Also, it should be noted, “ACMA accepts no responsibility for the opinions and information posted on this site by others. ACMA disclaims all warranties with regard to information posted on this site, whether posted by ACMA or any third party” (ACMA website, n.d., Learning Link Disclaimer & Legal Rules, para. 1).

Postings were placed by 415 hospital case managers and physicians. Postings were categorized by subject heading and assessment of content for salient themes. Subject categories are not mutually exclusive, because postings might cross-reference other categories. As with all studies, data interpretation rests on certain assumptions. These data assume that the case managers’ postings on the ACMA Learning Link are a representative sample of hospital case management professionals and medical consultants. Therefore, the findings are subject to multiple interpretations. Figures 1 to 3 are accompanied by a glossary that operationally defines the figure categories.

**Findings**

The data illustrate that the issues related to the CMS compliance, 719 posts (18%), and specifically observation status and the accurate “leveling” of patients, and 933 posts (23%), have emerged as an intractable leverage of time for hospital case managers (Figure 1). It is surprising that observation status was identified as a problem area in 1994, with the Health Care Financing Administration publishing rules for appropriate utilization of observation status in 1996, followed by the inclusion of observation status in the Office of Inspector General Work Plan in 1998 (HCPro Inc, 2008). Utilization review committees have been authorized to change patients’ status from inpatient to outpatient since 2004 (Center for Medicare Advocacy, n.d.). Nonetheless, despite more than 18 years of grappling with the issue, hospital case managers seem shackled to observation status and the appropriate “leveling of patients.”

Discharge planning/care transitions ranks a distant third with 579 posts (14%), and best practice/quality only (6%), metrics/outcomes 77 posts (2%).
"Utilization review has a primary goal that is administrative in nature, that is, to place patients in the proper status and fulfill our obligation to provide assistance as to the optimal utilization of resources and patient care. It is stated at the outset that these issues are marked by potential conflict between patient care and placing barriers to that care" (p. 263). Daniels and Reece (2007) state, “Because their work was heavily centered on utilization review tasks, nurses became the ‘chart police’ and the instruments for growing chart review activities, such as core measure abstracting, medical documentation review, concurrent coding assignments, safety indicators, and numerous other performance improvement projects. The idea of resource appropriateness, advocacy, and navigation through the episode of care, cost reductions, and improved quality vanished, except for an obligatory mention in the job description” (para. 3). The 4,064 ACMA Learning Link postings call into question the initial vision of case management. “With the ‘big picture’ perspective, the hospital case manager harnesses the collective wisdom of the clinical team to assess, plan, and continuously evaluate the patient’s post-acute experience” (Phoenix Medical Management, n.d., para. 6).

**FIGURE 1**

Hospital case management role and function as reflected by American Case Management Association Learning Link posts from August 15, 2011, to August 18, 2012 (n = 4,064). ADM = admission; DCP = discharge planning; DOC = documentation; ED = emergency department; JD = job description; OBS = observation; OP = outpatient.

Figure 2 integrates the combined impact of CMS compliance issues and distinct compliance and revenue integrity issues related to observation status accounting for 1,654 (41%) of all postings. If we were to consider the revenue implications of compliance and observation and combine those categories with Billing, Utilization Review Criteria, Physician Advisor, and Denials, Figure 3 illustrates a combined impact of 2,348 (58%). This is significant, because case managers often find that organizational business imperatives often conflict with other facets of their professional identity, such as patient advocate. Of note is that Team Building received less than 1% of the overall postings. This may suggest that Team Building has been satisfactorily addressed by organizations or that other activities preclude team building activities.

**DISCUSSION**

The frequency distribution among categories suggests that hospital case management is strategically positioned to impact revenue and manage risk. However, has it done so at the opportunity cost of commitment to quality and patient advocacy? Cohen (2012) notes, “Utilization review has a primary goal that is administrative in nature, that is, to place patients in the proper status and fulfill our obligation to provide assistance as to the optimal utilization of resources and patient care. It is stated at the outset that these issues are marked by potential conflict between patient care and placing barriers to that care” (p. 263). Daniels and Reece (2007) state, “Because their work was heavily centered on utilization review tasks, nurses became the ‘chart police’ and the instruments for growing chart review activities, such as core measure abstracting, medical documentation review, concurrent coding assignments, safety indicators, and numerous other performance improvement projects. The idea of resource appropriateness, advocacy, and navigation through the episode of care, cost reductions, and improved quality vanished, except for an obligatory mention in the job description” (para. 3). The 4,064 ACMA Learning Link postings call into question the initial vision of case management. “With the ‘big picture’ perspective, the hospital case manager harnesses the collective wisdom of the clinical team to assess, plan, and continuously evaluate the patient’s post-acute experience” (Phoenix Medical Management, n.d., para. 6).
FIGURE 2
American Case Management Association Learning Link posts. DCP = discharge planning; ED = emergency department; OP, outpatient.

FIGURE 3
American Case Management Association Learning Link posts by major category and percent.
In an effort to justify and prove our organizational worth, perhaps case management leaders inadvertently contribute to the myriad confluence of varied roles and expectations that are assumed and consequently required of staff. Or, maybe as helping professionals, we are all too willing to have our capacity to care exploited as we compensate for organizational and leadership voids.

Does the dominance of CMS compliance, patient assignment, and/or leveling signify a risk that would “…fragment the unified skill set of case management into individual elements creating … the biggest threats to case management to building recognition of, and consistency in, the professional practice of case management?” (Powell, 2012, p. 228). I believe that the implications of the issue are exquisitely expressed in Smith’s (2011) treatment of role ambiguity, role confusion, and role conflict, and role overload in hospital case managers.

Although less overt than in the past and ample rhetoric to the contrary, many health care organizations continue to harbor a culture of blame. Because hospital operating margins continue to shrink, determining patient status and the concomitant compliance and operational implications have engendered increasing amounts of audit anxiety and undermine team cohesion. I have seen the abdication of other disciplines relative to Observation and patient leveling create a void that case managers have been compelled to fill. From the framework of thermodynamic theory, entropy is a measure of a system’s energy that is unavailable for work or of the degree of a system’s disorder or trend toward disorder (Entropy, n.d.). I would argue that the inordinate reliance on Case Management Assignment Protocols and other first-level review screening methodologies signify hospital case managers confronting a state of organizational and physician entropy. Because there is not a sufficient energy contribution by other sources, hospital case managers compensate for a multitude of organizational systemic deficits on the road to professional burnout.

In my own experience, with rare exception, the physician community has taken the stance that the leveling of patients is an administrative, nonclinical issue. Medical coders who have their own credentialed and practice guidelines consistently ask case managers how they should code on the basis of what the physician has (or has not) documented. Organizational goal misalignment manifests as Emergency Departments “move patients out” at a rate of acceleration that precludes hospitalists accurately leveling a patient at the point of entry. Emergency department registration processes frequently do not cohere to clinical/regulatory requirements by using the colloquial of “Admit” and “Observation” and create a web of confusion. Emergency department physicians, with no admitting privileges, write transitional orders that are confused with admission orders. The confluence of these forces creates massive amounts of re-work that case managers are held accountable to unravel at the “back end”. Compliance officers, Departments of Revenue Integrity, too often take a step back, “deferring” to case managers who then assume responsibility and liability for any missteps in what is the convergence of several volatile issues, leaving hospital case managers as the repositories for risk assumption.

A review of legal and regulatory issues seems to focus exclusively on Protected Health Information (Muller, 2012, 2013). This is consistent with the 2010 ANCC Role Delineation Study Overview survey findings, which ranked, “maintains client’s confidentiality” as the number one work area relative to overall criticality for hospital case managers (ANCC, 2011, p. D2). However, the slippery slope of case managers’ entry into billing compliance, admission status determination, revenue integrity, and interpretation of “CMSese” as it explains, or tries to, CMS regulatory stipulations for billing and take backs have received little attention as a professional practice issue. In fact, the ANCC survey question, “Reviews level of care based on utilization review criteria,” did not rank in the survey’s top-20 work items relative to overall criticality (ANCC, 2011, pp. 1–2).

There has been a consistent failure to capture this shift as a professional practice issue and to offer guidance as how to navigate the changing landscape. Perhaps the 2011 American Case Management Association National Hospital Survey (pp. 32–33; this survey is available to ACMA members only) is instructive, while noting a statistically significant increase in the number of case management departments reporting to “operations” and “other” departments, whereas the number of departments reporting to nursing/patient care services is almost equal to the number reporting to finance. This finding is again reflected in the 2013 ACMA National Hospital Case Management Survey (p. 23). Role confusion, role ambiguity, role conflict, and role tension have emerged as central themes in defining case management integrity as a practice specialty. There is evidence to suggest that, in varying degrees, these practice strains have not only job satisfaction and job effectiveness implications but mental health ramifications relative to burnout.
The frequency distribution among categories suggests that hospital case management is strategically positioned to impact revenue and manage risk. However, has it done so at the opportunity cost of commitment to quality and patient advocacy?

as hospital case managers endeavor to reconcile the many roles and expectations in a manner that is professionally acceptable.

In an effort to justify and prove our organizational worth, perhaps case management leaders inadvertently contribute to the myriad confluence of varied roles and expectations that are assumed and consequently required of staff. Or, maybe as helping professionals, we are all too willing to have our capacity to care exploited as we compensate for organizational and leadership voids. Smith (2011) has written insightfully about role ambiguity and role confusion for nurses transitioning from bedside to nursing case management. Specifically, “within the business culture and financial objectives theme, participants revealed feelings of conflict and being at odds with the employer regarding the expected focus on cost containment and financial issues; some perceived this expectation as conflicting with their role as patient advocate and created tension as well as decreased job satisfaction and self-confidence. Also was noted the participant’s perception of not being aware of the aspects of the case management role and of not being prepared for the role and not aware of the aspects of case management that would be problematic” (Smith, 2011, p. 184). Gray, White, and Brooks-Buck (2013) astutely note, “it is clear that role conflict and role ambiguity are important intervening variables that mediate the effects of various organizational practices on individual and organizational outcomes” (p. 69).

The authors also found that many responses indicate that there is role confusion and conflict and ambiguity related to the areas of time, resources, capabilities, and the “multiplicity of roles and responsibilities. Nurse case managers are held to different sets of standards that could be at odds with each other” (p. 72).

It is true that “case managers are a unique segment of the healthcare workforce, therefore, their unique role needs to be clearly articulated if the specialty is to gain industry-wide recognition and standardization” (Gray et al., 2013, p. 72). However, there is a good reason to believe that case management has become the Swiss Army Knife of health care, engaged in quality, utilization management, denial management, family intervention, discharge planning, compliance, etc. (see Figure 4). Although a seeming organizational convenience, the Swiss Army Knife

![Figure 4](image-url)

**FIGURE 4**
Hospital case management and role confusion case management as the Swiss Army Knife of health care. HIM = health information management; RAC = recovery audit contractors.
as an “All in One” solution is not a sustainable tool (Fry, 2007; Reynolds, 2004). It is meant as a stop-gap measure, not as a long-term solution because each application is a substitute for a full size, enduring, more efficacious specialty instrument.

Many organizations fail to recognize that hospital case managers provide direct care to patients. Although not necessarily at the “bedside,” they are direct care workers. The integration of “case” and “manager” as a job title creates a distortion of what case managers do. First, “case manager” implies an inordinate and misleading amount of control in the face of a multiplicity of organizational and external forces. Second, “manager” implies a nondirect care function with inherent hierarchical authority. I have been astounded at the amount of committee time direct care/case management staff spend in meetings, thus vitiating their direct patient service activities and creating time constraints relative to their numerous other activities.

What Can Be Done?

Case management practice education and departmental leadership will need to address the actual day-to-day operational and clinical emphasis on CMS compliance and the interface of professional practice and organizational business imperatives and the impact on the integrity of hospital case managers role boundaries, role conflict, and role ambiguities.

Case management is what I call a “lynchpin” practice specialty with numerous “spokes” emanating out to other departments. Heeding Powell’s caution that case management functions need not become independent titles, I do believe that there does need to be some acknowledgment of both the specialty skill and its link to the core case management role. A compromise nomenclature might be as follows:

- Case management utilization specialist.
- Case management compliance/recovery audit contractors specialist.
- Case management quality specialist.
- Case management discharge planning/care transition specialist.
- If job descriptions cannot be specialized, stipulate to new recruits what percentage of time is expected in each function/activity.
- Create clear reporting relationships with other departments.
- Orientation: Guarantee that each function receives the requisite amount and type of training/preceptorship to engender confidence and competence.
- Use staff meetings to explore whether current job descriptions reflect current departmental practice and update where needed. Revise departmental orientation as indicated.
- Use relevant articles and case vignettes at staff meetings to support staff and foster the coordination and integration of specialties.
- Utilize guest speakers who are subject-matter experts to support training and departmental curriculum development.
- Develop presentations for professional workshops and conferences that address the changing landscape and related skill sets while focusing on maintaining a commitment to core values.

The multitude of titles, functions, and activities that hospital case managers find themselves engaged in is testament to case management’s organizational value. It is no wonder that hospital case managers report role strain, role ambiguity, role conflict, and feelings of burnout. Nonetheless, hospital case management cannot be allowed to become a victim of its own aspirations and its own success.

Operational Definitions

- Billing: Non-RAC, billing-related issues.
- Compliance: CMS-related guidance and regulatory adherence.
- Observation: Admission status orders, RAC, prepayment reviews, utilization management plans.
- Care Transition: Difficult discharges, discharge assistance programs, discharge resources, transfer centers; readmissions; emergency department; outpatient.
- Denials: Non-CMS utilization review activity, denial management, criteria.
- Documentation: Issues related to clinical documentation improvement and other charting issues.
- Emergency department: Issues related to emergency department functioning, including staffing, coverage, job descriptions.
- Outcomes: Issues related to benchmarking, targets, acuity systems.
- Job descriptions (non-emergency department): Issues related to various job descriptions, including case management, utilization review, transfer center.
- Outpatient: Issues related to outpatient procedures, billing, and outpatient staff roles.
- Physician advisor/physician roles: Issues related to physician advisor, attending physician, medical director roles.
- Readmissions: Issues related to readmission prevention, tracking.
• **Staffing:** Issues related to roles/responsibilities, departmental structure, policies, staff ratios, mission.
• **Software/IT:** Issues related to discharge planning, case management/utilization review software, electronic medical records, meaningful use, etc.
• **Team building:** Issues related to interdisciplinary team building and “huddles.”
• **Misc.:** All other issues (see Figure 1).
• **Best practice/quality:** Standards of care for specific disease states, professional articles, certification, The Joint Commission compliance.
• **Compliance:** CMS-related guidance and regulatory adherence.
• **Observation:** Admission status orders, RAC, pre-payment reviews, utilization management plans.
• **Discharge planning/care transitions:** Difficult discharges, discharge assistance programs, discharge resources, transfer centers.
• **Denials:** Non-CMS utilization review activity, denial management, criteria.
• **Physician Advisor/Physician Roles:** Issues related to physician advisor, attending physician, medical director roles.
• **Documentation:** Issues related to clinical documentation improvement and other charting issues; *Billing:* Non-RAC, billing-related issues.
• **Emergency department:** Issues related to emergency department functioning, including staffing, coverage, job descriptions.
• **Outcomes:** Metrics: Issues related to discharge planning, case management/utilization review software, electronic medical records, meaningful use, etc.
• **Outpatient:** Issues related to outpatient procedures, billing, and outpatient staff roles.
• **Readmissions:** Issues related to readmission prevention, tracking.
• **Staffing:** Issues related to roles/responsibilities, departmental structure, policies, staff ratios, mission.
• **Job descriptions (non–emergency department):** Issues related to various job descriptions, including case management, utilization review, transfer center.
• **Team building:** Issues related to interdisciplinary team building and “huddles.”
• **Misc.:** All other issues (see Figure 2).
• **Best practice/quality:** Standards of care for specific disease states, professional articles, certification, The Joint Commission compliance.
• **Outcomes:** Issues related to benchmarking, targets, acuity systems; *Information technology/software:* Issues related to discharge planning, case management/utilization review software, electronic medical records, meaningful use, etc.
• **Compliance:** CMS-related guidance and regulatory adherence.
• **Observation:** Admission status orders, RAC, pre-payment reviews, utilization management plans.
• **Discharge planning/care transitions:** Difficult discharges, discharge assistance programs, discharge resources, transfer centers.
• **Denials:** Non-CMS utilization review activity, denial management, criteria.
• **Physician advisor/physician roles:** Issues related to physician advisor, attending physician, medical director roles.
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• **Team building:** Issues related to interdisciplinary team building and “huddles.”
• **Misc.:** All other issues (see Figure 3).

**References**


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