

MDwise Hoosier Alliance Chronic Kidney Disease Management Program Description

Purpose

Chronic Kidney (Renal) Disease (CKD) is a condition in which the kidneys are damaged and cannot filter blood as well as possible. This damage can cause wastes to build up in the body and lead to other health problems, including cardiovascular disease (CVD), anemia and bone disease.

In the United States, there is a rising incidence and prevalence of kidney failure with poor outcomes and high cost. There is also a higher prevalence of earlier stages of chronic kidney disease. Increasing evidence, accrued in the past decades, indicates that the adverse outcomes of chronic kidney disease such as kidney failure, cardiovascular disease and premature death, can be prevented or delayed by lifestyle changes. The only treatments for kidney failure are dialysis or a kidney transplant.

Chronic kidney disease is “under-diagnosed” and “under-treated” in the United States resulting in lost opportunities for prevention. CKD can only be detected through a blood test to estimate kidney function and a urine test to assess kidney damage.¹

The total number of Americans living with CKD is now estimated to be 19.2 million, representing 11% of the adult U.S. population.²

Diabetes and high blood pressure account for two-thirds of all cases of chronic kidney disease. Other conditions are glomerulonephrities, inherited diseases such as polycystic kidney disease, congenital malformations, lupus and other diseases affecting the body’s immune system, obstruction and repeated urinary infections.

MDwise Hoosier Alliance (MDHA) has adopted the National Kidney Foundation, Kidney Disease Outcome Quality Initiative (KDOQI) Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification.¹

MDHA assesses the characteristics and needs of its member population and relevant subpopulations based on eligibility categories, Hoosier Healthwise and Healthy Indiana Plan member demographics, self-referral services, specialty services and specific utilization patterns, such as members enrolled in the Right Choices Program.

The CKD Disease Management Program is offered to all eligible members who meet MDHA-established criteria for enrollment in the program.

¹ http://www.kidney.org/professionals/KDOQI/guidelines_ckd/toc.htm

² www.cdc.gov/pcd/issues/2006/apr/05_0105.htm • Centers for Disease Control and Prevention



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Key Elements

1. Program Objectives

- **Member:** to improve the health and quality of life for our members with CKD by providing specific information and interventions in the management of CKD. This includes assisting members with the development and implementation of self-management plans. This includes all aspects of National Committee for Quality Assurance (NCQA) QI 7 and 8 requirements.
- **Provider:** to enhance provider understanding of and compliance with MDHA and the National Kidney Foundation, KDOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification and Stratification. Providers will be active participants in the care of the member through collaboration with the care and/or case manager and through direct member contact.

2. Program Goals

- Identify, provide and coordinate services for members with CKD and other complex comorbid conditions
- Facilitate processes to actively assist members and providers with the management of CKD and other complex conditions
- Facilitate access to needed resources
- Systematically assess the characteristics of our member population and sub-populations
- Maintain, review and update as needed case management processes and resources to address members' needs
- Identify processes which specifically outline sources of information to identify members for case management
- Identify appropriate referral avenues for members to be referred to case management and other resources
- Maintain a case management system which supports the case management program by providing necessary evidenced-based clinical guidelines, algorithms, assessments, documentation, automatic prompts for case management follow-up and automatic documentation of staff demographics (i.e., staff member's name, title date and time of input or activity)
- Ensure case management activities address the assessment of individualized development of case management plans which identify a member's health status, history, medications, condition-specific issues, activities of daily living, cognitive and mental health status, life-planning activities, cultural and physical preferences and limitations, identification of barriers and how to overcome them, progress assessment, prioritization of goals, follow-up, communication and self-management plan, as well as involvement of caregivers and referrals to resources

Additionally, a case management plan will include goals for not only the member, but the caregiver, including caregiver preferences and the level of involvement the caregiver has in the member's case management plan.



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- Ensure documented case management processes are followed for assessments, including ongoing monitoring and evaluation of case management activities
- Provide a process to obtain feedback from members regarding satisfaction, complaints and inquiries
- Analyze and evaluate the program at least annually
- Identify and have systems in place to set performance goals, measure outcomes or effectiveness and to analyze results
- Provide interventions to support opportunities for improvement and remeasurement

3. Program Content

- Condition monitoring to include, but not be limited to, a member's self-management skills, inclusive of self-monitoring and medical testing, and documented self-reported information
- Development of and monitoring adherence to treatment plans, including but not limited to, medications, self-monitoring activities, and making needed appointments with PMP and specialist(s) and care gaps
- Identification of medical and behavioral health comorbidities on an individual basis to allow implementation of the most effective treatment/care plan and self-monitoring plan. This includes referrals to specialists.
- Identify possible health behaviors that may impede a member's ability to manage his or her condition. Promote healthy lifestyle practices such as exercise, nutrition, and smoking cessation efforts through education and resources.
- Identification of psychosocial issues that may play a part in a member's adherence to a treatment plan. These issues may include, but not limited to, perceived barriers such as access to care issues, transportation and financial limitations, and cultural, religious and ethnic beliefs.
- Completed depression screening during the first thirty (30) calendar days of enrollment into care management
- Identification of member's caregiver if appropriate and, with consent of the member, provide the caregiver information related to the member's condition and treatment plan
- Encourage and assist with communication between the member and provider related to his or her health concerns and treatment. By doing so, establishing a Medical Home for the member.
- Increase the administration of influenza vaccination
- Provide members with a list of external resources specific to the need(s) of the member

Interventions to Achieve Program Content

- Educate members about adherence to medication regimen and other items that might be included within an individualized self-management plan through telephonic outreach
- Assist members in executing a healthy lifestyle by educating them about smoking cessation, the importance of staying active, weight management, nutrition and the dangers of substance abuse, as appropriate for each member



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- Assist members in communicating with their provider about their health conditions, treatments and self-management plans
- Upon consent of the member, supply member's caregiver with information about the member's condition and treatment plan and provide resources to support the caregiver's role (i.e., About Special Kids, Indiana Family Helpline, Agency on Aging, among others)
- Assist members to take action to modify smoking or start a smoking cessation program by providing information by phone and/or mail related to the Indiana Tobacco Quitline program (refer to Section 9 for this program)
- Educate members about their disease state(s), future implications and comorbidities (including mental health) through phone contact, interactive phone response and disease-specific mailings per MDwise Policy MM-10.
- Coordinate care gaps with the member and provider through ongoing telephonic contacts and/ or phone reminders
- Assist members in receiving the influenza vaccination
- Coordinate with external resources as needed, such as but not limited to, 211, Indiana Family Helpline, Indiana Tobacco Quitline program and other appropriate CKD resources.
- Assist member with the identification of psychosocial issues that are creating barriers to the member achieving their goals for treatment and self-management

4. Population Identification and Integration of Member Information

All members identified as having CKD are eligible for the program. The following methods, while not an all-inclusive list, will be utilized to identify members for the CKD Disease Management Program:

- NURSEon-call encounters
- ER visit
- Health Risk Screenings
- Provider referrals (*HA416-Case Management Referral Form HHW-HIP P0017*)
- Initial Complex Assessment Tool
- Claims (medical and pharmacy)
- MDwise Corporate referrals
- DxCG (Diagnostic Cost Group) Scores
- UM/PA Department
- Medical Director
- Hospital Census and Discharge Planning
- ManagedCare.com
- Disease Management Program referral
- Self-referrals



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MDHA integrates member information from the following systems to facilitate continuity of care:

- Disease and Case/Care Management System (Pre-certification, Concurrent, Hospital, Discharge and Claims data)
- Utilization Management System (Pre-certification, Concurrent Review and Discharge Data)
- ManagedCare.com
- Claims (Hospital Admission and Discharge Data) DxCG risk scoring

5. Population Stratification

Identification Logic:

Any paid claim with Hypertensive Heart and Kidney Disease (HHKD) diagnosis

Exclude members with ESRD as defined by HEDIS 2011 CBP measure, Table CBP-C (ICD-9: 404.x1, 404.x3)

Stratification Logic:

Low: Member identified as having CKD/HHKD and

- DxCG score < 241

Moderate: Members with CKD/HHKD and one of the following:

- DxCG score between 241 - 400 or
- 2 or more co-morbidities (Diabetes, HTN, Lupus, pregnancy, Glomerulonephritis, polycystic kidney disease, kidney stones, enlarged prostate, or retinopathy)
- 1 or more ER visits within last 4 - 6 months with CKD/HHKD dx

High: CKD/HHKD member with one of the following:

- DxCG score >400
- 3 or more co-morbidities (listed above in Moderate)
- 1 or more claim for nephrology
- 1 or more claim for anemia (transfusions, EPOGEN, PROCRT, Iron supplements oral or intravenous - iron dextran, sodium ferric gluconate, iron sucrose)
- 1 or more claim for Phosphate binders: calcium carbonate (TUMS)
- 1 or more ER visits in last 3 months with CKD/HHKD dx
- Manually via HRS or assessments in PMT

Additionally, members can be identified internally through claims and stratified through DxCG risk scores as follows:

- Population-based (low): ≤ 299
- Case management (moderate): 300-499
- Care management (high): ≥ 500

Upon intake into the case management program an additional stratification occurs when the initial complex assessment has been completed within the first thirty (30) calendar days of identification. Members may risk higher or lower than the initial stratification received via the PMT. Members who have urgent case management needs are assigned to a case manager within one (1) business day of receipt of referral. Within ten (10) business days, the member will receive an initial outreach attempt by a case manager to obtain an assessment.



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6. Levels of Activity for Member Outreach

The stratification risk group drives the level of interventions.

- **Low-Population Based**

Criteria: Members who meet Low risk level as outlined in the Stratification Section. Members with CKD having a Low risk score are flagged for population-based intervention, but members can move from one classification to another based on changes in their severity or exacerbation of symptoms.

Primary Responsibility: MDwise

Interventions focus: Members will be engaged through disease-specific and preventive care population-based interventions – including educational materials, appointment and preventive care reminders. Pregnant members shall receive standard pregnancy care educational materials. Members will receive tobacco cessation materials about the Indiana Tobacco Quitline and access information for MDwise 24-hour nurse call line. All members in population-based management will receive the above-mentioned interventions bi-annually, per MDwise Policy MM-10.

- **Moderate-Case Management**

Criteria: Members who meet Moderate risk level as outlined in the Stratification Section are outreached to by automated voice response, United States Postal Service (USPS) and/or telephonically at least quarterly. Automated prompts are created in the documentation system to alert case managers when outreaches are scheduled.

Primary Responsibility: MDHA Case Management Technicians and Nurse Case Manager Level 1.

Interventions focus (but not limited to):

- Welcome letter providing the member with information about case management and how to contact the Case Management Department in order to speak with a nurse (*HA333-New Member Welcome Letter HHW-HIP M0001*)
- Resource Letter providing the member with MDwise Member Services information, including transportation services and 24-hour nurse call line, transportation benefit information and community resource information, including Indiana Tobacco Quitline, 211 and Indiana Family Helpline. (*HA426 Case Management Resource Letter HHW-HIP M0008*)
- Disease-specific outreach related to CKD and medication adherence through Soundbites (*HA413 Condition-Specific Soundbites Blasts M0549*)
- Preventive care reminders
- Assistance with transportation issues
- Assistance with setting up appointments with PMP and/or specialists
- Assistance with pharmacy issues
- Appointment reminders, as need



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- **High-Care Management**

Criteria: Members who meet High risk level as outlined in the Stratification Section are outreached to telephonically and/or USPS at least quarterly. Automated prompts are created in the documentation system to alert the case manager when outreaches are scheduled.

Primary Responsibility: MDHA Case Manager

Interventions focus (but are not limited to):

- All interventions under Low-Population Based and Moderate-Case Management
- Member participation letter sent to PMP (*HA058-Participation in Case Management P0268*)
- Goals letter sent to the member and PMP (*HA061-Case Management Intro Letter M0367 and PS058-Participation in Case Management Letter, respectively*)
- An initial complex health risk assessment will be completed within thirty (30) calendar days of identification including, but not limited to:
 - Initial assessment of members' health status, including condition-specific issues
 - Documentation of clinical history, including medications
 - Initial assessment of the activities of daily living
 - Initial assessment of mental health status, including cognitive functions
 - Initial assessment of life-planning activities, including the presence of health care power of attorney or DNR orders, if applicable
 - Evaluation of cultural and linguistic needs, preferences or limitations
 - Evaluation of visual and hearing needs, preferences or limitations
 - Evaluation of caregiver resources and involvement
 - Evaluation of available benefits within the organization and from community resources
 - Development of an individualized case management plan, including prioritized goals, that considers the member's and caregivers' goals, preferences and desired level of involvement in the case management plan
 - Identification of barriers to meeting goals or complying with the plan
 - Facilitate member referrals to resources and follow-up to determine whether member acts on referrals
 - Development of a schedule for follow-up and communication with member
 - Process to assess progress toward care management planned interventions
 - Review of the member's claim history
 - Contact with the member's family and health care providers
 - Development and communication of member self-management plans
 - A process to assess progress or course changes against the member's care management plan
- Identifying member's needs related to their diagnosis of CKD
- Evaluate the member's care gaps and coordinate services to achieve all preventive care with the provider
- Education around medication and self-management adherence, exercise, proper nutrition and smoking cessation



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- Evaluate the appropriateness of a specialty referral to a nephrologist
- Coordination with the provider regarding member education, self-management and use of appropriate medications, modifications to care plan and change in member classification from High-Moderate risk to Low risk
- Depression Screening completed within thirty (30) calendar days of enrollment
- Disease-specific assessments, as appropriate
- Condition monitoring to include comorbidities

7. CKD Program Outcome Measurements for Re-stratification

After six (6) months, the member's progress towards their self-management/treatment plan is evaluated using outcome measurements. Based on the outcome measures listed below, the member will be reassessed and re-stratified according to, but not limited to, Section 5 Population Stratification:

- Reduction of emergency room visits due to CKD
- Reduction of Inpatient Admissions due to CKD
- Increase in routine office visits
- Improvement of activity status per member account
- Plan of care goals are met
- Documented annual Microalbumin Urine test
- Documented annual Glomerular Filtration Rate (GFR) testing
- Documented annual Influenza Vaccination

Evaluation of member's outcomes will continue every six (6) months while engaged in case/care management activities. Based on this evaluation, the member can be moved to population-based, case management, or remain in care management.

8. Member Participation and Opting Out of the Program

Eligible members are considered enrolled in the Program and receive outreach and interventions without a specific request for participation. Participation is voluntary and the member has the right to "opt out" of the program. Following an explanation of case management and reason for the contact, if the member declines to continue with case management he/she is given the case manager's phone number in case of reconsideration. The member may re-enter the program at any time by contacting the case manager at the number provided.

9. Indiana Tobacco Quitline Information

The Indiana Tobacco Quitline is a free, phone-based counseling service that helps Indiana smokers quit. All members in Case or Care Management will receive information by phone and/or USPS. Services include:



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- One-on-one coaching for tobacco users who have decided to quit
- Resources for health care providers who want to improve patient outcomes
- Best Practices for Employers who want to implement smoke-free policies
- Support for family and friends who want to help loved ones stop smoking
- Tools for tobacco control partners to complement their current programs

Services are available seven (7) days a week in more than 170 languages. Members can call 1-800-QUIT-NOW (800-784-8669) or go online, <http://in.gov/quitline>.

10. Staff Training, Credentials, Certification and Documentation System

- Staff Training
It is imperative that our staff have training in the treatment of CKD to assure education continuity. The staff will be trained by MDHA Medical Director or designee annually on the National CKD Education and Prevention Program goals for CKD control.
- Credentials and Certification
The case manager will be a currently licensed RN with at least three (3) years of clinical experience. After initial training, the case manager will review the Clinical Practice Guidelines training annually. The case manager will receive ongoing training through seminars, publications and other education avenues as they become available. Education and training provided will focus on preparing the case manager to become a certified case manager (CCM).
- Documentation System
All interaction with the member and provider will be automatically documented in the member's case file with the staff member's ID and date and time of the action. Automated prompts for follow-up contacts with the member will be addressed in the member's plan of care. Clinical Care Guidelines are used to develop assessments with algorithms in the case management documentation system. Staffing ratio for case/care management is 1:200.

11. Provider Notification and Involvement

In-network providers are notified about the program in several ways:

- The MDwise Provider Manual
- The MDHA Web site, www.hoosieralliance.org
- The MDwise health plan provider Web site, www.MDwise.org
- Indiana Health Coverage Program (IHCP) Provider Bulletins
- Case management outreach encounters and updates with the provider

Providers receive the following written notification regarding their patients' participation in the CKD Disease Management Program:

- Notification of high-risk member enrollment in one-on-one care management, along with a copy of the plan of care goals (*HA058-Participation in Case Management P0268 and HA061- Case Management Intro Letter M0367*)
- Notification of a change in risk level of members enrolled in case/care management (*HA059-Discharge from Case Management M0368*)



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- Notification of members who are eligible for CKD disease case management but who the case managers were unable to contact, either initially or for follow-up to collaborate on patient demographics and update any relevant clinical findings (*letter to be developed*)
- Notification of members upon graduation from the CKD Disease Care Management Program (*HA059-Discharge from Case Management M0368*)

12. Measurements

Cost/ Benefit Measurements	Measurement Capture	Performance Goal
Rate of inpatient admissions for CKD per 1,000 total members	Claims with ICD9 code of 585.9 and CPT code of 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	3% reduction for members in CKD Care Management during a 6 month period
Rate of ER visits for CKD per 1,000 total members	Claims with ICD9 code of 585.9 and CPT code of 99281-99285	3% reduction for members in CKD Care Management during a 6 month period
Rate of patients with CKD fully engaged in management with a documented annual GFR and Microalbumin Test	Members with CKD as an active disease in CCNX, with a Program of Care Management that have a CPT code of (GFR) 80048, 82565, 84520, 80053, 82575, or 80069 and 82043 (Mircoalbumin)	90% of all members in CKD Care Management will have one GFR test and one Microalbumin test during a 12 month period
PMP Office visits every 6 months	Claim for a PMP office visit with a CPT code of 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 and an ICD9 code of 585.9	90% of members in CKD Care Management will have one (1) PMP visit during a 6 month period
Number of members fully engaged in either case or care management in the CKD Disease Management Program for prior 6 months and average time engaged.	Informatics report-Dashboard	NA
Documented influenza vaccination	Claims with ICD9 code of 585.9 and a HCPCS of G0008	100% of all members in CKD Care Management will have received an annual Influenza Vaccination during a 12 month period



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13. Annual Evaluation

The CKD Disease Case Management Evaluation is conducted collaboratively by the Senior Director of Clinical Services, Case and Disease Management Supervisor, Supervisor of Quality Improvement and the Chief Medical Officer. The program is evaluated annually and presented in the first quarter of the following year to the Physician Advisory Committee. Quarterly statistics are reported to the Physician Advisory Committee.

Objectives, activities, processes and outcomes are evaluated at a minimum of annually in order to:

- Calculate annual participation rates
- Determine whether the CKD Disease Management Program has demonstrated improvement in the services and quality of care provided to members
- Evaluate the overall effectiveness of the CKD Program
- Allow for exploration of barriers and limitations of the CKD Program
- Revise areas as needed to improve effectiveness of the CKD Program
- Obtain feedback from members regarding satisfaction with care management and to analyze member complaints and inquiries
- Implement intervention(s) to improve performance

MDHA also reviews and updates its case management processes and resources to address member needs. Policies are reviewed annually during the Quality Service Committee.