Care Coordination in Complex Cases

Kovler Diabetes Center

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Complex Care in Diabetes

How do we identify complex cases?

- Transportation barriers
- Housing instability
- Food insecurity
- Multiple DKA admits/ ED
- History of no shows to appointments
- Access to medication barriers
- DCSF/ parental involvement
- Medical neglect
- Treatment adherence issues
- Consistently elevated A1C

Who are the key players involved in complex case management and what are their roles?

- **Endocrinologist**
- **Social Worker:** Social resources and community communications
- **Nursing:** Triage and medication management
- **Pharmacist:** Medication accessibility
- **Community Health Worker:** Home visits and care coordination
- **Certified Diabetes Care and Education Specialists:** Nutrition specialist and diabetes technology management
- **Psychologists:** Behavioral health care
- **Patient Navigator:** Point person for patient to connect with regarding barriers to accessing care

"The Kovler Experience" Dream Team

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At the Kovler Diabetes Center, we want to empower you to effectively manage diabetes for a lifetime. These are just a few members of your diabetes care "dream tream" who, along with your endocrinologist, are here to help make the Kovler Experience as beneficial as possible.

- *Social Worker*
  Taylor Mossing, LCSW, NMT-I

  Role: Serves as a navigator to help physicians problem solve and identify the best resources for patients with a multitude of barriers that could impact their continuity of care in terms of diabetes management. Focuses on high risk patients and newly diagnosed pediatric patients.

- *Pharmacists*
  Kate Wees, PharmD & Cody Chan, PharmD, BCPS, MBA

  Role: Ensure medications are reasonably priced or covered by insurance. Educate patients on medication costs, side effects, and new medication regimens. Provide close follow-up, manage noncompliance, and aid with weight management.

- *Diabetes Care and Education Specialists*
  Amy Hess Fischl, MS, RD, LDN, BC- ADM, CDCES;
  Laura Cason RD, LDN, CDCES & Taylor Durkin RD, LDN, CDCES

  Role: Partner closely with physicians and offer diabetes education, meal planning, and nutritional instruction as well as teaching patients about new technology to help manage diabetes.

- *Health and Wellness Team*
  Tina Drossos, Ph.D., Associate Professor of Psychiatry & Behavioral Neuroscience, Director of Wellness Program and her team of fellows and externs

  Role: Offer short-term mental health support and refer patients to outside psychiatrists or therapists if more long-term services are needed.

- *Community Health Worker*
  Marquita McCarter

  Role: Support adults on the South Side of Chicago manage type 2 diabetes. Bridges gaps of service between appointments for the patient and the provider.

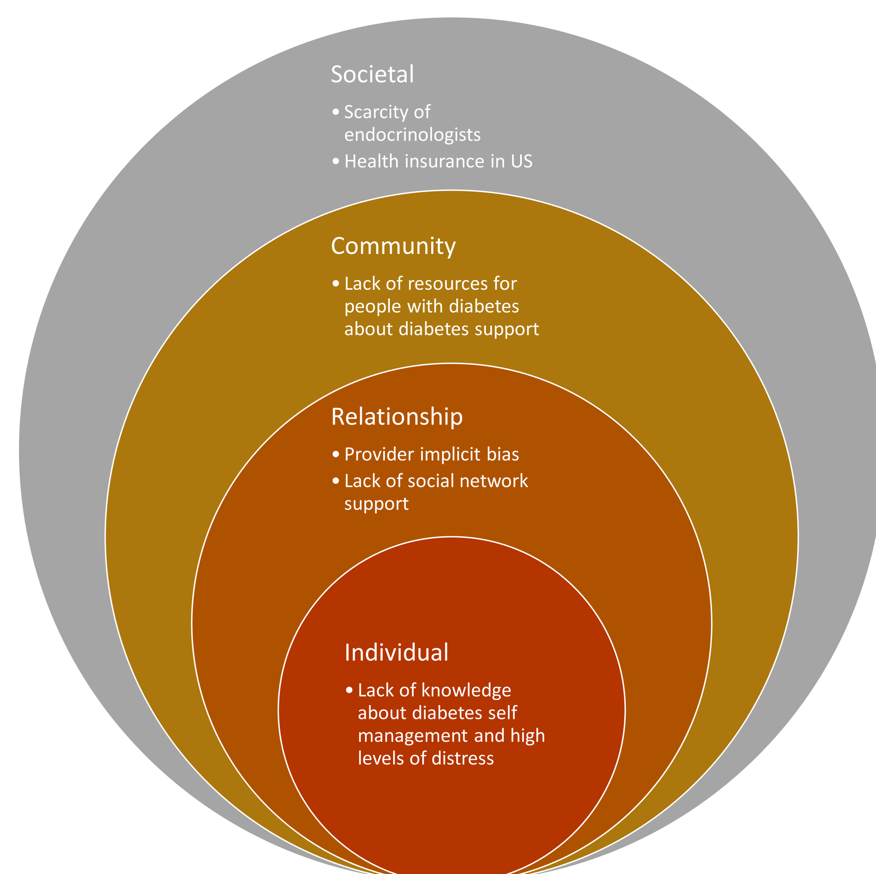
How do we manage complex diabetes cases in an academic medical institution?

- Interdisciplinary care team communication and collaboration
- Complex case meeting once a month with team
- Improving communication within the hospital system and with outside organizations (PCP, pharmacy, DCFS, schools, lawyers, probation officers, outside hospitals, other departments)

Patient Perspectives

- We asked patients: What makes a good Diabetes care experience?
- We received the following replies:
  - "Providing patients with education to things like low carb diets vs carbs at every meal"
  - "Having a Care Team that cares and isn't in a rush who listens to understand and wants to do everything in their power to help make you better and not using you like a lab rat just testing out medications or constantly adding medications to your regimen, instead of finding out why you're not getting better or controlled."
  - "A good diabetic care is someone who supports offers interactive services with patients"
  - "A good experience is when the doctor and team take into consideration the things that a patient says concerning the diabetes for themselves and tailoring a plan around that versus just saying try this and try this because it should work when in fact it hasn't been working up till that point"
  - "Being able to have your questions answered and having alternatives available."

Social Ecological Model of Barriers



Complex Care Ecosystem

Table 1. Driver Diagram

Aim/Goal	Primary Drivers	Secondary Drivers	Change Ideas
Reduce inequities in diabetes outcomes	Patient Goals	Shared decision making between provider and pt about what goals are Documentation of goal-setting System to check goals	Document goal in EMR Review goals with family Standardize goal-setting framework
	Nutrition	Food distribution Food deserts (food apartheid) Increasing food prices	Access to SNAP benefits Food pantries Southside diabetes project NowPow Rx
	Physical Behaviors	Knowledge about different types physical activity Time Neighborhood safety	PT referral UHI Zoom/FB live classes PA apps Chicago Park District Exercise Rx
	Medication access/ utilization	High cost of medications Insurance formularies and requirements for coverage may need manufacturer assistance programs Prior authorizations Uninsured, job loss, job changes, formulary changes Health literacy, medication and device understanding Medications require changing doses	Technology DCAM pharmacy (mail order) Referral for formulary investigation, mail order, or $5/$10 list Clinical pharmacist referral for med titration and tolerability
Table compiled as part of QI collaborative **Team Name**: STEPs (Supporting Teamwork that Empowers Patients) **Leadership Team** Dr. Celeste Thomas; Dr. Elbert Huang **Improvement team** Dr. Katie O'Sullivan; Taylor Mossing, LCSW; Elizabeth Murphy, MS, RDN, LDN, CDCES; Marquita McCarter, CHW; Cody Chan, Pharm. D.; Amy Wainright, Pharm. D., BCACP, BCGP; Nicole Young, RN **Project Sponsor** Dr. George Weyer	Social Needs	Transportation Insurance School/work Mental health Support system Barriers/behaviors impacting healthcare utilization Housing Advocacy	Pediatric support group, young adult support group, adult group class Health and wellness referrals, consult and depression screenings Community health worker referrals CTS forms, insurance provided transportation

Next Steps

What can you do at your organization?

- Identify key players who can be involved in complex case management
- Set up list in medical record of identified complex patients or encrypted file sharing
- Set up a time to meet as an interdisciplinary team monthly to review patients
- Format of meeting for each patient could include the following information:
  - Name of patient
  - Primary endocrinologist
  - Synopsis
  - Members of care team involved
  - Updates
  - Action steps
  - Next appointment
  - Goal for next appointment
- Establishing appropriate communications between appointments (such as in basket messages with the team or with outside organizations)
- Persistence, team member engagement, and continued patient encouragement!

Complex Case Example

- **Background**
  - 21 year old female with Type 1 Diabetes African American aged out of DCSF
  - History of trauma , mental health, substance abuse history
  - Unstable housing, poor food access, inconsistent employment
  - Medicaid insurance
  - Limited community and family support
- **Barriers/ Interventions**
  - Banned from pharmacy therefore team members escort her to pharmacy
  - Unstable housing so made sure medication pick up proactively with help of pharmacist and pharmacy tech
  - Social work coordination with DCFS until aged out
  - Missed multiple psychiatry appointments but used our team psychology resources to secure continuity of care
  - Transportation barrier addressed through her insurance
  - Provided cell phone for use with insulin pump through help of patient navigator
  - Coordination for insulin pump training and diabetes technology education with the diabetes care and education specialist
  - Connected with PCP, gynecology, dentist, eye, and psych appointments
  - Patient engagement (meal vouchers, stickers, case for insulin pump) to continue follow up care

Acknowledgements

Kovler Diabetes Center Dream Team

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