Alexander Valley Healthcare
Feel Good... We Have You Covered

April 18th, 2019

Diabetes Case Manager

Redwood Community Health Coalition
Promising Practice

PROMISING PRACTICE OVERVIEW

Alexander Valley Healthcare (AVH) utilizes the knowledge and skill set of one of their Registered Nurses (RN) to act as a Case Manager (CM) to help patients with diabetes manage their disease and work on lifestyle goals. This CM began working 32 hours a week in this role in August 2017. She also sees patients with prediabetes and obesity (adults and children).

Appointments with the CM are free and bilingual. At this point, AVH cannot bill for these visits. The CM is currently undergoing diabetes educator certification through the National Diabetes Educator Association. Keeping up with recommended medications is challenging. There are other CMs at AVH that work in similar ways with patients and collaborate with one another.

AIM

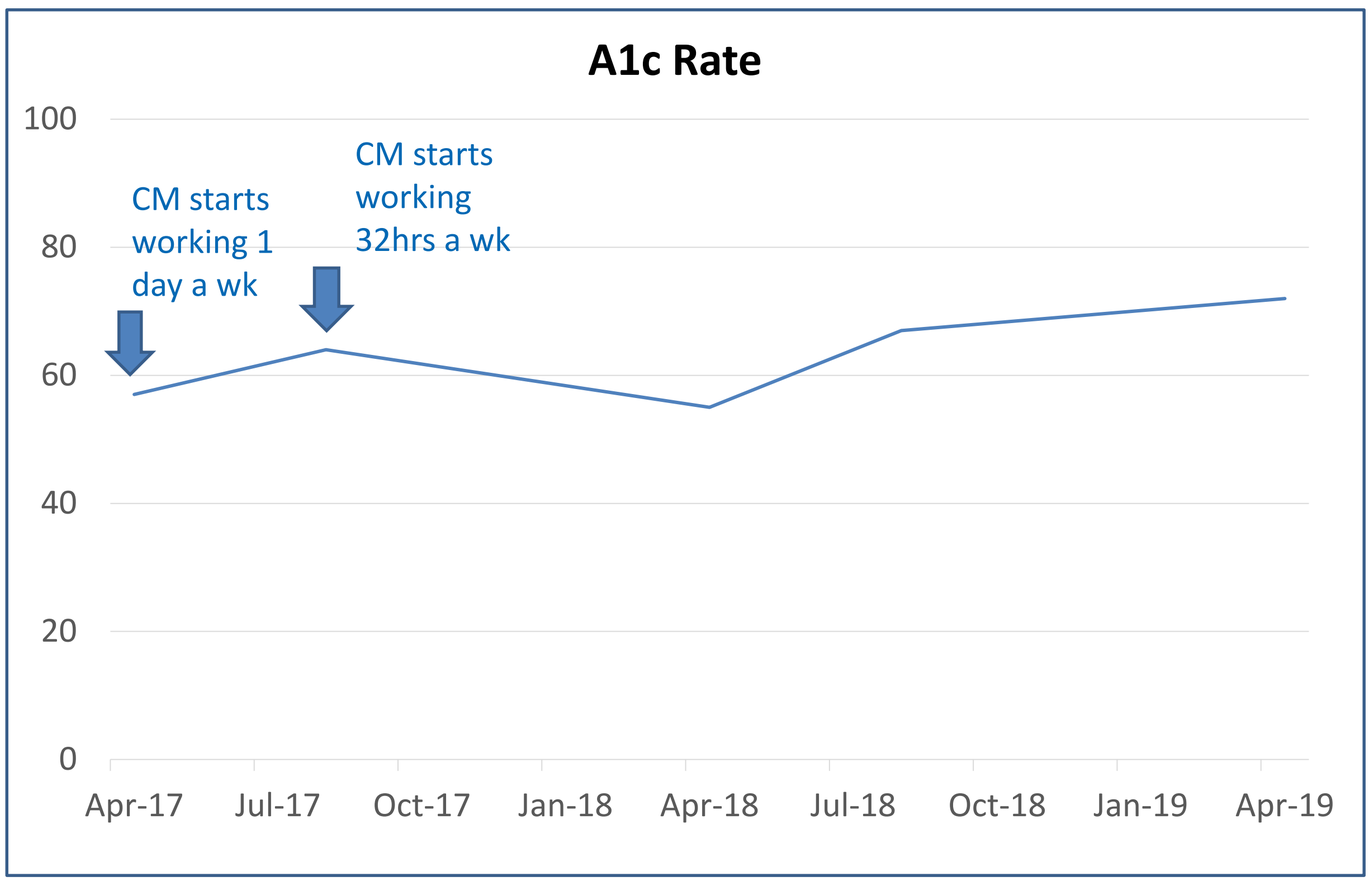
To lower Alc rates and accomplish lifestyle changes (including healthy eating) among patients with diabetes through working with an RN case manager.

MEASURES

UDS Diabetes: Hemoglobin A1c Control (<=9%)
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) less than or equal to 9.0 percent during the measurement period.

RESULTS TO DATE

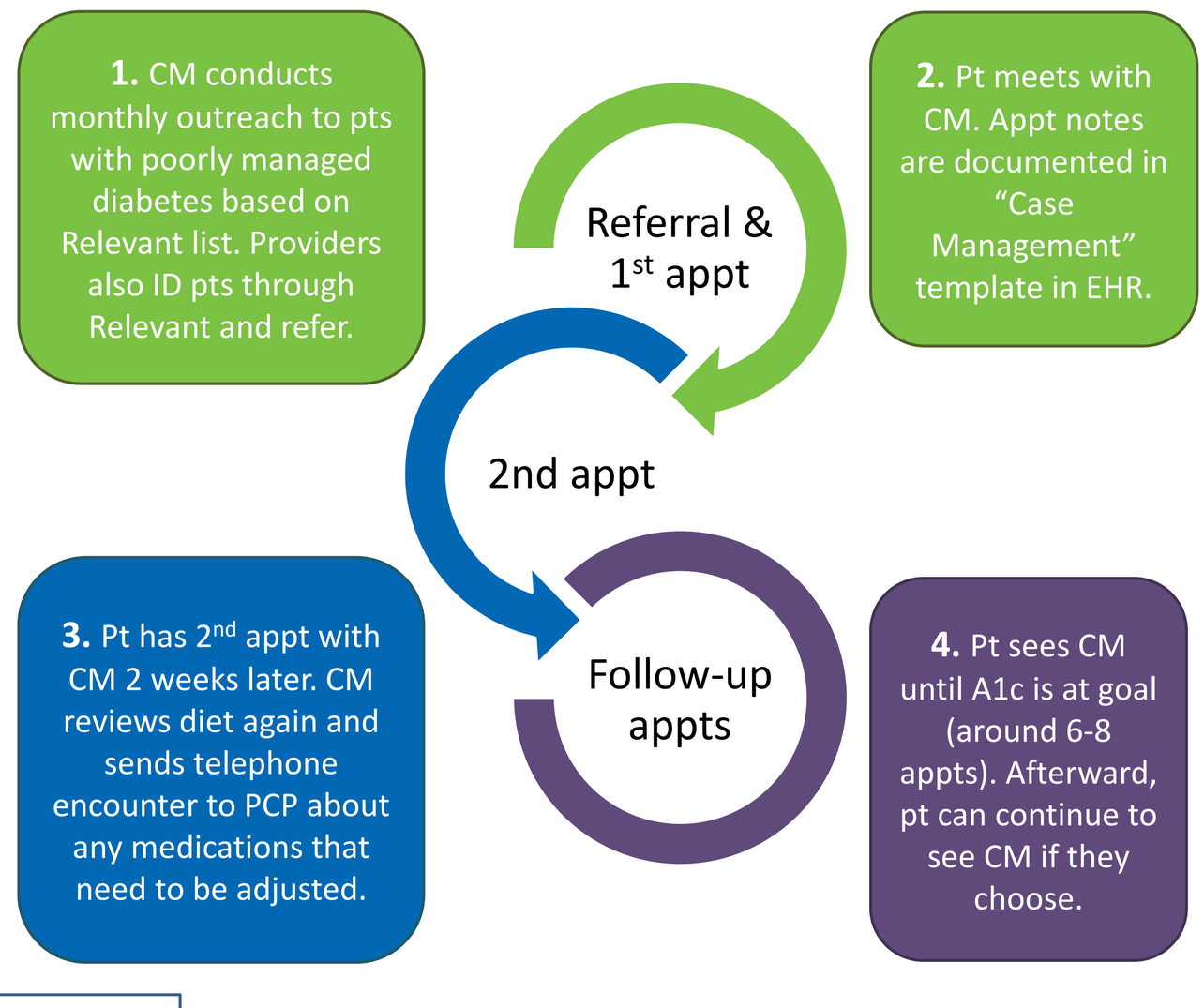
AVH's A1c rate improved from 57% in April 2017, to 62% when the CM was working 1 day a week in this role. The rate continued to increase to 69% in 2018 after the CM increased to 32 hours a week, and is currently at 72%. While the CM started working in her current role at AVH in April 2017, she'd worked as a nurse DM educator for 5 years. She understands the importance of having culturally appropriate nutrition information and created her own materials to suit the culture and education level of her patients.



ACTIONS TAKEN

- Developed role for CM to meet one-on-one with patients (pts) struggling to manage diabetes. CM can create pt appts on their schedule and works until 7pm on Monday to see more pts.
  - Reviews pt: Medications (any problems with access or cost), BMI, blood sugar log (from at home glucometer), blood pressure, cholesterol, completes 24 hour food recall, and ensures all labs are up to date. Continues to review this data through all appts.
  - Educates: 1. Why/when to check blood sugar and 2. Healthy eating based on ADA guidelines. CM sets dietary goals with pt.
- Refer pts to CM directly from providers, including warm hand offs.
- Aim for pts to see CM at least monthly.
- Refers pts to food pantries, farmer's markets, and WIC offices to connect pts with affordable healthy food.
- Partners with CERES Community Project to refer pts with Congestive Health Failure for nutrition assistance.

WORKFLOW



LESSONS LEARNED

AVH recognized that having a CM work with and educate patients with diabetes was beneficial to patients. Although they can't bill for these visits, AVH has made the decision to do what's best for patients, regardless of reimbursement.

Relevant has been helpful allowing the CM to access patient data without relying on someone else to create reports. At this point there is still room in the CM's schedule to see more patients.

Plate Method for Meal Planning

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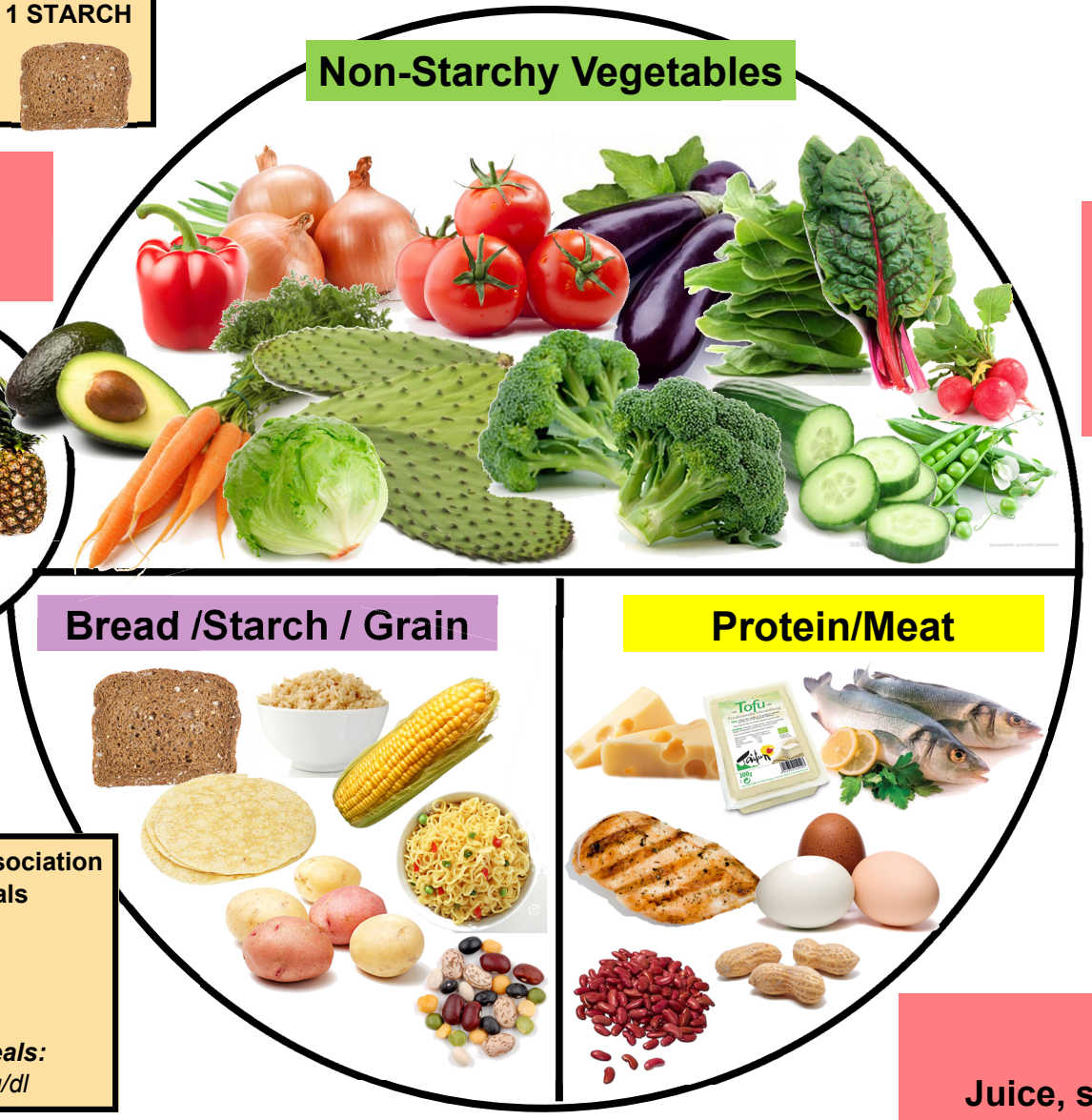
1 FRUIT = 1 MILK = 1 STARCH

Fruits

3 small a day



Best beverage water

LIMIT

Package foods, cheese, butter, margarine, oil

Portion of Food Groups in a Meal

- 1/4 plate of Bread/Starch/ Grain
- 1/4 plate of protein/meat
- 1/2 plate of vegetables

American Diabetes Association Blood Sugar Goals

Before Meals
80-130 mg/dl

1-2 hours after meals:
Less than 180 mg/dl

AVOID

Juice, soda, cereals, rice

Vclo

Método de Plato Para Planificar las Comidas

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1 FRUTA = 1 LECHE = 1 PAN/ALMIDÓN/ GRANOS



La major bedida es el agua

LIMITE

Comida empaquetada, quesos, mantequilla, margarina y aceites .

Porción de cada grupo de alimentos

- **La cuarta parte de un plato de pan/almidón/ granos**
- **La cuarta parte de un plato de carne/proteína Medio plato de verduras**

Metas para el control de la glucosa en la sangre del American Diabetes Association:

Antes de comer

80-130 mg/dl

1-2 horas despues de comer:

Menos de 180 mg/dl

VClow RN

Sample article case manager sends to staff about nutrition.

Less beef, more beans. New world diet.

A report attempting to overhaul the universal "diet" says a hamburger a week is about as much red meat you should be consuming. Eggs should be limited to less than four a week and dairy, one serving per day.

A panel of nutrition, agriculture, and environmental experts recommend a plant-based diet. This recommendation stems from many published studies that link red meat to health problems and livestock farming to environmental issues.

The report highlights the deadly effects meat production is having on the environment. "Producing red meat takes up land and feed to raise cattle, which also emit the greenhouse gas methane."

The report was organized by a Swedish-based nonprofit seeking to improve the food system. They believe a "great food transformation" is necessary by 2050. They also believe their recommended diet could be inclusive to all cultures around the world.

Of course a major obstacle is convincing cultures who are traditionally meat and cheese heavy, to make the shift.

"The diet encourages whole grains, beans, fruits and most vegetables, and says to limit added sugars, refined grains such as white rice and starches like potatoes and cassava. It says red meat consumption on average needs to be slashed by half globally, though the necessary changes vary by region and reductions would need to be more dramatic in richer countries like the United States."

Scientists believe you don't have to completely switch to a vegan diet to make a big impact on health.

Advice to limit red meat isn't a new concept and has been linked to lowering high saturated fats. However, the meat and dairy industries argue that their products carry important nutrients necessary for a healthy diet.

A report conducted by the United Nations, concluded that livestock is responsible for 15% of gas emissions that warm the climate. International Climate Researcher, Robbie Andrew, believes that utilizing practices that help the animal to grow bigger faster may help decrease emission, however the animal will still produce methane, which is a powerful greenhouse gas.

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Job Title:	**RN Case Manager**		**Page 1 of 3**
Department:	**Medical**		**Supervisor: Chief Medical Officer**
Supervises:	**N/A**		**Compensation Status: Exempt**
Impact of Error	**High**		**Work Setting: Clinical Environment**
Level of Access to Patient Charts:	**Access allowed to health information necessary to do the job.**		**Created: 09/2018** **Revised: 03/2019** **Reviewed: 03/2019**
Level of Access to Practice Management System:	**Access to Basic Level**		

Job Summary: *The primary function of the RN Case Manager is to utilize the nursing process to provide direct and indirect support to the provider and the patient in the area of nursing case management including patient triage, phone advice, Care Team coordination and patient education. The RN Case Manager is expected to demonstrate critical thinking skills, leadership, and appropriate role modeling.*

Job Duties and Responsibilities:

The following statements for this position reflect the general duties considered necessary to describe the principal functions of the job as identified and shall not be considered a detailed description of all the duties required that may be inherent in the position.

- Work closely with the Primary Care Provider and clinical Care Team in providing Nurse Case management which may include:
  - Coordination of care within primary Care Team.
  - Proactive management and education of patients with chronic illness with poor clinical outcomes or with complex healthcare needs.
  - Assist patients in care management and system navigation with recent critical diagnosis.
  - Provide management of Care Team's Care Transitions program for patients discharged from an inpatient setting.
  - Active participation in Care Team's High Risk Case Management program.
  - Provide home visits as indicated.
- Assess, identify problems, plan goals, monitor and evaluate client plans, and develop strategies that meet the client's immediate and long term needs.
- Work closely with Primary Care Provider to manage patient care items which could include: medication refills per protocol, labs, triage, document management, management of durable medical equipment, prior authorizations of needed medications or other services, and other items as needed.
- Coordinate population management of Care Team patient panel.
- Provide proactive utilization management for patients with high risk needs, inappropriate utilization of Emergency Room services and with complex medication needs.
- Assist patients in obtaining appropriate medications and other medical supplies and equipment including coordination of Pharmaceutical Patient Assistance programs.
- Participate in patient and staff education.
- Provide nurse visits for designated conditions per clinical protocol.
- Coordinate Care Team support for patients with new health management goals.
- Coordinate tracking of patients for follow-up and continuity of care which may include:
  - Use of flow sheets, problem lists, and medical data bases.
  - Development and use of critical pathways.
  - Tracking outcomes and reporting to Primary Care Provider.
  - Tracking and expediting referrals.

- Assist with discharge planning / home care referrals.
- In collaboration with the Behavioral Health Team, provide assessment, diagnostic, and intervention services for clients who are overwhelmed by an acute episode, or for those others who have limited self-care abilities.
- Oversee Care Team Medical Assistant administration of immunizations and medications, both injection and oral, within the office visit.
- Participate in Care Team meetings to include daily huddles, monthly care team meetings, complex care case conferences and other related meetings.
- Participate in quality improvement, quality assurance, and innovation activities to ensure optimal level of care.
- Work collaboratively with Care Team to optimize communication, coordinate needed services, and meet the needs of the patient.
- Participate in activities related to addressing the social determinates of a patient's health.
- Work collaboratively with the Care Team to complete needed patient care items.
- Work with Care Team to actively manage the patient schedule to optimize efficiency, patient experience, and meet the needs of the patient.
- Assist in the coordination of Transfer of Trust between Care Team, Behavioral Health Staff, or other support services during the office visit.
- Actively seek out opportunities to assist other team members in collaboratively meeting the needs of the patient and Care Team.
- Assist in the adoption and implementation of new technologies and activities that improve patient care and clinic efficiencies.
- Other duties as assigned.

Knowledge, Skills and Experience:

- Ability to read, analyze, and interpret medical reports, professional journals, technical procedures, and governmental regulations.
- Ability to solve practical problems and deal with a variety of concrete variables.
- Ability to work well within a multidisciplinary team.
- Ability to interpret a variety of instructions furnished in written, oral diagram, or schedule form.
- Ability to manage priorities and workflow.
- Ability to deal effectively with a diversity of individuals at all organizational levels.
- Excellent written and oral skills, strong organizational and analytical skills.
- Basic computer skills.

Education/Licensing/Training:

- Required: Current California Registered License and in good standing with the Board of Registered Nurses.
- Five years of clinical experience preferred.
- Experience in a non-profit health center/community service setting preferred.
- Current CPR certification.

Personal/Relationships/Behavior:

- Displays cheerful demeanor and makes positive comments when on duty.
- Refrains from participation in harmful gossip, dysfunctional group interactions, and divisive behavior.
- Displays courteous and professional behavior in all interactions with the public.
- Works cooperatively with other staff members.
- Displays flexibility in accepting, changing, or carrying out assignments.
- Adheres to dress code expectations, including fragrance-free requirements.
- Displays sensitivity in a multicultural environment.
- Maintain patient and organizational confidentiality.

Physical Demands:

Essential Physical Requirements may include:

- Sitting
- Walking
- Standing
- Twisting (trunk and neck)
- Bending (waist)
- Flexing/extending (neck)
- Gripping/grasping
- Fine Manipulation/pinching
- Reaching below and above shoulder level
- Kneeling
- Squatting
- Cart/exam table mobilization (scooting/rolling)
- Lift up to 25 pounds
- Push/pull up to 50 pounds
- Carry up to 10 pounds
- Vision (close, distance, color, peripheral and depth perception)
- Talk (average ability and fluency in English)
- Hear (average hearing ability)
- Additional physical requirements may be required.

The overall physical demand rating for a job of the RN Case Manager falls within the Medium classification. The physical demands and fine motor skills described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Accepted by: _____ Date: _____
Signature

Print Name: _____

Approved by: _____ Date: _____
Chief Executive Officer