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Annotation 8:
Maintenance Planning and Relapse Planning

It can be very discouraging to experience a setback or a recurrence of symptoms. However, relapse is common. Having the care manager develop a written maintenance plan with the patient is an important step in preventing this setback. A maintenance plan helps support patients in their effort to maintain healthy behaviors, identify early signs associated with poor disease control, and prevent relapse. The maintenance plan is designed to be printed out and given to the patient. It should be included it in the EMR, with a note to the patient's PCP *(McGregor, 2011)*. The local care system capabilities to manage chronic disease must also be taken into account when planning and creating the maintenance and follow-up plans.

Generally, a written maintenance plan contract between the care manager and patient includes the following steps: (1) review progress, (2) review risk factors, (3) review the rationale for continuing treatment and reinforce the patient's autonomy and motivations, (4) discuss early warning signs (such as insomnia as a prodromal symptom of depression), (5) make a maintenance plan, (6) remind the patient how the care manager and PCP can be reached, (7) reinforce messages about long-term treatment, and (8) discuss future follow-up contacts *(Unützer, 2004)*.

Caregivers, family or friends may notice the warning signs before the patient does, so it can be helpful to involve them in the monitoring process. It is also important to remind the patient that a follow-up PHQ-9 and quantity and frequency questions for alcohol and drug use (if applicable) will still be conducted at 6 and 12 months post-enrollment as part of routine care, even if the patient is no longer active in the program.

Leading up to the maintenance plan, it is important to prepare the patient for the transition into the maintenance phase by emphasizing their healthy lifestyle changes *(McGregor, 2011)*.

Complete a maintenance plan for each condition once the target for the condition has been achieved and maintained over three months. In other words, if one condition is at target and stable, but the other is not, then the care manager should complete the maintenance plan with the patient for the stable condition and continue to work with the patient for the condition that is not yet at target.

Depression

The ultimate goals of depression treatment are to achieve symptomatic remission (PHQ-9 < 5), reduce relapse and recurrence, and return to previous level of occupational and psychosocial function *(ICSI, 2013)*. It is more challenging for aging patients to reach remission despite adequate treatment, but many will at least achieve a 50% or more decrease in depression symptoms and improved functioning. After the patient has been in remission (PHQ-9 < 5) or had a 50% or more reduction in depressive symptoms for three consecutive months, the care manager initiates the maintenance plan with the patient. The maintenance plan is a document that facilitates the development of the patient's plan to maintain symptomatic remission, minimize stress, and continue self-monitoring, pleasant activities, and a healthy lifestyle.

Monthly contacts for about 6-12 months are helpful to actively monitor the patient's treatment adherence, self-management skills, and relapse of symptoms *(Unützer, 2004)*. Typically, these may occur via telephone calls, however, individual or maintenance groups may be considered. Routine follow-up is important, because relapse is common within the first six months (20-85% may relapse *[APA, 2010])* and patients with recurrent depression may not seek help from their PCP as soon as symptoms reappear. Patients who show signs of relapse during this follow-up period should be discussed in the SCR team and with the primary care team to determine next steps for intervention as clinically indicated (e.g., a PHQ-9 ≥ 10) *(McGregor, 2011)*.

When encouraging patients to stay on their treatment after their depression is in remission, the following guidelines may be considered to prevent reoccurrence of depression *(ICSI, 2012)*:

- Patients with a single episode of major depression should continue treatment for four to nine months after they achieve remission.
- Patients with a second episode of major depression should stay on the treatment for three years after they achieve remission.
- Patients with persistent depressive disorder or three or more episodes of major depression with complicating factors (e.g., rapid recurrent of episodes, over 60 years of age at onset of major depression, severe episodes, or family history) should stay on the treatment indefinitely, if appropriate.

After these recommended treatment durations, for those taking antidepressants, they can be tapered off the medication over a period of several weeks to months, if clinically appropriate *(ICSI, 2012)*. When considering these guidelines, it is helpful to keep in mind that 70% of patients with diabetes and depression have been depressed for two or more years *(Katon, 2004)*.

Diabetes and Cardiovascular Disease

Once diabetes or cardiovascular disease (e.g., SBP, HgbA1c, LDL) is at target for three months, complete the maintenance plan with the patient for the relevant condition. The same relapse prevention process, as described for above for depression, can be used to create a continued care plan for diabetes or cardiovascular disease to maintain adherence to their continued care medication, glycemic and blood pressure home monitoring, and their healthy lifestyle behaviors *(McGregor, 2011)*.

Transition is defined as the first three months after the patient's targets were met. During this phase, the contacts should be monthly. As a general guideline, the next follow-up contact could be scheduled two to three months after the maintenance plan visit and then every three to four months. Encourage the patient to monitor their blood work and complete tests to check on their diabetes control or heart disease risk about every three months *(McGregor, 2011)*. Inform the patient to call their primary care provider before changing his/her medications.

Alcohol and Other Drug Misuse

After the patient has met his/her behavior change goals and has stated that he/she feels comfortable sustaining these changes independently, the care manager may suggest that the patient create a maintenance plan to increase the likelihood that the changes will be sustained over time. The plan should include the following: reasons the patient wants to sustain these changes, activities or environments that the patient would like to avoid, behaviors and people that support them in continuing their success, ways that the patient can identify if they are getting off track, and actions they will take if they feel they are getting off track.

Care Coordination and Transitions

As part of the routine follow-up process, the care manager should continue to assist in coordinating the patient's care, including tracking and responding to transitions between care settings, such as hospitals and nursing facilities. After receiving the admission and discharge notification, the care manager should complete a follow-up call within 24-48 hours of discharge and schedule a follow-up visit with the PCP within five to seven days. Assess your current system to understand its capabilities to accept patients to COMPASS, and to transition patients back to routine care.

Supporting Documents

- *Summary of Care Letter*
- *Relapse Prevention Plan Letter*
- *Strategies for Community Coordination of Care*
- *PIC Maintenance Plan Guide*
- *PIC Maintenance Plan Template*
- *Registry Maintenance Plan Example*
- *CM Follow-Up Contact Best Practices*
- *PRHI Follow-Up Contact QI Project*