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

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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

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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 2007at 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.

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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.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park: Addison-Wesley, pp. 13-34.

Appendix B

Patient Care Coordinator Competencies Checklist

Patient Care Coordinator Competencies

NAME:		Employee ID:		
Hire Date:		Date Completed:		
1	OVERVIEW	Preceptor's Assessment	Preceptor's Initials/Date	Comments/Follow-up
1.1.0	Introduction			
1.1.1	Review [redacted] Mission, Vision & Strategies			
1.1.2	Review [redacted] Organizational Structure			
1.1.3	Review general overview of Resource Management / Resource Stewardship			
1.1.4	Review NCAL Regional Resource Management Goals / Initiatives / Strategies			
1.1.5	Review NCAL Regional Resource Management Structure			
1.1.6	Review Local Medical Center Goals & Structure			
	Review definitions & identify for both NCAL and current (monthly) local facility performance metrics for the following:			
1.2.1	• PDR: Patient Day Rate			
1.2.2	• Length of Stay (LOS).			
1.2.3	• Discharge Rate (DC Rate).			
1.2.4	• Membership: NCAL & Medical Center.			
1.2.5	• Patient Days (PD).			
1.2.6	• One (1) Day and Observations.			
1.2.7	• Extended Length of Stay (ELOS) outliers (>5/Days). Review ELOS report and identify trends within the Medical Center.			
1.2.8	• Avoidable and Variance Day Codes and associated facility reports. Are there readily identifiable "outlier" trends?			
1.2.9	• Hospital Capacity Dashboard. Identify where local Medical Center is as compared to NCAL.			
1.2.10	• World Class Hospital Dashboard. Identify where local Medical Center is as compared to NCAL.			
1.2.11	Verbalize how the PDR, LOS and DC rate are associated with the throughput process			
1.3.0	Regulatory / Compliance			
1.3.1	IRR: Inter-Rater Reliability: Review Regional Policy #3: Consistency of UM Application. Completes Pre-Test (at hire). Complete Annual IRR test to monitor consistency of RM/UM decision making.			
1.3.2	Review Regional Policy #17: Issuance of Notice of Non-Coverage Letters, & notification as associated with Clinical Decision Support Unit			
1.3.3	Demonstrates knowledge of letter/notification process when CDSU is closed (ie, weekends, holidays, and/or not available) to select, create and deliver appropriate written notifications including but not limited to Regional Policy #17: Issuance of Notice of Non-Coverage (NONC) Letters, Pre-Service (SNF), Medi-Cal Notice of Action (NOA), etc from letter library, as indicated based on benefits/coverage, etc.			
1.3.4	Review and Identify Regional Contact Information (i.e. contacting CDSU: Clinical Decision Support Unit)			
1.3.5	Appeals and Grievances: Review Policy/Procedures associated with Medicare QIO (Quality Improvement Organization), Commercial products & Self-funded.			
1.3.6	Appeals and Grievances: Demonstrate use/application associated with Medicare QIO (Quality Improvement Organization) process (i.e., Regional Policy #30: CMS Important Message & DND: Detailed Notice of Discharge)			

2	DEPARTMENT			
2.1.0	RM Department Logistics			
2.1.1	Review Facility RM Department Attendance policy and use of Paid Time Off (PTO) &/or Sick- time, etc.			
2.1.2	Review Facility RM Department Policy/Process on Professionalism.			
2.1.3	Review Facility RM Department Policy/Process on Dress Code			
2.1.4	Review and identify local Medical Center contact information.			
2.1.5	Sign and submit all applicable forms to Manager &/ or COCSD			
2.1.6	On initial contact, PCC has clear presentation of Kaiser ID badge			
2.1.7	PCC provides introduction of self and role			
2.1.8	Provide issuance of contact numbers &/or business cards (Facility specific)			
2.2.0	Core Competencies			
2.2.1	Demonstrate ability to access P&Ps			
2.2.2	Review Regional Policies & Procedures			
2.2.3	Review Advance Directives Policies & Procedures			
2.2.4	Review Durable Power Attorney Policies & Procedures			
2.2.5	Review Conservatorships process			
2.2.6	Review and present knowledge of Values-Compass			
2.2.7	Documentation: Review general KP process: SBAR, SOAP, MIDAS/ CERMe Templates (Documentation process is Facility specific)			
2.2.8	Documentation: Review KP Healthcare acronyms			
2.2.9	Able to accurately interpret and communicate health plan benefits and various health and welfare services to the patient/family			
2.2.10	Provide evidence of Continuing-Education (CE) associated with Resource / Utilization Management &/or Case Management			
2.2.11	Complete new hire training modules in Healthstream as assigned by RWC Clinical Education appropriate for PCC			
2.2.12	Complete General Compliance Training for New Employees in KP Learn (for current year)			
2.3.0	Training			
2.3.1	Health Connect			
2.3.2	Benefits			
2.3.3	Midas/CERMe			
2.3.4	eDME			
2.3.5	eConsult			
2.3.6	IT: NCAL Intra-net site; Local Intra-net and Local RM Share Drive			
3	ELIGIBILITY AND BENEFIT VERIFICATION			
3.1.0	Eligibility and Insurance Coverage			
3.1.1	Ability to identify membership status in Health Connect system			
3.1.2	Ability to identify types of insurance coverage in Health Connect system			
3.1.3	Ability to identify eligibility status in Health Connect system			
	Demonstrates knowledge of the various insurance plans/coverage:			
3.1.4	- [redacted] **Commercial plans			
3.1.5	Employer Group plans including Self-funded			
3.1.6	Personal Choice plans			
3.1.7	KPIC			
3.1.8	COBRA			
3.1.9	- State Plans/Programs: MRMIP			
3.1.10	Medi-Cal			
3.1.11	Medi-Cal Managed Care			

Appendix B Continued

3.1.12	- Medicare: Medicare Fee-For-Service			
3.1.13	[redacted]ser Permanente Senior Advantage			
3.1.14	Medicare ESRD			
3.1.15	- Worker's Compensation			
3.1.16	- Coordination of Benefits (COB)			
3.1.17	- Third Party Liability (TPL)			
3.2.0	Insurance Verification (Primary/Secondary)			
3.2.1	Ability to identify Primary and any Secondary insurance coverage in Health Connect system			
3.2.2	Upon identification, provide notification to the Business Office for research and confirmation of any possible secondary insurance coverage			
3.3.0	Benefit Coverage / Copayments Billing			
3.3.1	Ability to identify benefit coverage issues from the appropriate resources (e.g., CDSU, Home Health, SNF, DME Referral Desk, etc)			
3.3.2	Contacts the Member Services Department to research the member's Evidence of Coverage (EOC) regarding any benefit coverage issues			
3.3.3	Demonstrates knowledge of the Medicare Rules & Regulations for Skilled Nursing, Home Health, Hospice, Acute Rehabilitation, ST/PT/OT			
3.3.4	Appropriately contacts the Financial Counselor upon notification that the patient's benefit's) has been exhausted, excluded from coverage, or disenrolled			
3.3.5	Review Regional Policy #8: UM Transition of Care for Members			
3.3.6	Demonstrate ability to research and obtain information regarding co-payments and billings from the appropriate resources (e.g., CDSU, Member Services, Home Health, SNF, DME, etc)			
4	UTILIZATION MANAGEMENT			
4.1.0	UM Process			
4.1.1	Accurately implements case reviews utilizing prioritization process based on Regional Policy#26: Hospital Utilization Review (ABC Model)			
4.1.2	Consistently conducts and documents timely reviews			
4.1.3	Proactively resolves barriers to efficient delivery of care and services			
4.2.0	Rounds			
4.2.1	Actively participates in Rounds			
4.2.2	Ability to articulate case/ Plan of Care (POC) and respond to questions, including Level of Care (InterQual criteria)			
4.2.3	Ability to present and fully discuss any special needs and identify options as appropriate			
4.3.0	Midas/CERMe/InterQual			
4.3.1	Consistently and appropriately applies InterQual Criteria/ Guidelines			
4.3.2	Demonstrates appropriate use/ application of MIDAS/ CERMe (InterQual)			
4.3.3	Ability to verbalize interQual review processes for Observation, Admission, Continued Stay and Discharge process including Alternate Levels of Care (ALOC)			
4.3.4	Utilizes and documents in MIDAS/ CERMe appropriate application of including Level of Care (LOC): Observation, Admission, Continued Stay, Discharge Screens and as needed, Alternate Level of Care (ALOC)			
4.3.5	Conducts appropriate investigation when InterQual criteria is not met including, but not limited to, reviewing chart notes, discussion with nurses and treating physicians			

S

4.4.0	Escalation Process			
4.4.1	Appropriately escalates unresolved RM issues/ cases timely according to Escalation-Process in Hospital Utilization Review policy (#26)			
4.4.2	Discusses cases with treating physician(s) to gain clarity surrounding cases not meeting RM/ IQ criteria for either Level of Care, Admission, Continued Stay (including alternatives as "next steps", when appropriate)			
4.4.3	Escalates cases to RM leadership according to facility protocol-either: UM Manager and/or COCSD prior to RM chief (or designee) and/or directly to RM Chief (or designee)			
4.4.4	Documents in MIDAS/ CERMe the escalation intervention and outcomes			
4.5.0	Avoidable Days			
4.5.1	Accurately demonstrates appropriate steps in identifying and collecting avoidable/ variance days			
4.5.2	Reports all avoidable/variance days to RM/UM Manager/ Director on the day they begin			
4.5.3	PCC makes every effort to resolve avoidable/variance days for "real time" resolution			
4.6.0	Observation Status			
4.6.1	Review Regional Policy #10: Hospital Outpatient Observation (see also 2.2.2)			
4.6.2	Review 24 Hr/ Observation Compliance Training Power Point (PPT) (October 2008)			
4.6.3	Accurately interprets & implements Regional Policy #10: Hospital Outpatient Observation (HOO)			
4.6.4	Verbalizes CMS Condition-44 (Observation LOC to In-Patient) and able to demonstrate use/ application			
4.6.5	Demonstrates notification and/or alert mechanism/process that notifies care team members when Observation patients are nearing the end of their 24/48 hour stay.			
4.7.0	Emergency Department Patient Care Coordinator : ED PCC			
4.7.1	The ED PCC conduct InterQual/ CERMe reviews for all admissions - at the appropriate LOC			
4.7.2	Have knowledge of ED department / team / operations			
4.7.3	The ED PCC is an effective liaison to the PCP, clinic and community agencies in coordinating continuity of care.			
4.7.4	The ED PCC coordinates appropriate follow-up and continuity of care as needed...			
	Demonstrate knowledge of:			
4.7.5	Outpatient and community resources.			
4.7.6	Arranging home health/hospice and DME			
4.7.7	Referral to pain team - as applicable			
4.7.8	Various KP & Community Programs: CCM / CCOP / DM, etc.			
4.7.9	The ED PCC effectively educates patients and families regarding appropriate utilization of ED services, post-acute services, and outpatient services.			
4.7.10	The ED PCC effectively dispositions patients directly to SNFs, etc from the ED as opposed to admitting for transfer the next day.			
4.7.11	The ED PCC accurately generates Notices of Non-Coverage NONC/DENC), and pre-service referrals for SNF.			
4.7.12	Review and presents knowledge of Regional Policy #23: Discharge of the Homeless (see also 2.2.2)			
4.7.13	Have knowledge of AB 1203 - Requirment to obtain authorization post-stabilization of non-KP member/outside health plan to obtain timely authorization for poststabilization care			
4.7.14	Have knowledge and ability to verbalize importance & processes of EMTALA			
4.7.15	Have knowledge of processes to address and manage potential Social Admits			
4.7.16	Have knowledge to address and manage ESRD patients needing only dialysis without other clinical indications (i.e. referral to out patient dialysis unit)			
4.7.17	Have knowledge of process & integration of care associated with Clinical Decision Unit / Area (CDU/A)*Medical Facility specific*			

Appendix B Continued

5	CONFERENCES			
5.1.0	Clinical Case Conferences			
5.1.1	Ability to identify cases for clinical case conference			
5.1.2	Ability to initiate and facilitate a Clinical Case Conference			
5.1.3	Ability to state the primary focus of the Clinical Case Conference			
5.1.4	Ability to identify key providers to be involved in clinical care conference and make appropriate referrals			
5.1.5	Ability to articulate and communicate the case conference outcomes, including documentation			
5.2.0	Patient / Family Interactions / Conferences			
5.2.1	Ability to identify cases for case conference			
5.2.2	Ability to initiate and facilitate patient and family discussion regarding treatment and discharge plans			
5.2.3	Ability to accurately identify any discharge barriers			
5.2.4	Consistently communicates status of discharge plan and provide the patient/family with the names and contact information of the referral agencies			
5.2.5	Ability to assist and coordinate follow-up appointments or outpatient services that may be needed upon discharge (i.e., referral to community resources, clinics, etc)			
5.2.6	Ability to initiate and facilitate patient and family discussion regarding any social issues or needs			
5.2.7	Ability to assess patient's social and support system			
5.2.8	Ability to assess possible need for Conservatorship			
5.2.9	Ability to initiate and facilitate patient and family discussion regarding any financial issues or needs			
6	COMMUNICATION			
6.1.0	Team Approach , Interactions & Service			
6.1.1	Serves as a resource to the Medical Center staff for Resource Management and Care Coordination issues			
6.1.2	Shares knowledge of resources with colleagues (i.e.: RM, Clinical, Nursing/ PCS, and other services).			
6.1.3	Provides annual update of Continuing Education (CE) course taken (Annual)			
6.1.4	Participates in a continuous evaluation of own learning needs.			
6.1.5	Customer Services: Demonstrates application of positive customer-service standard when interacting with "customers" both internal to KP &/or external to the Organization.			
6.1.6	Communications: Demonstrates best routes & methods / approaches to communicate with other health care team members / colleagues.			
6.1.7	Interactions are respectful of colleagues.			
6.1.8	Ability to listen attentively to team members and appropriately provides constructive feedback.			
6.1.9	Works collaboratively with colleagues to meet departmental and organizational goals.			
6.1.10	Demonstrates flexibility in a changing environment			
6.1.11	Volunteers as RM resource within the department and Medical Center.			
6.1.12	Demonstrates leadership in daily activities by helping/ mentoring other PCC's.			
6.1.13	Have knowledge of Service processes (improvement process & satisfaction surveys): Avatar, People Pulse, MPS, HCAHPS			
6.2.1	Consistently provides accurate, & complete information (verbal or written) of the patient assessment and plan of care for hand off.			
6.2.2	Ability to communicate and provide appropriate report for intra-agency handoffs (SNF / Sub-Acute / HH/ HO, etc)			

7	PATIENTS AND FAMILIES			
7.1.0	Service			
7.1.1	Utilizes appropriate language skills to meet the age and needs of the patient and family			
7.1.2	Assess patient's cultural and linguistic needs (e.g., patient's race, ethnicity, spoken and written language)			
7.1.3	Respectfully incorporates the patient's cultural and religious beliefs when providing service			
7.1.4	Informs members of their right to receive language assistance service			
7.1.5	Offer interpreter services to non-English or limited English speaking and hearing impaired patients			
7.1.6	Interprets and communicates health plan benefits and various health and welfare services to patient, families, significant others			
7.2.0	Patient's Rights			
7.2.1	Demonstrates an understanding of the patient's Rights and Responsibilities			
7.2.2	Ability to locate and provide a copy of the Patient's Rights when requested			
7.3.0	Conservatorship			
7.3.1	Demonstrate a general knowledge of Conservator of the Person, Conservator of the Estate, and a LPS Conservatorship			
7.3.2	Makes appropriate and timely referral to Social Services to initiate the conservatorship process			
7.3.3	Have knowledge of referral process to JFCS: Jewish Family & Childrens Services			
7.4.0	SB853: Preferred Language & Translators			
7.4.1	Review & demonstrates knowledge of SB853: Issuance of Translated Letters & associated Regional Policy #31: Issuance of Translated Letters			
7.4.2	Completes supportive documentation form appropriately for CDSU to generate letter to non-English or limited English speaking patients			
7.4.3	Demonstrates ability of locating letters in Chinese and Spanish in the NONC library			
7.4.4	Informs members of their right to receive language assistance services, including interpreter services and services for the hearing impaired			

Appendix B Continued

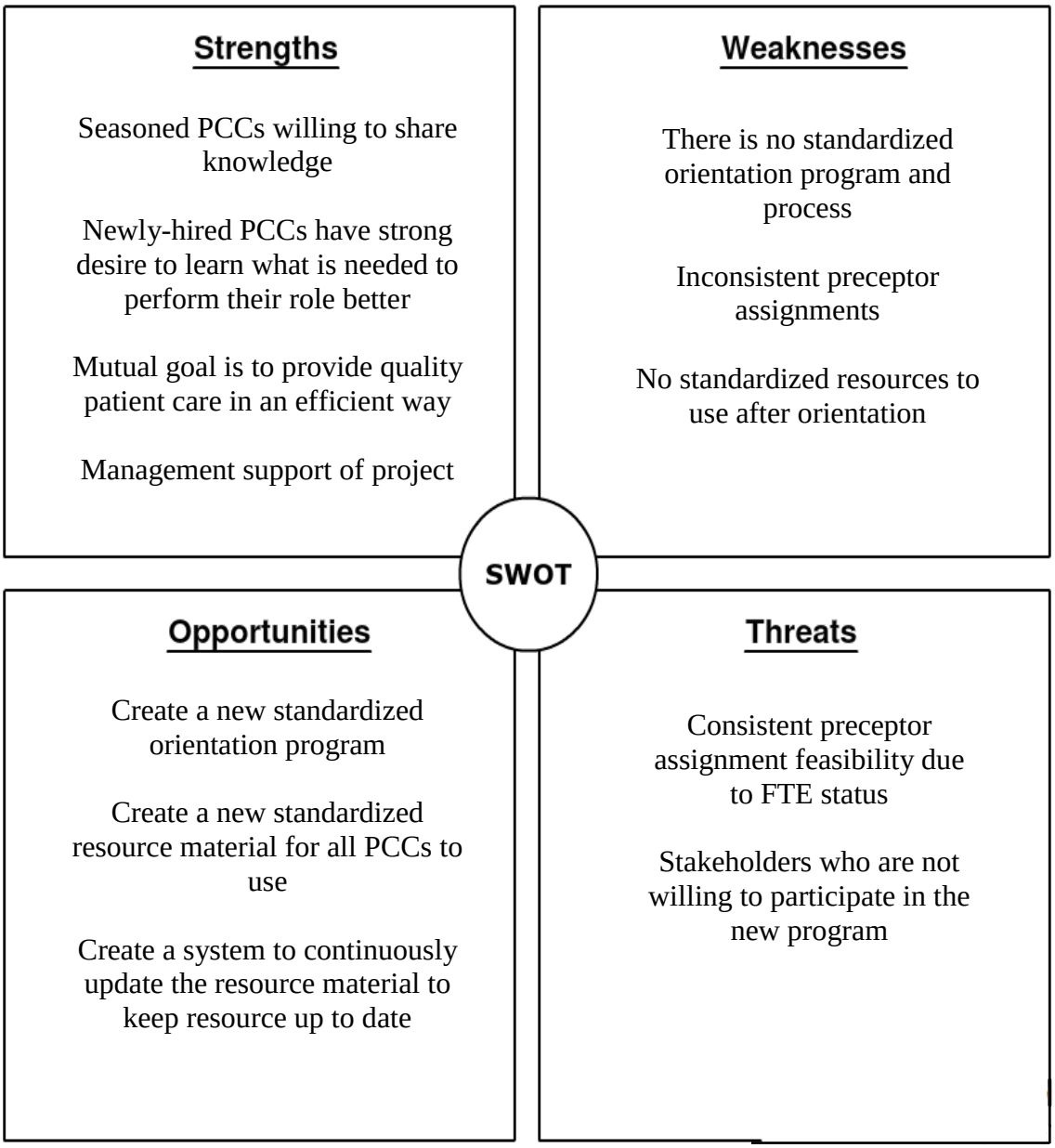
8	DISCHARGE PLANNING			
8.1.0	Discharge Assessment & Plans			
8.1.1	Initiates and accurately completes the initial discharge assessment on day one of the hospitalization			
8.1.2	Communicate status of discharge planning to all involved parties: interdisciplinary team, physician, patient/family, all other staff involved (HH,SNF,DME)			
8.1.3	Identifies barriers to discharge (psychosocial, financial, required resources/support, complex teaching needs) in the initial discharge assessment plan & subsequently throughout hospitalization			
8.1.4	Identify appropriate referrals as indicated.			
8.1.5	Effective in solving barriers to promote timely discharge			
8.1.7	Incorporates the estimated LOS and discharge criteria into the integrated care plan			
8.1.8	Prompts physicians/ health care team regarding code status			
8.1.9	Identifies patients who are unable to make health care decisions			
8.1.10	Consistently partners and communicate with the health care team and patient and/or representative to coordinate the discharge plan			
8.1.11	Finalizes all outstanding elements required for discharge for those patients being discharged the next day			
8.2.0	Patients and Families			
8.2.1	Keeps families informed of discharge date and time to facilitate transportation home			
8.2.2	Identify if the patient and or family is NOT aware of the plan to discharge			
8.3.0	Referrals and Coordination of Services			
	Demonstrates comprehensive knowledge of the following…			
8.3.1	- Referrals to Case Management Programs: CCC: Complex Chronic Conditions Case Management,CCOP: Chronic Conditions Outpatient Program, CHF Program, Home Telemonitoring, etc. Regional Policy #29: Chronic Conditions Management Program			
8.3.2	- Referrals to Financial Advisors			
	- Referrals to Social Services			
8.3.3	- Ability to appropriately identify psychosocial and financial issues			
8.3.4	- Notifies Social Services when psychosocial and financial issues			
8.3.5	- Identify and initiates Social Service referral for potential DPOA or Conservatorship needs			
8.3.6	- Identify of potential Social Admits			
8.3.7	- Identification of and appropriate referrals to Community Resources			
	- Home Health (HH)			
8.3.8	- Eligibility for Services: skilled needs, homebound			
8.3.9	- Referral process / intake desk			
8.3.10	- Content and completion of Home Health Referral			
	- Dialysis: Hemo (HD) or Peritoneal (PD)			
8.3.11	- Eligibility for Services: skilled needs			
8.3.12	- Referral process / intake desk			
8.3.13	- Content and completion of referral (when indicated)			
	- Home Ventilator Care			
8.3.14	- Identify skilled needs & equipment			
8.3.15	- Referral process / intake desk (Home Health)			
8.3.16	- Content and completion of referral (when indicated)			
	- Palliative Care Program (Inpatient / Outpatient)			
8.3.17	- Program components - criteria			
8.3.18	- Referral process / intake desk			
8.3.19	- Content and completion of referral (when indicated)			

	- Hospice			
8.3.20	- Eligibility for services			
8.3.21	- Medicare, Medi-Cal and Kaiser Permanente benefit coverage			
8.3.22	- Referral and intake process			
8.3.23	- PCC and MSW role in referral process			
	- Home Infusion			
8.3.24	- Eligibility and planning			
8.3.25	- Referral and intake process			
8.3.26	- Access lines and drugs commonly used at home			
8.3.27	- Inpatient teaching documentation			
8.3.28	- Outpatient pharmacy process (OPIV)			
	- Durable Medical Equipment (DME)			
8.3.29	- Coverage and formulary			
8.3.30	- Referral and ordering process			
8.3.31	- Completion of DME prescription			
8.3.32	- Access & ordering out of DME closet			
8.3.33	- SNF Liaison's Role and interface			
8.3.34	- Skilled Nursing Facilities (SNF) - Including			
8.3.35	- Skilled-care criteria			
8.3.36	- Referral and intake process			
8.3.37	- Medicare, Medi-Cal and benefit coverage			
8.3.38	- Verifying insurance coverage			
8.3.39	- SNF patient education video			
8.3.40	- Bed availability issues			
8.3.41	- Contracted facilities and capabilities			
8.3.42	- Post Acute Care Center: access & referrals			
	- Acute Rehabilitation, including in VLO			
8.3.43	- Eligibility for acute rehabilitation			
8.3.44	- Location and transportation			
8.3.45	- Benefit coverage			
	- Transportation			
8.3.46	- Ambulance ordering and HUB			
8.3.47	- Guerney-van resources & scheduling			
8.3.48	- Transportation costs			
8.3.49	- Homeless transportation			
Comments:				

Note: Internal document, obtained by Marsha Belen, January 2018.

Appendix C

SWOT Analysis



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

Appendix D

Gantt Chart of Projected Timeline

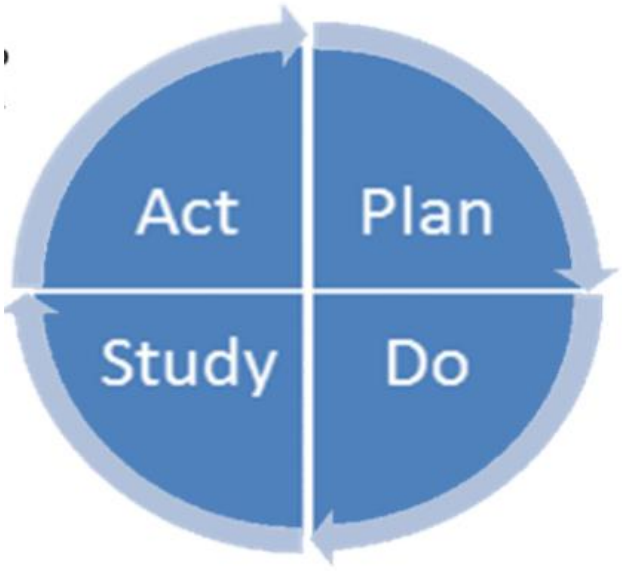
Tasks	January				February				March				April				May				June				July			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Microsystem Assessment																												
Literature Review																												
Initial Survey																												
Collecting Material																												
Compiling Material																												
First Peer Review																												
Modification or Material																												
Second Peer Review																												
Produce Material																												
Final Survey																												
Writing Papers																												
Prepare Poster																												

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

Appendix E

PDSA Cycle

ACT	**PLAN**
Produce the material for department use	Identified the needs of having a standardized resource material



STUDY	**DO**
Discussed with peers to modify the material Discuss with management to modify the material	Collection data to develop the identified material Develop the identified material

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.

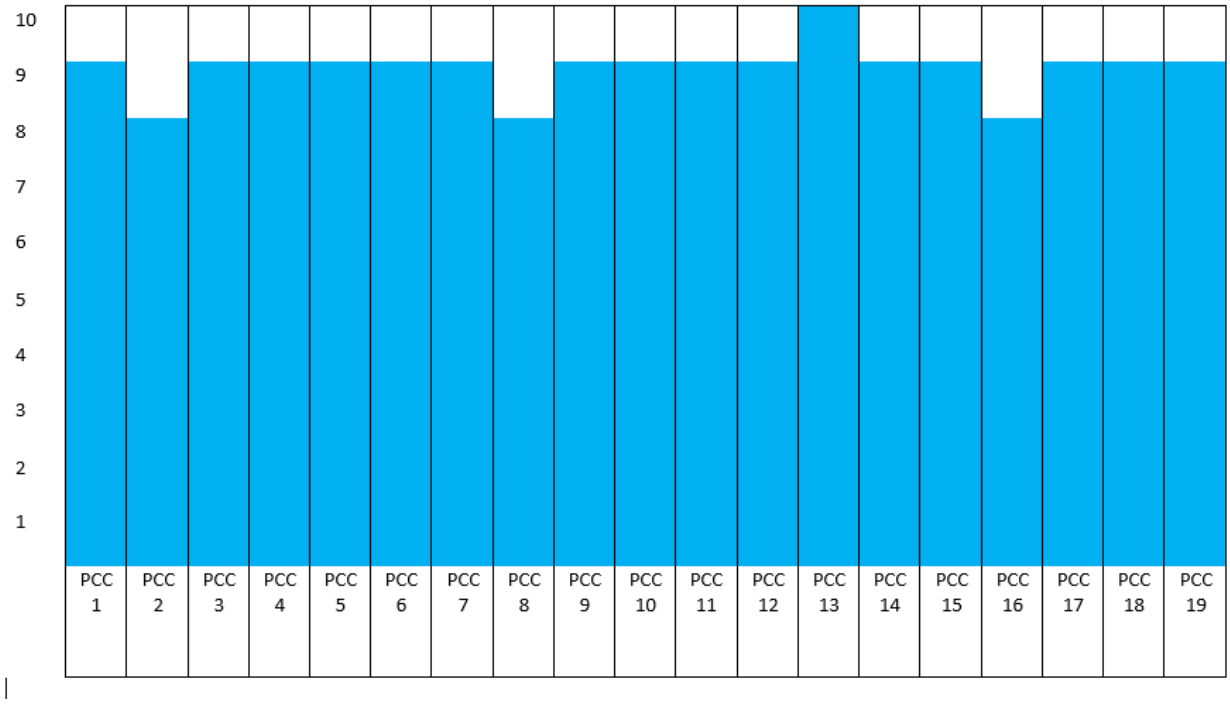
_____

_____

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

Appendix G

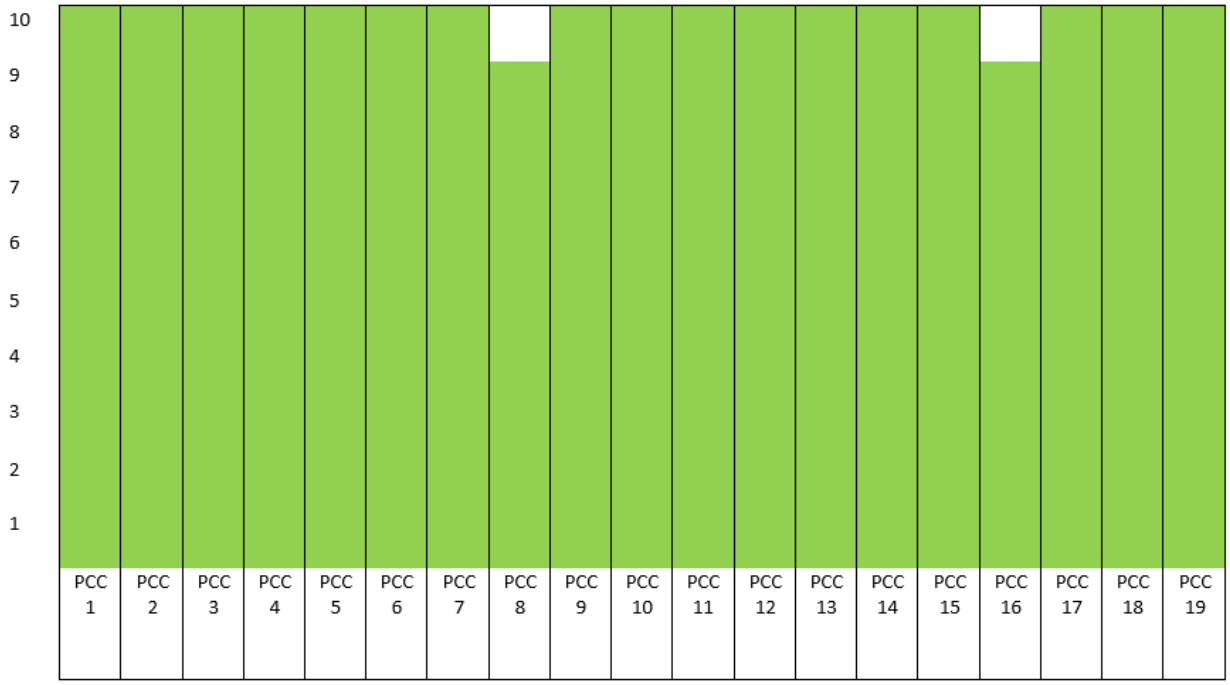
Satisfaction Level of the New Orientation Materials



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

Appendix H

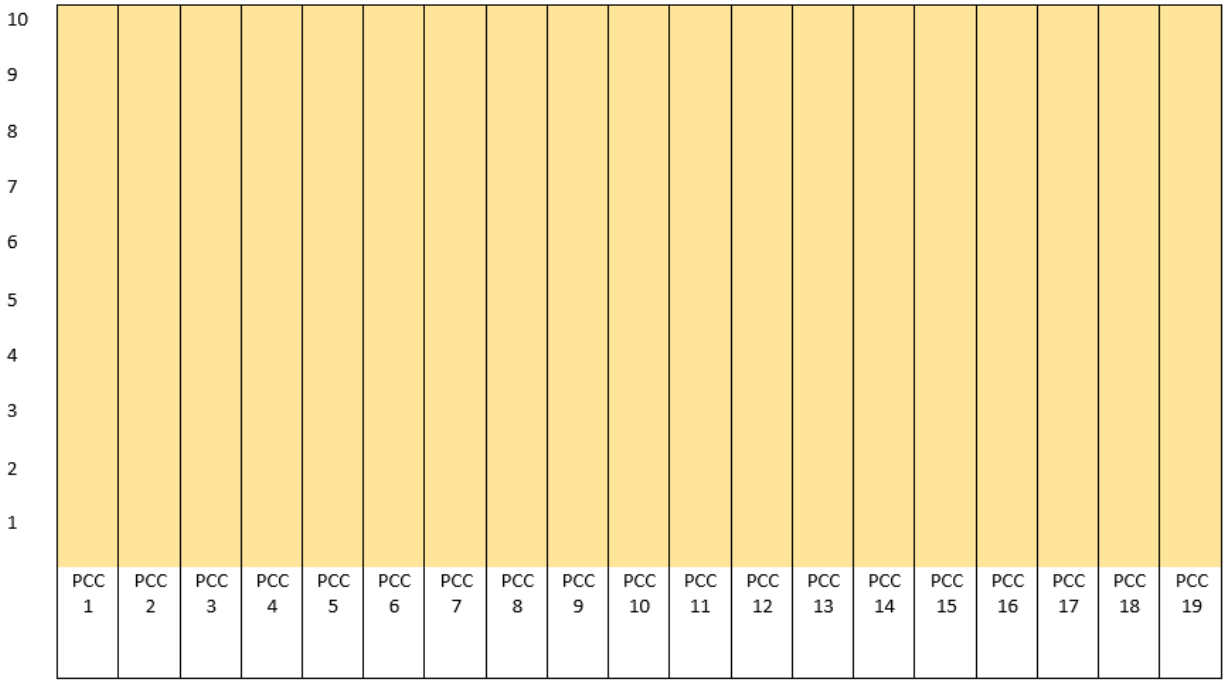
Usefulness of the PCC Resource Pocketbook



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

Appendix I

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



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

Appendix J

Sample Page of the PCC Resource Pocketbook

RESOURCE POCKETBOOK

	A	
NAME	PHONE	NOTES
Absolute Care Fahima	650-361-1211 C: 650-771-0752	Provide CG referral
Absolute Care Transportation	650-361-1211	WC Van only
Alameda Alliance	855-313-6306 F: 510- 747-4540	
Amberwood – Carlos Clinical Liaison	408-990-6506	
American Lifestar Transportation	650-738-8100 Angela	
AMR - Ambulance	888-650-5472	
Kaiser Ambulance Hub	800-438-7404	
Apria Annette Sup	888-452-4363 650-330-2405 F: 844-572-7742	
Apria Wound Vac	800-780-1228 F: 800-323-1882	
Applied Orthotics Mike Dots	408-358-9741 Cell: 408-316-3921	TLSO Brace for IP ED has own TLSO in stock
Asian Network Home Health	510-268-1118	HH for Medical
Assurance Wireless Cell phone for free, needs mailing address.	888-898-4888	Society of St. Vincent de Paul 650-343-4403 50 North B Street San Mateo, CA 9440
Acute Rehab St. Francis	415-353-6000	AR for HPSM

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

Appendix K

Index page of the PCC Orientation Resource Booklet

TABLE OF CONTENTS

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

Appendix L

Index page of the PCC Extended Resource Binder

TABLE OF CONTENTS

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