RN/Care Coordinator Roles In the Integrated Health Home

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The Magellan ICN, IHH site care coordinators and managed care nurses work together in a partnership to improve on the consistency and quality of health care through team based coordination of care for both physical and behavioral health care issues.

- The goals of the IHH team are to improve the quality of care through a team based approach. The team works together to:

  - Improve overall health

  - Offer support by coordination of the services the members receives, i.e. Provider appointments, therapy appointments, annual care etc.

  - Provider better access of care to the member and the family support; i.e. same day appointments, crisis intervention

  - Help to make the member accountable for their care and in control of the outcomes; i.e. incentive plans, crisis plans etc.
Magellan ICN

• The Magellan Integrated Care Nurse (ICN) role is more of a resource/consultant role with their partnered sites

• Sharing information with the care coordinators and managed care nurses

• Assess the member’s needs

• Completing regularly scheduled calls with the care coordinators and managed care nurses at the IHH sites in order to collaborate on recent events and medical care
Magellan ICN

Member needs that are discussed are:

• Gaps in care: Annual physicals, lab work, dental care, eye care, flu shots etc.

• Medication adherence: Do they have the medications, taking it correctly etc

• Teaching opportunities—both for behavior health and physical health: Diabetic education, health information, weight management, crisis interventions etc.

• Trouble shooting for any and all issues regarding the member

• Ways to think outside the box of conventional cares, standard care that the member receives
Magellan ICN

The ICN will be reviewing the high needs, high utilizer members regardless of the HWQ score and managing as needed. High needs members are defined as:

• Inpatient admission for both behavioral health and physical health: the admissions will be evaluated by the ICN for appropriate involvement

• Members with 3 or more ER visits in a quarter

• Members with HgA1C >8 : evaluated by ICN for appropriate involvement

• Pregnant members

• Cases the IHH sites want help managing
Magellan ICN

National Calls:

The ICN nurse partakes in a national call weekly with Medical providers, behavioral health providers, Internal Medicine providers, all Magellan ICN, supervisors and other in–house staff to discuss complicated members care. The calls are conducted to help bring new ideas for treatment/plans of care, Doctors perspective for plans of care and general ideas for complicated care. The information that is discussed on the calls are then passed along to the site (managed care nurse /coordinator) as ideas to improve the quality of care.
Nurse Care Manager IHH Site

- External Role of the Nurse Care Manager-
  - Support the Health Home in meeting the provider standards
  - Deliver Health Home services to qualified members.
  - Creates health promotion opportunities for all members.
  - They must be an RN or BSN with an active Iowa license.
Nurse Care Manager IHH Site

Responsibilities include:

• Promote Health
• Provide disease management education
• Scheduling appointments
• Tracking medical referrals
• Collaborating with providers to ensure communication
• Enrollment of new clients
• Provide education on medication and diet
Nurse Care Manager IHH Site

• Track labs for disease management
• Transport to appointments when necessary
• Advocate for clients
• Develop care coordination plans/update as needed
• Manage high risk and high utilizers
• Track client medication list
Care Coordinator IHH Site

• Supports the Health Home in meeting the provider standards

• Delivers Health Home services to qualified members

• Must be a BSW with an active Iowa license, or a BS/BA in the related field

• Understands and monitors each IHH member’s concerns and the types of whole health resources needed

• Supports day-to-day collaboration, applies tools, and coordinates enrollment and communication
Care Coordinator IHH Site

The Care Coordinator also provides the following:

- Conducts needs assessments
- Make and track community referrals
- Promotion of substance abuse prevention
- Promote self-direction and skill development and advocate for member
- Authorize habilitation services
- Placement
- Create care plans/update
- Create incentive plans
- Assist with crisis plans
Working Together

• The ICN, Nurse Care Managers and Care Coordinators work closely together with high risk and high utilizer clients to strategize and develop a plan to best ensure quality care for the client:

• We have a weekly conference call that we discuss these clients.

• We share information regarding lab records, hospital visits, substance abuse issues, any risky behaviors, etc.

• We discuss how we can assist these clients with better coping skills, developing crisis plans, referrals to behavioral health, primary care physicians, or specialist depending on the client’s needs. Everything we do for clients is based on that individual’s needs.
Working Together

• We collaborate with the IHH team, ICN nurse, and providers to get these clients the care they need to keep them out of the hospital.

• We assist them with education on medications, diet, exercise, importance for going to the doctor, disease management, etc.

• We set up interdisciplinary meetings with providers to ensure communication and collaboration is taking place for best practice and quality care
Crystal

- This client is a 31 year old female that has had two hospitalizations in one month. This client is diagnosed with bipolar, polysubstance abuse, and PTSD. She has a crisis plan that she has developed with her IHH team, therapist, and community support worker. This client called with c/o scabies. She was delusional, anxious, and paranoid. IHH nurse assisted this client with getting a prescription for scabies. She used coping skills and calmed down. The client went to the ER over the weekend.

- She was admitted and stayed for 3 nights. During her hospitalization she was prescribed Ambien. The client was discharged from the hospital and a week later was calling with c/o more bites. IHH nurse questioned bed bugs at this time. She continued to work with her IHH team for care. Another week later, the client called her behavioral health office and requested a refill of Ambien. She also requested lorazepam. She complained of terrible anxiety and had heard this medication worked well.
Crystal

• The office offered her a same day crisis visit and explained she would need to be seen before any prescriptions would be ordered. She declined the visit due to “no ride”. The Ambien was requested 11 days too soon and this client wasn’t prescribed lorazepam. The BH provider had told this client they wanted to start her on Lexapro which she declined. The client called me from ER to tell me she was there. IHH nurse offered the client a ride to her provider’s office for a crisis visit.

• She declined and stated she would prefer to be in the hospital because she is going to be started on a new medication and doesn’t feel safe to do this at home. She then proceeded to explain how anxious she is and she doesn’t want to live this way and is thinking about ending her life because of how anxious she is. Later the client called her IHH nurse to advise she was being admitted to Mercy Behavioral unit. The IHH team discussed this client to see what we should do next because we thought she was seeking.
Crystal

• The community support worker explained she felt she was seeking medications because this client admitted she snorted a pill but didn’t know what it was. She explained this client has had risky behaviors as well. I consulted the ICN and explained the situation. We gathered all the information and the IHH nurse contacted the hospital social worker to explain our thoughts and worries. The social worker thanked me for advising her.

• This client didn’t receive the medications and wanted to be released the next day because she didn’t get what she wanted. This client had to stay two nights due to her anxiety and she was started on Lexapro. After the client was released from the hospital she did admit to being an addict. She admitted that the medications she was requesting were due to an addiction. This client has been going to meetings regularly and has been sober for about 3 weeks.
Bobby

- This client is a 51 year old male diagnosed with stage 3 renal failure, diabetes type II, hypertension, COPD, sleep apnea, obesity, bipolar, depression, alcohol abuse. This client was enrolled with IHH in July. This client has been in and out of the hospital multiple times. He was there almost monthly. He has several health care providers. He had home health care setting up his medications. It sounds like everything should be great with all of the health care providers and home health care assisting with medications.

- That was not the case. This client ended up on temporary dialysis due to non-compliance, lack of education, lack of collaboration amongst providers, etc. This client was hospitalized for edema due to renal failure at the end of November. This is when a temporary port was placed and he started dialysis. This client was on the max dose of every diuretic. While he was on dialysis an IHH nurse care manager educated this client on fluid restriction.
Bobby

• We contacted all the providers and educated them on IHH and started assisting the client with appointments and ensuring collaboration. In February, this client was taken off dialysis and his port was removed. During this time, IHH found this client’s home health agency was not communicating which lead to medication errors and more hospitalizations. Today, this client has a new home health agency. I assist the client with all medical appointments.

• I keep track of all medication changes and updates. I make sure communication is happening amongst all providers. In February this clients A1C was 12.5 and today it was 8.5. He hasn’t been in the hospital since March. He still needs reinforcement but he is compliant with medications and his providers communicate.
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