**CASE MANAGEMENT GUIDELINES**

**Case Management Guidelines**

Northwest Washington Indian Health Board

**Northwest Washington Indian Board Healthy Heart Project**

The Core Element of “Case Management” of program participants is the foundation of the Healthy Heart Project (HHP). The protocol for the CVD Risk Reduction Projects describes this Core Element as having 2 components: individual case management/self management and disease management. While both of these types of management can be achieved and followed with the monthly Case Management visit, we want to make sure that all case managers are following similar formats to assure a continuity of care for all of our HHP participants.

These guidelines are developed with the idea that CMs are coming from many different professional backgrounds (nursing, medicine, pharmacy, nutritionist, education, dieticians) and we all have our specialties. This will be a strength in the type of service we give our participants. However, to make sure all of our participants are being provided the same minimal type of service and the same educational message, and we will consider exchanging ideas with all CMs. We will continually try to improve the support we can give our participants by striving to make healthy lifestyle changes in their lives.

**Role of Case Manager:**

As stated in the Core Elements, the CM visit will provide participants with the different types of services: bridge between the individual and their health care provider, coach, encourager and support to self manage their diabetes and adopt permanent lifestyle habits to improve their health.

1. Individual Case Management/Self Management:
   1. Assessment of needs based on initial baseline assessment; develop an individualized care plan to attain their measurable/non measurable goals and documentation of care in personal medical record/HHP record.
   2. Education for participants will include: reinforcement of self monitoring, education on nutrition/healthy food choices, healthy portions, types of exercise/activity, medication compliance, smoking cessation (if appropriate), stress management, setting treatment plans and encouragement to meet their goals.
   3. Assessment for motivation to change and evaluation of what stage of change participant is at: pre-contemplation, contemplation, preparation, action, maintenance.
2. Disease Management:
   1. Includes tracking the measurements and lab values for HHP treatment goals the participants will be required to obtain on a regular monthly schedule: blood pressure, Weight, Random BS, A1C and Lipid panels.
   2. Indicate any medication changes, additions, or deletions for the patients.

Given these requirements, the relationship that builds between CM and participant is a unique blend of clinician, coach and supporter. While the monthly visit is a chance to review any recent labs or measurement to monitor the participant’s progress with the HHP goals, it is also a chance to address any personal goals the participants has or barriers to addressed in preventing participants meeting their personal goals or project goals. Personal goals may include changes with food choices, daily activity level, medication use, self glucose monitoring, smoking cessation and stress management. During this review, barriers each individual faces will be addressed with their CM. CM may access other resources to prevent participants in reaching their personal/program goals.

When a participant decides to join the HHP, they are making a choice to move in the direction of making changes in their life that will help them control their diabetes and prevent heart disease. This is not an easy task and it is with the support of the CM and time that changes can be made. The difference between what they may have tried before in the past with their independent providers has proven the need for additional support for the participants. Participants through this project can rely on the HHP staff for support and provide direction in making lifestyle changes. Through the HHP, intensive CM will support participants by closely tracking their progress and will provide participants and their medical providers with a monthly update of the participant’s progress.

The HHP not only gives the project an opportunity to support the current health care system, but augments the services being offered to our participants.

**Definition of Case Management:**

What is CM? There are many answers to that question, depending on who you speak to. However, for our program we will define it as “a process of managing care that involves assessing, planning, facilitation of care and advocacy for services for a patient and/or their family” (from the Case Management Society of America, 2006).

**How are participants assigned to a CM?**

A participant is recruited individually by a CM; CM will set up a scheduled time to have participants sign: consent, HIPAA & complete baseline questionnaire/assessment. Once Baseline Assessment/PE is completed with participants’ primary care provider, they will then need to have their first CM visit within 2 weeks. CM will be responsible for completing the Baseline Assessment forms after primary care provider performs the PE. Once forms are completed, forms will then be given to the Data Coordinator for evaluation of completion.

Assigning of participants to CM will be based on the site, caseload & at the discretion of each CM and Project Coordinator.

**CASE MANAGEMENT VISITS**

**First Visit:**

Probably the longest visit you have with the participant (45-90 minutes). It’s important to try and communicate the project goals/participant responsibility during this visit. Participant prior to this visit needs to agree to project participation:

* Review what the HHP is, what our 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?”
* Assess the patient knowledge level of the following items (this may take more than one visit):
  1. Basic diabetes disease process and understanding
  2. diabetes affect on the heart
  3. basic information of what heart disease is
  4. understanding of healthy nutrition, exercise/activity, smoking, stress management
  5. what cholesterol, triglycerides, glucose, BMI/weight are and their affect on diabetes and the heart
* Assess the motivational level of the patient to make changes in their life (stages of change)– where are they at in terms of willingness to make changes, changes they have tried to make before. Assess their understanding of what their past experiences have been with diabetes or what they have seen as success/failure in people they know about controlling diabetes
* If family is present, encourage them to participate in the discussion and assess their knowledge level and level of support, and experience has been with diabetes.

Once you have an idea of their knowledge level and motivational level, review these points:

* Stress to the participant that we are not going to just tell them what they HAVE to do about their diabetes and heart disease prevention.
* We are here to provide them with information/education about how they can manage their diabetes to prevent heart disease and we are to support them to start making the changes they know they need to make to live healthier with diabetes.
* Communicating your respect for their choices, whatever they may be, is important in building trust. We just want to make sure they have the most correct information available so they can make informed choices.
* Review most recent measurements and lab results: make sure you ask them if anyone has ever explained what cholesterol is, how blood pressure affects their heart, what triglycerides are, what BMI is, etc. (many have not and do not know what they are or the role they play in their health).
* It’s important that they understand WHY we are measuring the labs and measurements we are – why is cholesterol, triglycerides, A1C, BP and weight/BMI important for achieving heart health and better management of their diabetes. .
* Blood pressure – needs to be taken at each CM Visit (per Core Elements).
* Explain that we can adjust and change their medications much quicker to help manage their blood sugar and cholesterol levels by doing these assessments.
* Identify what type of family support each participant has – ask them directly how they feel their family may react to their changes. Encourage them to bring any family member to their CM Visit in the future to support them with their changes.

**Short Term Goal Setting:**

Each month, reevaluate short-term and long-term goals. Give the participant a copy before they a copy of whatever goals you collectively decide on so they have something to look at between CM Visits:

* Short term goals for month:
  + Areas to complete: activity, eating healthy, medications, tobacco use, blood sugar checks, other (as needed)
  + Complete each area at each visit. The participant may decide they may want to skip a goal section this month, which is perfectly ok, but will need to be addressed at next visit.
  + Remember small goals mean small success every month and will have a higher chance of them making permanent changes and help increase their confidence..

For subsequent visits, be sure to write down what goals they did accomplish from the previous month so they can remember goals they have succeeded on. At the next visit, you will be reviewing this same document with them to see what they accomplished during that month.

**Other Areas to Cover:**

Pt Education:

Areas to cover during your CM Visits depend upon the participant’s level of knowledge that you have assessed at Baseline Assessment, which will give you as the CM a starting place:

* Keep it simple – letting them direct the discussion during the visit will frequently give you the opportunity to identify the area of education and focus of your visit. .
* Topics to try and cover during different visits can be found in the Healthy Heart Curriculum: What is heart disease, What are the different lab values, Heart healthy nutrition, Healthy food choices, What are healthy portions, How to get exercising/types of activity (focus on movement) each day, Tobacco cessation, Stress management, What are complication of heart disease (heart attack/stroke), and fitness center services/classes.

There are educational materials to utilize, including the handouts from the Gift of Heart Health curriculum (HGHH). Please be sure to review whatever literature you give the patients (highlight areas with a highlighter for them) and not just hand it to them. This increases the likelihood they may actually refer to it after they leave here and not just throw it away.

There are also teaching models (clogged artery, posters, and Education boards) to utilize during educational session. Using visuals with your participants will help tremendously.

Medication Adjustments:

Medication adjustments consult with the participants Provider or pharmacist for support.

For Case Managers without prescriptive authority:

* Identify if lab draws are needed - consult with HHP Provider who is tracking lab values on participants. Evaluate if there are any changes the MD will want to make and discuss those with your participants.
* A1C can be taken every 12 weeks (or every 6 weeks if being closely monitored)
* Lipids (LDL, HDL, Triglycerides to be taken every 6-12 weeks)
* If labs are ordered, notify participant and stamp labs/complete labs per site and direct participants where to go. Instruct patient on a fasting lab(12 hours no food is the best)
* Measurements (BP/Weight) are needed, take them during each case management visit
* Review results of lab/measurements with HHP Provider to determine any medication changes recommended and request medications in participants’ medical record.
* At next case management with participant, review results, recommendations by provider. If participant needs additional counseling or has additional questions regarding medications, refer them to their provider or address concerns to provider as we have access to them if there are concerns.
* Be sure to emphasize the continued importance of continued lifestyle changes even though medications are being adjusted.
* If the participant agrees to the medication change, refer them to Pharmacy to pick up the medications.
* Be sure to document the interaction in medical record, so if the participants is seen by their provider, there will be clear communication of the change made

**Referrals:**

The following areas may be appropriate for services to refer for support:

* Fitness Center – if interested in seeing someone before going down there, refer them to Lenae Sisco, Lead Case Manager/Fitness Specialist.
* Give list of health classes available in each of the participating communities
* Refer to pharmacy for any med questions per site or inform participant of your findings after consulting with provider & pharmacist.
* Other referrals (as necessary): Counseling, DM Dept (supplies), Social Worker
* Always schedule next case management & document each visit in the participant file folder & medical chart.

Follow-up between CM Visits:

Studies on successful case management services have shown that the closer the follow-up and relationship between CM and patient, 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 pt to call in 2 weeks for f/u.
* Inform of retention activities: incentive gifts, newsletters, quarterly get-togethers, motivational speakers if presenting, classes or community gatherings.

To develop a long-standing relationship with the participant and their family is going to be the backbone of support for the participant to choose to be active in their care plan and development of their personal goals, will improve clinical outcomes for the participant and the project and most importantly for the individual who controls their diabetes and prevents heart disease.

You are advocating for the participant with any interaction you have on their behalf.

Gift of Heart Health Curriculum

* 10 session regarding Native American healthy heart education
* Use Sessions as they pertain to your participant.
* Review the corresponding handouts for each Session as they are great handouts to review with participants.
* Consider using the highlighted options of each session for your case management visit.

Each subsequent visit:

* Refer to First Visit guidelines
* 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
* Take BP, Weight, and RBS at each visit
* Review new subject material for the participant at each visit.
  + Although you can follow the HGHH curriculum schedule for participants visit, you may want to tailor your visit focus to what the participant is currently trying to work on, or a specific question they might have.
  + If you are searching for something new, ask the participant what materials they feel they would need for their families and for their own use.

Location of Case Management visit:

The flexibility you offer the participant to make their case management visit is going to be crucial to their ability in participating with the project. Offering early morning or after work hour appointments, visit at the clinic sites or at their home all provide the flexibility unique to the HHP and can not be found in any other outpatient services available.

**DOCUMENTATION**

Documentation Medical File/HHP folder:

All documentation for case management visits will be made in the progress notes, or “Notes” section of your visit in the medical file/HHP file. There will be a current “HHP Case Management” template that will be available for you to use when you document your visits. Please indicate different types of notes to select: consult, CM visit, chart review, telephone call or home visit (06, 77, 52). Please review your coding sheet for your visit.

When documenting, please be sure to select the appropriate patient education provided to the patient during your CM visit. Some suggested primary patient education codes to use are:

* Coronary artery disease (the closest to heart disease that we have)
* Diabetes Mellitus (not the Diabetes Curriculum Education)
* Dyslipidemia
* Hypertension
* Obesity

Sub codes to utilize would be: exercise, nutrition, home management, patient literature, prevention, disease process, complications, lifestyle adaptations, etc. If unsure, please make sure to check the “Display Outcome and Standard” to make sure you are meeting the requirements.

**Reminders**

Keeping the atmosphere of the case management visit as positive and supportive as possible and it will go a long way to retaining our participants in the HHP.

Planning goals:

* Set a goal that is attainable and realistic. If the participants states, “I want to loose 5 lbs this month” ask them how they want to loose that weight and document the specific actions (walking every day for 30 minutes, eating less candy and pop, etc.)
* LISTEN! Utilize the luxury of time you have with the participant. Let them talk and actively listen to what they have to say. This does not happen very often in their clinic appointments.

Motivation to make changes

Utilize motivational interviewing techniques to aim at changing behavior by addressing any difficulties the participant has in setting and meeting their behavior change goals.

* Actively listen and reflect back to the participant any barrier/challenge they may identify.
* Ask open-ended questions – no “yes/no” questions – to encourage discussion about feeling about behavior change
* Express acceptance and affirmation of where the participant is in their “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 those goals.

Utilize the Incentive gifts:

* Let the patient know what types of incentives we are hoping to provide them and how it will benefit some of the goals they maybe setting (i.e. gift cards, gas vouchers, fish oil, slow cookers, etc.)