

UPMC HEALTH SYSTEM

JOB DESCRIPTION

Job Title: Primary Care Coordinator [PCC] **Reports To:** Director of Care Management

Effective Date: July 1, 2007

Job Purpose

This position coordinates the clinical and financial plan for targeted patient assignments. Performs overall utilization management, resource management, discharge planning, care facilitation, and referral to other levels of care and related duties. Works with the physician, social worker and multidisciplinary care team to facilitate clinical pathways and achievement of desired quality and financial outcomes. Carries a caseload of 15-20 patients on a designated nursing unit. Reports to the Director of Care Management and has a matrix relationship to the Unit Director in the area they work in. Assumes the 24 hour management of the cases in their control and accepts responsibility for care that is delegated.

- Neonate (0-1 month) Pediatric (2 months-12 year) Adolescent (13 – 17 year)
 Adult (18 – 65 years) Geriatric (66+ years)

Minimum Requirements:

Educational/Knowledge requirements: Registered Nurse required, licensed in the state of Pennsylvania, BSN or Bachelors degree required. If not a BS/BSN at time of initial hire, must complete degree by December 31, 2007. Extensive clinical knowledge (3-5 years or equivalent) of the targeted patient population is required. Knowledge of healthcare financial and payor issues, eligibility for state, local and federal programs required. Previous case management experience is preferred. Experience in the use of InterQual criteria preferred. Managed care and payor experience preferred.

Licensure/Certification: Licensed as a professional nurse in the Commonwealth of Pennsylvania.

Responsibilities:

1. **Through active involvement in patient's care, the Primary Care Coordinator (PCC) expedites the patient's progression along the continuum of care to effect timely and appropriate case management.**
 - a. Collaborates with multidisciplinary care team to facilitate appropriate clinical pathway assignment, implementation, variance tracking and documentation of the individualized plan of care to address needs for a caseload of 15-20 patients. ***Consultation and Resources***
 - b. Validating ongoing appropriateness of health care setting using InterQual Criteria for designated patients by reviewing clinical information and data and making recommendations when alternate levels of care are indicated.
 - c. Addresses/resolves process problems impeding diagnostic or treatment progress. Proactively identifies and resolves delays and obstacles to discharge. ***Autonomy***
 - d. Performs utilization management and monitors appropriate resource utilization and continued stays and documents findings based on standards.
 - e. Refers cases and issues to Physician Advisor in compliance with identified procedures and ensures follows up.
 - f. Seeks consultation from appropriate disciplines/departments as required to expedite care, monitor length of stay and facilitate discharge dictated.

- g. Coordinates resources to address psychosocial situations discharge planning issues, and continuing care needs in order to develop an in-depth plan of care that addresses needs.
 - h. Assesses, reviews and assures documentation of clinical and other relevant information every 24 hours and as needed to provide rationale for the continued stay. Organizational Structure
 - i. Documents relevant clinical and discharge planning information in the medical record. Organizational Structure
 - j. Documents in and utilizes CM technology as per policy.
 - k. Communicates and rounds with physicians to establish and support plan of care and address all issues regarding acute care stay resource utilization, third party payer issues, etc. Nurse to Physician Relationship
 - l. Identifies and plans strategies to reduce length of stay and resource consumption within patient population.
 - m. Collaborates with system-wide Resource Center to manage denial management processes and communicate with multidisciplinary team as appropriate.
- 2. Collaborates with the patient, family, designated caregivers, multi-disciplinary team to facilitate prioritization of care from acute care experience through the continuum by:**
- a. Communicates with Pre Arrival Center for benefit checks.
 - b. Facilitates transfer to other facilities for care management population
 - c. Directs multidisciplinary team meetings to address complex clinical issues, system barriers and patient/family conflict. Documents outcome of meetings in discharge planning guide.
 - d. Effective January 13, 2003 the System Wide Resource Center no longer will coordinate payor calls. Each campus will manage independently.
 - e. Communicates with the System-Wide Resource Center Denial Management Team to identify potential denial issues.
 - f. Responsible for in house denial management, concurrent and occasionally retrospective.
 - g. Identifies at-risk populations using approved screening tool and follows established reporting procedures.
 - h. Assists physicians, care providers and patient/family in understanding payor plans and benefits as required.
 - i. Communicates with patients, family and/or designated caregivers within 24 hours of admission and every 48 hours as needed regarding home care needs, community agency assistance, or placement into skilled, subacute or rehabilitation facilities.
 - j. Communicates information required to appropriate disciplines.
 - k. Conducts daily visits to patients on assigned caseload, communicating directly with patients and families on all cases.
 - l. Acts as a change agent to advocate for patients in an effort to achieve positive outcomes.
- 3. Verifies development and implementation of a discharge plan relevant to the patient's clinical course and continuing care needs by:**
- a. Communicates and coordinates with patients, caregiver, health care professionals, and alternative patient settings on a regular basis. Autonomy
 - b. Re-evaluates and revises plan of care as additional information regarding patient's response to treatment is acquired.
 - c. Initiates the interdisciplinary plan of care and reassesses regularly to assure that the goals are being met
 - d. As appropriate, meets directly with patient/family based on identified needs and develops an individualized continuing care plan in collaboration with the multidisciplinary team. Community and Teaching
 - e. Ensures patient education is conducted and documented with patients and families to ensure successful transitions to alternative levels of care. Community and Teaching
 - f. Reviews goals and makes revisions to plan of care every 48 hours and following-up with the appropriate clinical nurse and unit director on deficiencies.
- 4. Evaluates issues, trends, and recommends improvement to the Director and/or multidisciplinary team by completing periodic written or verbal reports detailing improvement activity.**
- a. Uses data to drive decisions and plan/implement performance improvement strategies related to care management for assigned patients, including fiscal, clinical and patient satisfaction data. QI
 - b. Resolves day-to-day barriers that prevent a patient's advancement along the continuum.

- c. Analyzes patient care and system operations data for trends and causative factors that promote or impede progression towards positive patient care outcomes and feeding that information to the director or appropriate team. QI, Quality of Care
 - d. Performs chart audits as assigned on respective caseload to assure documentation of care plan. Communicates teaching needs to staff on daily basis and follows through with staff to assure that teaching is done and documented. QI
 - e. Reinforces effective processes that result in achievement of desired outcomes.
 - f. Trends care delivery related issues and provides information to Unit Director/Director. QI
 - g. Evaluates the effectiveness and satisfaction of nursing interventions for patients beyond own shift based on 24-hour accountability for the plan of care.
- 5. Supports ongoing clinical practice.**
- a. Participates in research activities as negotiated with the Director to explore, validate, and direct delivery of care for specific patient populations.
 - b. Facilitates implementation of new clinical practice techniques among clinical caregivers. Quality of Care
- 6. Promotes advancement of knowledge and skills of other disciplinary teams and lay members of the community by serving as a resource to internal and external individual groups.**
- a. Actively serves as an expert consultant in a variety of multi-disciplinary teams' within/beyond the unit. Consultation and Resources
 - b. Participates in developing clinical guidelines and care delivery protocols. Community and Teaching, Professional Models of Care
 - c. Actively participates and contributes to process improvement/clinical design initiatives to support the successful attainment of organizational goals. Organizational Structure
 - d. Bases decisions on relevant scientific principles, established standards of care and/or research findings.
- 7. Serves as a role model of excellent customer service and patient care by:**
- a. Responds constructively to the needs of all those he/she interacts with on a daily basis. Image of Nursing
 - b. Assesses and monitors customer satisfaction and responding promptly to voiced and identified concerns.
 - c. Acts as a clinical resource/expert to all staff. Professional Models of Care, Nurses as Teachers
 - d. Communicates with staff complimentary feedback from self and others. Management Style
 - e. Acts to investigate and remedy patient complaints received from within the staff, physicians, patient relations and members of the other departments or healthcare team. Works closely with patient relation's representative.
 - f. Assists in implementing strategies to see a statistically significant increase in patient satisfaction results each quarter.
 - g. Assists in monitoring customer satisfaction.
 - h. Acts as a consultant to unit personnel, external customers, and/or individuals from other disciplines. Nurse to Physician Relationship
 - i. Serves as a resource to staff to improve/develop/expand knowledge base for patient care decisions.
- 8. Serves as a leader within the case management department and in area of clinical assignment and beyond.**
- a. Applies advanced interpersonal and communication skills in all interactions. Professional Development, Nursing Leadership
 - b. Demonstrates attitudes and behaviors which contribute to the smooth running of the department and which assure compliance with professional standards and regulatory requirements, including the following:
 - Treats all individuals with dignity and respect and participates in activities to improve working relationships within the department.
 - Actively participates in department activities such as staff meetings, in-services, supervisory meetings, timely submission of statistics, etc.
 - Manages workload and assignment effectively.

- Practices all components of safety compliance.
- Participates in peer review/evaluation.
- Consistently holding peers accountable for practice according to unit and professional standards.
- Adapts to change in practice

Professional Policies

- Performs all other duties as assigned.
- Uses the nursing processes and assumes 24-hour accountability for caseload to achieve desired individualized patient care outcomes.
- Accepts 24-hour accountability for care provided by self and others to whom care is delegated.
- Initiates actions for continuous self-development in order to meet the demands of a dynamic professional practice. **Autonomy**
- Supports quality and cost-effective patient outcomes. **OL, Quality of Care**
- Demonstrates flexibility with organizational needs such as covering other Primary Care Managers caseloads for volume fluctuation and vacation coverage.
- Assures staff compliance with the Department of Health Regulations and JCAHO Requirements. Role models compliant behaviors. **Nursing Leadership**
- Communicates all regulatory concerns to Director. **Nursing Leadership**

Care mgmt to staff packet 11-18-02/primary care coordinator

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