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

August 1st, 2019

Diabetes Case Manager

Redwood Community Health Coalition
Promising Practice

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H2QCS30258, Health Center Controlled Networks, for $1,500,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government

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.

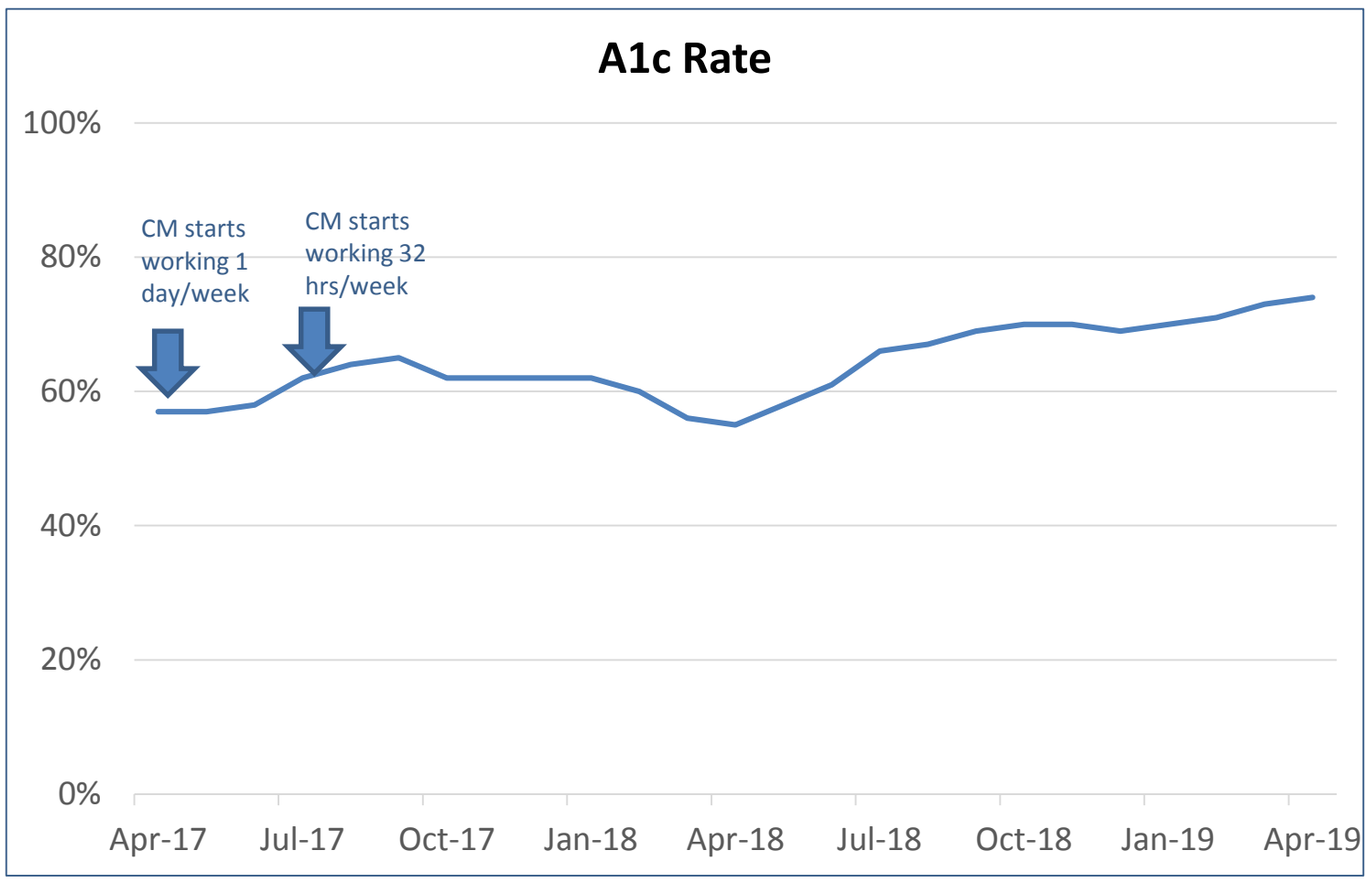
MEASURES

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 74%. 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.

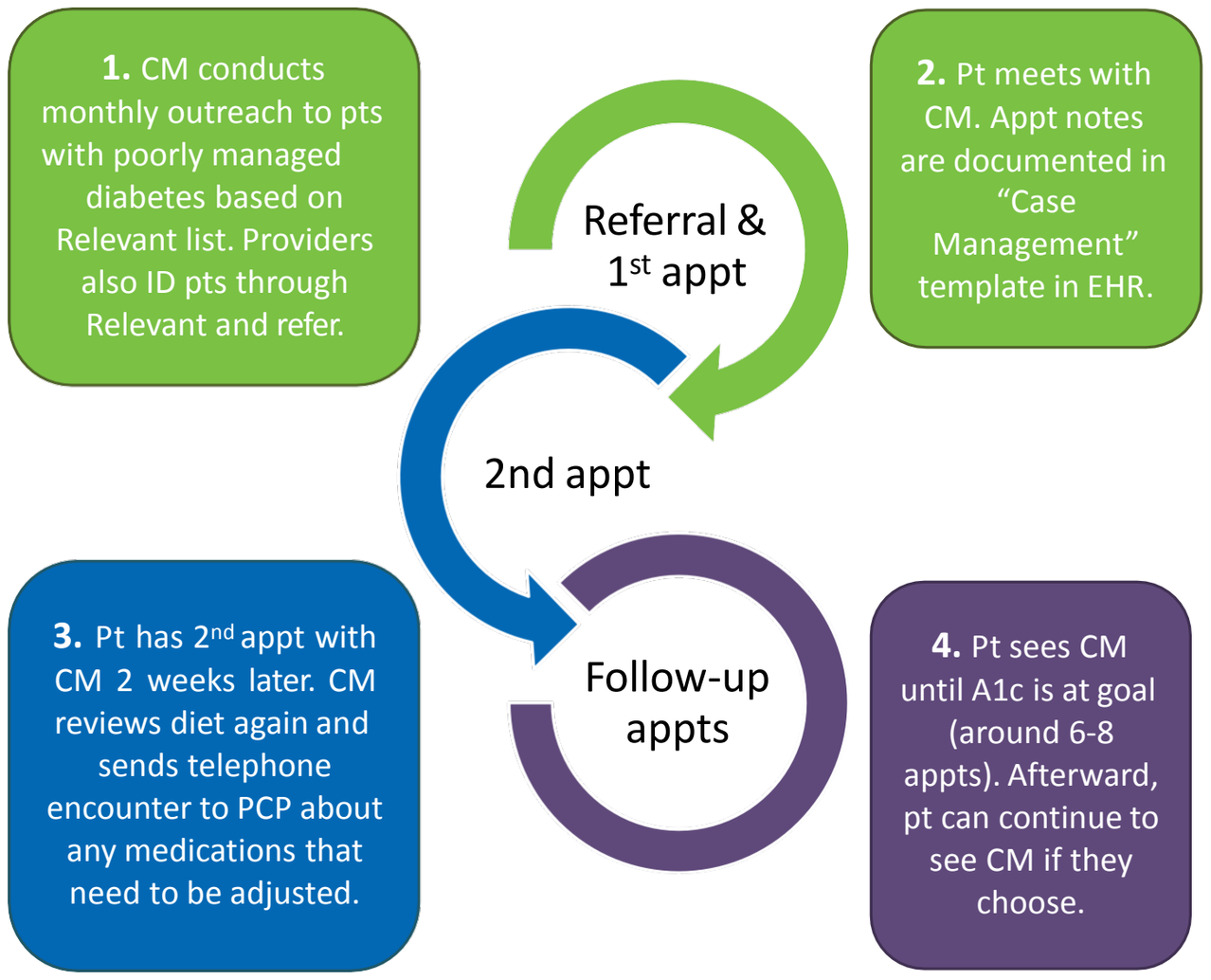
PROMISING PRACTICE OVERVIEW



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.