Diabetes Case Management

The Key to Improving Diabetes Care & Outcomes

Monica Giotta, MS, RD/Nutritionist, CDE
Contractor to IHS CAO

Session goals

- Provide background on principles of Diabetes Case (aka Care) Management
- Play a game to promote networking and ideas
- Hear from a Diabetes Program Manager about how their Diabetes Program engages tribal communities

What is Diabetes Case Management?

- Assessment of an individual’s diabetes care, organizing & coordinating interventions such as education, support, counseling and disease management.

- Resources on IHS DDTP website:
  - “Integrating (Diabetes) Case Management into Your Practice”
  - “Integrating Diabetes Self-Management Education & Support (DSMES) into Your Practice”

Why should we do it?

- Our diabetes care can be better and ultimately that promotes good health in AI/AN people
- Look at population data for evidence (ex: Annual IHS Diabetes Audit)
- ABC Bundled Measure for California is only 25%
  - HbA1c<8%
  - Blood Pressure <140/<90
  - On Statin medication
- Care Management is a Patient-Center Medical Home standard

Who should be involved?

- Multi-disciplinary Team. Team members may include:
  - Registered Nurse(s)
  - Registered Dietitian(s)
  - Community Health Representatives (CHR, CHW, Outreach)
  - Pharmacists
  - Behavioral Health staff
  - Medical provider(s)
  - Fitness specialist
  - Lifestyle coaches

Advisory role: Community representative(s); CDAC

Where do we start?

- Diabetes Registry
- Develop systems for tracking:
  - Patient visits
  - Diabetes care data
  - Follow-up
  - Outcomes
- Identify case/care managers and their knowledge/abilities
- Introductions to clients
- Identify available resources
- Write protocols
- Troubleshoot problems

Use your data

- Diabetes Audit report for all your Active status clients
- Diabetes Audit report for individual client
- Identify high-risk groups

Start with the basics

- Regular medical visits for Active AI/AN clients
  - Quarterly
  - How will you contact?
- Work with medical providers
  - Make sure they can rely on you to follow through
- Talk to your communities about your plan
- Evaluate high priorities
  - Such as uncontrolled Blood Pressure

Care Plans

- Not just the EMR printout
- Client’s wishes
- Short list
- Follow up
- Example: In the next month-
  - I will eat 1 less fast food meal each week
  - I will walk 20 minutes a day
  - I will take my blood pressure medication daily

Be aware of potential obstacles & barriers

- Client’s perception of ‘case manager’
- Your first visit with the client
- Telephone case management
- How many clients in your caseload?
- Lack of community input
- Provider support
- Psycho-social barriers
- Team members’ lack of diabetes knowledge
- Clinic flow, timing
- Lack of Quality Improvement focus
- CM is not a cookbook method; it is an art form

Network & share

- Don't re-invent the wheel
- We have Stars in California and IHS

“Have You Ever…” Game

- Ask about something you or your program has done for diabetes care
- Those who have done that will come into your circle
- Those who haven’t done it can see who to connect with
- Example questions:
  - Have you ever…. led a Talking Circle?
  - Have you ever…. organized a community needs survey?
  - Have you ever …. done a Foot Exam?
  - Have you ever …. spoken before your Health Board?
  - Have you ever …. had a Walking Program?