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

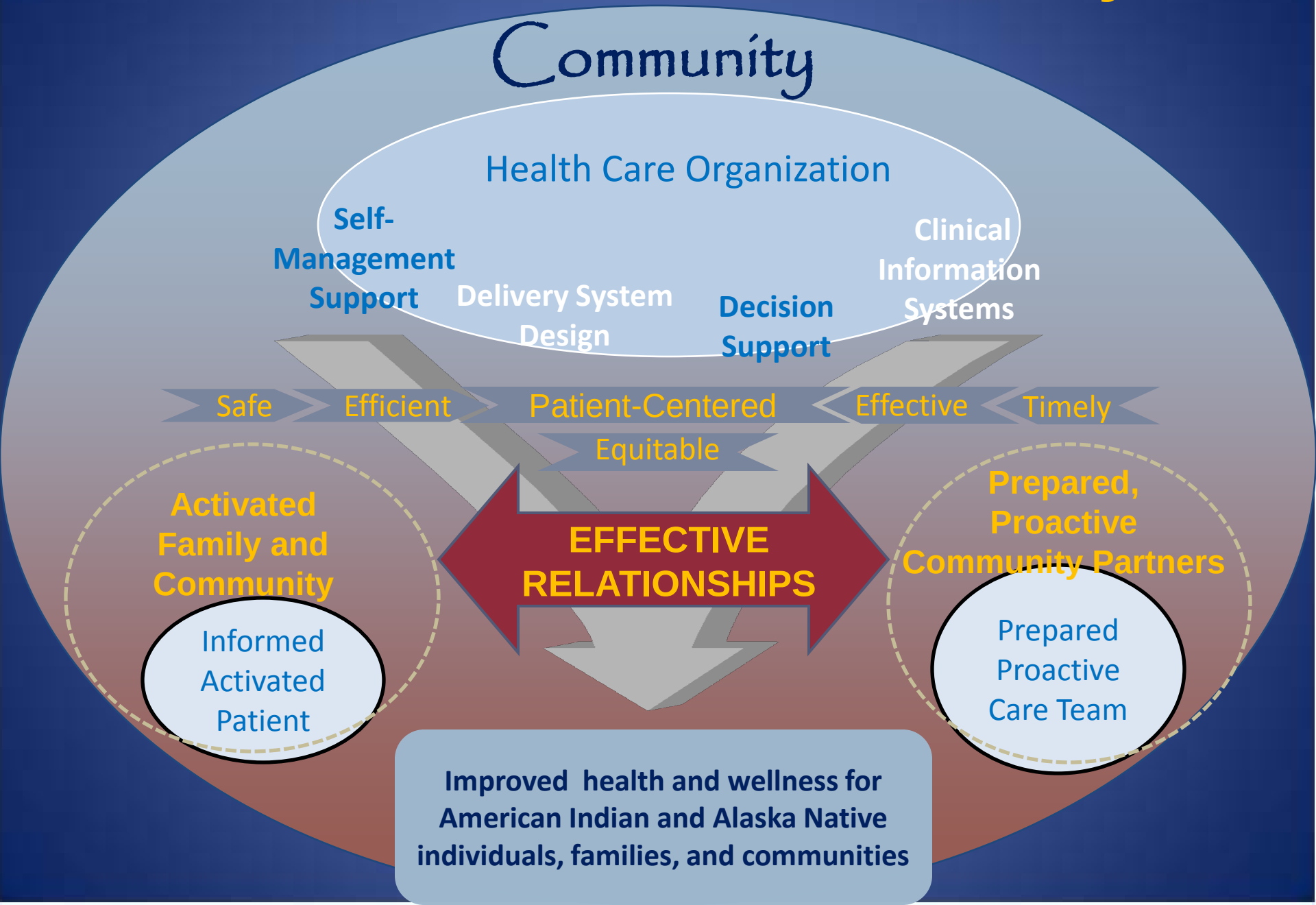
Remember…

- 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?

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.