Case Management for Diabetes

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Objectives for today

• Define our view of Diabetes Case Management (D-CM)
• Discuss methods to integrate D-CM into your clinic system
• Promote a Multi-disciplinary Team approach
• Emphasize the need for community input into your Diabetes Program plans
Questions for the group

• What professions represented?
• Who is a new employee?
• How many CDEs? (Certified Diabetes Educators)
• How many Diabetes Coordinators?
• How many implementing case management?
• How many downloading glucometers?
What is “case management”?  

- Has multiple meanings  
  - Resource coordination  
  - Utilization management, etc.  
- Also called “care” management  
- Our definition is specific to diabetes patients and their care  
- Purpose is to guide and facilitate a patient’s care
What does a case manager do?

• Monitors patients proactively
• Coordinates providers
• Smoothes transitions between sites of care
• Assesses needs and preferences
• Develops evidence-based care guide and action plans
• Supports chronic illness self-management
• Facilitates access to resources
• Educates and supports caregivers
What Case Management will do:

- Effective for managing patients with chronic illness and other high cost patients
- Case Management occurs along the continuum of care
- Close collaboration with the multi-disciplinary team
- Helps to determine how and when health care is provided to those requiring substantial amounts of care
What CM will do (page 2):

• A long-term patient-case manager relationship leads to enhanced patient trust and improved patient adherence and outcomes
• Better monitoring of the disease management trajectory
• Improved patient self-management of health care
• Enhancement of patient and organizational outcomes
Remember...

• Most common POVs are diabetes and URIs = you always need to pay attention to diabetes
• Perfect opportunity to do case management in Indian health compared to other medical systems
  – Patients can come in for multiple visits with educator
  – Community health, CHRs, home visits
• Patient and staff satisfaction
• It works!
Before you start, think about...

• What are we trying to accomplish?
• How will we know that a change is an improvement?
• What changes can we make that will result in improvement?
Effective relationships between Health Care Organization, Delivery System Design, Decision Support, Clinical Information Systems, and Community Health Care Organization are essential for improved health and wellness.

Activated Family and Community, Informed Activated Patient, Prepared, Proactive Community Partners, and Prepared Proactive Care Team work together to achieve patient-centered, effective, and timely care.

Improved health and wellness for American Indian and Alaska Native individuals, families, and communities is a key outcome of this Care Model for the Indian Health System.
10 Key Principles of D-CM

- Patient Registry(ies)
- Tracking System
- Assessment of outcomes
- Self-Management Support/Education
- Planned visits
- Multi-Disciplinary Team
- Case Managers
- Leadership support
- Know your resources
- Troubleshooting capability
1. Registries

• Up-to-date list of all your patients with diabetes
• Status categories
• Ability to evaluate adherence to Standards of Care (audit)
2. System for tracking

- Remember when we used notecards?
- Who is coming in to clinic, how often, and for what purpose
3. Ability to assess outcomes

- Cumulative IHS Diabetes Audit
- Individual diabetes audits
- Graphs of data points
- Patient goals
4. SMS/Education

- Evidence-based curriculum
  - IHS Balancing Your Life and Diabetes
  - IDC BASICS
- Make sure you document education electronically
- Brief Action Planning (BAP)
- Individual patient assessments
- Individual care plans
- Patient self-selects goals
5. Planned visits

- Pre-planning for patient’s needs
- Huddles before clinic
- Use of information systems to determine what is due
  - CRS Forecast
  - iCare
6. Multi-Disciplinary Team

- Participation of several Departments
- Meet regularly
- More than ‘case review’
7. Case Managers

- RNs
- RDs
- Other members of your Diabetes Team
- Program Assistants
8. Leadership support

- Keep Administration and Health Board informed
- Make sure Medical Dept. on board
- Sell concept to your community and gain support
9. Know your resources

• Assessment of:
  – Resources in the clinic and in the community
  – Resources within Indian Health
  – Yourself and Diabetes Team members (knowledge, skills, time and interest)
  – Your patients (health issues, education needs, motivation/interest, determine their goals)
10. Problem-solving

- Know who can knock down barriers for your program
- Be BFF with IT Department
- Providers may not always be supportive
- Departments sometimes do not get along
Stepped Case Management

- (Picture here)
Basic D-CM: ALL DM patients

- Patient Lists/Register – accurate and up to date
- Determine method for follow-up with quarterly visits as a guideline
- Planned visits with mechanism to alert providers for diabetes Standards of Care and health maintenance
- Self-management Support/Diabetes Education
- Run cumulative Diabetes Audit frequently
Intermediate D-CM

• Patients at higher risk of poor outcomes
  – Multiple chronic illnesses
  – Adherence issues
  – Barriers in accessing resources to manage health care problems
Intermediate, cont’d.

- Divide cases among case managers
- Document patient assessment
- Document care plan
- Document patient’s self-selected goals, action plan, follow-up and outcomes
Advanced D-CM

- Coordinate care with other health systems and multiple providers
- Facilitate access to resources
- Participate in Quality Improvement
- Manage costs
- Monitor and Evaluate
- Patient Advocate
Case Management “Heaven” would look like this:

- Provided through a true multi-disciplinary team approach
- Understanding of the population being served
- Practice and system silos come down
- The Team, Patient and the Patient’s Family share in decision making
- IT systems ensure timely and accurate information and facilitate communication
What do YOU need?

• More info about:
  – Use of IT systems/programs?
  – Diabetes Standards of Care?
  – Diabetes Physiology/Complications?
  – Diabetes Education curricula/SMS?
  – ?
Clear Lake at Lakeport near Lake County Tribal Health

Thank you to IPC3 for Case/care management background information.