

BIO-MONITORING NURSE CARE MANAGEMENT PROTOCOL MANUAL

The Bio-monitoring Nurse Care Management is a collaborative program between Alabama Medicaid Agency (AMA), Alabama Department of Public Health (ADPH), and the University of South Alabama, Center for Strategic Health Innovation (USACSHI). This Medicaid Patient 1st program targets patients with chronic disease. ADPH provides the Bio-monitoring Nurse Management for the direct patient contact. The USACSHI maintains the secure, web-based data collection and documentation system, Real-time Medical Electronic Date Exchange (RMEDE™). These services are provided under the direction and orders of the patient's Primary Care Physician (PMP).

The goal of the Bio-monitoring program is to provide Nurse Care Management to patients with chronic diseases with the goal of decreasing exacerbation episodes, emergent care visits, hospital admissions and costs.

I. ELIGIBILITY

A. Medicaid Patient 1st recipients having **one or more** of the following specific, primary, chronic disease diagnosis:

1. **Congestive Heart Failure (CHF)**
2. **Diabetes (DM)**
3. **Hypertension (HTN)**

B. Need for daily monitoring for one or more of the above chronic diagnosis.

C. Physician orders for Bio-monitoring.

II. CONFIDENTIALITY

The Bio-monitoring Nurse Care Management program and staff adhere to the guidelines for the use and disclosure of protected health information (PHI) for the purposes of payment, treatment, and program operations to ensure adherence to the Privacy Standards set forth in the enacting of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All patients are provided a Privacy Notice upon admission.

III. BIO-MONITORING NURSE CARE MANAGEMENT DEFINITION AND ACTIVITIES

Bio-monitoring Nurse Care Management is defined as a client-centered, chronic disease focused, assessment-based, collaborative approach to provide education, monitoring and on-going evaluation for patients with specific chronic disease management needs. Individual's environment and willingness to participate will be assessed for Medicaid recipients having designated chronic diseases.

A bio-monitoring plan of care is developed, monitored and reassessed by the Bio-monitoring Nurse Care Manager using standards of practice, evidence based practice guidelines, clinical judgment and reasoning skills. Utilizing disease specific

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Best Practice Guidelines and Disease Management recommendations, the recipient will be provided bio-monitoring of specific physiologic parameters, disease management education, appropriate referrals, ongoing assessment and monitoring and clinical follow-up as indicated. The goals for the recipients under the Bio-monitoring Nurse Care Management program are: optimum symptom control, decreased emergency visits, hospitalizations, and re-hospitalizations due to exacerbations of chronic diseases. Both parties agree to the terms and conditions described in the Bio-monitoring Nurse Care Management Protocol manual jointly approved by ADPH and the Alabama Medicaid Agency.

Bio-monitoring Nurse Care Management activities include:

- A. Initial home assessment.
- B. Collaborate with the PMP and the patient/caregiver to develop the Bio-monitoring Care Plan.
- C. Initial delivery and set up of the bio-monitoring equipment.
- D. Instruct the patient/caregiver on the use of the monitoring device(s) i.e. scales, blood glucose monitor, blood pressure monitor, and/or speaker telephone.
- E. Instruct the patient/caregiver on the use of RMEDE™ for data entry.
- F. Instruct the patient/caregiver on the importance of following the Bio-monitoring regime ordered by the PMP.
- G. Provide education to the patient/caregiver on chronic disease management.
- H. Provide education on the appropriate use of the emergency room, physician's office, and other medical providers.
- I. Instruct, reinforce, support appropriate use of emergency room services, and monitor the results of the PMP ordered physiologic readings through RMEDE™ .
- J. Evaluate the variances.
- K. Contact patient with variances to verify and further assess.
- L. Report the variances to the PMP as indicated.
- M. Assess compliance with Bio-monitoring regime.
- N. Evaluate reasons for non-compliance to Bio-monitoring regime.
- O. Instruct, reinforce, encourage and support patient compliance with the Bio-monitoring regime.
- P. Provide the PMP with graphic reports from RMEDE™ at least **once** a month.
- Q. Facilitate referrals.
- R. Instruct, reinforce, support compliance with medical regime, including diet, and activities as prescribed by the patient's PMP.
- S. Collaboration with PMP, Patient 1st Coordinator, Patient, Caregivers, others to ensure appropriate level of care is being provided and unnecessary emergency department visits, hospitalizations and re-hospitalizations are avoided.
- T. Evaluate the outcome of Bio-monitoring Nurse Care Coordination utilizing data from Medicaid and RMEDE™.
- U. Provide education to PMP, other health care providers and Medicaid recipients on the Medicaid Patient 1st Bio-monitoring Nurse Care Management program.

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IV. REFERRAL SOURCES

Bio-monitoring Nurse Care Management referrals can be accepted from any source, including physicians, Patient 1st Care Coordinators, patient or caregiver, health department, hospitals, home health/hospice, community-based organizations and other entities, working with Medicaid Patient 1st populations. Orders for Bio-monitoring along with the specific parameters for daily monitoring must be obtained from the patient's PMP prior to evaluation and admission.

V. BENEFITS OF BIO-MONITORING NURSE CARE MANAGEMENT

Bio-monitoring Nurse Care Management extends the PMPs ability to more closely monitor patients with chronic diseases. The potential goals of the Bio-monitoring Nurse Care Management program are:

- A. Increased number of patients will receive preventative care.
- B. Increased number of patients will be compliant with their medical regime.
- C. Decrease in acute exacerbations of disease symptoms for patients with chronic diseases.
- D. Decrease in visits to emergency room and urgent care.
- E. Decrease in urgent care and hospitalizations.
- F. Decrease in cost for chronic care in select patient populations.

VI. COLLABORATION

Collaboration is a key function of the Bio-monitoring Nurse Care Manager. It is essential to the management of patients with chronic disease diagnosis. The Bio-monitoring Nurse Care Manager collaborates with the PMP, Patient 1st Care Coordinator, Medicaid staff, and other health care providers and community resources. The Bio-monitoring Nurse Care Manager acts as a liaison for the patient and caregiver with other health care providers and community services to focus on the medical aspects of the patient's needs. Communication and collaboration with the Patient 1st Care Coordinator or Network staff are essential functions to ensure the psycho-social needs impacting the patient are being managed.

VII. COMPLETION OF THE REFERRAL FORM

Referrals are tracked with a hard copy forms. A file is kept at the local office with the referrals that are not admitted with documentation to support the disposition of the referral.

VIII. REPORTS TO REFERRING PROVIDERS

The patient's PMP will be provided monthly reports, including graphs of the Bio-monitoring results. Written report or contact by electronic fax or phone call will be provided to the PMP when indicated. These may include, but are not limited to:

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- A. Threshold violations
- B. Reports of non-compliance with medical regime
- C. Medication reconciliation

IX. QUALIFIED BIO-MONITORING NURSE CARE MANAGER

The Bio-Monitoring Nurse Care Manager must demonstrate competency in assessing and completing psycho-social assessments and case plans, coordination of services and provision of referral and follow-up services. The Care Coordinator must be employed by the Alabama Department of Public Health. The Bio-monitoring Nurse Care Manager will;

- A. Be a registered nurse with current license to practice in Alabama.
- B. Be a registered nurse with a Bachelor's Degree in nursing and have least one year of experience in home care or community nursing.
- C. Be a registered nurse with ASN or Diploma degree and have minimum of three years of experience as a registered nurse, one being in home care or community nursing.
- D. Completion of the Bio-monitoring Nurse Care Manager training approved by Alabama Medicaid and Alabama Department of Public Health Bureau of Home and Community Services.
- E. Provide services in accordance with state and federal regulations and ensure protocols, policies and procedures are followed.
- F. Demonstrate an administrative capacity to:
 - 1. Ensure quality of services are in accordance with state and federal regulations.
 - 2. Complete documentation within McKesson for billing and financial reports.
 - 3. Complete document in RMEDE™ for clinical and direct patient interventions.

X. SUPERVISION

Within the established structure of the ADPH, the Life Care Nurse Manager (RN) or Area Home Care Director (BSN RN) is responsible for the supervision and ongoing training for the Bio-monitoring Nurse Care Manager. Documentation of this supervision will be available to the Alabama Medicaid Agency for review.

XI. BIO-MONITORING NURSE CARE MANAGER RESPONSIBILITIES

A. Contacting Patient Referrals

Once a referral is received, the PMP will be contacted to obtain initial (verbal or written) orders for an in-home assessment for Bio-monitoring Nurse Care Management. The patient's Patient 1st Medicaid eligibility will verify (See XI. D.)

Active Referral is one that has

- 1. A PMP order for an in home assessment
- 2. Medicaid Patient 1st Eligibility
- 3. Has one or more of the required medical diagnosis

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Once a referral is in Active status, the Bio-monitoring Nurse Care Manager will attempt to contact the patient within two (2) working days. All reasonable attempts to contact the patient will be made for a period of two (2) calendar weeks. Reasonable attempts are phone calls on different days and different times of day and a letter. If the patient cannot be contacted after two (2) weeks, the referral source and PMP will be notified that attempts to contact the patient have been unsuccessful.

Once the patient is contacted, a brief introduction of the Bio-monitoring Nurse Care Management program will be provided and a home visit will be scheduled at the earliest time possible.

B. Physician's Orders

Physician's orders for the Bio-monitoring program will be obtained by the Bio-monitoring Nurse Care Manager for:

1. Initial/Assessment/Admission Visit (including primary diagnosis and threshold parameters for blood sugar, blood pressure, and/or weight)
2. When there is a change in the Plan of Care
3. Annually (The initial and annual physician orders are valid for one calendar year to date. New orders must be obtained at least annually from the date of the initial or previous physician's orders.)
4. A nurse practitioner, who is the primary Patient 1st medical provider, may sign the Bio-monitoring orders if needed.

C. Initial Visit and Assessment

An initial home visit will be made by the Bio-monitoring Nurse Care Manager to:

1. Further explain the Bio-monitoring program.
2. Assess the patient's willingness and ability to participate in the Bio-monitoring program or caregiver's willingness and ability.
3. Assess the home environment.
4. Medication review and reconciliation with PMP.
5. Deliver set-up and train on the use of the Bio-monitoring equipment.
6. Assist the patient in development of the Plan of Care.

D. Patient Eligibility

Patient eligibility is verified through the Alabama Medical Assistance Program Interactive Services Website www.medicaid.alabamaservices.org or card swipe machine using the patients Medicaid number or accessing Medicaid's Automated Voice Response System by calling 1-800-727-7848 and requesting a fax verification of eligibility.

The Bio-monitoring Nurse Care Manager/or designee will print out eligibility verification and place in the patient's clinical record. Eligibility will be checked on

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a monthly basis at the beginning of the month. Eligibility will be valid until the first of the following month. A printed copy of the eligibility verification will be filed in the patient record.

E. Patient Records

Financial, billing and reports will be maintained in the ADPH McKesson system. RMEDE™ is the system for entering the clinical documentation. It is also necessary to maintain a hard copy patient record to include:

Section 1

RMEDE™ In-Home Monitoring Provider Orders.
Referral Care Coordination form or printed email referral (if referral made to Patient 1st Care Coordinator).

Section 2

RMEDE™ In-Home Monitoring Patient Enrollment Form.
RMEDE™ In-Home Monitoring Patient Consent Form.
Privacy Notice Acknowledgement Statement (HBS-322).
Emergency Preparedness Plan (CBW-291).

Section 3

Copies of any printed reports from RMEDE™, as applicable.
Continuation Notes.

Section 4

Monthly verification of Medicaid and Patient 1st eligibility – Medweb or MSIQ.
Service Reports and any other billing reports from McKesson, as applicable.

RMEDE™ -Nurse Care Management Documentation including:

1. Admission
2. Assessment
3. Follow-up, Interim and Annual Visits
4. Collaboration
5. Plan of Care
6. Interventions
7. Education
 - a. Use of bio-monitoring equipment
 - b. Use of RMEDE™
 - c. Disease Management
 - d. Compliance
8. Medication Reconciliation and Education
9. Monitoring Threshold Violations
10. Evaluation

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F. Development of a Bio-monitoring Care Plan

Patient participation in self-directed care is essential to both increased patient compliance and reducing costs. Through an interactive process, the Bio-monitoring Nurse Care Manager will work with the patient, support persons and other care providers to develop a plan of care to include performing daily bio-monitoring, reporting and other activities to expand their chronic disease management. The care plan will be re-evaluated at least annually and as needed.

G. Referrals

If the Bio-monitoring Nurse Care Manager along with the patient/caregiver identifies an unmet need, a referral may be made to other health care or community service providers. It is the choice of the patient/caregiver if the referral is to be made and to choose which provider they will use. The Bio-monitoring Nurse Care Manager will report ALL referrals in writing (electronic or hard copy) to the Patient 1st Care Coordinator or the Care Network staff and the PMP.

H. Monitoring Threshold Violations

1. **Daily-** Threshold violations (any physiologic reading outside the physician's pre-set critical levels are monitored twenty four hours a day/seven days a week (24/7) by the USA CSHI's RMEDE™. All threshold violations readings are reported to the Bio-monitoring Nurse Care Manager by web email, fax, pager, and/or answering service. Each threshold violation will require a phone call and/or visit to the patient's home in order to assess the reason for the alert. The Bio-monitoring Nurse Care Manager will determine what interventions are needed to provide patient compliance/safety. The PMP will be notified of the Threshold Violation and interventions. After 5:00 pm weekdays, weekends and holidays, the threshold violations will be monitored by the Bio-monitoring nurse care manager or designee on call.
 - **Once a pattern is established, the parameters may be adjusted with a physician's order to better capture critical violations.**
2. **Monthly-** The Bio-monitoring Nurse Care Manager will make at least a *monthly contact* with each active patient by phone call or home visit, if necessary, to follow up on any changes in the patient's condition or medical plan of care, response to the Bio-monitoring program, medical regime compliance, emergency room visits, hospitalizations or unplanned PMP visits.
3. **Annually** – An annual home visit will be made prior to the annual renewal of physician orders to observe and assess the patient environment, condition of monitoring equipment, compliance and re-evaluate patient parameters of bio-monitoring. Physician orders for Bio-monitoring are obtained with specific physiologic parameters at least annually and as indicated by the physician.

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I. Reassessment/Follow-up

Reassessment/Follow-up visits are made at least on an annual basis prior to the annual renewal of the physician's orders. These visits may be made on an interim basis as indicated by

1. Annually prior to the renewal of the physician's orders
2. Threshold violations follow-up
3. Re-education on Bio-monitoring equipment or Disease Management
4. If reassessment is warranted
5. No contact from patient within set time frame

J. Discharge

Patients on this service will be discharged when;

1. They are no longer eligible for Alabama Patient 1st Medicaid.
2. The PMP decides the services are no longer needed and provides a discharge order.
3. PMP refuses to sign the annual re-assessment orders.
4. If the patient is non-compliant with the Bio-monitoring Nurse Care Management Plan of Care for greater than sixty (60) days, the case will be assessed for discharge.

Non-compliance is defined as a patient who is not following a routine pattern of self-monitoring for greater than sixty (60) days. If a patient has not been following a routine pattern of self-monitoring for at least thirty (30) days, the Bio-monitoring Nurse Care Manager will make all reasonable attempts to contact the patient and ascertain why the patient is no longer following the plan of care. The patient's Patient 1st Care Coordinator will be contacted to determine if resources to assist the patient are needed. If the patient is not located or is unwilling or unable to continue on the program, the PMP will be notified. A verbal or written order will be obtained prior to discharge of the patient for non-compliance. The Life Care Manager and Area Home Care Director will also be notified along with USA/CSHI. USA CSHI will provide a 30 Day and 60 Day Non-compliant list on a monthly basis.

K. Transfer to another County/Area

When a patient relocates to another county/area covered by a different Bio-monitoring Nurse Care Manager, there will be a coordinated transfer. There will be documented notification from the BIO-MONITORING NURSE CARE MANAGER transferring the patient to

1. Receiving BIO-MONITORING NURSE CARE MANAGER
2. PMP
3. Patient 1st Care Coordinator
4. USACSHI to make changes in RMEDE™.

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The receiving BIO-MONITORING NURSE CARE MANAGER will contact the patient and assess for any changes in the plan of care.

XII. CASE LOAD

The active caseload of each of the Bio-monitoring Nurse Care Manager should not exceed 100 active patients. The caseload is monitored by the Life Care Manager and the Area Home Care Director to ensure manageability. Regular contact with the patient/caregiver is essential to providing Bio-monitoring Nurse Care Management. Active cases require a minimum of one personal contact (telephone call or home visit) with the patient per month. Total caseload numbers are reflective of active cases only.

- A. Active Case** Patient that is being evaluated for admission or has current PMP orders and is self-monitoring and reporting at the agreed intervals.
- B. Inactive Case** Patient who is not actively self-monitoring and reporting at the agreed intervals for greater than sixty (60) days.
- C. Discharge Case** Patient who has been terminated from services and currently not being followed by the Bio-monitoring Nurse Care Manager.

XIII. DUPLICATION OF SERVICES

Bio-monitoring Nurse Care Management provides a focused, specialized service under the direction of the Patient 1st PMP and in collaboration with Patient 1st Case Coordinators. This is a specialized Nursing Care Coordination for a designated group of Patient 1st Medicaid patients with specific diagnosis. These services provide the patient with in-home Bio-monitoring of specific physiologic parameters, 24 hour access to a clinician, assessment in the patients home, training on use of bio-monitoring equipment and RMEDE system, education and reinforcement of chronic disease management strategies and referrals to other health care providers as indicated.

XIV. DOCUMENTATION

The electronic billing system, McKesson (ADPH) is used for all admissions to the Bio-monitoring Nurse Care Management program for billing only. The information necessary to complete the billing process in McKesson will be entered in order to create tracking data and set up the electronic files for billing. Bio-monitoring Nurse Care Management activities will be documented in USACSHI's RMEDE™.

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XV. BIO-MONITORING NURSE CARE MANAGER TRAINING

Initial training will be required for all registered nurses who provide Bi-monitoring Nurse Care Management. This includes any registered nurse who supervises the program or who provides on-call coverage. Further, ADPH and USACSHI have the responsibility to provide training and technical assistance consultation to all Bio-monitoring Nurse Care Managers on AMA and Network guidelines, McKesson, and RMEDE™.

XVI. QUALITY IMPROVEMENT

Bio-monitoring Nurse Care Management is part of the overall ADPH Home and Community Services Quality Improvement program. Records will be reviewed on a quarterly basis by the Area Management staff.

XVII. MEDICAL RECORD MANAGEMENT

Active ADPH records are housed in secure areas, assessable to authorized personnel only. ADPH follows all HIPPA requirements. All admission documentation will be maintained in a confidential manner in accordance with Life Care policies and procedures.

XVIII. RELEASE OF PATIENT INFO

Original documentation of the client's clinical record will not leave the office without administrative approval. The client's written authorization is necessary for the release of information contained in the clinical record other than for treatment, payment, and healthcare operations. The client/responsible person will sign the Authorization For Release Of Confidential Information (HBS-320) to authorize the release of information.

The Life Care Manager and/or Area Home Care Director will be contacted before releasing any part of the patient record. The Life Care Manager and/or Area Home Care Director will contact and forward the request for release and copying of clinical records to the department's legal counsel with consultation/communication with the State Home Care Director.

Access to confidential client clinical records will be granted to the following persons on a need to know basis following proper identification:

- A. Area Home Care Director.
- B. Life Care Supervisor/Manager.
- C. Staff members directly involved in the client's care.
- D. Those persons involved in the filing, billing, and automation process for services provided.
- E. Persons directly involved in the supervision of the personnel or services provided to include local, county, area, and state personnel.

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- F. Persons involved in evaluating the agency for Utilization Review or Quality Improvement.
- G. Regulatory and accreditation entities evaluating the agency or program:
 - 1. Centers for Medicare and Medicaid Services (CMS).
 - 2. Alabama Medicaid Agency (AMA).
 - 3. Office of Program Integrity, Alabama Department of Public Health (ADPH).
 - 4. Others as approved by the AMA, State Home Care Director, Bureau of Home and Community Services.

XIX. GRIEVANCE MEDICAID

If a patient has a grievance, the Patient 1st Care Coordinator will be notified to assist the patient with this process.

XX. EVALUATION

In conjunction with USACSHI and the AMA, an evaluation process will be designed to identify, operationalize and measure process and outcome indicators of serviced. The following potential goals have been identified for the patients who participate in the Bio-Monitoring Nurse Care Management program:

- A. There will be a decrease in the cost to Medicaid for the provision of services to patients with the target chronic diseases.
- B. There will be an increase in compliance to the medical regime.
- C. There will be a decrease in the number of emergent care visits for exacerbation of the target chronic diseases