January 2015 – The COMPASS Consortium

Annotation 5:
Personalized Treatment Plan

Upon first contact with the patient, the care team begins to establish a relationship. The relationship is pivotal in planning and implementing the personalized treatment plan. Care managers will take a lead role in this.

Communication with Patient

Ongoing contacts between the patient and care manager should always include:

- Partnership in reviewing the treatment plan to ensure patient's continued engagement in self-care
- Review of clinical targets through re-administration of the PHQ-9 and review of current lab readings (HgbA1c, SBP, LDL)
- Review of hospitalization or ED use
- Motivational interviewing and behavioral activation to facilitate patient goal setting
- Education and support for treatment adherence and review and discussion of medication (side effects, adherence, etc.)

As treatment progresses, different strategies can be employed. Here is an example of post enrollment tactics.

Engagement and Patient Partnering

Validated and reliable tools can help care managers identify and systematically assess patient's motivation and knowledge. Based on a patient's readiness/motivation, the care team can more readily identify the response that will stimulate patient engagement for a more positive course of action.

Motivational Interviewing

By using the "spirit" of motivational interviewing, the care team will use open-ended inquiry and reflective listening to elicit patient's reasons for change *(Miller and Rollnick, 2012)*. Behavioral change is rarely a discreet, single event – rather it's a process with identifiable stages. The care team should assess the patient's knowledge and health literacy to determine appropriate self-management tools and style.

Behavioral Activation and Goal Setting

Behavioral activation is a brief, structured intervention that aims to activate patients in specific ways that will increase rewarding experiences in their lives *(Martell, 2010)*. "Activity scheduling" is a straightforward behavioral intervention in which patients are taught to increase their daily involvement in pleasant activities and to increase their positive interactions with the environment *(Lewinsohn, 1973)*. This is an attractive intervention because it is simple in concept, easily taught, efficient and does not require complex skills on the part of either patient, clinician, or care manager.

The relative simplicity of encouraging patients to increase their daily participation in pleasant activities makes activity scheduling an attractive treatment approach for otherwise difficult to treat populations such as depressed dementia patients. As an example, regular outings and get-togethers, participation in a senior day care program, or participation in available

nursing home activities, are all likely to reduce depression in the elderly *(Cuijpers, 2007)*. Moreover, follow-up assessments reflected that the improvements in depression persisted after the active treatment had been discontinued *(Mazzucchelli, 2009; Cuijpers, 2007) (Excerpt taken from the ICSI Depression guideline, 2013)*.

Problem Solving Treatment in Primary Care

Problem Solving Treatment in Primary Care (PST-PC) is an effective, relevant treatment option for depression to help the patient understand the link between problems and symptoms, develop a systematic strategy for problem-solving, and engage in pleasant activities *(Arean, 2008; Hegel, 2003; Haverkamp, 2004; Malouff, 2007)*.

The goal of PST-PC is to help the patient understand the link between problems and symptoms, develop a systematic strategy for problem-solving, and engage in pleasant activities. This brief form of psychotherapy is delivered over 4-8 sessions by clinicians who have received specialized training. The first session, which is typically 60 minutes, builds the rationale for PST-PC, and collects an initial problem list. Follow-up sessions are typically 30 minutes each. Each session works through at least one problem through the following seven stages, with action between sessions: 1) clarifying and defining the problem; 2) setting a realistic and achievable goal; 3) generating multiple solutions; 4) evaluating and comparing solutions; 5) selecting a feasible and preferred solution; 6) implementing the solution; and 7) evaluating the outcome. In the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study *(Unützer, 2002)*, roughly 30% of their patients received a full course of PST-PC sessions in primary care delivered by the care manager. Primary care offices that do no have care managers trained in PST-PC should cultivate relationships with a local therapist who can provide PST-PC or other evidence-based psychotherapies for patients who are not fully responding to antidepressant medications or who prefer psychotherapy to medications. If the psychotherapy is provided outside the practice, the care manager should closely coordinate with this provider to make sure treatment is effective and patients are improving as expected.

Brief Intervention for Patients who Misuse Alcohol or Other Substances

Brief Intervention for substance misuse involves offering feedback and recommendations and assessing readiness to change. All patients who screen positive on the AUDIT for alcohol misuse and/or DAST-10 for drug misuse should have a brief intervention by the care manager. Brief interventions help to raise the patient's awareness of the risks and consequences with unhealthy substance use, help the patient set and assess specific substance use goals, and elicit the patient's internal motivation toward behavioral change.

Education and Support for Treatment Adherence

Based on the patient's health care literacy and knowledge, the primary care team and care manager will provide disease management education and support in a readiness-sensitive approach. Following evidence based guidelines and physician recommendations; the care team should identify the gaps in care with the patient. It should develop a plan of care to reduce these gaps in care and provide the patient with written information that indicates their current status as well as the goals they are trying to attain.

Coordinating Specialty Referrals and Community Resources

Collaborative care management can complement specialty care: it does not replace it. Though the SCR team makes treatment recommendations, the primary care team is still responsible for making and monitoring referrals for specialty care, such as mental health, substance abuse treatment services, and health system or community referrals for diabetes education, health education, or lifestyle classes.

The care manager will actively monitor these referrals for completion. Once a referral has been made, the care manager should routinely ask the patient if he/she is has attended the appointments. The care manager will report pertinent findings to the SCR team.

The care manager will assist the patient in connecting with self-help or support groups and other community resources (such as exercise classes), as needed, for chronic medical diseases, substance use, and/or depression.

Steps to build your medical neighborhood:

- In the practice – identify roles and responsibilities for the planned visit, addressing gaps in care, and follow-up on tests/procedures/radiology.
- In the system – establish relationships/communication process/protocols for system services (notification of admissions and discharge, report from home care, communication with system specialist, diabetes and health education, etc.).
- In the community – identify community resources for financial, social and behavioral needs. Establish relationships with key services that are significant to the population served by the practice (see below).
- In the region – establish relationships/communication process/protocols with area home health care agencies not part of the system, skilled nursing facilities, rehab facilities, outpatient services, etc.
- In the state – establish communications/protocols for services/care provided at tertiary centers within the state and out of state.
- Nationally – identify resources for national patient supports such as the rare diseases.

Comprehensive coordination of care including hospital readmissions and transitions of care

- Establish processes for admission/discharge notification (automated or manual process exist), determine whom to call with significant discharge concerns, and for complex patients determine the ability to have care conferences with the treating team.
- Complete a follow-up call within 24-48 hours of discharge. Complete a telephonic risk and safety assessment as well as complete the six-item cognitive screen. If the patient has an abnormal screen check on social support to help with taking medication and transportation to the clinic, conduct medication reconciliation, identify barriers/risk and coordinate as need is identified.

Consider establishing referral assistance for community care services and centers with a focus on the following processes

- Does the practice have a process of informing patients they are available to assist them with financial and or social services?
- Does the practice assist the patient in arranging referrals to community resources?
- Once a referral is provided, does the practice have a tracking system in place (for high risk services) to ensure the patient followed through on the referral, and the referral was able to meet their needs?
- Does the practice track and follow-up with ongoing recommendations for the community service provider?

(Excerpt taken from BlueCross BlueShield of Michigan PGIP PCMH 2012 Interpretive Guidelines)

Supporting Documents

- *SBIRT for Risky Substance Use*
- *ICSI's Adult Depression in Primary Care guideline*
- *ICSI's Diagnosis and Treatment of Hypertension guideline*
- *2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults*

- *ICSI's Preventive Services for Adults guideline*
- *BCBS PGIP PCMH 2012 Interpretive Guidelines*
- *Resources for Collaborative Depression Care Management (PIC)*
- *American College of Sports Medicines' "My Exercise Plan"*
- *Six Item Cognitive Impairment Test (6CIT)*
- *Post-Enrollment Phases of COMPASS Care Management*