Diabetes Case Management

The Key to Improving Diabetes Care & Outcomes

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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?