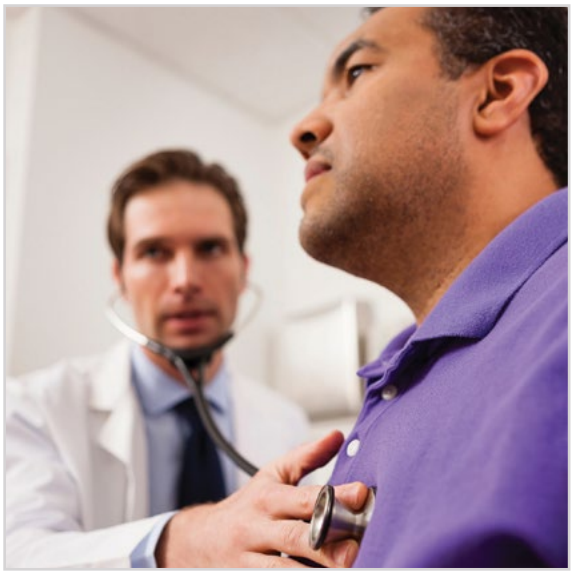
CARE COORDINATION IN PATIENTS WITH TYPE 2 DIABETES

An Overview for Healthcare Providers

INTRODUCTION

As you may know, patient-centered care and care coordination of patients with complex conditions have garnered increased attention from national quality organizations such as the Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF). As a result, care coordination has emerged as a cornerstone of quality healthcare.[1,2]

The following document outlines potential approaches to delivering coordinated care to patients with complex needs including diabetes—some of which you may already be doing. It is intended to provide an overview of the elements of care coordination but is not intended to guide treatment or replace clinical judgment.



ESSENTIAL ELEMENTS OF CARE COORDINATION
IN PATIENTS WITH COMPLEX NEEDS, INCLUDING DIABETES

As you can attest, effective coordination of care addresses the needs of each patient, with an increase in disease complexity receiving an increase in appropriate care. Patient preference and degree of engagement in care can also affect the need for care coordination.[3]

The AHRQ's key elements of delivering coordinated care for patients with complex needs include[1]:

1. **Comprehensive needs assessment**
2. **Individualized care planning**
3. **Access to needed services and equipment**
4. **Communication and monitoring**

Care Coordination

The goal of care coordination is to help ensure that the needs and preferences of each patient and the family/caregivers are acknowledged and accounted for during development of a comprehensive plan of care across providers, services, and settings.[1,2]

1 | COMPREHENSIVE NEEDS ASSESSMENT

Conduct and regularly update a comprehensive needs assessment[1]

Care coordination for patients with complex chronic conditions such as diabetes starts with a comprehensive assessment that aims to identify all care needs and preferences of the patient and family/caregivers to formulate the individualized care plan.[1]

A comprehensive assessment starts with the patient data you already have and adds additional factors addressed by any member of the care team.[1]

Standard baseline information

- **Care goals**
- **Medical history**
- **Complete physical exam**
- **Evaluation of medical diagnoses**
- **Family history**

Additional care coordination factors

- **Updated care goals, if appropriate**
- **Assessment of patient daily functioning with/without additional support**
- **Updates that include patient status changes**
- **New-onset comorbid conditions**

How This May Impact Your Patients With Type 2 Diabetes

Coordinate with the patient and multidisciplinary team to help ensure that the needs assessment is periodically updated to include baseline and additional factors such as individual patient needs, preferences and engagement level, new comorbid conditions, polypharmacy information, and psychosocial concerns[1,4]

2 | INDIVIDUALIZED CARE PLANNING

Collaboratively develop and update an individualized care plan[1]

You and other members of the care team may see the benefits of collaborating to develop an individualized care plan that is easily accessible and reflects patient values and preferences. You can help the team understand current and long-term needs and goals for care as well as[1]:

- **Types and frequency of all health, rehabilitation, and mental health services**
- **Home care services and other services that may be needed**
- **Identifying who is responsible for providing each service**
- **How to address medications prescribed by multiple providers**
- **Critical issues that may trigger revisions to the care plan**

How This May Impact Your Patients With Diabetes

Work with your patients and other healthcare providers to individualize diabetes care to help address aspects such as diabetes education needs and preferences, physical activity level, eating patterns, social/work/cultural factors, existence of diabetes complications, psychosocial issues, and comorbid conditions.[4,5]

3 | ACCESS TO NEEDED EQUIPMENT AND SERVICES

Facilitate access to medical care, home and community-based services, and supports[1]

Patients with complex conditions require care coordination for a variety of health and long-term services and support, including assistive technology and durable medical equipment, physical therapy, personal care assistance, transportation to get to medical appointments, and home-delivered meals. Some patients need help accessing public benefit programs, such as Medicaid or the Supplemental Nutrition Assistance Program.[1]

How This May Impact Your Patients With Diabetes

For appropriate patients, facilitate access to other diabetes care support services such as diabetes self-management education (DSME), nutrition therapy, exercise instruction, and case management.[5,6,7]

4 | COMMUNICATION AND MONITORING

Regularly monitor health status and communicate effectively[1]

Successful care coordination is achieved when team members communicate effectively with the patient and share relevant findings with each other and with you, the prescriber. In addition to standard forms of communication, electronic tools can also be employed, such as remote physiologic monitoring, electronic data acquisition and reminders, networked electronic health records, patient education modules, and informed decision-making tools.[1]

How This May Impact Your Patients With Diabetes

Encourage continued monitoring and communication among patients, family/caregivers, and all providers to ensure adequate understanding of the diabetes care plan, patient self-care responsibilities (eg, glycemic assessment, foot care, lifestyle changes, etc), and the importance of adherence to therapy.[1,4]

SUMMARY

Care coordination is fundamental to effective chronic care management. It is a patient-centered model of care that seeks to deliver the right care to the right patient at the right time and ensure a patient's needs, preferences, and individual goals are met over time.[2]

Open communication among members of the care team, the patient, and his or her family/caregivers and a comprehensive, individualized care plan are essential elements of care coordination. Patients who suffer with complex chronic conditions such as diabetes can benefit from care coordination that emphasizes self-management, goals, and support and encourages an open dialogue between providers and patients.[2]

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CarePath Healthy Engagements is a comprehensive program designed to help improve the lives of people living with type 2 diabetes and assist those that care for them. CarePathHealthyEngagements.com