Clinical Nurse Leader as Educator: Creating Standardized Orientation Materials for Patient Care Coordinators

Sylvia Su
sylviaksu@gmail.com

Follow this and additional works at: https://repository.usfca.edu/capstone

Recommended Citation
https://repository.usfca.edu/capstone/803
Clinical Nurse Leader as Educator: Creating Standardized Orientation Materials
for Patient Care Coordinators

Shuwei Su

University of San Francisco
Abstract

The purpose of this quality improvement project is to create standardized orientation materials for patient care coordinators (PCC) in a medium-sized community hospital. The problem of not providing standardized orientation materials to newly-hired PCCs presents a risk of PCCs being unable to render the same level of quality of care to patients. Standardized orientation materials can help the newly-hired PCCs to access needed resources in a timely manner and provide patients with consistent quality of care. In order to create the orientation materials, a pre-intervention qualitative interview was conducted to determine the need for developing such tools. Through several PDSA processes, three final products were made: a PCC Resource Pocketbook, a PCC orientation resource Booklet, and a PCC extended resource binder. A post-intervention survey was conducted to ensure the resources created met the expectations of the PCCs.

*Keywords: orientation, patient care coordinator, standardized orientation material*
Clinical Nurse Leader as Educator: Creating Standardized Orientation Materials for Patient Care Coordinators

A patient care coordinator (PCC), also referred as a case manager in other healthcare settings, is a position within this medium-sized community hospital that is open to a registered nurse who has a minimum of two years of experience in direct patient care delivery and management (Kaiser Permanente Careers, 2017). The education requirement for a PCC is a bachelor's degree in nursing or four years of direct patient care experience and an associate’s degree. Case management experience is not required when a registered nurse applies for the PCC position.

A newly hired PCC at the microsystem is offered a three-month orientation with an experienced PCC preceptor. The experienced PCC preceptors are usually very comfortable in their roles; however, many of them cannot adequately explain the necessary requirements for the new PCCs to be in compliance with state and federal regulations (Hospital Case Management, 2011). For example, The Centers for Medicare & Medicaid Services (CMS) or other commercial payers require PCCs to present documentation to patients in a certain time frame to be compliant with the law. For seasoned PCC preceptors, these regulations are easy to follow, but it is challenging for new PCCs to be in compliance with all of the necessary regulations.

Description of the Problem

According to the macrosystem (2014), all new employees must attend two days of new employee orientation. After the general new employee orientation, nurses are required to attend department/unit clinical orientation. Under the direction of the unit manager or designee, nursing service employees receive a department/unit orientation following the clinical area’s
orientation plan and checklists before providing services to patients (Kaiser Foundation Hospitals Redwood City, 2014).

There is no description of how and what a PCC should receive in the orientation and what kind of competency the newly hired PCC should develop. A PCC plays an important role to ensure patients receive appropriate levels of care and to facilitate discharge plans that anticipate and meet patients’ needs. Without a proper orientation, a PCC will not have the skills and tools to assist patients and families through their journey to recovery.

Since the orientation is specifically for PCCs, the Continuity of Care department should be the primary agency to develop the materials and implement the procedure. With the proper skills, tools, and checklists, PCCs will be able to anticipate patients’ and families’ needs. According to Stanhope and Lancaster (2014), the patients were more satisfied with their care if they had a nurse case manager. With the new orientation resources for PCCs, patients’ satisfaction will increase as they are provided appropriate services. The medium-sized community hospital will also have a better patient day rate because PCCs facilitate discharge plans in a more timely manner.

**Rationale**

Traditionally, hospital patients were discharged home after the attending doctors completed the discharge orders and the primary care nurses went over the discharge instructions with the patients. With the improvement of ancillary services, today patients can receive appropriate care in sub-acute settings. The patient care coordination model encompasses an array of health care delivery models and providers that provide extra assurance for patients to receive quality care other than the hospital inpatient setting.
Skillings and MacLeod (2009) studied the implementation of the patient care coordinator model from April 2007 to November 2007 at Mid Coast Hospital, a 94-bed community hospital in Brunswick, Maine. The study occurred in the unit with a 36-bed medical-surgical unit and 11-bed intensive care unit. Five full-time experienced BSN-prepared nurses were assigned to the two units in the new patient care coordinator role, and every patient was assigned to a patient care coordinator on admission. Patient care coordinators were expected to provide continuity of care and ensure evidence-based care was provided for patients every day. They also planned and coordinated discharge plans by communicating and collaborating with members of an interdisciplinary team. After a half year of implementation, the hospital length of stay decreased from 4.25 days to 4 days. Furthermore, patient satisfaction scores related to transitions of care remained relatively high at 92% or above.

The findings of this study suggest that the patient care coordinator model produces positive outcomes such as reducing hospital length of stay and maintaining high patient satisfaction scores. The results of the study could be generalized if this model were implemented in more than just one hospital. Unfortunately, Skillings and MacLeod did not indicate how to prepare the five experienced BSN-prepared nurses to become a patient care coordinator.

However, the study conducted by Nolan, Harria and Kufta (1998) identified the skills and knowledge that would be valuable for a new case manager. The primary researcher who designed the survey is a clinical nurse researcher at The John Hopkins Hospital. A panel of experts, including five case managers at three institutions, reviewed the designed survey questions. Using a 4-point Likert scale, respondents chose to what extent they agreed that a topic would provide useful information for someone preparing to become a case manager. There were
a total of 39 educational topics identified, 19 of which were clinical issues and 20 system-related issues.

The researchers paid attention to the differences between teaching and community hospitals and sought case managers from both healthcare settings. The initial 14 case managers participating in this survey were from the regional case manager meeting and they all served as case managers in different community hospitals. The researcher also contacted eight teaching hospitals located in the eastern, western, and midwestern regions of the country. Six case managers from another region of the country who expressed willingness to participate in this survey were provided the questionnaire by fax or mail. Twenty case managers completed the survey, and all of the case managers were female aged from 26 to 54 years.

The results of the study found that the identification of discharge planning and community resources are useful education topics to help the case managers identify their roles beyond the primary nurses who provide bedside care. The topics about third-party reimbursement, coding system, and health care finance were identified as helpful to case managers for explaining the insurance benefit to their patients and also to advocate for their patients according to the reimbursement guidelines.

The survey conducted by Nolan, Harria, and Kufta (1998) shared the same outcomes this author experienced when she was orienting the newly hired PCCs at this medium-sized community hospital. As in this study, they found it effective to include the topics of discharge planning, provide patients with proper community resource, identify and assist with patients' financial concerns, and advocate for patients according to the various insurance guidelines. The results of the study provided ideas of what should be included in a PCC orientation.
A patient care coordinator faces many complicated scenarios every day which makes this nursing role challenging but interesting. During the three-month orientation periods, the newly-hired PCC might not be able to learn all of the skills because the needs of each patient are different; therefore, a simulation can assist new PCCs to assess patients’ needs. Furthermore, the simulation can offer a tool for the newly-hired PCCs to evaluate their clinical judgment abilities and the effectiveness of their skills.

Olejniczak, Schmidt, and Brown (2010) conducted a study using simulation as an orientation tool for new nurse graduates. The researchers used keywords such as simulation, transition, and orientation to conduct a general research and found 4000 articles with the search terms. After narrowing down the search results by using additional search criteria such as written in English and published in the past 10 years, three studies were chosen in the final sample of articles to review. After the review of these three articles, three themes were identified by the researchers including socializing into the professional role, having confidence and being competent in performing the new nursing role, and continuing to learn in a secure and supportive working environment.

Besides using simulation as an orientation tool, socializing into the professional role allows the new PCCs to facilitate clear and effective communication among multidisciplinary team members. Exposing new PCCs to different programmed scenarios offers them examples of how to foster effective communication skills among health care team members in an emergency situation. Simulation can also function as a highly effective tool for building PCCs’ confidence and develop competency. New PCCs are presented with the carefully designed scenarios which require PCCs to assess the situation by using their clinical judgment, performing skills, asking for associated help, or initiating a correct referral. The last benefit of the use of simulation as an
orientation strategy is to ensure the new PCCs continue to learn in a safe and supportive working environment. Simulation enables the new PCCs to practice their decision-making and clinical reasoning skills without any unfavorable outcomes.

The theoretical framework adopted in this quality improvement project drew primarily from Benner’s (article?) “From Novice to Expert” (1984). This model indicated that a novice nurse evolves through different levels of development as they advance through their career. The model illustrated five levels of capabilities as seen in Appendix A. The more experience held by the nurse, the more knowledge they obtained which would allow them to provide more holistic and competent care to patients. With this framework in mind, the proposed orientation material includes the following components: a PCC resource pocketbook, a PCC orientation resource booklet, and a PCC Extended Resource Binder, all of which would offer an opportunity for the novice PCCs to advance smoothly through their careers.

**PICOT Statement**

The population of this project were not the patients within the community hospital but were instead the patient care coordinators. All PCCs were invited to participate in this project. This project created an initial orientation material which includes three separate resource books. The initial orientation material were? presented to the PCCs for modifications and changes. Since there was no previous orientation resource for PCCs at this facility, hopefully this project serves as a start of the standardization of their orientation materials. The outcomes will be measured by a post-intervention survey to determine the level of satisfaction with the new PCC resource materials. This project started in January 2018, and is in the final approval stage with management as of the third week of July 2018.
Specific Aim

The proposed quality improvement project was conducted to determine whether a standardized orientation material was needed for PCCs and to create standardized orientation materials for the PCCs.

Context

This medium-sized community hospital is a certified Comprehensive Stroke Center located in the San Francisco Bay Area. There is a total of 23 patient care coordinators employed in the Continuity of Care department. Nine PCCs are scheduled to cover the patients in the hospital including the patients in the emergency department. There are five specific service lines including Hospital Based Specialist (HBS), Medical-Surgical, Neurology, Intensive Care Unit (ICU), and the Emergency Department (ED). These proposed orientation materials are for the HBS service line. The orientation materials also serve as a basic knowledge resource for the PCCs to advance to the more specialized service lines which require more in-depth training.

Newly-hired PCCs were provided with an eight-page patient care coordinator competency checklist as seen in Appendix B which describes what PCCs need to know. There are no other associated materials for PCCs to use when they are performing their daily tasks. PCCs need to make phone calls in order to connect with multidisciplinary teams to facilitate discharge. PCCs also need to have quick access to referral processes to ensure an effective and timely discharge planning. In a study by You et al. (2016), the researchers found that PCCs spent the largest portion of their time coordinating care, especially in frequent communication and negotiation with patients, patients’ families, care providers, and other outside service providers. Having easy access to the frequently used phone numbers and resources will increase the productivity of the PCCs as the time to look for information will decrease, which allows
PCCs to spend more time with patients and their families. The PCC’s priority is to avoid any deviations from appropriate procedures which may delay the delivery of patient care (Cesta, 2017). However, sometimes merely avoid delay is not sufficient; PCCs need to expedite the delivery of care due to superimposed time requirements. In order to provide a patient with timely care, it is crucial to have easy access to the phone numbers and the reminders of how to perform a task.

**Intervention and Methods**

In January 2018, this writer started to interview her PCC colleagues regarding their opinion about what is their opinion about current orientation process, what kind of resources would be beneficial, and in what format they feel more comfortable with. A SWOT analysis was performed (see Appendix C for more information) and identified that due to the lack of standardized orientation material and the inconsistency of preceptor assignment, it is a good idea to create a new standardized orientation program. However, after further analysis of the feasibility of the preceptor schedule, it is identified that a standardized PCC orientation resource booklet is more ideal for the newly-hired PCC. With the standardized orientation material, different preceptors will be able to orient the novice PCC according to the same resource and knowledge that new PCC needs to know and perform daily.

Gantt chart for projected timeline was created (see Appendix D for more information) to identify the timeframe for each task and ensure the project completion.

Besides the PCC orientation resource booklet, it was also identified that a pocketbook which contained frequently used phone numbers and frequently accessed resources would be beneficial for the newly-hired PCC as well as all the PCCs. Some senior PCCs who have worked as a PCC for more than five years as well as all current PCC staff also suggested that an
extended resource binder may be beneficial for the department to have when assisting patients with different insurance coverage.

After identifying the needs for PCCs, three resource materials were produced for this project: a PCC Resource Pocketbook, PCC Orientation Resource Booklet, and PCC Extended Resource Binder. According to the microsystem and learning needs assessments, PCCs are requesting to have the PCC Resource Pocketbook to be distributed to both existing and newly-hired PCC. The PCC Orientation Resource Booklet will be distributed to the newly-hired PCC. The PCC extended Resource Binder will be produced into 5 individual binders to be placed in the four PCC offices which are located in the ED, 6th floor, and two offices on the 7th floor. One master copy will be provided to management for future modification and a future application (APP) for secure mobile use is being considered.

**Study of the Intervention**

The initial qualitative survey was conducted in January of 2018 which identified the needs for creating a standardized orientation program. After reviewing the potential PCC preceptor schedule, it became clear that it would be hard to have the same preceptor orient all the new employees; therefore, the standardized orientation resource materials were identified to customize the needs of the department. As stated above, there are three materials identified to be produced for department use. Resource collection was invested from January of 2018 to the end of May 2018. The information was collected from individual PCCs, department internal documentation, and organization job-aides.

The first draft of the materials, including the PCC Resource Pocketbook, the PCC Orientation Resource Booklet, and the PCC Extended Resource Binder were completed by the second week of May 2018 and were presented to individual PCCs for feedback. Using a small
test of change, the Plan-Do-Study-Act (PDSA) analysis was performed to modify the development of the resource materials (see Appendix E for more information). After the modification of the first draft, a second draft was presented for peer review. Another PDSA analysis was performed to make changes, then the three resource materials were presented to management for final approval.

**Measures**

A post-intervention survey was conducted to evaluate the satisfaction level of the PCCs with the newly developed orientation materials (see Appendix F for more information). The survey also inquired about the usefulness of the resource pocketbook and asked if PCCs would like to have the PCC Orientation Resource Booklet during their orientation process.

**Analysis**

During the survey period, there were 22 hired PCCs in the department, two of which were per-diem so did not work during the survey time window. One of the regular PCCs was on vacation and unable to participate in the anonymous survey. The initial survey of asking PCCs whether standardized orientation materials were needed in the department received 100% "yes" responses. When asked about their satisfaction level with the new orientation materials on a scale of one to ten, one out of the 19 PCCs indicated a ten out of ten score of extremely satisfied, three out of 19 indicated a score of eight out of ten, and 15 out of the 19 PCCs indicated a nine out of ten satisfaction score (see Appendix G). All of the PCCs rated their satisfaction level at 8/10 or higher.

When asked to rate how useful the PCC Resource Pocketbook was to them, two out of 19 PCCs replied a score nine out of ten satisfaction score and the rest 17 PCCs replied ten out ten satisfaction score (see Appendix H for more information). All of the PCCs rated their satisfaction
level 9/10 or higher. Nineteen PCCs were asked to also rate how beneficial it was to have the PCC Orientation Resource Booklet during orientation all 19 PCCs in the department gave a ten out of ten (see Appendix I for more information).

**Ethical Consideration**

During the process of making the standardized materials, it was necessary to utilize the Electronic Health Record (EHR) project, the Clinical Nurse Leader/PCC was empowered to not only create the orientation materials for the new PCCs, but also to create a learning environment, stimulate collaboration and build team cohesion for the existing PCCs who appreciated the continuing education. to demonstrate where and how to access the resources. It is of course imperative to avoid revealing any patient’s personal data and to be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

**Results**

As the result of this project, three practical orientation materials were produced for the Continuity of Care department use. A PCC Resource Pocketbook was produced for both newly-hired and existing PCCs (See Appendix J for a sample page of the PCC Resource Pocketbook). This pocketbook includes the frequently used phone numbers and resources for PCCs to carry with them to complete their daily tasks in a timely manner.

The PCC Orientation Resource Booklet will be provided to future newly-hired PCCs for reference during their orientation. Simulation case discussion will be conducted at the end of the orientation period and newly-hired PCCs will be allowed to use the Resource Booklet when answering the simulation questions (See Appendix K for the index page of the PCC Orientation Resource Booklet).
The PCC Extended Resource Binder is the final product of this project. Because not every patient admitted to this medium-sized community hospital has the same insurance plan, the extended binder will have the resources that are not frequently used but will be beneficial to PCCs when assisting patients with a different payer. Since it is a less frequently used resource, only five duplicates of the binder will be created, with four more copies in the PCCs' office and one master copy stored with management for future modification and reduplication (see Appendix L for the index page of the PCC Extended Resource Binder).

**Summary**

The final versions of all three resource materials are still pending the approval of management. All created resources will be stored in the Continuity of Care department shared drive for future reference and modification. There are discussions related to producing the PCC Extended Resource Binder into an electronic version and stored in the shared drive as well. The anonymous survey results showed that 15% of the PCCs prefer to have the PCC Extended Resource Binder in an electronic format while 85% of the PCCs still prefer to have the PCC Extended Resource Binder in a hard copy format so they have can have quick access in their offices.

The maintenance of the three resource materials is still under discussion. There are constant changes in regulation and the resources will need to be updated. This writer proposed to management to provide volunteer PCCs protected time to update or modify the resource materials on a quarterly basis. Currently, the proposed process is still under management review and will need further discussion to ensure the resource materials are up to date.

With the support of department management to complete this project, the Clinical Nurse Leader/PCC was empowered to not only create the orientation materials for the new PCCs, but
also to create a learning environment, stimulate collaboration and build team cohesion for the existing PCCs who appreciated the continuing education. These orientation materials also support PCCs more effectively while caring for a diverse patient population with complex medical and psychosocial needs within a multifaceted, integrated delivery system. In summary, this practice improvement project served to support new approaches for orientation and continuing education of PCCs - across many microsystems - to achieve more timely, efficient and effective care coordination while attending to the learning needs and satisfaction of frontline staff in the Continuing Care Department.
References


Appendix A

Benner’s Stages of Clinical Competence

Benner’s Stages of Clinical Competence

In the acquisition and development of a skill, a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert.

Stage 1: Novice

The Novice or beginner has no experience in the situations in which they are expected to perform. The Novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. Practice is within a prolonged time period and he/she is unable to use discretionary judgement.

Stage 2: Advanced Beginner

Advanced Beginners demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations. He/she is efficient and skilful in parts of the practice area, requiring occasional supportive cues. May/may not be within a delayed time period. Knowledge is developing.

Stage 3: Competent

Competence is demonstrated by the nurse who has been on the job in the same or similar situations for two or three years. The nurse is able to demonstrate efficiency, is coordinated and has confidence in his/her actions. For the Competent nurse, a plan establishes a perspective, and the plan is based on considerable conscious, abstract, analytic contemplation of the problem. The conscious, deliberate planning that is characteristic of this skill level helps achieve efficiency and organisation. Care is completed within a suitable time frame without supporting cues.

Stage 4: Proficient

The Proficient nurse perceives situations as wholes rather than in terms of chopped up parts or aspects. Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long-term goals. The Proficient nurse learns from experience what typical events to expect in a given situation and how plans need to be modified in response to these events. The Proficient nurse can now recognise when the expected normal picture does not materialise. This holistic understanding improves the Proficient nurse’s decision making; it becomes less laboured because the nurse now has a perspective on which of the many existing attributes and aspects in the present situation are the important ones.

Stage 5: The Expert

The Expert nurse has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions. The Expert operates from a deep understanding of the total situation. His/her performance becomes fluid and flexible and highly proficient. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience.

# Appendix B

## Patient Care Coordinator Competencies Checklist

<table>
<thead>
<tr>
<th>Patient Care Coordinator Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
</tbody>
</table>

## OVERVIEW

1. **Instructions**
   1.1 Review: Mission, Vision & Strategies
   1.2 Review: Organisational Structure
   1.3 Review: General Overview of Resource Management/Finance Relationship
   1.4 Review: Regional Resource Management Goals/Initiatives/Outcomes
   1.5 Review: NCAAL Resource Management Structure
   1.6 Review: Local Medical Center Staff & Structure

## Checklist

- Check off items as you review and highlight areas for improvement.
- The checklist is divided into three sections: General Competencies, Departmental Competencies, and Eligibility and Benefit Verification.

### General Competencies

1. **General Competencies**
   1.1 Review: General Competencies

2. **Departmental Competencies**
   2.1 Review: Departmental Competencies

3. **Eligibility and Benefit Verification**
   3.1 Review: Eligibility and Benefit Verification

---

**Note:**
- The checklist includes various competencies ranging from knowledge of hospital policies and procedures to understanding patient care policies and procedures. It also includes eligibility and benefit verification requirements.
- The checklist is designed to ensure that PCCs are prepared for their roles and are aware of the competencies required for their position.
- This checklist is a part of the PCC orientation program and is provided to support the professional development of PCCs.

---

**Appendix B:**

**Patient Care Coordinator Competencies Checklist**

**Overview:**

- Review the mission, vision, and strategies of the organization.
- Review the organizational structure and general overview of resource management/finance relationships.
- Review the regional resource management goals/initiatives/outcomes and the NCAAL resource management structure.
- Review the local medical center's staff and structure.

**Checklist:**

- Check off items as you review and highlight areas for improvement.
- The checklist is divided into three sections: General Competencies, Departmental Competencies, and Eligibility and Benefit Verification.

### General Competencies

1. **General Competencies**
   1.1 Review: General Competencies

2. **Departmental Competencies**
   2.1 Review: Departmental Competencies

3. **Eligibility and Benefit Verification**
   3.1 Review: Eligibility and Benefit Verification

---

**Note:**
- The checklist includes various competencies ranging from knowledge of hospital policies and procedures to understanding patient care policies and procedures. It also includes eligibility and benefit verification requirements.
- The checklist is designed to ensure that PCCs are prepared for their roles and are aware of the competencies required for their position.
- This checklist is a part of the PCC orientation program and is provided to support the professional development of PCCs.

---

**Appendix B:**

**Patient Care Coordinator Competencies Checklist**

**Overview:**

- Review the mission, vision, and strategies of the organization.
- Review the organizational structure and general overview of resource management/finance relationships.
- Review the regional resource management goals/initiatives/outcomes and the NCAAL resource management structure.
- Review the local medical center's staff and structure.

**Checklist:**

- Check off items as you review and highlight areas for improvement.
- The checklist is divided into three sections: General Competencies, Departmental Competencies, and Eligibility and Benefit Verification.

### General Competencies

1. **General Competencies**
   1.1 Review: General Competencies

2. **Departmental Competencies**
   2.1 Review: Departmental Competencies

3. **Eligibility and Benefit Verification**
   3.1 Review: Eligibility and Benefit Verification

---

**Note:**
- The checklist includes various competencies ranging from knowledge of hospital policies and procedures to understanding patient care policies and procedures. It also includes eligibility and benefit verification requirements.
- The checklist is designed to ensure that PCCs are prepared for their roles and are aware of the competencies required for their position.
- This checklist is a part of the PCC orientation program and is provided to support the professional development of PCCs.
### Appendix B Continued

| 1.1.2 | Medication Time for Service |
| 1.1.3 | Correctly document on chart |
| 1.1.4 | Maintain and score HAPI scores |
| 1.1.5 | Work's Compensation |
| 1.1.6 | Correct identification of patients (i.e., name, age, address) |

#### Utilization Management

| 4.1.1 | Accurately implements case reviews utilizing prioritization process based on Regional Policy/600-6200 Limits Review (RMC-Total) |
| 4.1.2 | Consistently conducts and documents timely reviews |
| 4.1.3 | Proactively reviews barriers to efficient delivery of care and services |

#### Policies

| 4.2.1 | Actively participates in Rounds |
| 4.2.2 | Actively coordinates care with PCP (PCC) and regional to operations, including Level of Care (Primary Care) |
| 4.2.3 | Ability to assist and fully discuss any special needs and identify options as appropriate |

#### Medical Records

| 4.3.1 | Complete and appropriately populate medical chart (updated) |
| 4.3.2 | Demonstrates appropriate use application of MDCS-CERT in (PCC) and/or appropriateness of Level of Care (PCP) |
| 4.3.3 | Demonstrates appropriate use application of MDCS-CERT for other Level of Care (PCP) and/or appropriateness of Level of Care (PCP) |
| 4.3.4 | Conducts appropriate investigation when Level of Care (PCP) is not included, but not limited to, reviewing chart notes, discussion with nurses and treating physicians |

#### Nursing Care

| 4.4.1 | Appropriately escalates unresolved PA issues to the Agitation Resolution Unit (ARU) |
| 4.4.2 | Discusses cases with treating physicians to gain clarity surrounding cases not meeting PA 101 criteria for either Level of Care (LCC), Admission, Continued Stay or Discharge process involving Utilization Review (PCC) |
| 4.4.3 | Escalates cases to Level of Care (LCC) according to facility protocol (i.e., Utilization Review (PCC) and/or Appropriateness of Level of Care (PCP)) |
| 4.4.4 | Documents in MDCS-CERT the escalation intervention and outcomes |

#### Admitting Process

| 4.5.1 | Identifies patients and accurately enters patient information (updated) |
| 4.5.2 | Reports all available/essential data to RN/Utilization Manager on the day they begin |
| 4.5.3 | conducts an accurate assessment of the patient and communicates it to the appropriate NUR |

#### Discharge Process

| 4.6.1 | Review Regional Policy #18: Hospital Outpatient Observation (see also 2.2) |
| 4.6.2 | Follows 34 CFR 482 Observation Compromise Policy (34 CFR 482.100) |
| 4.6.3 | Accurately implements Regional Policy #18: Hospital Outpatient Observation (HCO) |
| 4.6.4 | Utilizes CM D/C Criteria for Observation/Discharge (LOD) to (PCC) and ability to demonstrate use application |

#### Terminal Discharge

| 4.7.1 | In the event of a terminal illness, the appropriate end-of-life care is provided and the appropriate LOD is activated |
| 4.7.2 | Encourage and assist the family in seeking appropriate levels of care |
| 4.7.3 | Provide pain relief as appropriate |

#### End of Life Care

| 4.8.1 | Have knowledge of OAD requirements, OAD requirements for MDCS, and OAD requirements for OAD (see also 2.2.3) |
| 4.8.2 | Have knowledge of OAD, AD, and OAD requirements for MDCS, and OAD requirements for OAD (see also 2.2.3) |
| 4.8.3 | Have knowledge and ability to address and manage potential Social Security |
| 4.8.4 | Have knowledge and ability to address and manage potential Social Security |

#### Discharge Process

| 4.7.1 | In the event of a terminal illness, the appropriate end-of-life care is provided and the appropriate LOD is activated |
| 4.7.2 | Encourage and assist the family in seeking appropriate levels of care |
| 4.7.3 | Provide pain relief as appropriate |

#### End of Life Care

| 4.8.1 | Have knowledge of OAD requirements, OAD requirements for MDCS, and OAD requirements for OAD (see also 2.2.3) |
| 4.8.2 | Have knowledge of OAD, AD, and OAD requirements for MDCS, and OAD requirements for OAD (see also 2.2.3) |
| 4.8.3 | Have knowledge and ability to address and manage potential Social Security |
| 4.8.4 | Have knowledge and ability to address and manage potential Social Security |

#### Discharge Process

| 4.7.1 | In the event of a terminal illness, the appropriate end-of-life care is provided and the appropriate LOD is activated |
| 4.7.2 | Encourage and assist the family in seeking appropriate levels of care |
| 4.7.3 | Provide pain relief as appropriate |

#### End of Life Care

| 4.8.1 | Have knowledge of OAD requirements, OAD requirements for MDCS, and OAD requirements for OAD (see also 2.2.3) |
| 4.8.2 | Have knowledge of OAD, AD, and OAD requirements for MDCS, and OAD requirements for OAD (see also 2.2.3) |
| 4.8.3 | Have knowledge and ability to address and manage potential Social Security |
| 4.8.4 | Have knowledge and ability to address and manage potential Social Security |
## Appendix B Continued

### COMMUNICATION

- **Communicates patient and family information effectively**
- **Demonstrates sensitivity to cultural differences**
- **Ability to listen actively**
- **Ability to ask open-ended questions**
- **Ability to interpret non-verbal cues**
- **Demonstrates effective communication skills**
- **Ability to provide clear, concise, and relevant information**
- **Ability to handle sensitive information**
- **Demonstrates active listening skills**
- **Demonstrates ability to summarize information**

### PATIENTS AND FAMILIES

- **Demonstrates empathy and compassion**
- **Demonstrates understanding of patients' needs and preferences**
- **Demonstrates ability to provide emotional support**
- **Demonstrates ability to assist with decision-making**
- **Demonstrates ability to address patients' concerns**
- **Demonstrates ability to provide educational materials**
- **Demonstrates ability to provide emotional support**
- **Demonstrates ability to provide ongoing follow-up**

### ACCESSIBILITY

- **Demonstrates knowledge of accessibility resources and services**
- **Demonstrates ability to provide patient education**
- **Demonstrates ability to provide patient advocacy**
- **Demonstrates ability to provide patient empowerment**
- **Demonstrates ability to provide patient navigation**
- **Demonstrates ability to provide patient support**
- **Demonstrates ability to provide patient engagement**
- **Demonstrates ability to provide patient involvement**

### PATIENT EDUCATION

- **Demonstrates ability to provide patient education**
- **Demonstrates ability to provide patient engagement**
- **Demonstrates ability to provide patient empowerment**
- **Demonstrates ability to provide patient navigation**
- **Demonstrates ability to provide patient support**
- **Demonstrates ability to provide patient involvement**
- **Demonstrates ability to provide patient advocacy**
- **Demonstrates ability to provide patient education**

### DISSEMINATION

- **Demonstrates ability to disseminate information**
- **Demonstrates ability to provide patient education**
- **Demonstrates ability to provide patient navigation**
- **Demonstrates ability to provide patient support**
- **Demonstrates ability to provide patient engagement**
- **Demonstrates ability to provide patient empowerment**
- **Demonstrates ability to provide patient advocacy**
- **Demonstrates ability to provide patient education**

### ACCESSIBILITY

- **Demonstrates knowledge of accessibility resources and services**
- **Demonstrates ability to provide patient education**
- **Demonstrates ability to provide patient engagement**
- **Demonstrates ability to provide patient empowerment**
- **Demonstrates ability to provide patient navigation**
- **Demonstrates ability to provide patient support**
- **Demonstrates ability to provide patient involvement**
- **Demonstrates ability to provide patient advocacy**

### PATIENT EDUCATION

- **Demonstrates ability to provide patient education**
- **Demonstrates ability to provide patient engagement**
- **Demonstrates ability to provide patient empowerment**
- **Demonstrates ability to provide patient navigation**
- **Demonstrates ability to provide patient support**
- **Demonstrates ability to provide patient involvement**
- **Demonstrates ability to provide patient advocacy**
- **Demonstrates ability to provide patient education**
### DISCHARGE PLANNING

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.1</td>
<td>Identifies and ensures completion of the initial discharge assessment on the day of the hospitalization.</td>
</tr>
<tr>
<td>8.1.2</td>
<td>Communicates effective discharge planning to all involved parties, interdisciplinary team, physicians, patient/family, and other staff involved (e.g. pharmacy)</td>
</tr>
<tr>
<td>8.1.3</td>
<td>Identifies barriers to discharge (environmental, financial, required resources/supplies, complex teaching needs) in the initial discharge assessment plan and subsequently throughout hospitalization.</td>
</tr>
<tr>
<td>8.1.4</td>
<td>Identifies appropriate referrals as indicated.</td>
</tr>
<tr>
<td>8.1.5</td>
<td>Efforts to control barriers in the patient's/ family's discharge.</td>
</tr>
<tr>
<td>8.1.6</td>
<td>Incorporates the assigned ICU and discharge criteria into the Integrated Care Plan.</td>
</tr>
<tr>
<td>8.1.7</td>
<td>Provides patient and family education regarding care plan.</td>
</tr>
<tr>
<td>8.1.9</td>
<td>Consistently communicates with the health care team and patient and/or representative to coordinate the discharge plan.</td>
</tr>
<tr>
<td>8.1.10</td>
<td>Evaluates the effectiveness of the discharge planning process.</td>
</tr>
</tbody>
</table>

#### Appendix B Continued

- **Note:** Internal document, obtained by Marsha Belen, January 2018.
Appendix C

SWOT Analysis

**Strengths**
- Seasoned PCCs willing to share knowledge
- Newly-hired PCCs have strong desire to learn what is needed to perform their role better
- Mutual goal is to provide quality patient care in an efficient way
- Management support of project

**Weaknesses**
- There is no standardized orientation program and process
- Inconsistent preceptor assignments
- No standardized resources to use after orientation

**Opportunities**
- Create a new standardized orientation program
- Create a new standardized resource material for all PCCs to use
- Create a system to continuously update the resource material to keep resource up to date

**Threats**
- Consistent preceptor assignment feasibility due to FTE status
- Stakeholders who are not willing to participate in the new program

Note: Tables created by Shuwei Su, 7/26/2018
### Appendix D

**Gantt Chart of Projected Timeline**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4</td>
<td>1 2 3 4</td>
<td>1 2 3</td>
<td>1 2 3</td>
<td>1 2</td>
<td>1 2 3</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Microsystem Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literature Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collecting Material</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compiling Material</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Peer Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modification or Material</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Peer Review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Produce Material</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final Survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing Papers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare Poster</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Tables created by Shuwei Su, 7/26/2018
Appendix E

PDSA Cycle

<table>
<thead>
<tr>
<th>ACT</th>
<th>PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce the material for department use</td>
<td>Identified the needs of having a standardized resource material</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STUDY</th>
<th>DO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed with peers to modify the material</td>
<td>Collection data to develop the identified material</td>
</tr>
<tr>
<td>Discuss with management to modify the material</td>
<td>Develop the identified material</td>
</tr>
</tbody>
</table>

Note: Tables created by Shuwei Su, 7/26/2018
Appendix F

Post-Intervention Survey

Dear PCCs,

I am so excited about introducing this new orientation program and the associated resource to you. Please answer the following questions. Your feedback is very important to me. Appreciate your time in completing this survey.

1. Do you think there is a need for having a standardized orientation material in our department?
   Yes No

2. After reviewing the new proposed orientation material, please rate your satisfaction level of the provided material. 1 = Not satisfied to 10 = Extremely Satisfied.
   1  2  3  4  5  6  7  8  9  10

3. How useful do you think the PCC Resource Pocketbook will assist you daily?
   1 = Not useful at all to 10 = Extremely useful
   1  2  3  4  5  6  7  8  9  10

4. How beneficial do you think to have the PCC Orientation Resource Booklet when you were being oriented. 1 = Not beneficial at all to 10 = Extremely Beneficial
   1  2  3  4  5  6  7  8  9  10

5. Would you like to have the PCC Extended Resource Binder in Hard Copy or Stored in Share Drive for your daily use?
   Hard Copy Stored in Share Drive

6. Please share any additional comments or suggestions regarding this proposed orientation program and the associated resource materials.

__________________________________________________________________________

__________________________________________________________________________

Note: Tables created by Shuwei Su, 7/26/2018
### Appendix G

**Satisfaction Level of the New Orientation Materials**

Note: Tables created by Shuwei Su, 7/26/2018
Appendix H

Usefulness of the PCC Resource Pocketbook

Note: Tables created by Shuwei Su, 7/26/2018
Appendix I

How beneficial to have the PCC Orientation Resource Booklet during Orientation Period

<table>
<thead>
<tr>
<th></th>
<th>PCC 1</th>
<th>PCC 2</th>
<th>PCC 3</th>
<th>PCC 4</th>
<th>PCC 5</th>
<th>PCC 6</th>
<th>PCC 7</th>
<th>PCC 8</th>
<th>PCC 9</th>
<th>PCC 10</th>
<th>PCC 11</th>
<th>PCC 12</th>
<th>PCC 13</th>
<th>PCC 14</th>
<th>PCC 15</th>
<th>PCC 16</th>
<th>PCC 17</th>
<th>PCC 18</th>
<th>PCC 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Tables created by Shuwei Su, 7/26/2018
Appendix J

Sample Page of the PCC Resource Pocketbook

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute Care Falmaha</td>
<td>550-361-1211</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C: 660-771-0762</td>
<td></td>
</tr>
<tr>
<td>Absolute Care Transportation</td>
<td>550-361-1211</td>
<td></td>
</tr>
<tr>
<td>Alameda Alliance</td>
<td>855-313-6306</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P: 510-747-4540</td>
<td></td>
</tr>
<tr>
<td>Amberwood - Carlos</td>
<td>408-990-6506</td>
<td></td>
</tr>
<tr>
<td>Clinical Liaison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Lifeline</td>
<td>650-738-8100</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td>Angela</td>
<td></td>
</tr>
<tr>
<td>AMR - Ambulance</td>
<td>888-690-5472</td>
<td></td>
</tr>
<tr>
<td>Kaiser Ambulance Hub</td>
<td>560-438-7434</td>
<td></td>
</tr>
<tr>
<td>Apria Sup Annette</td>
<td>888-452-4390</td>
<td></td>
</tr>
<tr>
<td></td>
<td>850-330-2405</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F: 844-572-7742</td>
<td></td>
</tr>
<tr>
<td>Apria Wound Vac</td>
<td>800-780-1228</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P: 800-323-1882</td>
<td></td>
</tr>
<tr>
<td>Applied Orthotics</td>
<td>408-358-9741</td>
<td></td>
</tr>
<tr>
<td>Mike Dots</td>
<td>Cell 408-316-3921</td>
<td></td>
</tr>
<tr>
<td>Asian Network Home Health</td>
<td>510-236-1116</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F: 510-236-1116</td>
<td></td>
</tr>
<tr>
<td>Assurance Wireless</td>
<td>558-896-4866</td>
<td></td>
</tr>
<tr>
<td>Cell phone for free,</td>
<td>Society of St Vincent de Paul 650-343-4463 50 North B Street San Mateo, CA 94400</td>
<td></td>
</tr>
<tr>
<td>needs mailing address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Rehab St. Francis</td>
<td>415-353-6000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Tables created by Shuwei Su, 7/26/2018
Appendix K

Index page of the PCC Orientation Resource Booklet

TABLE OF CONTENTS

MY SIGN IN AND PASSWORD .......................................................... 2
DISCHARGE PLANNING – CONTINUUM OF CARE POLICY .................... 3
ADMISSION, TRANSFER, AND DISCHARGE POLICY ............................ 11

UTILIZATION/RESOURCE MANAGEMENT

SIGN IN TO DAILY ASSIGNMENT ..................................................... 17
CHECK PATIENT DX AND CLASS ..................................................... 18
VERIFY PATIENT DX MEETS CLASS ............................................... 18
ISSUE MOON ................................................................................. 19
CONDITION 44 ............................................................................ 20
CHECK TRANSITION SCORE .......................................................... 24
RM Round – Standardized Format .................................................... 26
KEY ELEMENTS FOR EFFECTIVE ROUNDS ..................................... 27

BENEFIT ELIGIBILITY, DENIAL MANAGEMENT

CHECK INSURANCE COVERAGE ...................................................... 29
CHECK INSURANCE BENEFIT USING CIPS ..................................... 29
CHECK INSURANCE BENEFIT USING MAIN FRAME .......................... 35
ISSUE IM ....................................................................................... 36

CARE COORDINATION/FACILITATION

INITIAL ASSESSMENT ..................................................................... 38
PLAN OF CARE ............................................................................... 39
PREP TO DISCHARGE ..................................................................... 40
PCC COMMUNICATION ................................................................... 42
DAILY ACTIVITY NOTE ................................................................... 44

REGULATORY COMPLIANCE

MEDICARE APPEAL PROCESS ......................................................... 45
CDSU WIKI SITE ............................................................................ 46
TRACK APPEAL PROCESS ............................................................... 49
AFTER HOURS/WEKEND/Straight Medicare Appeals ......................... 50
e-APPEAL PROCESS FLOWCHART ............................................... 54

Note: Tables created by Shuwei Su, 7/26/2018
Appendix L

Index page of the PCC Extended Resource Binder

TABLE OF CONTENTS

A

APRIA DME COPAY GUIDELINE
APRIA DEDICATED PHONE AND FAX NUMBER FOR KAISER
APRIA BREAST PUMP RENTAL GUIDE
APRIA AFTER HOURS ORDERING PROCESS
AMBULANCE LEVELS OF SERVICE GUIDE
APRIA DRAIN CARE GUIDE
APPEAL SCRIPT FOR NON-MEDICARE INSURANCE
ALAMEDA ALLIANCE PROVIDER LIST
ACUTE REHAB INFORMATION FLYER
ACUTE REHAB INFORMATION BOOKLET
ACUTE REHAB INFORMATION BOOKLET - SPANISH VERSION
AVOIDABLE DAY V.A. VARIANCE DAY GUIDELINE
APPEAL/E-APPEAL (MEDICARE) PROCESS GUIDE

B

BEHAVIORAL MONITORING FORM
BED HOLD REGULATIONS

C

CONTINUUM OF CARE SERVICES - EAST BAY URC FACILITY LIST
COMMUNITY RESOURCE LIST (2017)
COMMUNITY RESOURCE LIST (2016)
COMMUNITY RESOURCE FOR PATIENT PLACEMENT
CLEANING RESOURCE
COMFORT KEEPERS FLYER
CHRONIC CONDITIONS MANAGEMENT CONTACT LIST

D

DME DEPARTMENT CONTACT LIST
DME ORDERING – FOR NON-ADMITTED PATIENTS ONLY
DME ORDERING – PEG TUBE FEEDING SUPPLY
DME ORDERING – QUESTIONS TO ASK WHEN ORDERING HOSPITAL BED
DECISION MAKERS FOR MEDICAL TREATMENT FOR ADULTS
DMV CONFIDENTIAL MORBIDITY REPORT

Note: Tables created by Shuwei Su, 7/26/2018