Disease management in chronically ill older adults

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Unit X: Disease Management Concept

Following chronically ill older adults through their ongoing disease process requires a special kind of case management. Unlike standard case management for a condition or disease in the acute care setting and for only one episode of illness, disease-based case managers follow their clients through all levels of care. (Powell & Tahan, 2010) In this paper, I want to specifically examine disease-based case management concept and a peer reviewed trial titled *Effect of a Community-Based Nursing Intervention on Mortality in Chronically Ill Older Adults: A Randomized Controlled Trial* which utilized disease-based case managers to provide care to 1,736 adults aged 65 and older, with one or more chronic conditions such as: coronary artery disease, heart failure, diabetes, asthma, hypertension, or hyperlipidemia. (Coburn, Marcantonio, Lazansky, Keller, & Davis, 2012)

What are the functions of a disease-based case manager? A disease based case manager applies evidence based guidelines and protocols to manage the population of clients. These "protocols are nationally recognized standards of care that describe the necessary care and treatments (diagnostic and therapeutic interventions) for patients with a specific chronic health condition such as heart failure or end-stage renal disease and based on the severity of illness. These protocols also include the expected outcomes of care that are easily measured and tracked over time. Case managers assess patients and classify them, based on specific criteria, into low-, moderate-, or high-risk groups. They then manage the care of the patients, applying treatments and interventions indicated by their risk group. Treatments include medications, lifestyle changes, and health education. Such models of care have proven effective in preventing the need for emergency department visits or acute care hospital stays." (Powell & Tahan, 2010, p. 14)

Disease based management programs are often developed in sites such as physician practices or insurance companies and this is where disease based case manager will be employed.

This topic grasped my interest, because disease managers may prevent the need for recurrent emergency department visits or acute care hospitals stays which can translate to reduced mortality and a cost reduction measure for the hospital. In a randomized control trial RCT by Coburn and colleagues, which was conducted in Pennsylvania, they employed disease based managers to care for chronically ill older adults. Their sample size consisted of 1,736 adults aged 65 and over, with one or more eligible chronic conditions (coronary artery disease, heart failure, diabetes, asthma, hypertension, or hyperlipidemia) during the first six years of the study. "The intervention group (n = 873) was offered a comprehensive, integrated, and tightly managed system of care coordination, disease management, and preventive services provided by community-based nurse care managers working collaboratively with primary care providers. The control group (n = 863) received usual care. Overall, a 25% lower relative risk of death (hazard ratio [HR] 0.75 [95% CI 0.57–1.00], p = 0.047) was observed." (Coburn et al., 2012, p. 1)

These are startling statistical findings with $p < 0.05$. Coburn and colleagues were able to demonstrate 25% reduction of death in chronically ill older adults by utilizing nurses as disease managers in that sampled community. The control group in this trial that received medical care had traditional, fee for service Medicare Parts A (hospitals, skilled nursing facility, hospice, home health care) and B (physician services, outpatient care, home health services) insurance coverage. (Coburn et al., 2012) The limitations of the study were that few low-income and non-white individuals were enrolled and implementation was in a single geographic region of the US. Additional peer reviewed research to confirm these findings and determine the model's scalability and generalizability is warranted.

Cultural Competence Influence on Disease Management Concept

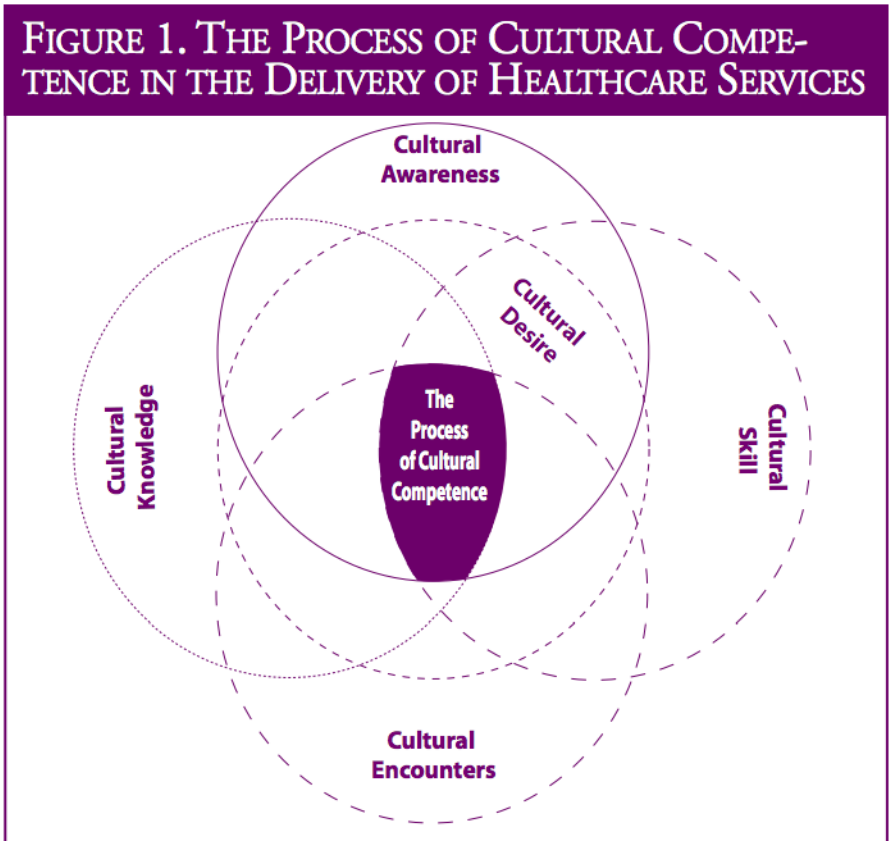
Cultural competence can be defined as the "process in which the case manager continuously strives to achieve the ability to work effectively within the cultural context of a client (individual, family, or community). This process requires case managers to see themselves as "becoming" culturally competent rather than "being" culturally competent. The components of cultural competence are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. These five components have an interdependent relationship with each other, and no matter where the case manager enters the process, all five must be addressed or experienced." (Campinha-Bacote & Munoz, 2001, p. 49)

The first of the five component is cultural awareness and it involves self-examination, in-depth exploration of one's own cultural and professional background. Cultural awareness should begin with insight into one's own cultural healthcare beliefs and values. Cultural knowledge involves the process of seeking and obtaining an information base on different cultural and ethnic groups. Nurses can develop and expand their cultural knowledge base by accessing information offered through a variety of sources, including journal articles, textbooks, seminars, workshop presentations, internet resources, and university courses. Cultural skill involves the ability of the nurse to collect relevant cultural data regarding the client's presenting problem and accurately perform a culturally specific physical assessment. Cultural encounter is defined as the process that encourages nurses to directly engage in cross-cultural interactions with patients from culturally diverse backgrounds. Directly interacting with patients from different cultural backgrounds helps nurses increase their cultural competence. Cultural desire refers to the motivation to become culturally aware and to seek cultural encounters. Inherent in cultural desire

is the willingness to be open to others, to accept and respect cultural differences, and to be willing to learn from others. (Flowers, 2004)

If disease-based case management concept is influenced by cultural competence model, together they can be confluent and achieve greater impact in the community. Culturally competent disease case managers can achieve greater impact in the community they service by being culturally aware. A disease-based case manager who is constantly striving to improve the five components of cultural competence is able to reach a much greater populace and further improve mortality statistics.

How a Cultural Competent Disease Manager Can Improve Case Management Practice



(Transcultural C.A.R.E. Associates, 2001, figure 1)

In Coburn and colleagues RCT a disease manger would create an individualized plan for each client enrolled. The plan included client specific education, symptom monitoring, medication reconciliation, counseling for adherence, help identifying, arranging, monitoring community health and social service referrals. Group interventions consisted of structured lifestyle and behavior change programs for weight loss, weight loss maintenance, exercise classes, balance & mobility program for fall prevention. (Coburn et al., 2012) However, the delivery of said plan can prove very challenging if the disease manager is not culturally competent. Culture plays a huge role in dietary choices, activities performed, when to seek healthcare, decision-making, cultural norms, etc. A disease manager who possess all five components (Figure 1.) of cultural competency: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire can design a much better tailored individual plan for each client. (Campinha-Bacote & Munoz, 2001)

Conclusion

Traditionally nursing BSN college course work incorporates cultural competence and case management concepts into the bachelorette degree. Thus, having disease managers who are registered nurses can offer case managers who are culturally competent and can facilitate such care as demonstrated by Coburn and colleagues. Nurse disease managers "collaborated with the participants' primary care physicians and specialists on an as needed basis to help participants achieve target clinical goals and receive appropriate and timely preventive care according to guidelines. Collaboration also allowed early identification of new or worsening conditions or symptoms, and facilitation of timely medical interventions in an effort to prevent disease exacerbation, hospital admissions, and unnecessary use of the emergency department." (Coburn et al., 2012, p. 4)

References

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Coburn, K. D., Marcantonio, S., Lazansky, R., Keller, M., & Davis, N. (2012, July 17). Effect of a community-based nursing Intervention on mortality in chronically Ill older adults: A randomized controlled trial. *PLoS Medicine*, *9*(7), 1-14. http://dx.doi.org/10.1371/journal.pmed.1001265

Flowers, D. L. (2004). Culturally competent nursing care A challenge for the 21st century. *Critical Care Nurse*, *24*, 48-52.

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Transcultural C.A.R.E. Associates. (Cartographer). (2001). FIGURE 1. THE PROCESS OF CULTURAL COMPE- TENCE IN THE DELIVERY OF HEALTHCARE SERVICES [Concept map]. St. Louis, MO: Mosby.