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a case management program

PIEDMONT COMMUNITY HEALTH PLAN
Community Partners for Quality Healthcare

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Piedmont Community Health Plan's Diabetic Case Management Program is a proactive management plan we designed to assist diabetic members in managing and controlling their diabetes. Our objectives with this program are to reduce incidences of chronic, disabling complications through a combination of early education and intervention.

OBJECTIVE #1 — Early identification of diabetic members to assess risk factors. Members will be identified by:

1. Analysis of the claims data.
2. Physician referrals.
3. Self referrals.

OBJECTIVE #2 — Once the member is identified, our Certified Diabetes Educator will make contact to:

1. Schedule an interview with the member.
2. Discuss history of member's disease.
3. Identify obstacles that hinder compliance.
4. Determine member's knowledge of the disease concept and process for both short and long term care.
5. Assess the individual needs of the member.
6. Invite member to participate in the program.
7. Assess member's "risk category".

OBJECTIVE #3 — Criteria is utilized for enrollment in the program to include:

1. Elevated Alc level of >8%
2. Documentation by the PCP/Endocrinologist of noncompliance with diabetes self management.
3. Type 1 diabetes.
4. Type 2 diabetes and chronic complications such as: cardiac disease, retinopathy, neuropathy, nephropathy, PVD, non-healing foot ulcers and amputations.

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OBJECTIVE #4 — Once the member is enrolled, the Certified Diabetes Educator will:

1. Develop a specific program including goals for improvement in diabetes care and overall health.
2. Notify member's physician of enrollment in the Diabetic Case Management Program to ascertain the patient's current medical profile including, most recent Alc level and any other relevant health conditions.

OBJECTIVE #5 — Upon enrollment, the member will be required to:

1. Check glucose levels as often as directed by personal physician.
2. Take all prescribed medications.
3. Visit personal physician as directed.
4. Document daily glucose levels in record book and provide the readings to personal physician and the Certified Diabetes Educator at PCHP.

OBJECTIVE #6 — The benefits of the PCHP Diabetic Case Management Program include:

1. A collaborative relationship between the patient, physician and the Certified Diabetic Educator.
2. Cost savings to employer through reduced incidence and severity of diabetic complications.
3. Continue education opportunities.

OBJECTIVE #7 — Methods utilized to measure the Diabetes Case Management Program's effectiveness include:

1. Tracking participant's Alc levels.
2. Tracking participant's compliance through cumulative office visits, testing patterns and glucose readings.