



INDIAN HEALTH DIABETES BEST PRACTICE

Diabetes/Pre-Diabetes Case Management

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Instructions for Using This Best Practice

The Best Practices are organized into topics on how to plan for and successfully implement a Best Practice in your community.

- **Part 1** provides background information on planning for your program and evaluation, Key Recommendations, and Key Measures.
- **Part 2** provides details on implementation of the Key Recommendations.
- **Part 3** includes appendices, tools, and resources.
- **Part 4** provides a list of references.

As you prepare to select, implement, and evaluate a Best Practice, consider these planning guidelines:

- Meet with your diabetes team to discuss which Best Practice(s) is best suited for your situation and resources.
- Use data from your Diabetes Outcomes and Audit and/or from a community needs assessment to guide your selection of the Best Practice(s).
- Determine your program goal(s) as a team. For example, your team may decide to work toward improving specific clinical measures such as A1C and blood pressure and increasing the number of patients who have individualized care plan, and goals recorded in their chart.
- Print out at least Part 1 of the Best Practice(s) your team feels is most appropriate to implement.
- Work with your diabetes team to review and discuss the Best Practice(s). You may choose to read it together as a team.
- Choose at least one Best Practice after carefully considering your goals and resources (funding, staff and time).
- **Review the entire Best Practice(s) you have selected with your diabetes team.**
 - Confirm that you have selected a Best Practice(s) appropriate for your community needs and resources and that you are confident that your team can successfully implement, evaluate (measure), and document progress and outcomes.
 - Target the population your team wants to improve outcomes for with the Best Practice(s). Remember, you probably do not have resources to do everything for everyone.
 - Carefully consider the Key Recommendations. The recommendations are based on evidence and have been proven to be effective. You may already be doing some of the recommendations and can easily fit these into your plan or you may want to consider some new recommendations to enhance and strengthen your program. Identify those your team can implement.
 - Carefully review the Key Measures. Choose those that best fit with your goals and the Key Recommendations you have chosen to implement.
 - If one Best Practice does not fit, then review another Best Practice until you find one that fits.

Throughout the document you will find links that draw your attention to important items within the Best Practice pdf. Here is a list of the items:

- **Action!** Indicates a **link**. Please use the link to access more detailed descriptions.
- **Note!** Indicates an **important** item. Pay special attention to this **important** item.

Summary of Key Recommendations and Key Measures

These are evidence-based actions that will lead to improved outcomes in the community. **Action!** See [Part 2](#) for details on the implementation of each Key Recommendation.

1. Conduct a diabetes services assessment for the community.
2. Identify eligible clients for case management.
3. Assess the client's needs.
4. Develop, implement, and monitor individualized care plans.
5. Monitor client outcomes.
6. Evaluate the diabetes case management program

These are specific measures that can be used to document changes in outcomes related to implementing the Best Practice.

Note! All SDPI grant programs that choose this Best Practice are **required** to report **as required in the terms and conditions attached to the notice of award** on the **indicated Measures**. Programs may report on other measures as well.

*The following measures are of primary importance:

1. * Percent of high risk (client subset) diabetes patients with an assigned case manager.
2. *Percent of patients with improvement (positive results) for at least one patient-identified self-management goal.

PART 1 Essential Elements of Implementing This Best Practice

Purpose and Target Population

This Best Practice describes case management recommendations for any person with diabetes, pre-diabetes, or at risk for diabetes.

Action! See [Part 3](#) – Appendix A. for the importance of case management.

Intended Users of This Best Practice

- Primary health care providers and teams,
- case managers,
- diabetes teams,
- community health education programs, and
- leaders of health care organizations.

Action! See [Part 3](#) – Appendix A. Supplemental Information for discussion of the benefits and risks of implementing this Best Practice.

Definition of Case Management

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes (Case Management Society of America, <http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx>).

In case management, a case manager (CM) is assigned to a client and serves as a guide and facilitator. The case manager is generally a non-physician such as a nurse, dietitian, pharmacist, health educator, or fitness coach. The goal of case management is to achieve client wellness via self management, efficient resource utilization, and coordination of services.

Case management can be a practical and effective strategy for Indian Health Service (IHS), Tribal, and Urban Indian health organizations. This Best Practice is being developed with the idea that CMs can have many different backgrounds (nursing, medicine, pharmacy, fitness trainer, health education etc.). Although diversity strengthens a program, it is also important to make sure all clients are being provided the same minimal type of service and the same educational message.

Action! See [Part 3](#) – Appendix C. If case management is new to your program, refer to the General Case Management Guidelines.

Goals of This Best Practice

- Increase the number of people with diabetes, pre-diabetes, or at risk for diabetes who receive case management services by trained team members.
- Increase the number of people with diabetes, pre-diabetes, or at risk for diabetes meeting clinical and behavioral goals

Key Recommendations

These are evidence-based actions that can lead to improved outcomes for persons with diabetes, pre-diabetes, or at risk for diabetes.

These are evidence-based actions that will lead to improved outcomes in the community.

1. Conduct a diabetes services assessment for the community.
2. Identify eligible clients for case management.
3. Assess the client's needs.
4. Develop, implement, and monitor individualized care plans.
5. Monitor client outcomes.
6. Evaluate the diabetes case management program

Action! See [Part 2](#) for details on the implementation of each key recommendation.

Planning for Your Program and Evaluation

Key Action Steps include

1. **Identify your program's goal(s).** There are many program goals consistent with the Key Recommendations of this practice. Examples of program goals include:
 - Increase the number of people with diabetes who receive case management services.
 - Increase the number of people with diabetes meeting clinical and behavioral goals.
2. **Define program objectives** that will be met to reach the program goal(s) in the **SMART format** (specific, measurable, action-oriented, realistic, and time-bound).
 - Examples of SMART objectives for this Best Practice:
 - Increase the number of diabetes patients with a target population subset of coexisting cardiovascular disease who have an assigned case manager from 40% to 50% by the end of the year.
 - Increase the number of diabetes patients with a target population subset of coexisting cardiovascular disease who are meeting their blood pressure goal from 60% to 70% by the end of the next year.
3. **Use Key Measures.** The following Key Measures can be used to monitor progress and the effectiveness of implementing this Best Practice. Results of measures will indicate the degree of success in implementing the **Key Recommendations** and meeting program goals.

Measures of progress need to occur before the intervention (baseline) and at designated times thereafter. Measurement needs to be frequent enough to provide meaningful information for planning and evaluation.

Key Measures

These are specific measures that can be used to document changes in outcomes related to implementing the Best Practice.

Note! All SDPI grant programs that choose this Best Practice are **required** to report **as required in the terms and conditions attached to the notice of award on the indicated Measures**. Programs may report on other measures as well.

*The following measures are of primary importance:

1. * Percent of high risk (client subset) diabetes patients with an assigned case manager.
2. *Percent of patients with improvement (positive results) for at least one patient-identified self-management goal.

4. **Collect, record, and analyze data** on an ongoing basis; share with the team and the organization leadership. Effectiveness is evaluated through data review. Individual client outcomes are acquired and then compiled to show programmatic outcomes.

Note! Here are some data and analysis options:

- Consider comparing case managed individuals with standard care individuals.
- Compare baseline data elements with post-case management data elements.
 - For example, your program may choose to compare case managed individuals to standard care individuals. Another way to use data is to collect and record baseline data elements of interest compared to post-case management of the same data elements.
- Consider sample chart audits (about ten per case manager per year) to look for goal setting, barrier discussion, and individualized care plans.

Action! See [Part 2](#) – Key Recommendation 6.

5. **Use creative ways to display data and measure outcomes, such as graphs or charts.** This helps the team understand the data and know whether there are improvements.
6. **Think about what the data are telling you.** What changes are you seeing? Are they improvements? Use data for planning next steps.

Action! See the following resources to help your program improve.

See [Part 3](#) – Appendix B. Key Measures Example to assist you with identifying ways to choose SMART objectives and Key Measures that incorporate your community data.

Action! See [online training](#) and a [workbook](#) to get more ideas about setting goals and objectives and developing a program plan. Available from:
<http://www.ihs.gov/MedicalPrograms/Diabetes/HomeDocs/Training/WebBased/Basics/Creating/Workbook.pdf> (pages 23–28).

Team Notes:

Summary Points of Case Management Best Practice

1. Case management can be a practical and efficient strategy to help manage people with diabetes, pre-diabetes, or at risk for diabetes.
2. Subgroups may need to be prioritized.
3. Assessing the client's needs will help direct your individualized case management strategy.
4. Case managers must maintain a relationship with clients. Goal setting and follow-up are vital to the success of case management visits.
5. Many different measures can be used to track client progress. You must assess the capabilities of your program and choose the elements most practical for your situation.
6. Program evaluation is a continuous process. Evaluations may compare case managed individuals vs. standard care individuals—OR baseline data elements vs. post-case management data elements.
7. Evaluation of case management program data is an essential component of identifying strengths and weaknesses of your program. Making changes based on these findings will help strengthen your program.

PART 2 Key Recommendations

Note! Part 2 provides **important** detail on the “why?” and “how?” of implementation of each Key Recommendation.

Key Recommendation 1. Conduct a diabetes services assessment for the community.

Why?

Before a program is started, you should make sure it is a service that will be useful to the population being served.

How to Implement the Key Recommendation

Answer the following questions:

- How many people have diabetes, pre-diabetes, or are at risk for diabetes?
- What services currently are available to each of these groups?
- Could these services be improved by a case management program?

Action! See [Part 1](#) – Definition of Case Management.

Team Notes:

Key Recommendation 2. Identify eligible clients for case management.

Why?

Clients who receive case management experience improvement in their level of blood glucose control, satisfaction with services, understanding of treatment goals, resource use, continuity of care, and efficiency and coordination of services (Norris et al., 2002; Wilson et al., 2005). Case management services may need to be prioritized to a subset of clients (see below for examples).

How to Implement the Key Recommendation

A. Identify clients with pre-diabetes, diabetes, or at risk for diabetes:

- Utilize all resources, including Resource and Patient Management System (RPMS), electronic health records (EHRs), community health screening reports, chart audits, and referrals.
- Establish separate registries/data lists for populations of clients including pre-diabetes, diabetes, or at-risk.

B. Identify subsets of clients that may benefit most from case management. Examples include, but are not limited to:

- impaired glucose tolerance (IGT)
- coexisting cardiovascular disease (CVD)
- poor blood glucose control (A1C > 9)
- poly pharmacy
- insulin requiring
- younger age groups (20–40 years)
- low health literacy
- males
- gestational diabetes or diabetes in pregnancy
- frequent Emergency Department visits
- frequent hospitalizations
- at high risk—strong family history of diabetes mellitus (DM) or family members of dialysis patients/amputees
- metabolic syndrome
- tobacco users

Team Notes:

Key Recommendation 3. Assess the client's needs.

Why?

Assessing the client's needs and readiness to make behavioral changes can help improve costs and client outcomes such as blood glucose control, blood pressure control, lipid levels, and quality of life (Norris et al., 2002).

How to Implement the Key Recommendation

A. Perform a comprehensive assessment of the client's needs.

Action! See [Part 3](#) – Appendix D. for an example of a comprehensive diabetes assessment.

B. Explore the client's knowledge of his/her own diabetes and how different actions affect his/her health.

C. Assess the client's readiness to make changes in his/her diabetes management using Motivational Interviewing (MI) or Stages of Change techniques.

1. Utilize motivational interviewing techniques to elicit behavior change. Motivational interviewing is “a skillful clinical style for eliciting from patients their own good motivation for making behavior changes in the interest of their health.” The ‘spirit of MI’ involves collaboration, evocation and an honoring of patient autonomy while using the following guiding principles: resist the ‘righting reflex’, understand, listen, and empower (Rollnick, Miller and Butler 2008).
 - a. Actively listen and reflect back to the participant any barriers/challenges he/she may identify.
 - b. Ask open-ended questions to encourage discussion about feelings about behavior change.
 - c. Express acceptance and affirmation where the participant is at in terms of “stage of change” with non-judgmental responses.

Action! See [Part 3](#) – Appendix E. for examples of types of tools and resources for motivational interviewing.

2. Stages of Change is a method to assess readiness to change and includes five stages (Prochaska et al., 1994):

Precontemplation

- The individual is not intending to change within the next six months.
- “Leave me alone—my life is OK the way it is.”

Contemplation

- The individual is not prepared to take action at present, but is intending to within the next six months.

- “My friend who started walking has so much more energy than before. I wonder if I would feel better, too?”
- “I wish I had more ideas on how to change.”

Preparation

- The individual is actively considering changing his or her behavior in the immediate future (e.g., within the next month).
- “My grandchild was born last week. I know I have to make changes so that I will be around to see her grow.”

Action

- The individual has actually made an overt behavior change in the recent past, but the change is not well established (i.e., for six months or less).
- “It’s not easy, but I’ve followed my plan for almost three months.”

Maintenance

- The individual has changed his or her behavior for more than six months and is working to sustain the overt change.
- “I don’t even think about it anymore—I know this works for me.”

Note! Adapted from <http://care.diabetesjournals.org/content/26/5/1468.full> and from the IHS *Balancing Your Life and Diabetes Curriculum*

Team Notes:

Key Recommendation 4. Develop, implement, and monitor individualized care plans.

Why?

Effective, individualized care plans have been associated with improved blood glucose control. Case management is effective when delivered in conjunction with disease management and with additional educational, reminder, or support interventions (Norris et al., 2002).

How to Implement the Key Recommendation

- A. **Assign a case manager (CM) to a set of individuals within the target group.** The consistency of one provider helps to establish a trusting relationship and minimizes repetition. Try to assign case managers with client preferences in mind (i.e., male clients may prefer a male CM). Showing potential clients the individuals who offer case management and letting them choose their CM may help establish a relationship early on.
- B. **Implement case management as a multi-component intervention.** Interventions that can be combined with case management include self-care education, home visits, telephone outreach, telemedicine, support groups/talking circles, group education, work site visits, letters, encouragement cards, and client reminders. Interventions combined with disease management have been shown to further reduce A1C levels than has case management alone (Norris et al., 2002).
- C. **Define individualized goals for client.** It may be necessary to only focus on one area at a time.
 - a. At each CM visit, the client and CM should negotiate a goal for at least one of the following areas (AADE 7™):
 1. Healthful eating
 2. Being active
 3. Monitoring
 4. Taking medication
 5. Problem solving (including pattern management)
 6. Reducing risks (such as smoking cessation)
 7. Healthy coping (including stress management)

Action! See [AADE 7™ resources](http://www.diabeteseducator.org/ProfessionalResources/AADE7) at <http://www.diabeteseducator.org/ProfessionalResources/AADE7>

Action! See [Part 3](#) – Appendix G. for a tracking sheet that can be adapted.

- b. Goal Setting: The case manager will need to assess the client status with regard to improving health through behavior change. Goals should come from the client, and the case manager should only serve as a guide. Goal-setting guidelines include:
- Goal setting should be short term and in small steps so clients can achieve feelings of success.
 - Exploration of conviction and motivation to change
 - conviction – how strong a desire the client has toward wanting to make lifestyle changes.
 - motivation – may be positive (e.g., “I want to be healthy for my family”) or may be negative (e.g., “I’m afraid of being on dialysis”).
 - SMART goals (specific, measurable, attainable, realistic, time-bound)
 - Goal negotiation between case manager and client until confidence is at an acceptable level for possible success. Goals should be changed until the client is able to say, “I can do this.”
 - Exploration of barriers and ways to overcome (i.e. poor self-discipline, low motivation, physical limitations, lack of support, financial constraints).

Action! See [Part 3](#) – Appendix F. for sample client Goal Setting/Action Plans.

- Follow up with goal reflection and review of how the client did toward meeting his/her goal at every CM visit. Always set a new goal for the next time, too.
- Client education and diabetes curricula are vital tools during case management visits.

Action! See [Part 3](#) – Web Resources for links to different diabetes teaching curricula.

Team Notes:

Key Recommendation 5. Monitor client outcomes.

Why?

Monitoring the outcomes of individuals or populations is essential to determine the effectiveness of case management (Norris et al., 2002).

How to Implement the Key Recommendation

- A. **Determine what types of data will be measured.** Because this Best Practice is utilized by both clinical and non-clinical programs, what types of data and how that data are collected will vary widely. Outcomes can be measured by establishing baseline data upon entry into the case management program and reviewed periodically throughout the program on a scheduled basis or at least annually. Some data will require more frequent intervals than others. The foundation of a program's success is individual client success.
- B. **During case management, data tends to be collected on more frequent intervals so that this information can be shared with the clients.** Providing clients with frequent updates of measurements most important to them can help reinforce the impact of lifestyle behaviors.
- C. **It is advised that a program collect several data elements to help assure positive outcomes in at least two of these elements.** The table below contains many options from which to choose:

Possible Data Elements to Monitor Client Outcomes

Lifestyle Questionnaires	Basic Measurements
<ul style="list-style-type: none"> • Physical activity levels • Healthful eating • Smoking • Emotional health • Medication management • Pattern management/Problem solving • Quality of life • Work related (lost work days) • Personal goal achievement • Immunizations 	<ul style="list-style-type: none"> • Height • Weight • Body Mass Index (BMI) • Waist measurement • Hip measurement
Service Utilization	Some Equipment Required
<ul style="list-style-type: none"> • Appointment show rates <ul style="list-style-type: none"> ○ Case management ○ Eye ○ Foot ○ Primary Care Physician (PCP) ○ Dental • Hospitalizations • Emergency Department visits for DM care • Achievement of standards of care 	<ul style="list-style-type: none"> • Home glucose monitoring • Body composition • Blood pressure • Fasting sugars • Patient activation (purchase of PAM[®] web access)
Lab / Point of Care	Long-Term Complications
<ul style="list-style-type: none"> • A1C • Lipid levels <ul style="list-style-type: none"> ○ LDL (low density lipoprotein) 	<ul style="list-style-type: none"> • Microvascular <ul style="list-style-type: none"> ○ Eye, kidney, foot ulcers, periodontal disease,

<ul style="list-style-type: none"> ○ TG (triglycerides) ○ HDL (high density lipoprotein) ○ Total cholesterol ● Albumin/creatinine (A/C) ratio (urine) 	<p style="text-align: center;">neuropathy</p> <ul style="list-style-type: none"> ● Macrovascular <ul style="list-style-type: none"> ○ Heart disease, stroke, peripheral vascular disease ● Mortality
Exam Completion Rates	Screenings and Education
<ul style="list-style-type: none"> ● Retinopathy exam ● Dental exam ● Complete foot exam 	<ul style="list-style-type: none"> ● Depression screening ● Tobacco screening ● Patient Education Protocols and codes on DM-related topics

D. Potential sources of data include:

- Resource and Patient Management System (RPMS)/EHR data
 - IHS Diabetes Care and Outcomes Audit
 - iCARE reports
 - GPRA and transparency reporting
 - workload data
- Chart audits
- Questionnaires

Action! See [Part 3](#) – Appendix G. for tracking sheet that can be adapted.

Team Notes:

Key Recommendation 6. Evaluate the diabetes case management program.

Why?

Evaluation is important because it helps uncover what is working and what is not working in a case management program. Evaluation provides you with information that can be used to share program successes with clients, providers, Tribal leaders, administrators, community members, funders, and other stakeholders.

How to Implement the Recommendation

A. **Program evaluation often starts with individual client outcomes** mentioned in the previous section. These data are then compiled and analyzed to show program outcomes. The two most common types of comparisons are:

- Pre-intervention data (baseline) vs. Post-intervention data (periodic data during case management process)
- Intervention group vs. Standard Care group

Action! See [Part 3](#) – Appendix G. for a tracking sheet that can be adapted.

B. **In addition to data elements listed above, programs may also show positive outcomes using the following:**

- Client stories
- Satisfaction questionnaires (Average Satisfaction Scores)
 - clients
 - primary care providers
 - diabetes department staff
- Percentage of clients receiving at least three CM (case management) visits within a year
- Show rates for CM appointments
- Number of CM appointments
- Program retention rate
- Contract health service referrals

C. **Software that can assist in data compilation includes:**

- Excel[®]
- Access[®]
- RPMS/EHR
 - IHS Diabetes Care and Outcomes Audit
 - iCARE reports
 - client record reviews
 - workload data
 - GPRA and transparency reporting
- Data Managing Systems (i.e., Filemaker Pro[®], Sage Intergy Database[®])

Team Notes:

Additional Recommendations

Working Together with Your Community and Organization

In addition to implementing the **Key Recommendations**, programs need to work on broader community and organizational support of the goals they are trying to achieve.

Organization Recommendations

A health care organization that wants to improve diabetes case management must be motivated and prepared for change throughout the entire organization. The organization's leadership must identify diabetes case management as important work. Medical expenses for people with diabetes in the United States are more than two times higher than for people without diabetes. Estimated direct medical costs for people with diabetes exceeds \$116 billion per year, and adding indirect costs such as disability, work loss, and premature mortality brings the yearly total to more than \$174 billion.(CDC, 2011). Leaders also must develop clear improvement goals, policies, and effective improvement strategies. This will help encourage the entire organization to make changes that will help improve diabetes care.

Make system and programmatic changes

Why?

Health care organizations that are ready to implement case management can help providers and educators to: (1) target clients more effectively; (2) design interventions that are more acceptable to clients; and (3) design interventions that reduce morbidity and mortality of diabetes and pre-diabetes. Changes in health care organizations also have been associated with increased delivery of appropriate diabetes care (Norris et al., 2002).

How to Implement the Recommendation

The following activities may help improve diabetes case management:

- A. Advocate for leadership support to initiate and improve effective case management services.
- B. Identify gaps in current diabetes services provided.
- C. Assess the organization for available infrastructure/capacity to deliver case management and other desired services.
- D. Use standing orders, practice guidelines, and clinical pathways that stakeholders have agreed upon.
- E. Use evidence-based features of case management to improve, monitor, and evaluate diabetes outcomes and program outcomes.

Action! See [Part 3](#) – Appendix H. for the essential elements of basic, intermediate, and comprehensive diabetes case management programs.

PART 3 Appendices, Tools, and Resources

Appendix A. Supplemental Information

1. Importance of a Diabetes/Pre-Diabetes Case Management Program

The effects of diabetes case management have been well-researched, carefully analyzed, and applied in many settings, including American Indian and Alaska Native communities. Numerous studies have demonstrated the effectiveness of case management in improving health outcomes.

- Nurse case management of diabetes increased the delivery of clinical services and contributed to improvements in blood glucose control when measured in periods of up to one year (Norris et al., 2002).
- In the IHS, case management improved blood glucose control as measured by improvements in A1C. It also improved self-monitoring, patient education, and laboratory testing, as well as eye, foot, and pre-diabetes or diabetes exams (Wilson et al., 2005).
- Case management for pre-diabetes was a key strategy used in the Diabetes Prevention Program (DPP) lifestyle intervention, where a 5–7% weight reduction resulted in a 58% decrease in diabetes incidence over a three-year period (Knowler et al., 2002).

2. Benefits and Risks of Implementing This Best Practice

The effects of diabetes case management have been well-researched, carefully analyzed, and applied in many settings, including American Indian and Alaska Native communities. Numerous studies have demonstrated the effectiveness of case management in improving health outcomes.

- Nurse case management of diabetes increased the delivery of clinical services and contributed to improvements in blood glucose control when measured in periods of up to one year (Norris et al., 2002).
- In the IHS, case management improved blood glucose control as measured by improvements in A1C. It also improved self-monitoring, patient education, and laboratory testing, as well as eye, foot, and pre-diabetes or diabetes exams (Wilson et al., 2005).
- Case management for pre-diabetes was a key strategy used in the Diabetes Prevention Program (DPP) lifestyle intervention, where a 5–7% weight reduction resulted in a 58% decrease in diabetes incidence over a three-year period (Knowler et al., 2002).

There is no potential harm identified in implementing this Best Practice.

3. Sustaining a Diabetes/Pre-Diabetes Case Management Program

It is common for new initiatives to require a certain level of maturity before care goals can be achieved. This maturational process may require more than a few years to produce the desired outcomes in a stable and self-sustaining fashion. Sustainability is a critical issue for programmatic success, and can be an elusive target. The following recommendations may be useful in fostering sustainability in newly implemented programs:

- Be ready to bill for diabetes case management services when Medicare designates case management as a reimbursable service. Also capitalize on pharmacist MTM billing and dietitian MNT billing.

- Use Special Diabetes Program for Indians (SDPI) grant funds to support diabetes case management.
- Demonstrate to organization leadership the cost savings associated with case management. Savings might be achieved through decreased hospitalization, effective medication use, and prevention of complications.
- Develop relationships with providers and clients that show value in having a case management program to which others can be referred.

Appendix B. Key Measures Example

Remember—this is an example! Apply this process to your community using your data.

Diabetes standards of care not being met. Our health care center and community are concerned that there has been no recent improvement in the number of patients with diabetes able to achieve clinical goals, including target goals for A1C, blood pressure, and cholesterol.

Diabetes team takes action. Our diabetes team talked about addressing this problem and how the diabetes team could be more involved. We read the Case Management Best Practice and talked about the Key Recommendations.

Identified sources of data. Local data included:

- Audit data for past three years:
- 30% of our patients in the diabetes registry had an assigned case manager. Of those patients, 20% are high risk (strong family history of diabetes mellitus or family members of dialysis patients/amputees)
 - 35% percent of patients had improved glucose control and improved control had decreased over the past two years.
 - 45% percent of patients had improved blood pressure control and this had not changed in the past two years.
- A list of community diabetes resources was available but not current.

Selected suitable Best Practice. After thinking carefully about our goals and resources, and reviewing data, we decided the Case Management Best Practice was a good fit for us. Because this would be a new program for us, we chose to work on two of the Key Recommendations: conduct a diabetes services assessment for the community and identify eligible clients for case management. We planned to create a multi-disciplinary case management team with three diabetes team members.

Identified target population. We decided to start implementing this Best Practice with patients listed in our diabetes registry who also have cardiovascular disease.

Identified program goals:

- Increase the number of people with diabetes who receive case management services by trained team members.
- Improve blood glucose and blood pressure control for patients with diabetes and cardiovascular disease.

Identified SMART objectives based on our resources and data:

- At least 50% of patients with diabetes will be assigned a case manager and receive case management services during the next twelve months.
- At least 40% of patients with high risk (client subset) diabetes will be assigned a case manager and receive case management services during the next twelve months.
- At least 50% of those patients receiving case management services will show both improved A1C and blood pressure control during the next twelve months.

- The community diabetes services resource list will be completely updated by the case manager by the end of the fiscal year.

Selected Key Measures. We chose the corresponding Key Measures for these Objectives and these Key Recommendations. Data will be collected and reviewed at baseline and mid-year.

Table 1. Selected Key Measures

	A. Measure	B. <u>Baseline</u> or beginning value and date (collected prior to starting activities)	D. Most recent value and date (if applicable)	E. Data source (where did these numbers come from)
1	Percent of patients with diabetes that receive case management services from the case manager	30% as of 1/4/2011	33% as of 4/12/2011	RPMS/Diabetes Registry
2	* Percent of high risk (client subset) diabetes patients with an assigned case manager.	20% as of 1/4/2011	25% as of 4/12/2011	RPMS/ Diabetes Registry
3	* Percent of patients with improvement (positive results) for at least one patient-identified self-management goal (A1C)	35% as of 1/4/2011	37% as of 4/25/2011	RPMS
4	* Percent of patients with improvement (positive results) for at least one patient-identified self-management goal (blood pressure control)	45% as of 1/4/2011	47% as of 4/25/2011	RPMS
5	Percent of the community diabetes services resource list that is updated	0% as of 1/4/2011	50% as of 4/12/2011	Resource list, CM meeting notes

* Required Key Measure

Appendix C. General Case Management Guidelines

Case Management Visits consist of several parts:

1. Individual Case Management/Self-Management:
 - a. assessment of needs based on treatment goals
 - b. development, implementation, and coordination of care plan
 - c. documentation of care in Electronic Health Record or other client record
 - d. education that includes basic understanding of diabetes and related complications, reinforcing self-monitoring of blood sugar, education on nutrition/healthful food choices, healthful portions, exercise/activity, medication management, smoking cessation, stress management, setting treatment plans, and motivation to meet their goals.
 - e. evaluation of the motivation for changes and Stage of Change (pre-contemplation, contemplation, preparation, action, maintenance).
 - f. address personal action plans/goals and any barriers to meeting these goals. Barriers will need to be explored and problem-solved together with their CM. Motivational interviewing techniques can be utilized so solutions originate from the client.

2. Disease Management:
 - a. tracking the measurements and lab values. These may include: blood pressure, weight, BMI, A1C, lipid panels, body fat composition, waist or hip measurement.
 - b. Clinical programs, may include medication changes (additions, changes, deletions)

Action! See [Part 3](#) – Appendix G. for tracking sheet that can be adapted.

3. Diabetes Education:
 - a. assess client knowledge about diabetes and it's complications and fill in gaps
 - b. utilize Diabetes Education Curriculums including:
 - i. Balancing Your Life and Diabetes (IHS Division of Diabetes)
 - ii. Honoring the Gift of Heart Health (IHS Division of Diabetes)
 - iii. AADE Curriculums

The relationship that builds between CM and participant is a unique blend of clinician, coach, and supporter. Case management is meant to be a more intensive process. The CM closely tracks progress and offers support and guidance in the changes clients choose to make.

First Visits:

During the first visit, it is important to try and communicate the foundation of support for a productive relationship during this visit:

- Review what the program is, what the program goals are, how the project is structured to support them. You may want to ask the participant “Tell me what you know about the project and why you were interested in joining?”
- Clarify the roles between the case manager and the participant: explain your expectations of him/her and what his/her participation in the intensive case management process is. Ask him/her to clarify any of his/her expectations of you.

- Assess the client's knowledge level of the following items (this may take more than one visit):
 - a. basic diabetes disease process and understanding
 - b. diabetes effects on the body
 - c. understanding of healthful nutrition (food choices and food preparation), exercise/activity, smoking, stress management
 - d. how other health issues affect diabetes/pre-diabetes and the body
- Assess the motivational level of the client to make changes in his/her life (stages of change), where he/she is in terms of willingness to make changes, changes he/she has tried making before, etc. Understanding what his/her past experiences have been with diabetes or what he/she has seen as success/failure in people he/she know trying to control diabetes.
- If family is present, encourage them to participate in the discussion and assess their knowledge level and level of support, experience, etc. If the family is not present, encourage the participant to include a family or friend in his/her visits for support, if appropriate.

Once you have an idea of his/her knowledge level and motivational level, review these points:

- Stress to the participant that we are not going to just tell him/her what he/she **has** to do about managing or preventing diabetes.
- CMs provide clients with information/education about how they can manage their diabetes and to support them to start making the changes they know they need to make. Clients are in control and are the ones to decide what and how they want to work on it.
- Communicating your respect for their choices, whatever they may be, is important in building trust. We want to make sure they have the most correct information available so they can make informed choices.
- Review most recent measurements and lab results: ask if anyone has ever explained these values to them.
- It is important that they understand **why** we are measuring the labs and measurements.
- If in a clinical program, explain the process for what medication doses adjustments can be made and any limitations for this.
- Complete a needs assessment form during the first few visits.
- Identify what type of family support each participant has. Ask him/her directly how he/she feels his/her family will react to the changes. Encourage him/her to bring any family member to the CM Visit in the future.

Other Areas to Cover:

Patient education (as needed):

Areas to cover during your CM Visits depend upon the participant's level of knowledge that you assess, but this may give you some places to start:

- Keep it simple—letting the participant direct the points of discussion so you can focus on areas of need.
- Review handouts and curriculums (Balancing Your Life with Diabetes, Honoring the Gift of Heart Health, etc.)
- Any written material should be reviewed with the clients and not just handed to them. Highlighting key points may increase the likelihood they may actually refer to it after they leave and not just throw it away.

- Use visual tools whenever possible during teaching sessions.

Medication adjustments:

- Your licensure (pharmacists, nurse, NP, MD, etc.) will determine whether you can make medication adjustments yourself or need to consult with the client's provider.
- If your program allows collaborative agreements between diabetes educators and providers for medication adjustments, then this is ideal. Medication adjustment protocols must be drafted and approved by medical staff.
- It is a good practice to communicate any major medication changes with primary providers.

Referrals:

Develop a list of local resources where clients can receive additional care. These may include fitness centers, behavior health services, social services, tobacco quit programs, nutrition counselors, etc. When clients' needs go beyond the scope of your program, readily offer these services as options.

Follow-up between CM Visits:

Studies on successful case management services have shown that the closer the follow-up and relationship between CM and client, the better the outcome. Consider a phone call to participants one time during the month in-between visits just to check in and see how they are doing:

- Phone follow-up—get permission from patient to call for follow-up.
- Inform of program activities: newsletters, group activities, planned conferences, classes, etc.
- The CM advocates for the participant with any interaction you have on their behalf with other providers or programs.
- A long-standing relationship with participants and families is going to be the backbone of support for the participant.

Subsequent visits:

- Review past written goals and what was achieved. Celebrate the achievements! If a goal was not achieved, discuss possible reasons why and barriers to reaching it next time.
- Review any new lab values and measurements
- Do DM maintenance (foot checks, BP checks, pulse checks, etc).
- Review a new subject material for the participant at each visit:
 - Follow a curriculum or tailor your visit focus to what the participant is currently trying to work on, or a specific question they have.
 - If you are searching for something new, ask the participant what materials they feel competent taking back to their families and teaching.
- Keep Case Management Visits as positive and supportive as possible.

Case management appointment reminders:

- Scheduling the next case management appointment at the end of each appointment gives the client an opportunity to give input and also a chance to give a written appointment card with contact phone numbers.
- Appointment flexibility (early morning, lunch break or after work) may allow more participation in your program.

Documentation:

- Notes in client record for face to face encounters, phone calls, chart reviews, etc.
- Patient education using IHS Patient Education Protocols and Codes
- Wellness information including: depression, tobacco, and activity level screenings

Planning goals:

- Set a goal that is SMART: specific, measurable, attainable, realistic, timely.
- LISTEN! Utilize the time you have with the participant. Let him/her talk and actively listen to what he/she has to say.

Motivation to make changes:

Utilize motivational interviewing techniques to elicit behavior change by addressing any ambivalence the participant has in setting and meeting his/her behavior change goals.

- Actively listen and reflect back to the participant any barrier/challenge he/she may identify.
- Ask open-ended questions to encourage discussion about feelings about behavior change.
- Express acceptance and affirmation of where the participant is at in terms of 'Stage of Change' with non-judgmental responses.
- If appropriate, directly confront any resistance to setting goals and making behavior changes.

Be supportive:

- Be the participant's cheerleader for success.
- Celebrate the small successes!
- Encourage making goals based on current successes.
- Acknowledge those goals not met and try to clearly identify what challenges/barriers there are to meeting them.

Case Management Team tips:

- Hold regularly scheduled meetings to review CM techniques and stay updated on clinical information.
- Be supportive of each other and fill in to meet patients' needs whenever needed.
- Review difficult cases with other case managers. Sometimes a different perspective is all you need.
- Offer a change in case managers if you get a sense that your relationship with the client might be better with another case manager.

Appendix D. Case Manager Initial Assessment Data Form (page 1 of 2)

Case Manager Initial Assessment Data

DATE _____

Name _____ DOB _____

Phone #s Home _____

Work _____

Mobile _____

Race _____ Ethnicity _____

Date enrolled in clinic (month/year) _____

Date enrolled in diabetes project (month/year) _____

Date diagnosed with diabetes (year) _____

Work/type of work _____

Transportation (circle) Drive own car
Family/friends drive
Walk
Public transportation
Other (list type) _____

Literacy—(circle) Read/Write YES NO
If YES- What language _____

With whom do you live? Spouse/partner Age _____
Daughter How many? _____ Age _____
Son How many? _____ Age _____
Other relatives Who? _____
Age _____

Who is the person who helps/supports you the most? _____
How does this person/people help you? _____

Do you feel people in the community help you (ex. Church, etc)? YES NO
If YES, who & how? _____
If NO, why not? _____

What do you do in your time off? Where do you go? _____

This product was developed by the Prescription for Health Diabetes Project at the Open Door Health Center in Homestead, FL with support from the Robert Wood Johnson Foundation® in Princeton, NJ.

Appendix D. Case Manager Initial Assessment Data Form (page 2 of 2)

Case Manager Initial Assessment Page 2

What are days you can NOT come to appointments? _____
Why? _____

What type of physical activity do you do? _____
How often (times per week/hrs. spend doing each activity) _____

Do you take your medicines every day? _____
If NO, how often do you forget & why? _____

Do you check your blood sugar at home? YES NO
If YES how often? _____
If NO why? _____

How often do you eat? (times of day they eat) _____
Do you use the plate method? YES NO
If NO why not? _____

PHQ-2 administered (if already done list date) YES NO
What is the result? Positive Negative
If positive complete PHQ-9 Results: Positive Negative
If PHQ-9 positive date referred to provider _____

Other information
(Questions/concerns): _____

Is there anything extra/different that you think you could do to manage your diabetes?
YES NO

If YES, what is it? What goal would you like to work on? (focus on 1-2 activity eating, medication, coming to appts. monitoring blood sugar)

NAME _____ DOB _____

This product was developed by the Prescription for Health Diabetes Project at the Open Door Health Center in Homestead, FL with support from the Robert Wood Johnson Foundation® in Princeton, NJ.

Appendix E. Reflective Listening: A Key Motivational Interviewing Skill (page 1 of 4)

http://www.interiorhealth.ca/uploadedFiles/Choose_Health/Tobacco_Reduction/Aboriginal/MotivationalInterviewing.pdf

Reflective Listening: A key MI skill

Traditionally Native Americans have a strong oral tradition. In general, Native people are good storytellers and good listeners. Using MI, you can tap into your client's ability and willingness to tell his or her own story to learn more about their drinking and life. As a counselor, you can use your skills of listening to clients. Being a good listener helps you let your clients know that you have heard and understood them (express empathy: accurately understanding your clients). In MI, the ability to use reflective listening starts with being a good listener and a good communicator. To keep the manual short, we only included a brief description of listening skills. For more information, you may consider some of the resources listed at the end of this manual on page 77.

We just mentioned reflective listening briefly – but it's important to learn some more about it because it is one of the keys to using MI. Here are some strategies that will help you:

Steps:

1. Hear what the client is saying.
2. Make a guess at the client's underlying meaning, energy, and emotion.
3. Choose your direction: What are you going to respond to and what are you going to let go by? Remember we want to encourage change talk and decrease resistance.
4. Make your reflection a statement instead of a question.

Types of reflective listening:

SIMPLE REFLECTIONS: Stays close to the client's words; may be most helpful at the beginning of sessions, when client is angry or to encourage more description of a word or feeling from the client. Be careful not to only use simple reflections because your client might get frustrated.



Repeat:

- ❖ Saying exactly what the client said using the same words.
 - Client: "It almost feels like my husband is judging me."
 - Therapist: "Your husband is judging you."



Rephrase

- ❖ Staying close to what the client said, but in different words. A rephrase is like a synonym.
 - Client: "It almost feels like my husband is judging me."
 - Therapist: "Your husband is critical of you."
 -

COMPLEX REFLECTIONS: Can help increase the pace of the session by helping clients get to the heart of the matter. A good goal is to use more complex than simple reflections.



Paraphrase

- ❖ Add information to what the client said, such as underlying emotions or feelings, in order to get a better understanding of their meaning. The clinician infers the client's meaning. These can be amplified, double-sided, and reflections of feeling.
 - Client: "It almost feels like my husband is judging me."
 - Therapist: "You're afraid he doesn't like what he's seeing in you."

Appendix E. Reflective Listening: A Key Motivational Interviewing Skill (page 2 of 4)

SUMMARY

Mini Summary

- ❖ Pulling together statements that your client has shared and presenting them back to the client. A summary is a bouquet that you hand back to the speaker. Each flower is something that the speaker has said. The mini summary asks for more information.

Transitional Summary

- Counselor: "You've said that your husband criticizes you in front of others, compares you to skid-row alcoholics and tells you you'll never amount to anything. What else have you noticed?"

Transitional Summary

- ❖ Pulling together statements so that you can change course or shift focus with your client or to wrap up a session. For example, you might switch from learning about the positives of drinking to the negatives of drinking. Another change might be from Phase 1 (building motivation to change) to Phase 2 (increasing commitment to change).
- Counselor: "Okay. So let me see if I've got this straight. Your husband's criticism has become too much, it's affecting your self-esteem, and you're worried that your daughter is learning that it is okay to mistreat women. Where does this leave you now?"

• Overshooting and Undershooting for Direction

- ❖ Reframing the extreme – Planful way to get the client to say more or less about something. Overshoot: you want the client to ease up in their intensity (useful when a client is being resistant and you want to decrease resistance). Undershoot: you want to draw out more intensity from the client (useful when you want more change talk).
 - Client: "It almost feels like my husband is judging me."
Therapist: "You're worried he thinks you are no good at all." (Overshoot: client might agree and burst into tears. Or your client may decrease intensity by disagreeing with such an extreme statement and go on to explain how her husband is upset about her drinking)
Therapist: "He's been a little critical of you" (Undershoot: likely that client will disagree and explain in detail and more intensely how harsh he has been.)

Using Metaphors

- ❖ Using a metaphor to help understand what the client is saying.
 - Client: "It almost feels like my husband is judging me."
Therapist: "He's the judge and you're on trial."

Judging the Quality of Reflection: Instant Feedback from client.

- ❖ If the client keeps talking and gives you more information, that is a good sign for the quality of your reflections.
- ❖ If the client talks less in a way that seems to be closing down, then that is not a good sign. (see "Are your MI skills improving" section, page 68).

Appendix E. Reflective Listening: A Key Motivational Interviewing Skill (page 3 of 4)

OARS: 4 key MI skills

Once you feel comfortable with reflective listening, there are a few additional steps that will help you and your client experience movement toward change or toward the client clarifying his or her feelings about change in your sessions. We like to abbreviate these four strategies as O-A-R-S. This is what it stands for:

1. Ask Open-Ended Questions (O)

- A. Ask questions that cannot be answered with a “yes” or a “no.”
Try to avoid closed-ended questions such as “Where did you grow up?” “How much do you drink?” when you want to encourage storytelling.
- B. When asking an open-ended question, the counselor does not know what the client’s answer will be. Using open-ended questions lets your clients know that you want to hear their story. A few examples of open-ended questions are: “What has your drinking been like lately?” “What have you liked about drinking?” “What, if anything, haven’t you liked about drinking?”

2. Affirm (A)

- A. It takes skill to find the positives in a client.
- B. A counselor should only offer support and praise when it is sincerely meant
- C. You can reflect behaviors such as showing up for appointments or talking about difficult topics.
- D. You can comment on your client’s character such as being brave, being a role-model for Future generations and being honest.

** For more information, see page 54

3. Listen Reflectively (R)

- A. A statement showing the client that you are trying to figure out the underlying meaning of their words.
- B. Reflections are difficult because the counselor has to make a guess about what the client means or where the client is going. That is the meat of the reflection. It is up to the client to agree with the reflection or pick another direction to go.
- C. Reflections are statements. Make sure not to end reflections with a question mark.
- D. A good goal when you are first starting out is to try to do two reflections for every one question.
- E. Your most common response to your client should be a reflection.

** For more information, see page 26

Appendix E. Reflective Listening: A Key Motivational Interviewing Skill (page 4 of 4)

3. **“What would it take to bump you up a few notches to a (choose a number two or three higher than originally given)?”** For example, “What would it take to bump you up a little from a 3 to a 5?” (This kind of question draws out more change talk and helps the client imagine the change becoming more important).

4. **Listen carefully, use reflection and small summaries**

❖ **Measuring Confidence to make a Change**

Not Confident	Unsure	A Little Confident	Very Confident
0...1...2	3...4...5	6...7...8	...9...10

1. “On a scale of 0 – 10, where 0 is not at all confident and 10 is extremely confident, how confident are you that you could make a change in (specific behavior) now?”
2. “What makes you choose (number client chose) rather than a 0?”
“What does it mean to be a (number client chose)?”
3. “What would it take to bump you up a few notches to a (choose a number two or three higher than originally given)?”

❖ **If it seems helpful with your client, you may use the same questions for readiness to make a change now.**

You are not ready to make a change.	You are unsure about making a change.	You are ready to make changes.	You are making changes.
You haven't prepared the ground for planting.	A seed is in the soil but hasn't been watered.	Your plant just broke through the soil.	Your plant is ready to be harvested.










- ❖ Summarize (highlight reasons it is important to change, what makes them confident they can make changes and what makes them ready to make those changes now being careful not to make them seem more ready than they are)
- ❖ Express confidence in them and appreciation

Appendix F. Action Plan

Action Plan

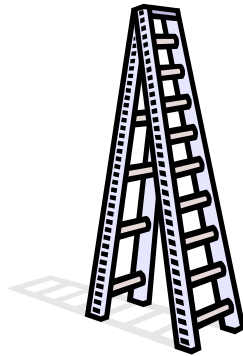
What is something you would like to do for your health over the next few days or weeks until we visit again?

- | | | | |
|---|-------------------------------------|---|-------------------|
|  | Be more physically active |  | Take my medicines |
|  | Improve my food choices |  | Reduce my stress |
|  | Cut down on tobacco |  | Check my sugars |
|  | Solve a problem that's bothering me | | ?Something else? |

The change I want to make is... (What? When? How often? Where?)

What might get in the way?

How sure are you that you can do this?



Very sure

Sure

Kind of sure

Not sure

I don't think I can

Next Visit: _____

Case Manager: _____ Phone # _____

Appendix G. Tracking Sheet

Patient name _____

Whiteriver Healthy Heart Tracking Sheet

year _____

Health Goal	Previous	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
A1C < 7													
LDL < 100													
HDL > 40 men, >50 women													
TG < 150													
Blood Pressure < 130/80													
7% wt loss (goal wt=_____)													
Tobacco													
M/C ratio (goal <30)													
Medicines		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Asprin													
Lisinopril													
simva/atorvastatin													
Metformin													
Pioglitazone													
Glipizide/Glyburide													
Insulin													
Insulin													
Other													
HGHH		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Heart Disease / Heart Attack													
Eating - a Family Affair													
Eating - short on time/money													
Activity / Healthy Weight													
Cholesterol													
Blood Pressure / sodium													
Tobacco													
Annual Monitoring		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Eye Exam													
Dental Exam													
Foot Exam													
EKG													
Month of Annual PE		Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec

Appendix H. Examples of Case Management Best Practice Program Components

	Community Resources and Policies	Organizational Leadership	Patient Self-Management Support	Delivery System Design: Services, Programs, Systems, and Procedures	Decision Support: Information and Training for Providers	Clinical Information Systems: Collecting and Tracking Information
Basic Diabetes/Pre-Diabetes Case Management Disease Programs	<ul style="list-style-type: none"> • Obtain evidence of community support through proclamations and other documentation. • Identify all potential resources in the community. 	<ul style="list-style-type: none"> • Support case management strategies to complement existing services. • Provide evidence of organizational support through policies and procedures, structures, and accountability processes. • Provide resources necessary to support a case manager, including space, budget, equipment, supplies, written position description, and 	<ul style="list-style-type: none"> • Identify and agree upon the target population. • Conduct an inventory of self-management programs and support groups, and of the eligibility requirements for those programs. • Ensure that the case manager has the ability to meet with the patient and family to understand their needs. 	<ul style="list-style-type: none"> • Establish a diabetes team (case management is not a substitute for a diabetes team). • Create or adopt scopes of service, standards of care, and specific curricula. • Design case management interventions. • Clearly specify goals and expectations for meeting goals. 	<ul style="list-style-type: none"> • Ensure providers are educated about case management and supportive of the approach. • Identify processes for involving physicians in case management. 	<ul style="list-style-type: none"> • Gather data from available sources including the diabetes registry, performance audits, and other systems or processes that may be required to identify and recruit members of the target population. • Track interventions and measure effectiveness of interventions at the individual and population

		<p>orientation plan.</p> <ul style="list-style-type: none"> •Include in the management plan an organizational structure that outlines the relationship to the diabetes team, defined performance standards, chief executive officer (CEO) performance contracts, and supervision responsibilities. 		<ul style="list-style-type: none"> •Define clinical and non-clinical policies and procedures. •Develop methods for continuity of care. 		levels.
	Community Resources and Policies	Organizational Leadership	Patient Self-Management Support	Delivery System Design: Services, Programs, Systems, and Procedures	Decision Support: Information and Training for Providers	Clinical Information Systems: Collecting and Tracking Information
<p>Intermediate Diabetes/Pre-Diabetes Case Management Programs</p> <p>Basic Program <i>Plus the Following</i></p>	<ul style="list-style-type: none"> •Acquire knowledge of health behaviors and practices in the community. •Commit to use any community resources that 	<ul style="list-style-type: none"> •Develop written policies and procedures regarding standing orders, practice guidelines, and clinical pathways. 	<ul style="list-style-type: none"> •Establish a method for two-way communication between the self-management program and case manager. 	<ul style="list-style-type: none"> •Hire or contract with a case management provider, or assign case management duties to an existing employee who 	<ul style="list-style-type: none"> •Establish standing orders, practice guidelines, and clinical pathways that are demonstrable and agreed 	<ul style="list-style-type: none"> •Use registries and available data to perform the five essential case management functions: (1) identify, conduct

	meet patient needs.		<ul style="list-style-type: none"> •Establish a method for two-way communication between the health care provider and case manager. •Provide education within the framework of an IHS-certified (or equivalent) curriculum. 	<p>has dedicated time, resources, and skills.</p> <ul style="list-style-type: none"> •Implement case management interventions. 	<p>upon.</p> <ul style="list-style-type: none"> •Develop and implement public marketing strategies on the role of standards of care and case management. 	<p>outreach for, and recruit eligible patients; (2) assess the patient within the context of the patient's and health system's readiness; (3) develop an individual care plan; (4) implement the care plan; and (5) monitor outcomes.</p> <ul style="list-style-type: none"> •Track and review process measures, such as measurement of referrals for examinations, laboratory testing, and exposure to patient education.
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	Community Resources and Policies	Organizational Leadership	Patient Self-Management Support	Delivery System Design: Services, Programs, Systems, and Procedures	Decision Support: Information and Training for Providers	Clinical Information Systems: Collecting and Tracking Information
<p>Comprehensive Diabetes/Pre-Diabetes Case Management Programs</p> <p>Basic and Intermediate <i>plus the following</i></p>	<ul style="list-style-type: none"> •Develop memoranda of understanding with community programs for referral processes. •Develop communication processes through business partner agreements or releases of information. •Evaluate programs using outcome measures to continuously assess community resources. Use 	<ul style="list-style-type: none"> •Develop defined outcomes that are amenable to the case management strategy. •Evaluate programs using outcomes measures to continuously assess organizational infrastructure. •Use evaluation findings to identify problems, gaps, needs, and solutions. 	<ul style="list-style-type: none"> •Ensure the case manager has access to and use of the patient medical record. •Evaluate programs using outcome measures to continuously assess patient self-management resources. •Use evaluation findings to identify problems, gaps, needs, and solutions. 	<ul style="list-style-type: none"> •Focus on clinical and behavioral measures 	<ul style="list-style-type: none"> •Use evaluation findings to provide feedback to the health care system and providers in order to: (1) inform them of gaps and needs; and (2) work collaboratively to problem-solve and identify a range of solutions. 	<ul style="list-style-type: none"> •Evaluate programs using outcome measures to continuously assess and reassess organizational infrastructure, community resources, and patient self-management resources to identify challenges and solutions. •Use evaluation findings to provide feedback to the patient, health care system, providers, and

	evaluation findings to identify problems, gaps, needs, and solutions					the community in order to inform them of gaps and needs. •Work collaboratively to solve problems and identify a range of solutions.
	Community Resources and Policies	Organizational Leadership	Patient Self-Management Support	Delivery System Design: Services, Programs, Systems, and Procedures	Decision Support: Information and Training for Providers	Clinical Information Systems: Collecting and Tracking Information
EXAMPLES	<ul style="list-style-type: none"> •Conduct an inventory of education programs, clinical services, third-party resources, and providers. •Conduct an inventory of community fitness resources and activity 	<ul style="list-style-type: none"> •Allocate staff time or dedicate a position for case management. •Monitor outcomes such as diabetes prevention, blood glucose control, blood pressure control, standards of care, health care service 	<ul style="list-style-type: none"> •Identify fitness resources and community activity programs. •Assess health behaviors, knowledge, and practices within the community. 	<ul style="list-style-type: none"> •Use materials from the IHS Integrated Diabetes Education Recognition Program (IDERP) to help develop a diabetes team. •Identify the roles and responsibilities for members of the diabetes 	<ul style="list-style-type: none"> •Use <i>IHS Standards of Care for Patients with Type 2 Diabetes</i>. •Use staged diabetes management practice guidelines. •Use diabetes curricula, such as the 	<ul style="list-style-type: none"> •Develop diabetes, case management, and kidney disease registries. •Ensure that case managers have access to clinical registries and patient medical records within

	programs.	utilization, and cost control.		<p>team.</p> <ul style="list-style-type: none"> •Use practice guidelines and standing orders. •Appoint a liaison or an on-call provider for the case manager to contact to discuss patient needs when the primary care provider is unavailable. 	<p>Diabetes Prevention Program (DPP) curriculum or the IHS Balancing Your Life and Diabetes curriculum.</p> <ul style="list-style-type: none"> •Use peer leaders and program champions who can support case managers. •Publicly market the role of standards of care and case management. 	<p>systems utilizing appropriate privacy protections per regulations.</p> <ul style="list-style-type: none"> •Use the Diabetes Management System, Diabetes Patient Care Summary, and diabetes audits for collecting and tracking information. <p>Action! See Part 3 – Appendix G. for tracking sheet.</p> <ul style="list-style-type: none"> •Use reminder systems.
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Tools and Resources

Web Resources

- Community Guide. This website provides information on diabetes case management interventions.
 - <http://thecommunityguide.org/diabetes/>
- IHS Division of Diabetes Treatment and Prevention.
 - <http://www.ihs.gov/medicalprograms/diabetes/index.asp>
- IHS Diabetes Education Curricula
 - <http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=toolsCurricula>
 - Balancing Your Life and Diabetes Curriculum
 - Balancing Your Food Choices: Nutrition and Diabetes
 - http://www.nhlbi.nih.gov/health/public/heart/other/amer-indian_risk/index.htm
 - Honoring the Gift of Heart Health
- Case Management Society of America
 - <http://www.cmsa.org>
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Area Diabetes Consultants website:

<http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=peopleADC>

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