

## What is diabetes case management?

Every person with diabetes deserves support, including emotional support, education, and assistance navigating a complicated health care system. **Case management (also called care management) is a system of planning, organizing and coordinating care, targeting individuals at high health risk, and ensuring an integrated flow of services.** Case management is a tool to achieve better health-related outcomes. This document provides a brief introduction to case management concepts.

*“When the care system offers individuals a genuine opportunity to gain ongoing support through a partnering relationship with a team member dedicated to aligning a care plan with the individual’s own health and life goals...the care system can be an integral part of the individual’s health journey.”*

IHI Innovation Series: Care Coordination Model, 2011

Case management is a component of population and panel management. Let’s begin by defining all three of these terms:

- Population management– Identifying a large group of people, such as everyone in a community, or everyone with diabetes, or every person >65 years old.
- Panel management – A smaller group than population management, such as a medical provider’s panel or a diabetes registry.
- Case management – A case is a single person; case management is a system to improve the care of that single person. Case management is a component of panel management or population management.

In describing diabetes case management, it’s helpful to understand how it is related to [diabetes self-management education and support](#)<sup>1</sup> (DSMES). DSMES promotes diabetes knowledge and self-efficacy. Case management, on the other hand, is the coordination of a broad array of services from multiple providers and institutions. One of these services is DSMES.

<sup>1</sup> Integrating DSMES Into Your SDPI Diabetes Best Practice: [https://www.ihs.gov/sdpi/includes/themes/responsive2017/display\\_objects/documents/DSME.pdf](https://www.ihs.gov/sdpi/includes/themes/responsive2017/display_objects/documents/DSME.pdf)

## Integrating Case Management Into Your SDPI Diabetes Best Practice

### Who can benefit from case management?

In developing a case management program, identify available resources and then select what group of individuals you can best help.

- Clients with chronic disease such as diabetes, especially if multiple illnesses are present.
- Clients having problems accessing resources to address their health care.
- Clients at high risk for medical complications (e.g., uncontrolled diabetes, hypertension).
- Clients with prediabetes.

Note: For consistency, we will use the term ‘client’, understanding other terms may be preferred for your population such as ‘patient’, ‘customer’, ‘participant’, etc.

### Who can implement diabetes case management?

- All Indian Health Service/Tribal/Urban (I/T/U) health care facilities
- Diabetes program coordinators
- Designated case managers from various disciplines [registered nurses (RN), pharmacists (RPh), registered dietitians (RD), licensed clinical social workers (LCSW), etc.]
- Outreach programs when coordinated with primary care provider(s)

### What does a case manager do?

A case manager may do all or some of the following:

- Coordinate diabetes care with all providers and define roles and responsibilities to avoid duplication of effort.
- Work with providers to develop evidence-based interventions and action plans.
- Participate as a member of the multi-disciplinary diabetes team.
- Assess client needs and preferences.
- Monitor clients proactively.
- Arrange transitions between sites of care.
- Assess local food programs/resources and develop a plan to refer food-insecure families.
- Make referrals for diabetes services, including specialty care, food assistance, and DSMES.
- Facilitate access to resources (e.g., health insurance, transportation, food, socialization for home-bound elders).

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- Educate and support caregivers.
- Analyze data to develop a comprehensive picture of the overall diabetes care received and identify current gaps in diabetes care.
- Identify those at high risk to receive case management services.
- Identify all services and resources available in the clinical facility or outreach program and in the community, especially tribal resources.
- Ensure services meet guidelines for Government Performance and Results Act (GPRA), Patient-centered Medical Home (PCMH), Accountable Care Organization (ACO), Meaningful Use (MU), Health Resources and Services Administration (HRSA) and other quality improvement initiatives.

### What training and credentials are needed for diabetes case management?

The training and credentials of case managers will determine what functions they can take on; those with less training will provide less complex services. Generally, any staff member who receives training can provide basic case management. Examples include:

- Medical assistants who manage a provider's panel for diabetes care (e.g., what is due at scheduled appointments, contact clients who need or have missed appointments).
- Community outreach workers who notify the case manager when a community member asks about new medications prescribed from an outside provider.
- A lifestyle coach who organizes transportation for clients to multiple educational programs offered by the Diabetes Program.

Professionals such as registered nurses, registered dietitians, and licensed clinical social workers most often provide more complex clinical or comprehensive case management. The examples below include both clinical and community case management:

- An RN who designs a blood pressure management program for identified high-risk hypertensive clients.
- An RD who identifies food insecurity as a problem in the community and creates a plan to review food access and available resources.
- A certified diabetes educator (CDE) who develops care plans for high-risk diabetes clients with elevated glycemic levels.
- An LCSW who manages a panel of clients with diabetes and depression and ensures communication and continuity of care between behavioral health and medical services.

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Clinical diabetes case managers often have these skills:

- Solid clinical knowledge of diabetes and diabetes care.
- Ability to view the client as a whole person within the context of their family and community.
- Behavioral counseling expertise.
- Excellent interpersonal and communication skills.
- Computer and analytic skills to run reports and review data.

### Why include case management in Special Diabetes Program for Indians (SDPI) Diabetes Best Practice?

Implementing a case management plan can increase the likelihood that clients will improve their health and receive needed services. Most of the current IHS SDPI Diabetes Best Practices are based on the IHS Diabetes Care and Outcomes Audit data measures and these measures are based on IHS Standards of Care and Clinical Practice Recommendations: Type 2 Diabetes. Once your program has chosen a Diabetes Best Practice for the SDPI Community-Directed grant, determine how to incorporate both case management and DSMES into your work plan. Providing case management services for clients targeted in your Diabetes Best Practice will enhance the chances of achieving your grant's objectives and measures targets.

### How can case management be integrated into any SDPI Diabetes Best Practice?

Here are two examples of incorporating diabetes case management into your SDPI Diabetes Best Practice – one from a clinical program and one from a community based program.

**Clinical:** Your site's Diabetes Audit report shows that 40% of active diabetes clients have an average blood pressure 140/90 mmHg and the diabetes team has decided to select the Blood Pressure Control Best Practice for their SDPI Community-Directed grant. The case manager generates a list of hypertensive clients from the clinical data system. The diabetes team plans an intervention protocol. The protocol includes identification of in-house resources (staffing and available programs) and division of tasks to achieve positive outcomes for clients.

The protocol targets those patients on no anti-hypertensive medicine, and includes:

- a medication review for those who are prescribed anti-hypertensive medication
- an evaluation of patient adherence to the medication regimen
- referral to diabetes educator(s) for lifestyle modification and DSMES
- follow-up in the home by public health nurses and community health representatives

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After a defined period of time, data for the target group is re-assessed and care plans for clients not meeting blood pressure targets are re-evaluated.

Community: Results of your community assessment show that community members are requesting healthy food and nutrition education for their families to help prevent diabetes. The diabetes team has decided to select the Nutrition Education Best Practice and ascertains available resources and what can be accomplished to make a difference. Families at highest risk are identified and nutrition education interventions are designed. The team decides on in-home education for their target group families as well as community programs on 'hot topics' requested by community members (documented in "other activities/services" in the SDPI grant). The case manager tracks implementation of the program and evaluates outcomes using satisfaction surveys and a spreadsheet for nutrition education sessions.

### What are steps to setting up a case management program?

Case managers coordinate the implementation of the steps below with medical providers and other members of the health care team.

#### Step 1. Define the area(s) of need.

- Query your organization's clinical database for gaps in diabetes care. The Diabetes Care and Outcomes Audit report is a good place to start, as it is based on IHS Diabetes Standards of Care.
- Identify areas in need of improvement. For example, the Audit shows that over 50% of clients with diabetes have an average blood pressure over 140/90 mmHg.
- Generate a list of patients in the high risk group.

#### Step 2. Determine available resources.

- Community and clinical staff who have diabetes experience and knowledge of population management.
- Obtain the support of administration, health board, and Tribal communities.
- Supplies (e.g., home blood pressure monitors, patient education materials).
- Community resources such as walking groups, talking circles and tobacco cessation programs.
- Computer tracking of data.

#### Step 3. Plan the intervention.

- Contact the clients you plan to assist (using client-preferred contact method).
- Assess client's willingness to participate in higher levels of case management.

- Outreach-only programs need to consult with their client's primary care provider (PCP) to ensure continuity of care.
- Review medical management protocols with providers and assign roles and responsibilities.
- Educate staff and clients on the care gap being targeted.
- Design personalized care plans.
- Develop a communication loop between medical, outreach, and other departments.
- Refer to specialists, as needed.
- Determine who will follow-up whether appointment was scheduled, was kept, and if a report with findings was sent to PCP?
- Focus on short-term interventions (e.g., treatment of hypertension) before long-term interventions (e.g., weight loss).
- Determine who will provide education and support services for clients and develop an education referral protocol.

#### **Step 4. Re-assess the problem.**

- Benchmark progress (e.g., baseline data, target(s), timeline).
- Analyze data for the high-risk group or case management cohort.
- Meet as a team to evaluate effectiveness.
- Provide feedback to clients and to the larger community.

#### **What are the key points for a successful case management program?**

- Ensure you have organizational support for diabetes case management.
- Conduct meetings that are effective with clear objectives and follow-up.
- Establish a communication plan among health care team members to:
  - Agree on the identified health disparity that is targeted.
  - Reach an agreement on individualized treatment goals.
  - Record and track goals in the client's medical record.
  - Determine if the client's wishes are incorporated into goals.
  - Ensure the client has participated in the design of the care plan.
  - Verify that the medication list is accurate and up-to-date.

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- Provide training for all staff in the EHR system, Diabetes Care and Outcomes Audit Report, GPRA reports, use of population management software (such as RPMS iCare), and any other local reporting or software.
- Develop patient registries and panels for tracking (for example RPMS Diabetes Register, Prediabetes Register, RPMS iCare panels, and spreadsheets).
- Establish good relationships with clients.
  - Case managers should have face-to-face meetings with clients to build rapport.
  - Case managers should get to know the family and home issues, which affect their clients.
- Determine the number of diabetes case managers needed and the client caseload for each case manager.
- Develop protocol(s) for case managers:
  - Frequency of case reviews
  - Interventions for complex cases
  - Adding and dropping clients
  - Referrals and follow-up
  - Inter-departmental communication
  - Identify staff who will provide DSMES
  - Process for tracking outcomes
- Develop protocol (with medical staff) for pre-visit planning:
  - Use RPMS CRS Forecast, iCare, individual Diabetes Care and Outcomes Audit or Diabetes Patient Care Summary.
  - Use care improvement techniques such as pre-clinic huddles.
- Determine medical clinic visit flow:
  - What medical exams, laboratory tests, referrals, etc. are due?
  - What services is the client requesting?
  - Medication reconciliation
  - Opportunities for health education
  - Client leaves with individualized goals, clear care plan, and target date for next follow-up visit.

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- Between visits, determine if:
  - Client went to referral appointment(s)?
  - Referral reports have been received and reviewed?
  - Between-appointment follow-up is indicated for client (e.g., a home visit or a phone call)?

### What are tools for diabetes case management?

- **IHS Resource and Patient Management System (RPMS)<sup>2</sup>**

The RPMS is designed with a public health focus and includes newer interfaces, such as EHR, Visual Diabetes, and iCare to allow for assessment of individuals and populations. The EHR reminders alert providers regarding routine examinations, labs, and procedures. Other software applications (e.g., Diabetes Management System, Clinical Records System) can forecast services due (e.g., diabetes care, GPRA).

- **Electronic Diabetes Register**

An electronic diabetes register can increase efficiency and effectiveness of care by organizing clients into subgroups. Active clients in the Register may be divided among several case managers. Client panels can also be created in RPMS iCare to track diabetes care by provider, case manager, diagnosis, or other criteria.

The Diabetes Management System (DMS) application includes the diabetes register, individual and cumulative IHS Diabetes Care and Outcomes Audit reporting functions, and ad hoc data search capabilities.

iCare is a population management software tool in RPMS and provides a comprehensive view of patient information. Patient panels can be created to the specifications of the user (e.g., age, diagnosis, community, or a combination of criteria). GPRA, Meaningful Use, and Improving Patient Care (IPC) data elements are accessible in iCare.

- **Non-RPMS EHRs**

Various population management software applications are available for use with EHRs other than RPMS.

- **IHS Division of Diabetes Treatment & Prevention (DDTP)<sup>3</sup>**

The DDTP website has numerous tools to facilitate diabetes care, including treatment algorithms, educational materials, recorded webinars, and more.

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<sup>2</sup> IHS Resource and Patient Management System (RPMS): <http://www.ihs.gov/RPMS>

<sup>3</sup> IHS Division of Diabetes Treatment & Prevention (DDTP): <http://www.ihs.gov/diabetes>





## Indian Health Service Division of Diabetes Treatment and Prevention

### Integrating Case Management Into Your SDPI Diabetes Best Practice

- Internal and External Resources

Include Tribal resources and those in the larger community that can support your health promotion efforts. Don't duplicate services provided elsewhere.

Examples:

- Your organization may already have a coordinator who tracks transitions in client care. This person obtains records from outside providers and hospitals, follows up on client appointments, etc.
- Your organization may already have professional staff providing diabetes education and support, therefore the case manager can refer rather than provide education. This allows for a larger case management caseload.
- A Tribal organization may already be offering tobacco cessation group counseling.
- A YMCA branch nearby that is implementing Centers for Disease Control and Prevention (CDC) diabetes prevention groups.

- Network

Join DDTP and other IHS webinars to identify other sites that are doing something you want to do, attend conferences and talk to people, ask advice of your Area Diabetes Consultant, join the DDTP Diabetes LISTSERV, and network with other organizations who have effectively implemented case management services.

## Summary

We hope you found this introduction to diabetes case management useful as you develop plans to improve your diabetes program and ultimately the health of the clients you serve. While case management was previously an SDPI Diabetes Best Practice on its own, we have learned that case management is optimally part of every SDPI Diabetes Best Practice.

## Resources

- [Integrating Diabetes Self-Management Education and Support Into Your SDPI Diabetes Best Practice](#)<sup>1</sup>
- [IHS Resource and Patient Management System \(RPMS\)](#)<sup>2</sup>
- [IHS Division of Diabetes Treatment & Prevention \(DDTP\)](#)<sup>3</sup>
- [RPMS iCare Training](#)<sup>4</sup>
- [Commission for Case Manager Certification](#)<sup>5</sup>
- [Healthcare Communities](#)<sup>6</sup>
- [Improving Chronic Illness Care](#)<sup>7</sup>
- [IHI White Paper: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs](#)<sup>8</sup>
- [National Committee for Quality Assurance \(NCQA\): Patient-Centered Medical Home Recognition](#)<sup>9</sup>
- [Robert Wood Johnson Foundation: Care Management of Patients With Complex Health Care Needs](#)<sup>10</sup>
- [Safety Net Medical Home Initiative: Improving Care for Complex Patients: The Role of the RN Care Manager](#)<sup>11</sup>
- [SAMHSA-HRSA Center for Integrated Health Solutions: Population Management in Community Health Center-Based Health Homes \(PDF\)](#)<sup>12</sup>

<sup>4</sup> RPMS iCare Training. <https://www.ihs.gov/rpms/index.cfm?module=Training>

<sup>5</sup> Commission for Case Manager Certification. <https://ccmcertification.org>

<sup>6</sup> Healthcare Communities. <http://www.healthcarecommunities.org/Home.aspx>

<sup>7</sup> Improving Chronic Illness Care. <http://www.improvingchroniccare.org>

<sup>8</sup> IHI White Paper: Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. <http://www.ihl.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx>

<sup>9</sup> Patient-Centered Medical Home Recognition. <http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx>

<sup>10</sup> Care Management of Patients With Complex Health Care Needs. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2009/rwjf49853](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf49853)

<sup>11</sup> Improving Care for Complex Patients: The Role of the RN Care Manager. <http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care/rn-care-manager>

<sup>12</sup> Population Management in Community Health Center-Based Health Homes. <http://www.integration.samhsa.gov/integrated-care-models/health-homes>