**Purpose**

The purpose of this policy is to define the conditions and procedures required to respond to member situations requiring further review and possible escalation to an Intervention Specialist, Nurse Care Manager or the Primary Medical Provider (PMP). This policy defines the procedures that a Care Coordinator will use to assess and refer an Indiana Chronic Disease Management Program (ICDMP) member to the Call Center Nurse (RN) for review and possible escalation. This policy further defines the process the Care Coordinator will use to refer a member to the Call Center Nurse for more intense care management or to evaluate the need to contact the PMP office for further information. The policy will also define the conditions and procedures to respond to inbound calls from members recently hospitalized and the referral to NCM’s as indicated.

**Scope**

AmeriChoice Care Coordinators, Care Coordination Manager, Care Coordination Call Center Nurse, Care Coordination Trainer and Helpline/Intervention Specialists will implement this policy.

**Policy**

The Office of Medicaid Policy and Planning (OMPP) recognizes that there may be situations that arise during the normal daily contact with ICDMP members or PMPs that require additional member education or further assessment and review by a trained clinical professional for possible action.

PMP requests for member education or reassignment in the following areas will be referred to the Medicaid Select Intervention Specialists via the appropriate Helpline for handling:

- Missed appointments
- Emergency Room misuse or abuse
- Threatening, abusive or hostile behavior
- Breakdown of the physician/patient relationship
- Accessing care from unauthorized providers

PMP requests for education around specific protocols for chronic disease management or the member’s unwillingness or inability to follow directions will be handled by the Care Coordinator or the Care Coordination Call Center Nurse if the need for clinical expertise is beyond the scope of the Care Coordinator.

PMP requests for more intense care management will be referred to the Care Coordination Call Center Nurse for further review and possible escalation to the Nurse Care Manager organization.
Care Coordinator contacts that reveal an “at-risk” member that may need referral to the PMP, more intense care management or other clinical intervention beyond the scope and expertise of the Care Coordinator will be referred to the Call Center Nurse for further review and possible escalation to the Nurse Care Manager organization, PMP or further contact with the member.

The Care Coordination Call Center Nurse will assess the situation by reviewing the PMP request, Care Coordinator contact notes and contact with the member to gain further information for an appropriate assessment of the situation. The Care Coordination Call Center Nurse will then take the appropriate action. This may involve contact with the Nurse Care Manager organization for possible movement of the member to a Nurse Care Manager (NCM) or a contact with the PMP office to discuss concerns and possible contact from the PMP.

Procedure

PMP Requests for Member Education or Reassignment

A PMP may request member education or reassignment for the following reasons:
- Missed appointments
- Emergency Room misuse or abuse
- Threatening, abusive or hostile behavior
- Breakdown of the physician/patient relationship
- Accessing care from unauthorized providers

The Care Coordinator receiving such a request will refer the PMP to the appropriate Medicaid Select Helpline for handling.

If the PMP is requesting education around specific protocols for chronic disease management or the member’s unwillingness or inability to follow directions, the Care Coordinator takes the following actions:
1. Sends an email to the Care Coordination Call Center Nurse
2. Completes a contact in the Chronic Disease management System (CDMS)

The Care Coordination Call Center Nurse takes the following actions:
1. Reviews the email and documentation in CDMS
2. Contacts the member and provides the appropriate education or intervention
3. Provides feedback to the PMP office
4. Completes a contact in CDMS
5. Provides feedback to the Care Coordinator
6. Enters member information into the Intervention Tracking Log

PMP Requests for Nurse Care Management

PMPs may feel that an ICDMP member requires more intense care management than can be provided by the Call Center Care Coordinator and faxes a referral to the Call Center. In these situations, the Call Center Nurse takes the following actions:
1. Reviews the referral form and CDMS notes, then verifies eligibility in AIM
2. Contacts the member for additional information and assesses the disease state(s)
3. Determines if NCM involvement appropriate
4. Contacts the NCM organization
5. Discusses the request and member circumstances
6. Reaches an agreement with the NCM point person as to whether an escalation to an NCM is appropriate
7. If agreement reached, faxes completed transfer form to the NCM organization. (Attachment A)
8. Sends Helpdesk request to the ICDMP Helpdesk Representative to escalate the transfer to the NCM. Include the following information: member name, RID, physician’s name, name of NCM organization and reason for transfer.
9. Notifies PMP of decision  
10. Completes contact in CDMS  
11. Documents intervention on the Intervention Tracking log

**Care Coordinator Referrals for At-Risk Members**

During a member contact, the Care Coordinator may identify circumstances that cause concern or alarm about the member’s current state of health or well being. The Care Coordinator may feel that a referral to the PMP, more intense care management or some form of clinical intervention is appropriate. In those circumstances, the Care Coordinator takes the following actions:

1. Sends email to the Care Coordination Call Center Nurse  
2. Completes a contact in (CDMS)

The Care Coordination Call Center Nurse takes the following actions:

1. Reviews the email and CDMS notes, then verifies eligibility in AIM  
2. Contacts the member to obtain more information and assess disease state(s)  
3. Determines if NCM involvement or PMP referral is appropriate and -  
   a. Contacts the NCM organization, if appropriate  
      i. Discusses the request and member circumstances  
      ii. Reaches an agreement with the NCM point person as to whether an escalation to an NCM is appropriate  
      iii. If agreement reached, faxes completed transfer form to the NCM organization. (Attachment A)  
   iv. Sends Helpdesk request to the ICDMP Helpdesk Representative to escalate the transfer to the NCM. Include the following information: member name, RID, physician’s name, name of NCM organization and reason for transfer.
   b. Makes the referral to the PMP office, if appropriate  
      i. Contacts the PMP office  
      ii. Identifies self and reason for calling  
      iii. Relays appropriate details to the PMP/office staff about concerns leading to referral

4. Documents outcome in CDMS  
5. Provides feedback to the Care Coordinator.  
7. **The ICDMP Helpdesk Representative will escalate the Helpdesk request to ISDH for member transfer.** Once member transfer is completed by ISDH, The ICDMP Helpdesk Representative confirms transfer in CDMS. Information logged on Transfer Report.

**Care Coordinator Referrals for Incoming Calls from Hospitalized Members**

When a member calls into the call center with a report of hospitalization, the Care Coordinators will document the findings in CDMS and send an email to the Care Coordination Call Center Nurse.

The Care Coordination Call Center Nurse takes the following actions:

1. Reviews the email and CDMS notes, then verifies eligibility in AIM.  
2. Contacts the member to obtain more information and assess disease state(s).  
3. Determines if NCM intervention is appropriate. *(Note: NCM services are a voluntary benefit and are subject to the member’s refusal.)*  
4. Contacts the NCM organization if appropriate  
   a. Discusses the request and member circumstances  
   b. Reaches an agreement with the NCM point person as to whether an escalation to the NCM is appropriate  
   c. Faxes the transfer form (Attachment A) to the NCM organization, including dates of hospitalization, identification of any significant change in condition, and current health needs.
5. **The ICDMP Helpdesk Representative will escalate the Helpdesk request to ISDH for member transfer.** Once the transfer is completed by ISDH, the ICDMP Helpdesk Representative confirms transfer in CDMS. Information logged on Transfer Report.

6. Advises the PMP member has been transferred from the call center to the NCM for closer intervention services.

7. Documents outcome in CDMS.

8. Documents the hospitalization on the Hospitalization Tracking Log.
Transfer from Call Center Coordination to Nurse Care Manager Intervention

Date: __________________________

Patient Name: __________________________          RID #: __________________________

Patient Address: ________________________________________________________________

Patient City and ZIP: ____________________________________________________________

Patient Telephone: ______________________________________________________________

Patient Diagnosis (Check All That Apply):

☑ CHF   ☑ Diabetes   ☑ HTN   ☐ CVD   ☐ Asthma

☐ Other (Explain): ________________________________________________________________

Physician Name: ________________________________________________________________

Physician Address: ______________________________________________________________

Physician City and Zip: __________________________________________________________

Physician Telephone Number: ____________________________________________________

Reason for Nurse Care Manager Intervention:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Additional Comments:
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Request for Transfer within CDMS by: ________________________________________________

Communicated by:  ☐ Telephone          ☐ Fax (IPHCA: 630-0832)

Signature of Nurse Taking Telephone Communication: ___________________________________