January 2015 – The COMPASS Consortium

Annotation 6:
Patient at Goal?

When the targeted conditions are at the patient's personalized goals, re-evaluate at three months (a shorter time may also be appropriate, except for HgbA1c testing). If the patient continues to be stable at three months post-target, work with the patient to create a maintenance plan and a relapse prevention plan. It is possible that a patient may be in a maintenance plan for one disease state, but in active care management for others. The care manager's contact frequency may continue to be monthly, but the follow-up of stable conditions may be less frequent, based on the maintenance plan. As patients will each respond differently to treatment, please refer to the referenced guidelines and/or your organizations guidelines for treatment duration and expected response timelines.

Care Management Phases and Follow-Up Guide

This tool provides guidance for the COMPASS team assisting a patient through the phases of care. Each system has to determine the tailoring needed within their own processes to operationalize this guide to its fullest. Above all, remember the patient is fluid and not a referral to be "handed off" to any one team member and then "given back." Communication leading up to and following each transition is critical to ensure all members of the team including the patient, are aligned with the same goals. The patient's readiness for change is a parallel aspect of this flow, and must be considered.

Active Engagement Phase *1st and 2nd contacts*	**Active Management Phase** *Weekly contacts in the first month* *Every other week during active management phase*	**Active Transition Phase** *Frequency gradually extended* *Average duration 5-18 weeks*	**Maintenance Phase** *Monthly to every 3 months* *Average duration 6-12 months*
• Determine eligibility and appropriateness • Introduce COMPASS and set the roadmap for care • Start building relationship with patient to identify preferences, strengths and challenges • Establish primary care team communication strategy, engagement plans, caseload impact and understanding of patient care needs	• Clinical prioritization, assessment of red flag risks and identify patient preferences • Establish treatment plan including both short and long term goals for optimal improvement • Purposeful care management using Motivational Interviewing, Behavioral Activation and goal setting that links treat-to-target clinical plan including med intensification with personal health goals by developing strategies for self-monitoring, treatment (including medications) adherence and problem solving skills • Shared understanding of working toward optimal maintenance of the chronic conditions and the organic but intentional process of outcome oriented care management	• Based on pt's progress with clinical and personal goals and agreement that significant improvement has been made • Less frequent contacts as an opportunity for pt to practice identifying triggers, problem solve and self-monitor • Duration may need to be variable based on patient readiness, unanticipated pitfalls and ongoing coaching needs but overall becomes longer periods of self-management success • Starting to build maintenance plan using patients own words for what has contributed to improvement and problem solve obstacles	• Patient has been practicing and more consistently demonstrating self-management including ability to identify triggers, setbacks and opportunities • Maintenance Plan has been developing along the way and patient can now articulate and complete own written plan for sustainment (example: own personal "yellow zone" and when to contact clinic when things come up and assistance is needed) • Schedule established for PCP follow-up and lab/clinical monitoring intervals • Primary care team understanding of maintenance plan including support role and routine follow-up expectations