DIABETES FOR CARE MANAGERS: PART 2

Webinar for Michigan Care Management Resource Center

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Objectives:

- Identify common barriers to self-management to diabetes
- Identify ways care managers can help patients overcome barriers
- Documentation tips
- Case studies

Barriers to Self-Care

- Physical:
  - Disability due to decreased strength, low vision, decreased sensation
  - Can interferes with provider access
- Psychological: depression and emotional distress
  - Diabetes doubles the risk of depression
  - Increased stress due to complicated treatment regimes
- Cognitive:
  - Knowledge deficit, low literacy, low health literacy
  - Language barriers
  - Poor memory, dementia

Barriers (cont.)

- Economic: lack of adequate financial resources
  - Inability to afford medications, supplies, healthy diet
  - Negatively impacts follow-up care, access to providers
- Social and Cultural:
  - Family involvement can either support or hinder self-care
  - Cultural traditions, religious practices can impact adherence to treatment plan
  - Traditional foods of certain ethnic groups

Helping to overcome barriers

- Physical:
  - For low vision: National Federation of the Blind(www.nfb.org) provides various diabetes resources, talking glucometers
  - For loss of sensation: transportation resources to increase access to medical providers
  - Physical therapy: to increase strength, balance and gait training, use of assistive devices
- Psychological:
  - Regular use of screening tools for depression
  - Diabetes support groups
  - Medication and counseling as indicated

- Cognitive:
  - Use of low-literacy tools (www.learningaboutdiabetes.org)
  - Educational materials in multiple languages
    - http://www.nlm.nih.gov/medlineplus/languages/diabetes.html
- Economic:
  - Medication savings with Rx savings cards, Rx assistance programs, $4/$10 generics, www.needymeds.org
  - Glucometer savings: store brand glucometers, Contour choice card (www.contourchoice.com) -- $35 off strips for 12 uses

Documentation tips

- G9001:
  - Poorly-managed DM with other co-morbidities
  - Multiple care management needs
  - Anticipate close monitoring and frequent follow-up
- G9002
  - More specific, targeted care management needs
  - Initiate self-management education
  - Assist with navigating medical neighborhood for necessary resources
  - Less frequent follow-up needed, short-term engagement

- CPT 98962 and 98962:
  - Group education sessions for 2-4 and 5-8 patients
  - NOT the same as group visits, which require physician involvement
  - Efficient use of care manager resources
  - Can help achieve new engagement metrics of commercial payers, assist with achieving budget neutrality
  - Bring in “experts” for additional support
  - Pharmaceutical companies have CDE’s, AE-C’s provide free classes, unbranded materials

Case Study #1: Ms. A

- 46 y.o. female with hx T2DM x 19 yrs with neuropathy, sarcoidosis, hypercholesterolemia, former smoker
- Permanent disability due to neuropathy, no longer able to drive
- Divorced, lives with teenaged son in apartment, parents live nearby, father provides transportation
- July 2012: A1c = 12.6, HDL = 98, LDL = 134, Trig = 173
  - Not following diet, not following up with Endo, not following mealtime insulin guidelines consistently
  - Wants to improve control but frustrated

Ms. A (cont.)

- Initially engaged and receptive, multiple barriers interfered with DM self-management
  - G9001 completed
  - PHQ9 = positive, antidepressant med initiated
  - Multiple barriers identified
  - Self-management goal: healthy eating
    - Introduced divided plate method
    - Provided various teaching aids
  - 2 face-to-face follow-up appts, multiple telephonic follow-ups
  - Minimal progress in first 3 months, pt having difficulty activating the change

Ms. A (cont.)

- October 2013: A1c = 14.1%
  - Very discouraged, frustrated with persistent elevated BS and lack of progress toward change
  - Finally revealed true barrier, plan made to overcome
  - Self-management goal changed to focusing on weight loss, instead of lower BS results
- December 2012: DRE revealed retinopathy, prompted urgency for improved DM management
  - Portion control
  - Consistent SMBG testing ac meals and bedtime
  - Insulin dose adjustments
  - Increasing physical activity

Ms. A (cont.)

- February 2013: A1c = 10.1, LDL = 120, Trig = 103
  - Improved confidence and motivation
  - Discontinued antidepressants
  - Fine-tuning insulin dose, carb counting
  - Establishing next health goal: increasing exercise when weather improves

Case Study #2: Mr. B

- 66 y.o. with hx T2DM x 8 yrs, hypercholesterolemia, smoker with COPD, gout, moderate ETOH use
- Glucose-lowering meds include Actoplus Met XL and Januvia
- Not consistent with treatment plan, follow-up appts, referrals, not testing BS, not receptive to insulin
- Aug 2013: A1c = 9.1%, HDL = 46, LDL = 120, Trig = 252
- Nov 2013: Elective cataract surgery cancelled due to BS > 500, given insulin and received same-day PCP appt
  - A1c = 19.2%, now ready to start insulin
  - Expressed anger at self for not taking care of his DM

Mr. B (cont.)

- Pt ready to engage, initiated Levemir® basal insulin at 10 u after dinner, titrated up based on FBS
  - Pt instructed and able to correctly inject 1st dose
- Assessed for needs:
  - Rx for glucometer provided
  - Supportive spouse, wife is RN
  - Dietary knowledge deficit
  - G9001 initiated
- Frequent telephonic follow-up to monitor BS levels
  - Pt found old glucometer, strips expired
  - Assisted pt to obtain new glucometer

Mr. B (cont.)

- In-office follow-up 1 week later:
  - FBS's in mid-high 200's
  - Insulin titrated to increase by 3 u every 3 days until FBS < 130
  - Initiated diet instruction: divided plate, portion control
  - Short-term pt goals: decreasing beverage portions, switch to diet soda, use portion plate
  - Mid-term goal: wt loss of 1-2 lbs/week
  - Long-term goal: prepare for smoking cessation in next 3-6 months

Mr. B (cont.)

- In-office follow-up 1 month later (late Dec):
  - A1c = 12.0%
  - Meet with PCP, but "didn't have time" for care manager follow-up at that time
  - Agreed to receiving phone call from care manager in 1-2 weeks
- Telephonic follow-up 2 weeks later:
  - Admitted to "getting off track" during the holidays
  - Refocused his efforts on diet management
- In-office follow-up in 2 weeks (late Jan 2013):
  - Levemir dose now 50 u/day, FBS = 120-130's
  - A1c = 10.3%, lost 6 lbs in 8 weeks

Mr. B (cont.)

- States “I’m doing great, and I don’t think I need to see you anymore”
- Offered additional support and availability to pt, help in future with smoking cessation when ready
- Telephone call for follow-up 1 month later: pt did not return call
- Due for 3 month DM recheck at end of April, not yet scheduled
- Care manager plan: telephonic contact at end of March, re-assess and hopefully re-engage pt to continue healthy lifestyle changes

Questions?