Implementation of the Care Coordinator Role: A Grounded Theory Approach

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The purpose of this study was to explore the process of implementing a new care coordinator role on a medical-surgical unit. Qualitative data were collected from employees and patients during a 3-month period; data analysis occurred concurrently. Using the constant comparative method, a grounded theory was developed to explain the initial process of implementation of the clinical nurse III (CNIII) role. The basic social psychological problem associated with implementation was role ambiguity. The basic social psychological process used to resolve this problem was "making the role of the CNIII." Making the role involves the following four strategies, which may occur simultaneously: communicating the vision, gaining new knowledge, accessing resources, and defining boundaries. Communicating the vision refers to efforts to articulate the role before and during the implementation process. Gaining new knowledge includes participating in educational workshops and acquiring new skills. Accessing resources refers to development of new relationships and acquisition of office space and equipment. Defining boundaries includes determining the scope of responsibilities and differentiating the role from other roles. This theory may be useful to researchers, educators, and administrators interested in role implementation. (Index words: Care coordinator role; Differentiated nursing practice; Grounded theory) ***J Prof Nurs 15:356-363, 1999. Copyright © 1999 by W.B. Saunders Company***

RAPIDLY CHANGING health care environments have challenged organizations to respond with innovative care delivery systems. New models of professional nursing practice are being proposed and implemented to meet the organizational mandate for cost-effective health care. A professional practice model of nursing emphasizes the competencies of professional nurses to organize and deliver quality care (Fralic, 1992). Many of these models incorporate differentiated nursing practice as a key component (Milton, Verran, Murdaugh, & Gerber, 1992).

The University of Kansas Hospital has developed a model of differentiated nursing practice entitled Career Advancement, RN Excellence (C.A.R.E.). One role within the C.A.R.E. Model is the clinical nurse III (CNIII) role. According to the model, the nurse who assumes the role must be "an RN with a minimum of two years clinical experience and a bachelor's degree in nursing." The model specifies that the CNIII "will be responsible for coordinating care for a group of patients from admission through discharge. This is accomplished through the development and implementation of care pathways and through the evaluation of patient outcomes." A term synonymous with CNIII is "care coordinator." For this reason, the terms "CNIII" and "care coordinator" will be used interchangeably in this article.

Purpose of the Study

Few studies have addressed the implementation of the care coordinator role. The purpose of this study was to discover the processes of implementing the CNIII role and to develop a grounded substantive theory (Glaser & Strauss, 1967) that explains the social and psychological processes (Chenitz & Swanson, 1986) associated with implementation of the role. A fundamental assumption of the grounded theory method is that these processes result from attempts to resolve a key social psychological problem (Hutchinson, 1985). The research question guiding this study was this: What are the social psychological processes that occur in the implementation of the CNIII role?

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Methods

SETTING

The initial setting for this study was unit B, a medical-surgical unit at the University of Kansas Hospital. Unit B serves inpatients treated predominantly for neurological or orthopedic problems. Two weeks after data collection began, a staff nurse chosen from unit B began to function in the CNIII role. The scope of responsibility of the new CNIII initially was to include only unit B. Before the CNIII was hired, however, the scope of responsibility was expanded to include unit A, a medical-surgical unit that serves trauma patients. The new CNIII was to be one of two CNIIIs on unit A, and the only CNIII on unit B. Thus, the study setting expanded to include unit A. Study participants included individuals who interfaced with staff on either units A or B or with the CNIII on unit B.

DATA COLLECTION PROCEDURES

The study was approved for implementation after review by the University of Kansas Medical Center Human Subjects Committee. After approval was obtained, data collection began by meeting with the nurse manager of unit B during which information was provided about the unit. After this meeting, each investigator completed a minimum of 4 hours of nonparticipant observation to gain familiarity with the physical environment, personnel, social structure, and activities of unit B. Subsequent data were collected through participant observation and formal and informal interviews. During participant observation, the investigators actively engaged the participants, accompanied them as they performed their work or attended meetings, and made inquiries about their activities.

All but one of the formal and informal interviews took place at the hospital. The exception occurred at a location convenient to the interviewee. Initially targeted for interview were the nurse manager, the CNIII, and a member of the Design Team.* Subsequent decisions regarding who would be interviewed were made as data collection and analysis progressed. A total of 17 interviews were conducted with the following individuals: the CNIII, two nurse managers, a unit coordinator, three staff RNs, a unit secretary, two social workers, a physician, a physical therapist, two clinical nurse specialists—one of whom was a member of the Design Team, a clinical pathway coordinator, and two patients. Most formal interviews were tape-recorded. The decision whether or not to tape-record the interview was determined by the investigator based on the proposed length of the interview and the interviewee's willingness to be recorded. Participants whose responses were audiotaped were required to provide written consent for the interview. All other participants were provided with an information sheet about the study.

Interviews focused on helping the investigators understand the changes occurring with the implementation of the CNIII role through the eyes of the participants. Attempts were made to obtain a broad base of understanding about the processes of implementing the CNIII role. Questions that were asked during interviews included but were not limited to the following: (1) What were your initial thoughts when you first heard about the new professional practice model? (2) How was the information about the care coordinator role communicated to you? (3) What was your initial understanding of the care coordinator role? (4) From your perspective, how was the care coordinator role filled? (5) How has the care coordinator role been implemented on this unit? Through observation and interviews, the investigators began to clarify the meanings attributed to the situation by the participants.

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Additional data included records related to unit organization and structure. The investigators noted an absence of information related to the role of the CNIII in these documents. Other documents included handouts distributed at meetings, clinical pathways, and materials describing the C.A.R.E. Model.

All observations and interviews were recorded immediately into a notebook and were further developed and transcribed by each investigator. Field notes were typed single-spaced, with page numbers, line numbers, and appropriate headings to specify the date, time, method of data collection, and the investigator who collected the data.

*The Design Team was a group of nursing staff and management who had worked for 18 months on developing the overall design and structure of the differential practice model for the nursing department.

DATA ANALYSIS

Constant comparative analysis (Glaser & Strauss, 1967) was used to develop theoretical constructs and generate a grounded theory. This process began with level I coding (Hutchinson, 1993), during which the data were divided into small pieces, with each piece including one or more sentences that represented an abstraction related to the research question. Each abstraction was rewritten as a concept (or code) in the margins of the field notes or transcripts. All data "pieces" were coded into as many codes as possible in this manner.

During level II coding, the level I codes were condensed into categories. The following 10 categories were identified: communicating, defining boundaries, developing a network, gaining new knowledge, accessing resources, questioning "who am I?," strategizing, preventing the patient from "falling through the cracks," mismatched expectations and reality, and the institution's environment. These emerging categories were analyzed by comparing and contrasting them with each other to ensure that they were mutually exclusive and covered the variation in the data (Hutchinson, 1993).

In level III coding, the basic social psychological process (BSP) of "making the role" was identified as a central integrating theme of the data. This core variable became the basis for generating the grounded theory. A core variable is a theoretical construct that occurs frequently in the data, weaves the data together, and explains the variation observed in the data (Hutchinson, 1993). One characteristic of a BSP is that it "must have at least two clear stages or phases so that it can account for process, change, and movement over time" (Hitchcock & Wilson, 1992, p. 179). The investigators attempted to determine the relationships among the core variable and other identified variables for the purpose of determining the phases of making the role. During the process of level III coding, a review of relevant literature was conducted, and the information obtained was used as additional data in the analysis. Role theory was found to augment the proposed theory and was interwoven with the data.

As data collection progressed, the investigators met as a team on a regular basis to share and code data, identify personal biases, and make decisions regarding further data collection. Identified codes and preliminary hypotheses were documented in memos, which served as written records of the analytic process. Concurrent data collection and analysis continued for 3 months, after which it was determined that saturation had occurred (Corbin, 1986; Hutchinson, 1993).

CREDIBILITY

Several procedures were used to enhance credibility of the data and findings (Lincoln & Guba, 1985). First, transferability was strengthened by having four investigators make consensus decisions regarding categories. Second, dependability was augmented by writing memos in which decisions and conclusions were documented. Third, confirmability was enhanced by documenting feelings and potential biases in reflexive journals for discussion. Conducting qualitative research requires investigators to become aware of personal preconceptions, values, and beliefs. To facilitate this process, each investigator kept a journal of personal feelings and reflections that were shared with coinvestigators during data analysis sessions. The final procedure to enhance credibility was a member-check procedure. The research report was provided to selected participants who were asked to comment on the validity of interpretations.

Results

The basic social psychological problem (BSPP) associated with implementation of the CNIII role was identified from the data as "role ambiguity." The basic social psychological process (BSP) used to resolve this problem was "making the role of the care coordinator." Four processes (or strategies) used in making the role were (1) communicating the vision, (2) gaining new knowledge, (3) accessing resources, and (4) defining boundaries. A model representing the theory variables and relationships is shown in Fig 1.

BSPP: ROLE AMBIGUITY

During the review of relevant literature, the investigators became aware of the congruence between the emerging theory and role theory (Hardy & Conway, 1988). In this study, individual and social expectations were clearly interacting against a backdrop of the hospital environment during early implementation of the CNIII role. This interaction emerged as the variable, role ambiguity. Role ambiguity is defined by Hardy and Conway as a condition in which the norms for the role "may be vague, ill-defined, or unclear" (p. 197), and it occurs "when disagreement on role expectations occur, associated with a lack of clarity on those expectations" (p. 197).

In this study, both system and individual factors contributed to role ambiguity. System factors stemmed from role expectations of people in the hospital environment. One system factor was the lack of clear

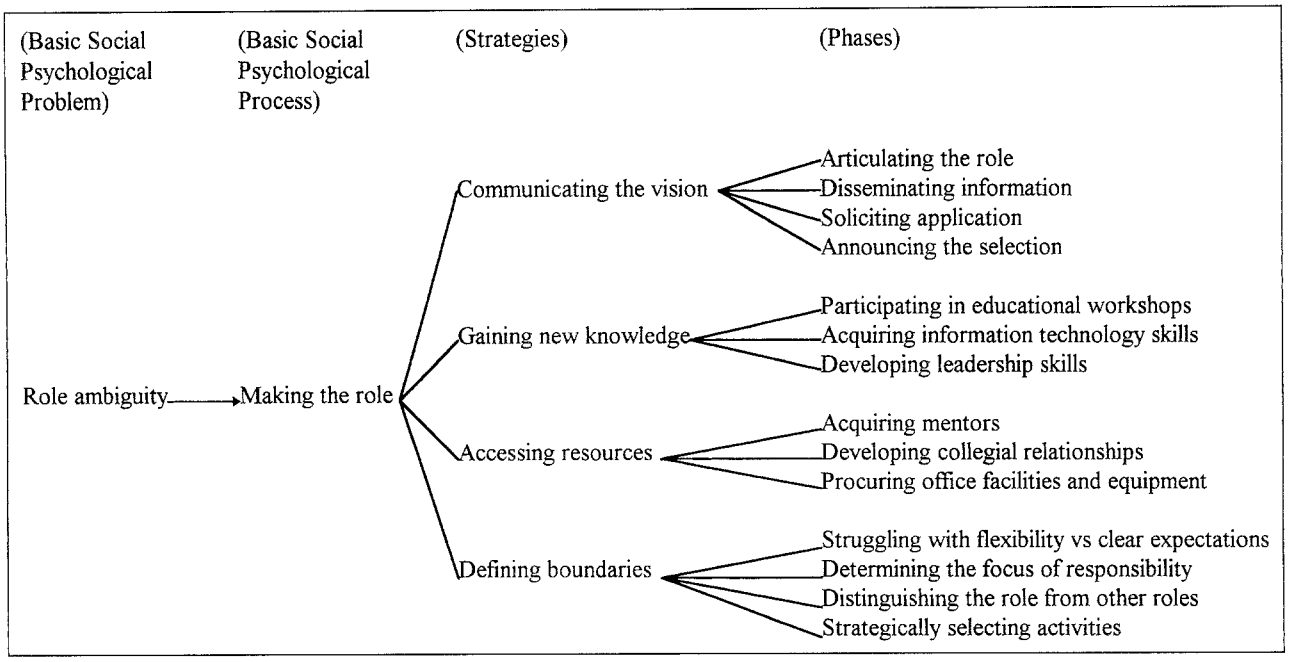

Figure 1. Conceptual model of the theory of implementation of the care coordinator role.

expectations from the Design Team regarding activities that make up the role. Another factor stemmed from an initial lack of adherence to the role requirements. Although the initial requirements for the role included a bachelor's degree in nursing, some nurses hired into the role did not have this academic credential. This temporary modification of the requirements was implemented to facilitate the timely filling of the CNIII roles. A third factor was confusion related to inconsistency of functions among care coordinators in different areas of the hospital. Perceived lack of preplanning for the physical needs of the role, such as office space and computers, was a fourth factor that may have contributed to role ambiguity.

Individual factors that contributed to role ambiguity stemmed from personal role expectations and included (1) expectations of the care coordinator of herself, (2) perceived inconsistent feedback from other health professionals with whom the care coordinator interacted, and (3) the perceived expectations of others. In summary, role ambiguity resulted from the interaction of personal and system expectations for the role. This interaction was experienced keenly by the care coordinator.

BSPP: MAKING THE ROLE OF THE CNIII

Hardy and Conway (1988) defined role making as a "means of creating and modifying one's concept of one's own role" (p. 243). They suggested that "role making emphasizes the interpretation of one's own role prescriptions and emphasizes the positive process of creating and modifying one's own role" (p. 243). In this study, the CNIII attempted to resolve the role ambiguity by identifying "Who am I?" and "Who do others say I am?" On numerous occasions she expressed the need to make the role less ambiguous by redefining existing relationships, learning to deal with other's expectations and suggestions, identifying personal physical and emotional needs, accepting 24-hour accountability, dealing with surprises, and establishing personal power. As a result of these activities, she had embarked on a path of making the role.

The process of making the role was found to take time and to involve the community of hospital employees. Several health professionals talked about the evolutionary nature of implementation. One health professional stated, "I think [the role] will evolve, . . . it'll just take time to see what [the care coordinators] are going to do, and for them to understand the limitations of what we can do." Another interviewee stated, "My understanding of the role continues to evolve. I don't know if I completely understand it as of yet." This person expressed the desire to know to what extent the care coordinator saw herself being utilized and added the following comment: "I have some ideas as far as what I think optimum utilization would be, but we really haven't sat down and talked about that. So basically, I'll push her as far as she'll let me push her, as far as utilization. But I don't know what she thinks is appropriate."

Unsolicited suggestions regarding potential activities for the care coordinator commonly were offered

during interviews. Participants believed the care coordinator could "prevent the patient from falling through the cracks," address issues of continuity of care, and "fill the void" of the overall system.

In sum, the process of making the role is evolutionary, involves many individuals, and is dependent upon the context, the individual, and the social factors that impact role development. Four strategies for making the role were (1) communicating the vision, (2) gaining new knowledge, (3) accessing resources, and (4) defining boundaries. Each of these variables are discussed separately.

Communicating The Vision

In terms of temporal sequence, communicating the vision describes events preceding and during the early implementation stage. Four phases were identified: (1) articulating the role, (2) disseminating information, (3) soliciting application, and (4) announcing the selection. Articulating the role includes efforts by the Design Team and nursing management to describe the CNIII role to hospital employees. Presentations and written materials were prepared that described the C.A.R.E. Model and the CNIII role within that context. Disseminating the information began 3 to 6 months before implementation of the CNIII role when the cochairs of the Design Team met with staff of each nursing unit to provide information about the role. Staff attending these meetings received the verbal and written information prepared in the previous phase. Applications for the CNIII role were provided to the nurse managers, who, in some cases, approached individual nurses regarding the role. In addition, nurses were advised to contact the nurse manager regarding interest in the new role. On unit B, a single application was received and approved for the CNIII role, and the selection was announced to the unit staff.

Despite several activities by the Design Team and unit management to provide information about the new model and the projected implementation process, investigators repeatedly heard that staff were generally unaware of the new role. Clearly, the Design Team and nursing staff had different perceptions about what information was communicated. Comments such as, "I was never informed about what the role was," "I first heard about the care coordinator role in January [of this year]," and "It took a little digging before I figured out where and how they were coming up with this," were expressed by nursing staff. Some nurses expressed confusion about the application process. One nurse noted, "We just kind of heard about it and the position was filled." Several interviewees expressed concern about the process of CNIII selection. In striking contrast, members of the Design Team and nursing management described a careful process of education and feedback.

Nonnursing health professionals also expressed confusion about the appearance of a new role without previous information. One participant made the following comment, "The distressing thing was the lack of communication. They should have said, 'This is what they're going to do and this is how you're going to fit in.' " A similar comment was made by another participant, "We got both the care coordinator and the unit coordinator at the same time and there was a lot of talk about roles but we were never informed about what the role [of the care coordinator] was." In addition, one investigator was asked by an interviewee, "Can I ask you what *is* the role of the care coordinator?"

Although the data clearly suggest the vision of the CNIII role was not fully communicated to the stakeholders in the organization, this did not seem to be an isolated event. Comments that "the system isn't working" referred to the general lack of communication between professional departments. One respondent spoke of "the right way, and the wrong way, and the KU way" of implementing change.

Gaining New Knowledge

The care coordinator for unit B had held a full-time staff position on unit B for several months. Before coming to work at the University of Kansas Hospital, she had been exposed to a similar role at another work setting. Despite an extensive clinical background in medical–surgical nursing, additional information was needed to perform the new role. Three phases were characteristic: (1) participating in educational workshops, (2) acquiring information technology skills, and (3) developing leadership skills. The care coordinators attended educational workshops provided by management on differentiated practice models, managed care, clinical pathways, and insurance regulations. Although some of the information presented in these educational workshops was perceived as critical by the CNIII, other information was thought to be too vague to be useful. The need for specific information was expressed by the care coordinator with comments such as, "What we need is meat and potatoes, not Jell-O and Fluff."

Opportunities were provided for the CNIIIs to learn computer software programs and applications. In addition, there was a focus on the development of new leadership skills, including motivation, negotiation, problem solving, dealing with resistance, conflict management, and effective communication with physicians and other professionals. The care coordinator on unit B indicated that she was "learning to use the right terminology." She gave examples of using words like "issues" and "concerns" to describe problem areas.

Accessing Resources

The CNIII recognized the need to access resources to facilitate patient care and to understand the role of the CNIII better. This strategy includes three phases: (1) acquiring mentors, (2) developing collegial relationships, and (3) procuring office facilities and equipment. In the first phase, the care coordinator was actively involved in the development of supportive relationships in the hospital environment. As data collection progressed, evidence pointed to the nurse manager as clearly functioning in the role of mentor to care coordinators on both units A and B. The second phase, developing collegial relationships, refers to the process of developing relationships with knowledgeable health professionals within and outside the institution. Examples included insurance representatives, home health agency representatives, physicians, utilization review personnel, and other care coordinators. Late in the data collection, the CNIII on unit B sought national resources for clinical pathway development.

The implementation of the CNIII position created confusion regarding the boundaries of the role.

In the third phase, physical resources needed to perform the role were identified. These included an office, a telephone, a computer, and a beeper. Efforts to procure these resources were ongoing. A humorous example of the impact of these resources occurred the day after the CNIII obtained a beeper. On receiving her first page during a multidisciplinary discharge planning meeting, she revealed her excitement with those in attendance by announcing, "It's wonderful to share this milestone with you."

Defining Boundaries

The implementation of the CNIII position created confusion regarding the boundaries of the role. The Design Team had purposely defined the role loosely. As stated by a Design Team member, "People wanted a template, a pattern. 'Now let me cut this out and take it home and sew it up tonight and I'll come tomorrow and I'll look like all of these others." We purposefully designed the role so it could be modified, so it would flex with the different areas."

The absence of clear boundaries, while providing needed flexibility, also resulted in the lack of clarity regarding expectations and thus contributed to role ambiguity. Defining boundaries involved four phases: (1) struggling with flexibility versus clear expectations, (2) determining the focus of responsibility, (3) distinguishing the role from others, and (4) strategically selecting activities.

In the first phase, the struggle was with the tradeoff between flexibility and clear expectations. Although flexibility was welcome, the lack of clear expectations created discomfort. The care coordinator alluded to this discomfort when making the following statement, "I'm usually an organized person. I have no problem prioritizing. I just don't know what I'm doing now." Another health care professional, who was uncertain about how the CNIII role might impact her own, voiced discomfort in the following comment, "This whole thing has been a little disconcerting. It's been unsettling. I wish they would have included us in a little more."

Determining the focus of responsibility included efforts to define the parameters of the role. Almost immediately on implementation of the CNIII role, the responsibility shifted from a unit-specific to a service-specific focus. This change occurred because coordinating care from admission through discharge clearly demanded that the CNIII maneuver within a broader area. As a result, the CNIII had to become familiar with several additional units, including the surgical intensive care unit, associated outpatient clinics, and the rehabilitation unit. This expansion in focus made the process of defining boundaries more difficult.

Distinguishing the role from others involved a process of clarifying the role by comparing it with others. One problem identified by participants was the perceived confusion between the CNIII role and the unit coordinator role. The unit coordinator was a position created at the suggestion of a managerial consultant just 5 months before implementation of

the CNIII role. The unit coordinator is a unit-based, nonmanagerial, day-shift registered nurse who facilitates staffing and the admission and discharge process. The implementation of both roles within the same time period contributed to the confusion.

Perceived overlap of duties was another problem identified by participants. For example, two clinical nurse specialists voiced concerns related to "duplicating efforts" and the impact of this duplication on the future of their role. Health professionals who contributed to patient care and discharge planning also voiced concern about the overlap of their roles and the role of the CNIII. One interviewee asked, "Are we having too many people doing the exact same role? It is already a confusion to the physicians and the nurses." Another participant voiced the same concern in the following statement, "Why do we need two people doing the same job?"

The overlap of duties was not a problem unique to this study. McCarthy (1991) described overlap of duties between charge nurse and care coordinator roles during implementation of a new clinical coordinator role in the emergency department at Baylor University Medical Center.

Strategically selecting activities refers to the careful selection of activities for the care coordinator to perform. On one occasion, the care coordinator talked about seeing things that she knew needed to be done but wondered whether or not she should be doing them. She gave an example of the need to order commodes for specific patients, but she wasn't sure whether this should be her responsibility. When an investigator suggested that she was carving out her role when making these types of decisions, she said, "I want to make sure I don't carve out a role too big."

In summary, defining the boundaries of the CNIII role was an active, ongoing process during implementation of the role. The future boundaries of the CNIII role are yet to be negotiated. As one person put it, "We're all going to have to learn who does what."

Discussion and Implications

Implementation of a new role in a health care setting requires more than a good idea. Successful implementation requires an understanding of the social psychological problems and processes that occur in the implementation of the role. According to role theory (Hardy & Conway, 1988), the problem of role ambiguity can result in role stress, which may have detrimental effects on those involved in implementation. The process of making the role is used to reduce or eliminate role ambiguity. Making the role takes time and can involve many individuals.

Strategies used in making the role were (1) communicating the vision, (2) gaining new knowledge, (3) accessing needed resources, and (4) defining boundaries. Communicating the vision occurs before and during implementation of the role, yet these efforts may not be entirely successful. Careful planning and coordination among all individuals associated with patient care must occur for successful role implementation. Progress stalls when communication does not reach everyone who is affected. The process of making a role is shaped by knowledge, which is gained via information presented formally and informally through workshops, collegial relationships, and printed and electronic media. Some information may be discarded as useless, whereas other information may be assessed as critical. Successful implementation requires ongoing evaluation of educational offerings. Access to resources and teamwork is essential. Role making requires the development of relationships with individuals who can offer support and information to assist in achieving desired patient outcomes. Defined boundaries give a clear indication where one role ends and another begins, yet not all roles have defined boundaries. In the hospital environment, attempts to prevent patients from "falling through the cracks" may either be successful and embraced by others or may create friction related to unnecessary duplication and the convergence of incompatible work processes. In this study, both scenarios were observed. How the role was perceived was dependent on the extent to which clear boundaries between roles were delineated. Because many new roles are not clearly defined and are evolving, periodic group discussions regarding this process may help to minimize problems related to confusion and overlap. In summary, role making is a complex undertaking. Successful role making reduces role ambiguity and results in smooth transition.

This conceptual model of implementation of the care coordinator role may be useful to nurse executives when implementing a differentiated practice model. For example, they can use the model to (1) plan practical and informative education for persons hired into new roles, (2) assist in development of mentoring relationships and a network of contacts to facilitate patient care delivery, (3) facilitate acquisition of space and equipment necessary for implementation of the role, (4) determine the need for clarity in responsibilities related to the role, and (5) plan strategies for communicating the vision to all stakeholders in the

system. By using the model, decision makers can make plans to minimize the detrimental effects of role ambiguity. In addition, the model can be used to help understand the process that occurs during early role implementation.

The model suggests that impaired communication may alter role making and therefore indirectly affect role performance. Despite some communication problems, role making on unit B has been largely successful. This may be related to both the personal strengths of the individual in the CNIII role and the administrative support for the role. As one staff nurse commented, "It's really going great." A patient noted, "She really made the hospital seem together." Boundaries continue to be negotiated among health professionals. Each member of the health care team is adjusting to changing roles and responsibilities. According to the model, open dialogue among all stakeholders facilitates the making of a role that is focused on providing effective and efficient seamless care delivery.

Use of the model is limited to understanding the process that occurs during early implementation of a new role. This theory may be useful to researchers, educators, and administrators interested in role implementation. In describing the process of clinical nurse specialist role implementation, Page and Arena (1991) used Kramer's (1974) phases of reality shock: honeymoon, shock/rejection, recovery, and resolution. The care coordinator in this study was clearly in the honeymoon phase. A longitudinal study would be helpful to understand the process of implementation more fully.

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