

## NC HealthSmart: Supporting North Carolina State Health Plan Members with Chronic Kidney Disease

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The North Carolina State Health Plan (State Health Plan) covers approximately 647 000 teachers, state employees, retirees, current and former lawmakers, state university and community college personnel, state hospital staff, and their dependents. The State Health Plan also administers NC Health Choice, a fee-for-service program that provides health insurance to more than 122 000 uninsured children in North Carolina.

In January 2002 the State Health Plan began to offer targeted case management services to members with chronic kidney disease (CKD). Since that time, multiple programs and services have been implemented to provide a continuum of support as disease progression impacts members' needs.

NC HealthSmart, an initiative launched in 2005, encourages members to make healthier lifestyle choices and become partners in meeting their health care needs. This innovative program includes health promotion and disease prevention through health coaching, worksite wellness programs, and Web-based educational materials and services. NC HealthSmart includes disease and case management programs to assist members with chronic illnesses including CKD as well as members whose medical situations requires intensive intervention.

In 2006 the State Health Plan first offered a preferred provider organization (PPO) benefit plan in addition to the traditional indemnity plan. The PPO improved members' access to primary prevention services by offering coverage for all preventive services rendered

in a physician's office through a single copayment. Preventive services include screenings for hypertension and diabetes, which are known precursors to CKD. Once a member is diagnosed with a chronic illness (such as hypertension or diabetes), NC HealthSmart encourages secondary prevention through member education and screenings for chronic kidney disease.

In addition to these value-based services, NC HealthSmart includes an information tool for physicians called the SMART Registry. Through the SMART Registry, primary care physicians receive information about clinical gaps in care for eligible

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members. One measure reported is microalbuminuria testing for members with diabetes, a KDOQI<sup>1</sup> (Kidney Disease Outcomes Quality Initiative) guideline for kidney disease management.

a The only members who are eligible for NC HealthSmart program services are those with the NC State Health Plan as their primary insurer. Members with Medicare as their primary insurer or members on COBRA are not eligible for NC HealthSmart services.

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Provider services specialists are available to assist physicians with questions about the SMART Registry and other NC HealthSmart programs.

NC HealthSmart also uses targeted marketing to reach State Health Plan members with chronic disease. Part of this targeted marketing includes an informational flyer about kidney disease. The flyer contains instructions on how to contact a NC HealthSmart health coach for assistance and disease management support. Health coaches are available 24 hours a day, 7 days a week, to provide disease-specific information. They also assist members with early-stage kidney disease with the best way to address questions and concerns with their physicians.

For eligible members with chronic kidney disease that has progressed to a more advanced stage, the State Health Plan offers intensive care management services through Renaissance Health Care. Trained and experienced kidney disease care managers provide patient education, disease management, and care management services to patients with an eGFR of less than or equal to 45 (stage 3 in KDOQI guidelines). Members are referred to Renaissance Health Care from other State Health Plan vendors and providers and are identified through claims analysis. They are then contacted directly and offered care management support. With early identification of members with chronic kidney disease and referrals to care management services, the goal of the NC State Health Plan is to prevent or delay disease progression or decrease disease-associated complications.

Renaissance Health Care helps identify clinical gaps in care for patients with CKD. Care managers work with members and treating providers to improve clinical indicators such as blood pressure control for patients with coronary artery disease or hypertension and blood glucose control for patients with diabetes. In addition, each State Health Plan member with advanced CKD is offered intensive care management and education services as they prepare for transition to renal replacement therapy. Educational modules that describe the various treatment modalities are provided along with an explanation of the benefits and challenges of each option. Taking a holistic approach, the care management needs assessment also includes depression screening. Members identified as having depression are referred for treatment if that is an appropriate strategy. As of December 2007 there were 235 State Health Plan members active in chronic kidney disease care management.

A claims data review does not identify all patients with CKD. As a result, the State Health Plan has been working to understand the barriers to member identification and care management engagement. One effort involves partnering with the University of North Carolina (UNC) Kidney Clinic to develop alternative methods of identifying members for care management. The UNC Kidney Clinic has identified State Health Plan members in their patient panel who are appropriate for referral to Renaissance Health Care. Within the first 3 months of the program (fourth quarter 2007), there were over 30 new referrals and an 85% enrollment rate (screened and engaged with a care manager). Other results showed an increase in immunization rates and an increase in the use of

Angiotensin-Converting Enzyme Inhibitor/Angiotensin Receptor Blocker (ACE/ARB) medications (also a KDOQI guideline). Additional efforts to improve the identification of members with CKD include enhancements to the data provided to Renaissance Health Care from the claims processing contractor as well as the review of Renaissance data mining processes.

The care management and patient education services provided by Renaissance Health Care have contributed to positive health outcomes for people with advanced stages of kidney disease. The following outcomes have been reported of the members with CKD who have been participating in Renaissance Health Care care management for at least 180 days:

- 80% of members completed educational modules on dialysis modalities.
- 90% of members had an appropriate hemoglobin level.
- 80% of members initiated dialysis with a permanent access in place.
- 50% of members initiated dialysis without the use of a central venous catheter (to include fistula and peritoneal dialysis catheters).
- 50% of members transitioned to dialysis on an outpatient basis (in contrast to requiring emergency inpatient hospitalization to begin dialysis)

The North Carolina State Health Plan was an active participant on the North Carolina Institute of Medicine Task Force on Chronic Kidney Disease and supports the task forces recommendations. As a result, the State Health Plan drafted a letter to laboratory providers to be cosigned with Blue Cross Blue Shield of North Carolina (BCBSNC) that requests automatic eGFR reporting when serum creatinine levels are ordered by a physician, a priority recommendation of the task force. To date, most of the task force's recommendations for health plans regarding CKD have been implemented by the State Health Plan. Through the implementation of these recommendations, the North Carolina State Health Plan will continue its support of chronic kidney disease prevention, treatment, and management.

#### **Lessons Learned Include:**

- From a health plan perspective, the complex needs of members with kidney disease can be addressed effectively through a partnership between a specialized care management vendor, the attending physician, and laboratory providers. The care management vendor utilizes claims data to identify members who may benefit from services, while the physician has the ability to refer members for services when a need is identified. Laboratory data provide information on kidney disease progression through eGFR values and informs the provider and care management vendor of the members' status. The partnership affords the opportunity for timely access to care management services.
- The most successful strategy for early identification of members with chronic kidney disease is a combination approach including claims and lab data monitoring and

direct referrals to care management services from providers and other disease and case management vendors.

- The care management vendor should have the knowledge and experience needed to assist members with chronic kidney disease to manage their condition, provide oversight

of clinical quality measures, and ensure education and support for members transitioning to renal replacement therapy. The provision of these services on a coordinated basis leads to better outcomes for members with chronic kidney disease. **NCMJ**

## REFERENCES

- 1 National Kidney Foundation. K/DOQI clinical practice guidelines for chronic kidney disease: evaluation, classification, and stratification. *Am J Kidney Dis.* 2002;39(2)(suppl 1):S1-S266.

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