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Acknowledgments:
This study on which the TEAMcare Program is based was supported by grants MH041739 and MH069741 from the National Institute of Mental Health Services Division, Bethesda, MD (Dr. Katon), and by institution support from Group Health Cooperative. The TEAMcare study would not have been possible without the support and participation of Group Health patients, primary care physicians, consultants and leaders. We would also like to acknowledge extraordinary efforts and expertise by Tara Beatty, MA; Malia Oliver, BA; Sue Ruedebusch, RN; Diana Griffith, RN; and Sandy Randles, RN. We also thank R. James Dudl, MD, and Kaiser Permanente Care Management Institute for providing the treat-to-target diabetes guidelines that we adapted. Last, but not least, thanks to Matthew Handley, MD; David McCulloch, MD; and Susan McDonald, RN, MN and the Group Health Quality Department for the evidence-based guidelines that helped focus the care provided.

Intervention Manual:
The TEAMcare Intervention Manual was prepared from the original research project manual by Eddie Edmondson, LICSW (Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, WA).
# Table of Contents

## Summary

1. **Introduction**  
   A. Adverse Bi-Directional Interaction Between Depression, Diabetes, and CHD  
   B. Inadequate Care  
   C. Research Evidence

2. **Overview of TEAMcare Intervention**

## TEAMcare Model

3. **The TEAMcare Team**  
   A. Patient  
   B. TEAMcare Care Manager  
   C. Primary Care Physician  
   D. TEAMcare Caseload Consultants

4. **TEAMcare Treat-to-Target Approach**

## TEAMcare Intervention Tasks

5. **Patient Visits**  
   A. Process  
   B. Engagement  
   C. First Visit  
   D. Follow-up Visits

6. **TEAMcare Care Planning: My Better Health Plan**

7. **Moving from In-person to Phone Visits**

8. **Transition to Maintenance Care**  
   A. Targets  
   B. Phone Follow-up

9. **Relapse Prevention**

10. **Returning Patient to Usual Care: TEAMcare-PCP Transition**
# Table of Contents

## Record Keeping

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Documenting Clinical Encounters</td>
<td>19</td>
</tr>
<tr>
<td>12. Tracking of Patient Outcomes</td>
<td>19</td>
</tr>
<tr>
<td>13. Weekly Team Meeting with TCM &amp; Consultant Physicians</td>
<td>19</td>
</tr>
<tr>
<td>A. TEAMcare Priorities</td>
<td>20</td>
</tr>
<tr>
<td>B. Supervision Outline</td>
<td>20</td>
</tr>
</tbody>
</table>

## Program Administration

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Considerations for the Administrator of a TEAMcare Program</td>
<td>23</td>
</tr>
<tr>
<td>A. Characteristics of the TCM</td>
<td>23</td>
</tr>
<tr>
<td>B. Caseload of the TCM</td>
<td>23</td>
</tr>
<tr>
<td>C. Location of the TCM</td>
<td>24</td>
</tr>
</tbody>
</table>

## Depression Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. TEAMcare Assessment of Depression</td>
<td>25</td>
</tr>
<tr>
<td>A. Diagnosis</td>
<td>25</td>
</tr>
<tr>
<td>B. Depression Screening Tool</td>
<td>25</td>
</tr>
<tr>
<td>C. Screening for Psychiatric Disorders in a Patient’s Family</td>
<td>25</td>
</tr>
<tr>
<td>D. Screening for Anxiety Disorders and Panic Attacks</td>
<td>26</td>
</tr>
<tr>
<td>E. Screening for Previous Depression Treatments</td>
<td>27</td>
</tr>
<tr>
<td>16. Depression Affects Other Behaviors</td>
<td>27</td>
</tr>
<tr>
<td>A. Behavioral Problems Related to Comorbid Depression</td>
<td>27</td>
</tr>
<tr>
<td>B. Biological Effects Resulting from Comorbid Depression</td>
<td>28</td>
</tr>
<tr>
<td>17. TEAMcare Treatment of Depression with Medications</td>
<td>28</td>
</tr>
<tr>
<td>A. Initiating Antidepressants</td>
<td>28</td>
</tr>
<tr>
<td>B. Antidepressant Side Effects</td>
<td>29</td>
</tr>
<tr>
<td>C. Choice of Antidepressant</td>
<td>30</td>
</tr>
<tr>
<td>D. Strategies for Overcoming Common Issues with Taking Antidepressants</td>
<td>31</td>
</tr>
</tbody>
</table>
# Table of Contents

## Medical Issues

18. TEAMcare Approach to Treating Diabetes with Medications  33

19. TEAMcare Approach to Lowering Coronary Heart Disease Risk with Medications  33

20. TEAMcare Approach to Enhancing Self-care Strategies 34
   A. Smoking Cessation 34
   B. Exercise 34
   C. Diet 35
   D. Weight 36
   E. Self-Monitoring 36
   F. Insomnia 37
   G. Pleasurable Activities 37

21. TEAMcare Approach to Enhancing Medication Adherence 38
   A. Assess Medication Routine 38
   B. Offer Complete Information About the Medication 38
   C. Discuss the Importance of the Medication 38
   D. Limit the Number of Medications 39
   E. Ways to Decrease Cost 39
   F. Simplifying Medication and Dosage Routines 39
   G. Tying Medication Administration to Daily Task 39
   H. Long-acting Medications 40
   I. Discontinuing Medications 40
   J. Medisets 40

22. TEAMcare Approach to Pain Assessment and Treatment 40
   A. Etiology of Chronic Pain 40
   B. Assessment 41
   C. TEAMcare Treatment of Pain 41

23. TEAMcare Treat-to-Target Rationale 42

## Behavioral Interventions

24. Behavior interventions 45
   A. Rationale for Behavioral Activation for Depression 45
   B. Interviews that Engage and Motivate 46
   C. Helping Patients to Change 47
   D. Helping Patients to Solve Problems (Problem Solving Treatment) 52
   E. The Seven Steps of Problem Solving 53
# Table of Contents

F. Strategies for Working with “Difficult” Patient-Provider Interactions 54

## Appendices

### Appendix 1: TEAMcare Treat-to-Target Protocol
- TEAMcare Intervention Timeline ................................................................. A-1
- TEAMcare Treat-to-Target Tools ................................................................. A-3
- Antidepressant Medications ...................................................................... A-11
- Patient Health Questionnaire (PHQ-9) ....................................................... A-13
- GAD-7 ................................................................. A-17

### Appendix 2: TEAMcare Visit Tools
- TEAMcare Visit 1 ..................................................................................... A-19
- TEAMcare Visit 2 ..................................................................................... A-21
- TEAMcare Follow-up Visits ..................................................................... A-25

### Appendix 3: My Better Health Plan
- TEAMcare My Better Health Plan .......................................................... A-29

### Appendix 4: Documentation
- Medical Record Documentation Tools .................................................. A-31
- Initial Note ......................................................................................... A-32
- Progress Note .................................................................................... A-32
- TEAMcare-PCP Transition Letter to Patient ...................................... A-34
- Maintenance Note for Patient ............................................................. A-35
- Your Relapse Prevention Note ............................................................... A-36

### Appendix 5: TEAMcare Tracking Tools
- TEAMcare Tracking Database ................................................................. A-39
- EMR Patient List Tracking Tool .......................................................... A-40

### Appendix 6: Supervision
- TEAMcare Supervision Action List ....................................................... A-41

### Appendix 7: Patient Education Materials
- Pleasant Activities Schedule ................................................................. A-43
- Patient Education Materials ................................................................. A-43
- Tools for Managing Your Chronic Diseases ......................................... A-43
Summary

1. Introduction

Disease management interventions that focus on single conditions—such as diabetes, coronary artery disease, or depression—have been shown to improve control of these chronic conditions. However, health care systems face serious challenges in being able to afford quality improvement interventions for each medical condition. Moreover, the most difficult and costly patients for medical systems often have multiple comorbid conditions. These conditions are often complicated by psychological and behavioral impairments including depression, unhealthy lifestyles, and poor adherence to medical regimens.

Over 90% of Medicare patients have more than one medical condition. These individuals with multiple conditions have greater physical disability, poorer quality of life, and increased morbidity and mortality. Among Medicare beneficiaries with common chronic illnesses, more than 95% of those with congestive heart failure, depression, or diabetes have at least another chronic condition, and the majority (80%, 71%, and 56%, respectively) have four or more chronic conditions. However, few quality improvement programs have been tested to address more than one chronic condition simultaneously.

A potentially cost-efficient way to organize services for patients with multiple disorders is to identify “natural clusters” of illnesses that are highly comorbid, have poor outcomes when they co-occur, and have similar guideline management recommendations (such as diabetes and coronary heart disease). Depression, coronary heart disease (CHD), and diabetes are three of the most common conditions seen in primary care.
A. Adverse Bi-Directional Interaction Between Depression, Diabetes and CHD

In recent years, researchers have shown there is a bidirectional link between depression, diabetes, and CHD (see figure below).

Depression early in life has been shown to be associated with adverse health behaviors, such as lack of physical activity, poor diet, development of obesity, and smoking, as well as changes in brain function. These adverse health behaviors and psychophysiologic changes associated with depression explain depression being associated with increased risk of diabetes and CHD.

Among patients with diabetes and CHD, depression is associated with higher medical symptom burden, additive functional impairment, poor adherence to self-care regimens (diet, exercise, smoking cessation, taking medications as prescribed), increased risk of
Summary

complications and mortality, and increased medical costs. Complications such as heart attack, stroke, amputation, or blindness may also provoke depressive episodes.

B. Inadequate Care

Only about 50% of patients with comorbid depression and diabetes and/or CHD have their depression accurately diagnosed in primary care. Of those who are diagnosed, only about half receive guideline-level pharmacotherapy or psychotherapy. Few of these patients receive specialty mental health services, and most prefer that their mental health and physical health care be integrated into one clinic system. Similarly, only about half of patients with CHD or diabetes receive guideline-level care. Only 10% of patients with diabetes have all 3 disease control targets (HbA$_1$c, LDLs, and systolic blood pressure) treated adequately so that they reach guideline-recommended levels.

Both patients and medical providers may assume that depression is an understandable consequence to complications of medical illness, losses or illnesses in loved ones, or related financial stressors. But, treatment trials have clearly shown that patients with comorbid depression and diabetes and/or heart disease can be effectively treated with both antidepressant medication and evidence-based psychotherapies. Effective depression treatment is a necessary first step to improve self-management of chronic illness. But, specific behavioral and pharmacologic interventions are often needed following or in parallel with successful depression treatment to improve patient self-care in managing chronic medical conditions.

C. Research Evidence

TEAMcare is an intervention that was developed and shown to be effective in improving the quality of both depression and medical care in patients with comorbid depression and diabetes and/or CHD. It was tested in a randomized trial in patients with depression and diabetes and/or CHD and, compared to usual care, improved depression outcomes and HbA$_1$c, LDL, and systolic blood pressure levels. Patients in the intervention arm compared to controls were significantly more likely to self monitor blood pressure and glucose levels and to have enhanced titration of medications to achieve disease control. This intervention was also associated with improved function and quality of life.
2. Overview of TEAMcare Intervention

Competing demands on primary care providers, clinical inertia (i.e., not increasing dosages of medication or changing type of medication despite poor disease control), and inadequate self-management by patients all contribute to the suboptimal outcomes of many common conditions such as depression and hypertension in primary care settings. The TEAMcare intervention is designed to overcome these challenges and achieve better outcomes among patients with multiple conditions such as diabetes, coronary heart disease and co-existing depression.

TEAMcare is an evidence-based, patient-centered approach that enhances the primary care team’s ability to provide optimal care. This intervention integrates the Chronic Care Model and Collaborative Depression Care principles and approaches to systematically provide comprehensive care for diabetes, CHD and depression simultaneously. Another key element of the TEAMcare intervention is consistent use of Treat-to-Target strategies to ensure optimal treatment intensification across the treated conditions. Treat-to-Target strategies use clinical guidelines to provide persistent medication adjustment until individualized patient goals for disease control are reached.
Summary

The core elements of the TEAMcare program include:

- evidence-based treatment guidelines for each chronic condition – diabetes, hypertension, depression and coronary heart disease
- a clinical information system
- weekly case review and supervision by physicians
- specialty consultations as needed
- continuity of care with the primary care physician and nurse care manager to enhance accountability to better outcomes

A nurse – called the TEAMcare Care Manager (TCM) – is added to the primary care team to collaborate with the patient and the primary care physician (PCP). The TCM:

- formulates an individualized health plan with specific and measurable targets
- supports patient self-management such as taking medicines and engaging in healthy lifestyle
- carries out Treat-to-Target treatment intensification through frequent, incremental, and consistent medication treatment titration steps to achieve individualized goals
- engages in weekly case review and medical supervision
- monitors clinical progress pro-actively with appropriate and timely outreach

By implementing the core elements of the TEAMcare intervention, the functioning of the primary care team is enhanced in the following ways:

- addition of a new member (nurse)
- closer attention to clinical changes based on treatment guidelines
- more frequent and effective facilitated medication adjustment
- enhanced patient self-management support
- systematic monitoring of patient outcomes
- specialty consultation for patients who do not achieve timely targets

Patients work collaboratively with the TCM and PCP to create individualized clinical and self-management goals. In structured visits in the patient’s primary care clinic every 1-3 weeks, the TCM monitors patient progress in depression (PHQ-9), HbA1c, blood pressure, LDL levels, and self-care activities (including medication adherence). Carefully developed treatment protocols guide medication adjustments for patients who do not achieve specific goals using commonly available medicines (see Appendix 1).
The TCM follows patients proactively to support changes in lifestyle and medications, and to monitor adherence and medication side effects.
3. The TEAMcare Team

The TEAMcare intervention relies on a collaborative approach between the following individuals who make up a healthcare team:

- the patient
- the TEAMcare nurse care manager (TCM)
- the patient's primary care physician (PCP)
- caseload consultants—psychiatrist, primary care physician and psychologist
- consultants as needed—diabetologist and cardiologist
**TEAMcare Model**

**A. Patient**

A patient who would be appropriate for the **TEAMcare** approach is one with:

- an ICD diagnosis of diabetes and/or coronary heart disease
- clinically significant depression (PHQ ≥ 10)
- one or more of the following parameters of poor diabetes and/or coronary heart disease control:
  - blood pressure > 140/90 mmHg
  - LDL > 130 mg/dl
  - HbA1c ≥ 8.5%

Patients must also be ambulatory, not have psychiatric diagnoses of bipolar disorder or schizophrenia, not have confusion suggestive of dementia or significant cognitive impairment, and not be in a terminal phase of medical illness.

**B. TEAMcare Care Manager (TCM)**

The TCM is a registered nurse who has experience working with patients with diabetes and/or coronary heart disease in primary care settings. Ideally the TCM has facility with lifestyle change, in-person or telephone counseling experience in disease management, and comfort using clinical data systems such as an electronic medical record (EMR) or a medical disease register.

The TCM is trained in depression management and behavioral strategies—such as motivational interviewing, behavioral activation and problem-solving. Additional training includes continuous monitoring and management of glycemic, blood pressure and lipid controls. Reinforcement of TCM education and skills training is continually integrated through weekly supervision discussions during which the care of individual patients is discussed.

**C. Primary Care Physician (PCP)**

The primary care physician works with the nurse TCM to provide continuity of health care services for their patients with chronic illnesses. Evidence-based treatment recommendations guide clinical practices. If available, a shared electronic medical record (EMR) provides the necessary clinical data and facilitates communication among
TEAMcare Model

the primary care team, consulting specialists, and the patient. In the absence of a formal integrated EMR, a database (using software such as Access) can be developed to follow patients receiving the TEAMcare intervention.

The primary care physician orders treatment changes throughout the TEAMcare intervention. Using Treat-to-Target protocols for some medicines, the PCP authorizes the TCM and the patient to make incremental dose adjustments until the desired target is reached.

D. TEAMcare Caseload Consultants

TEAMcare caseload consultants should include one or two medical professionals from primary care (internal medicine or family practice), a psychiatrist, and a psychologist or behavioral specialist.

The TEAMcare caseload consultants and the TCM should have EMR, phone, and/or e-mail access to a diabetologist and a cardiologist. These specialists can be consulted as needed—such as when a patient develops atypical insulin management regimens, when a patient needs more intensive insulin therapy, or when a patient has complex cardiac presentations.
4. TEAMcare Treat-to-Target Approach

The TEAMcare intervention applies Treat-to-Target strategies across each of the patient’s multiple conditions, physical and mental illnesses alike. Core elements of Treat-to-Target include:

- Identify specific and measurable goals (blood pressure, HbA\textsubscript{1c}, LDL, PHQ-9 score).
- Utilize Treat-to-Target clinical action steps which require consistent and persistent treatment adjustment until individualized treatment goals are reached OR a patient’s condition precludes a further adjustment. All actions or decisions not to act to change medications should also be documented.
- Support self-care, taking medicines, self-monitoring of outcomes, and healthful behaviors.
- Monitor patient progress toward reaching specified goals, by using systematic and proactive follow-up.
- Engage in regular medical supervision—weekly case reviews and treatment recommendations.

After clarifying clinical goals, the initial step should be primarily focused on improving pharmacologic management and adherence. Many patients with depression simply stop taking their diabetic or heart medications, or take them erratically. By initially focusing on depression, the patient may more quickly become hopeful and active in managing the other chronic conditions. For depression care, in addition to antidepressant medication, it is especially important for a TCM to identify pleasant activities and overcome barriers to these activities. Increasing physical activity is a common and worthwhile theme in this population; the patient and the TCM should undertake an action plan including increased physical activity for improve both physical and mental well-being. For diabetes, and coronary heart disease risk reduction, the TCM educates the patient on home self-monitoring of glucose and blood pressure. Among patients with uncontrolled diabetes, transitioning to insulin therapy provides an important area for the TCM to collaborate closely with the patient and their primary care physician.
TEAMcare Intervention Tasks

5. Patient Visits

A. Process

While the TCM may have significant past experience with chronic disease management or with problem-solving self-care issues, s/he may find the TEAMcare intervention different from “usual” nursing visits in the following ways:

- **Partnership**: These visits should be carried out as a partnership. The patient and TCM craft agendas, work plans, and next steps in a working partnership.

- **Preplanning**: Prior to each visit, the TCM should review the patient’s medical record to include:
  - all encounter notes since the last visit
  - laboratory results, including a check to see that planned tests were done
  - the PHQ-9 score from the last visit
  - review of updated care plan from the last TCM visit (see *My Better Health Plan* in Appendix 3), with attention to the action plans written at that visit
  - suggestions from TEAMcare supervisors about medication or behavioral changes to consider at the visit

- **Agenda Setting**: The TCM can incorporate a short synopsis of this pre-planning review into the health care visit agenda. This is shared with the patient at the start of a visit.
  - “My agenda this week is to check in with you to see how your Citalopram worked, and also to see how you did with this past week’s ‘care plan’. What’s on your agenda this week?”

- **Focus**: Sometimes interventions get overly focused on talking about and understanding the details of life. While this is important for building a therapeutic alliance, it may not lead to lifestyle or disease management change. In contrast, TEAMcare should be predominantly focused on action.
  - “What is needed to improve your health and mood this week?”
  - “What do you need to do in the next few days or weeks?”
  - “What do you need from me (your TCM) and your primary care team to help you achieve your goals?”

- **Targeted Printed Educational Materials**: By listening to the patient and eliciting their needs, the TCM can tailor the content of printed educational materials to meet expressed needs of the patient. These may include educational materials on managing blood glucose, blood pressure or lipids.
TEAMcare Intervention Tasks

- **Homework:** During a visit, there will inevitably be patient requests that the TCM may not be able to answer immediately. These requests become the TCM’s “homework” (i.e., issues to research prior to the next visit). Homework can help the TCM to avoid becoming distracted during a visit, yet attend to issues that are important to patients.

- **Care Planning:** Care plans should be updated at every patient visit to integrate the most recent information on medications and action plans.

- **Clear Enrollment and Discharge Criteria:**
  - Often nursing interventions are not optimized because it is unclear why a nurse and a patient are working together. For example, a PCP might say “Jean, please fix Mr. Smith’s diabetes.” In the TEAMcare intervention, specific instructions are used that include measurable parameters about what is to be done, what the expected outcome or measured metric is, when the action should take place or be completed, and what to do if there are barriers preventing the action from being carried out.
  - At the end of the working partnership, it might be difficult for the nurse to move the patient back to usual primary care. The TCM should act as a liaison between the patient and the PCP to streamline a transition back to full engagement with the PCP. See Appendix 4 for sample letters that were used in the TEAMcare study to aid with the transition back to primary care.

B. **Engagement**

To start engagement, the TCM should contact patients meeting inclusion criteria for receiving the TEAMcare intervention to set up an in-person visit. Health care systems may use automated data from electronic records to find patients, screen patients for depression with PHQ-9 and/or accept physician referrals for patients meeting the following criteria:

- uncontrolled diabetes and/or coronary heart disease
- \( \text{HbA}_1c \geq 8.5\% \), SBP > 140 mmHg, or LDL > 130 mg/dl
- co-existing major depression (PHQ-9 score of \( \geq 10 \))

Prior to the first visit, the TCM reviews the patient’s medical record. After the first visit, the TCM discusses the patient with the supervisor team, follows up with the PCP to
TEAMcare Intervention Tasks

review the intervention, discusses the patient, and identifies clinical goals and develops a care plan.

C. First Visit

During the first visit, the TCM focuses on:
- getting to know the patient
- talking about the TCM role
- discussing collaboration
- conducting a good psychiatric and social history
- getting an accurate medication list
- starting to understand the patient’s priorities regarding their chronic conditions
- reviewing the need for antidepressant medications
  - If clinically appropriate, antidepressant medications may be started or dosages titrated. This assumes appropriate collaboration with the PCP, and that consultation with the psychiatrist and primary care physician consultants are available.

It is highly recommended that the TCM utilize a semi-structured interview form to help structure the content of this first visit (see Appendix 2 for schedule and content of visit and subsequent visits).

D. Follow-up Visits (see Appendix 2)

During subsequent visits, the TCM and patient focus on:
- depression status
- antidepressant medication effect
- medication management for diabetes or coronary heart disease risk
- behavioral interventions

It is recommended that all visits be structured to be practical and action-oriented. During these visits, the TCM and patient should continually update the patient’s action plan(s), and focus on enhancing medication treatment and behavioral strategies.
6. TEAMcare Care Planning: My Better Health Plan

An important component of the working relationship between the TCM and patient is co-creating a TEAMcare care plan known to the patient as My Better Health Plan (see example below and in Appendix 3). It is patient-centered and designed to assure that:

- patient/TCM collaboration is emphasized
- behavioral strategies and lifestyle changes are consistently reviewed and updated
- collaborative self-monitoring goals for reviewing progress are clearly defined
- regular medication reconciliation results in congruence between the patient’s and the TCM’s medication lists
- the patient and the TCM have congruent, transparent, regularly-reviewed disease control goals: PHQ-9 score, HbA1c, BP, lipid levels and medication use (see Appendix 3).
- the next appointment time is included in the plan and it is printed out for the patient during the visit.

A form for My Better Health Plan: Next Step is also included in Appendix 3.
TEAMcare Intervention Tasks

My Better Health Plan: Next Step

My Health Goals: What do I want to change?

Making the Changes: How do I plan to get there?

What might get in my way?

My To Do List

Medical Followup Scheduled
7. Moving From In-person to Phone Visits

During the course of the TEAMcare intervention, in-person visits change to phone visits when:

- the collaborative TCM/patient relationship is established
- the patient is making behavioral and chronic disease progress
- the patient’s or the TCM’s schedule make an in-person visit impossible

8. Transition to Maintenance Care

A. Targets

Once targeted levels for all relevant disease parameters are achieved for at least one month, the TCM and patient should develop a Maintenance Plan (see Appendix 4 for maintenance note). This includes stress reduction behavioral goals (e.g., walking four times a week), and recommended dosage levels for medications.

B. Phone Follow-up

The TCM can then follow patients with telephone calls every 4 to 6 weeks. A PHQ-9 is completed and adherence and lab test results are reviewed. Patients showing worse depression, hyperlipidemia, hyperglycemia, or elevated blood pressure are offered more frequent in-person or phone visits.

9. Relapse Prevention

When a patient is nearing the end of the 6- to 12-month TEAMcare intervention, a Relapse Prevention Plan can be crafted. This plan is designed to help the patient identify early symptoms associated with poor disease control. The patient then makes plans for “getting back on track” should disease parameters fall out of range (see Appendix 4 for relapse prevention note). This relapse prevention note is printed out and given to the patient.
10. Returning Patient to Usual Care: TEAMcare-PCP Transition

At the end of the intervention, notes are written to the PCP describing the patient’s initial and ending clinical status and self-care plans. A copy of the *Relapse Prevention Plan* should be included in the patient’s medical record. If an EMR is available, the *Relapse Prevention Plan* should be included in the patient teaching section. (See Appendix 4 for templates of the initial note, progress note, maintenance note, and relapse prevention note.)

This transition can often be a difficult one for both the patient and the TCM. The quality of this TEAMcare partnership is often rich and life-changing for patients. Therefore, it is important to adequately prepare for this transition. This is not only to exchange information, but also to appropriately deal with emotional aspects of the transition by using supportive counseling approaches during the last few sessions. For the patient, the TCM should discuss this transition with the patient several times before the last contact, emphasize the positive changes the patient has made, remind the patient of what they have learned, and encourage them to continue this dialogue with their PCP. For the TCM, it is important to acknowledge the help they have given the patient, realize that the patient will continue their care, and appreciate that the TCM can now help other patients.
TEAMcare Intervention Tasks
11. Documenting Clinical Encounters

Brief documentation summarizing clinical and medical status, medication or laboratory orders written, and patient plans should be included in the patient’s medical chart/EMR. Medication titration orders can be copied to the PCP for their signature. Notes could be copied to the PCP with a cover note if the TCM feels there is a need for the PCP review and “sign off” that they have read the note. Automated template notes can be created to streamline documentation (see Appendix 4 for examples of scripts for these notes). These recommendations may require discussions and approval of the appropriate administrators of the health organization.

12. Tracking of Patient Outcomes

The following patient outcomes should be actively tracked in the patient’s medical record:

- HbA$_{1c}$ and date when last test was done
- Average weekly blood glucose
- LDL and date when last test was done
- Clinic-derived blood pressure and home blood pressure
- PHQ-9 score

Because not all of these measures can be tracked in EMR patient tracking systems, organizations can rely on Access or similar databases that can be created for the TEAMcare intervention relatively quickly. “Mock-ups” of the EMR and Access database tracking systems are shown in Appendix 5.

13. Weekly Team Meetings with TCM and Consultant Physicians

For the TCM, the weekly caseload review team sessions with the psychiatrist and family doctor or internist are a big change from previous practices. It is useful for the TCM and physician consultants to have open discussions about the process of the supervision.
Record Keeping

sessions, particularly to agree about expectations of everyone’s roles during the sessions. It is recommended that the TCM have continual access by phone, e-mail, or face-to-face with a psychologist for suggestions on helping patients with non-adherence or other behavioral issues. While the initial team sessions may be overwhelming to all parties involved, the collaborating team typically develops a style that facilitates non-threatening and efficient supervision, with a high likelihood of leading to behavioral change in the team’s patients.

**A clinical summary sheet of patient progress in each of the diabetes, depression, and CHD outcomes is prepared weekly for the TCM’s caseload, based on medical record data (see Appendix 5).**

A. **Team Meeting Priorities**

Each week, the TCM should discuss their patients with the TEAMcare physician consultants. While this can be done by telephone or via the web, there are many advantages to working in-person. This is particularly true if there are several TCMs sharing a caseload; they can learn from hearing about each other’s cases. The priorities for supervision sessions should be as follows:

1) Newly enrolled patients, including a review of the medical chart/EMR with a focus on depression and chronic disease risk
2) Patients with poor disease control
3) Patients who have not been successfully contacted for a defined number of days
4) Patients who are a concern to the TCM or to the physician consultants
5) Patients who present relationship challenges to the TCM
6) Patients with PCPs who are more challenging to work with for the TCM

B. **Supervision Outline**

For each patient discussed, the following questions are systematically answered.

1) What are the current outcomes versus targets in *My Better Health Plan.*
   - HbA\textsubscript{1c}
   - SBP
   - PHQ-9
   - LDL
Record Keeping

2) What self-care is the patient doing?
   o Taking medicines (name, dose, frequency)
   o Self-monitoring (blood pressure, glucose or weight)
   o Physical activity or nutrition
   o Pleasant activities, especially for depressed patients

3) Have Treat-to-Target goals been reached?
   o Adjust treatment—be persistent, make it individualized, and document reasons.
   o If no adjustment is planned, document the reasons.

4) What are the dates of the pro-active follow-up activities?
   o Patients monitor progress, with glucometers and home blood pressure cuffs, and email or leave telephone message about results
   o Labs or eye exams that need to be completed before follow-up
   o Schedule next contact before ending visit

The TCM should meet weekly with caseload consultants, including a psychiatrist, a primary care physician (family doctor or internist), and a psychologist to review new cases and patient progress (behavioral and chronic disease control measures). The consulting physicians recommend initial choices and changes in medications tailored to patient history and clinical response. Recommendations about starting medications or changing medications are then brought to the patient’s primary care physician for approval. In addition to the data tracking tools, a TEAMcare Supervision Action List can be used to ensure that all patients receive interventions discussed by the team and that the plans discussed are easier for the TCM to remember. This tool is included in Appendix 6.

Weekly team meetings also offer a time to review aspects of behavioral intervention, relationship strategies, depression care, and diabetes or coronary heart disease management.
Program Administration

14. Considerations for the Administrator of a TEAMcare Program

A. Characteristics of the TCM

There are several characteristics that help a person to succeed in the TCM role. Having ample experience working in various clinical settings, as well as flexibility in working with patients and other clinicians, is a good foundation. Other important characteristics of clinical staff for the TCM role are:

- Passion for working with people and, particularly, passion for working with people with chronic conditions
- Experience working collaboratively with patients, rather than “educating” them
- Comfort working with patients whose problems cannot be “fixed,” but must be strategically approached over time
- Ability to learn new medical and behavioral algorithms
- Flexibility to let go of being “in charge” of a patient
- Intent to allow a patient to eventually move back to usual care once they have successfully met their clinical goals

B. Caseload of the TCM

The caseload of the TCM should remain relatively low. Approximately 35-50 patients for a half-time TCM will ensure ongoing, high quality care. These caseload numbers may be influenced by the need:

- to commute between several clinics that may be separated by considerable distance
- to be in a central location for weekly team meetings that may not necessarily be in the same area as clinics
- to potentially document TEAMcare intervention visits in two systems (i.e., the main clinic medical chart/EMR and the intervention database)

Depending on the intervention setting, feasible variations may be appropriate:

- intervention visits done over the telephone
- manage visits in one or two close geographical locations
- documentation might be managed in one system
- team meetings can occur by Skype or telephone
Program Administration

C. Location of the TCM

An office for the TCM located in the patients’ primary care clinic is essential. It ensures efficient collaboration with the PCP and the primary care team, as well as facilitating a better understanding by the PCP of the ongoing, integrated work that the TCM is doing. It is important for the TCM to be located in an office with a door to ensure confidentiality and to reduce competing demands that are common in clinical settings. This helps the TCM to remain focused on his or her work with the patient.
15. **TEAMcare Assessment of Depression**

**A. Diagnosis**

Developing an accurate diagnosis of major depression and dysthymia during a brief primary care visit can be a challenge. The key indicators for a diagnosis are:

- Suspicion of its presence [due to a prevalence of up to 20% in a chronically-ill population]
- Knowledge of its usual presentations
- Use of an appropriate screening tool

The TCM should use a semi-structured interview form to go over key clinical questions in the first intervention visit (see Appendix 2, *TEAMcare Visit 1: Depression and Chronic Disease Assessment and Care Plan*).

**B. Depression Screening Tool**

In the **TEAMcare** intervention, the PHQ-9 should be used during every visit to track depression status. This helps to guide antidepressant medication and behavioral interventions (see Appendix 1). Scores on the tool range from 0 to 27. Patients with scores ≥ 10 are considered to have a high risk of major depression and/or dysthymia. During the first visit, after obtaining a PHQ-9 score, patients should be asked how long they have had symptoms of depression and/or when they last felt “well” (non-depressed). In populations of patients with multiple chronic conditions, it is not uncommon for the majority to have chronic depression. In the **TEAMcare** study, for example, over 70% of patients had been depressed for more than two years (thus meeting the additional diagnostic criteria for dysthymia).

**C. Screening for Psychiatric Disorders in a Patient’s Family**

A family history of psychiatric disorders suggests that depression could be more complex to treat and may require longer treatment. Patients should be asked whether first-degree relatives have had depression, drug or alcohol problems, anxiety problems, bipolar disorder, hallucinations, or if they have attempted or completed suicide (see Appendix 2).
D. Screening for Anxiety Disorders and Panic Attacks

Screening for anxiety disorders and panic attacks should be performed during the first TEAMcare visit. The GAD-7 is a screening tool that has been developed to screen for four anxiety disorders: Post Traumatic Stress Disorder, Panic Disorder, Generalized Anxiety Disorder, and Social Phobia. A score of \( \geq 10 \) indicates a high probability of one or more of these disorders (see Appendix 1 for GAD-7).

Patients with undiagnosed anxiety disorders or panic attacks can have an exacerbation of anxiety symptoms if an antidepressant is started at therapeutic dose or if an antidepressant like buproprion is used. If patients screen positive on the GAD-7, they should be asked the following questions to screen for panic disorder.

- Did you ever have a time when all of a sudden you felt frightened, anxious or very uneasy?
- Did you ever have a time when for no reason your heart began to race, you felt faint or nauseous, or couldn’t catch your breath?

If the patient answered yes to either question, they should be asked the follow-up question:

- Did you ever have a time when \textit{all of a sudden} you felt:
  - chest pain or discomfort
  - chills or hot flashes
  - feeling “outside of yourself”
  - sudden fear of dying
  - fear of losing control or going crazy
  - dizzy, unsteady, lightheaded or faint
  - like you were choking
  - nausea or abdominal fullness
  - palpations
  - pounding heart or fast heart rate
  - numbness or tingling sensations
  - shortness of breath
  - sweating,
  - trembling or shaking
Depression Information

Answering “yes” to more than 4 of 14 of these symptoms suggests the presence of a panic disorder. Patients with suspected panic disorder should be discussed with the consulting psychiatrist before starting or increasing the dosage of a patient’s planned antidepressant. SSRIs are effective treatments for both panic disorder and depression, but patients with comorbid panic should be started on lower dosages initially.

E. Screening for Previous Depression Treatments

The TCM should also screen for current and/or previous use of antidepressants, experience with psychotherapy, and the patient’s sense of how well these treatments worked. For a patient already receiving some kind of depression treatment, their TEAMcare intervention may vary considerably. Some may be taking less than a therapeutic dose of medication; others may be on medication regimens that are not effective. Regardless, most patients are usually willing to try antidepressants or a change in their medications – after a thorough discussion about the expected benefits, as well as potential side effects, of these treatments.

16. Depression Affects Other Behaviors

Comorbid depression often reduces a patient’s ability to self-manage other medical conditions. There are both behavioral problems and biological effects associated with depression.

A. Behavioral Problems Related to Comorbid Depression

- Assume a depressed patient is experiencing “lack of control” of some aspects of self-management or outcomes – resulting in frustration, bewilderment or resignation.
- Assess for understanding of the bidirectional link between stress and suboptimal disease self-management and outcomes.
- Assess if a feeling of “helplessness” or “giving up” is present. If so, identify any associated patterns of missed appointments, high or erratic health care utilization (frequent missed or cancelled appointments), unhappiness with care, or inability to rely on others.
Depression Information

- Assess for associated eating concerns (emotional eating, binge eating, purging or night eating).

B. Biological Effects Resulting from Comorbid Depression

- Increased glucose levels and higher HbA1c
- Increased pain—neuropathic and generalized
- Increased weight
- Decreased exercise

17. TEAMcare Treatment of Depression with Medications (see Appendix 1)

A. Initiating Antidepressants

When starting patients on antidepressants, they need to understand that side effects can occur before the medication's therapeutic effects help them to feel better. It is helpful to draw the figure below for patients, illustrating that side effects peak in the first 1-2 weeks and then subside, whereas therapeutic effects often peak at 3-4 weeks. This figure can prevent patients from getting discouraged prematurely and discontinuing medications.
B. Antidepressant Side Effects

Short-Term Side Effects:
These occur within the first several weeks and include jitteriness, insomnia, headache, and nausea. These symptoms are usually lessened by starting antidepressants at a low dose and increasing the dose weekly. Short-term side effects usually disappear within 2-3 weeks.

Long-Term Side Effects:
- **Diarrhea** is particularly common with sertraline (Zoloft), but can occur with other SSRIs or with buproprion (Wellbutrin). Changing to a low dosage of paroxetine (Paxil) at 5-10 mg and titrating upward by 5-10 mg every 7-10 days to a dosage of 20-50 mg may help because paroxetine (Paxil) has slight anticholinergic effects.

- **Sexual dysfunction** can occur in up to one third of patients receiving selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine. It is important to ask about sexual function, since many patients with diabetes already have problematic sexual functioning. The most common sexual side effect is delayed orgasm or inability to experience orgasm. Patients can be switched or cross-tapered to buproprion SR if they experience this side effect on an SSRI. The addition of buproprion SR 100 mg twice a day or buspar 15 mg twice a day to an SSRI regimen also often alleviates sexual dysfunction.

- **Sleep problems** continue to occur in approximately 25-33% of patients despite effective SSRI treatment. For people bothered by insomnia, trazodone could be prescribed, starting at 25 mg at bedtime and increasing the dose by 25 mg increments every 5 days until insomnia is successfully treated.

- **Weight gain**, a significant problem for many people with type 2 diabetes, is worsened for 5-10% of SSRI-treated patients. Paroxetine is the SSRI that has the most weight gain associated with it. Because buproprion and fluoxetine are not associated with weight gain, these antidepressants are good first choices for overweight people.
C. Choice of Antidepressant

For patients on sub-therapeutic doses of antidepressants, the first treatment action step is to titrate up the antidepressant dosage. All titrations should be done slowly, on a weekly basis, until PHQ-9 score goals are achieved: either < 5 or a decrease of half the baseline total score. Appendix 1 describes initial and therapeutic dosages of antidepressants.

For patients who have never taken antidepressants, citalopram or buproprion SR are good first-line antidepressant choices. Initiation and titration are shown in the schematic below. These medications were used as first-line antidepressants in the TEAMcare randomized controlled trial.

Patients who have tried one SSRI unsuccessfully in the past can be switched to either a second SSRI, buproprion SR, or venlafaxine XR.
Depression Information

Patients with coexisting anxiety can usually be effectively treated by starting on citalopram or sertraline.

Patients with moderate to severe neuropathy should be treated with either venlafaxine XR, duloxetine, or buproprion SR. These medications have been shown in randomized controlled trials in non-depressed individuals to reduce neuropathic pain.

Patients with pre-existing sexual dysfunction can usually be successfully treated with buproprion SR. While other antidepressants are likely to worsen problems with sexual response, initiating treatment with buproprion SR may improve function. Adding an antidepressant such as bupropion SR or an anti-anxiety agent such as buspar to an SSRI can also help sexual function in patients with diabetes and may be viewed very positively. The TCM should work with the consulting psychiatrist when carrying out antidepressant augmentation strategies.

D. Strategies for Overcoming Common Issues with Taking Antidepressants

A variety of strategies may help patients take antidepressants, including:

- Provide rationale for use.
- Pay vigorous attention to side-effects.
- Counter demoralization, fear of dependence, and loss of control.
- Enlist family/spousal support.
- Elicit resistance and relationship to prior experience with medication.
- Identify relevant illness aspects (phobic, paranoid).
- Increase contact with brief phone check-ins.
- Give specific instructions (take regardless of symptom change, don’t stop on own).
- Use symptom scale PHQ-9 to chart progress.
Depression Information
Medical Issues

18. TEAMcare Approach to Treating Diabetes with Medications

The TEAMcare Treat-to-Target approach for medications for people with diabetes includes:

- Metformin can be titrated to goal or 2500 mg/day, if needed unless contraindicated.
- Sulfonurea agents should not be used as first line medications.
- Insulin should be initiated if oral hypoglycemic medications did not achieve goal.
  - Begin with NPH at bedtime
  - Add daytime short-acting Aspart Insulin before meals, if needed to achieve goals

  Most patients will achieve glycemic goals without complex insulin regimens.

- TEAMcare treatment protocols are included in Appendix 1.

19. TEAMcare Approach to Lowering Coronary Heart Disease Risk with Medications

The TEAMcare medication approach for lowering coronary heart disease risk includes:

- Aspirin, enteric-coated 81 mg or 325 mg per day, unless contraindicated.
- Statins should be used to achieve lipid level goals.
- A combined ACE inhibitor and diuretic (e.g., prinazide) is recommended as the first-line antihypertensive medication.
- Even if patients are recently started on other antihypertensive medications, TEAMcare supervisors may suggest medication regimes to the TCM and the PCP that are in line with TEAMcare treatment protocols.

- TEAMcare Treat-to-Target treatment protocols for lowering coronary heart disease risk are included in Appendix 1.
20. TEAMcare Approach to Enhancing Self-care Strategies

A. Smoking Cessation

When working with patients who smoke, one of the highest priority goals should be to help them quit smoking. Because frequent reminders about smoking have been shown to enhance smoking cessation, the TCM should ask about readiness to quit smoking at most visits. For example, “As we’ve discussed, my biggest worry is your smoking. Are you interested in talking about smoking today?”

If patients are interested in further discussion, the TCM can use motivation techniques (exploring ambivalence, realistic goal-setting) discussed in the Behavior Interventions section (Chapter 24) of this workbook to encourage change.

Free & Clear®, a smoking cessation program originally developed by Group Health Cooperative, was offered to patients who were interested in smoking cessation in the TEAMcare study. This program, staffed by former smokers, has good quit rates. Other programs may be available in other states or countries. Free & Clear® uses low-dose bupropion SR and varenicline as agents to help patients stop smoking. It is important to speak to patients about how both these medications increase the likelihood of smoking cessation, and that both can have varying effects on mood and anxiety. Given the patient’s antidepressant use and psychiatric profile, TEAMcare supervisors should give the TCM advice to share with the patient about these medications. It is recommended that patients tell Free & Clear® staff, or other providers or programs who would be administering similar agents, about their current antidepressant use. It is important to have patients talk with their PCP before starting one of these agents for smoking cessation.

B. Exercise

Despite the national recommendation for 30 minutes of exercise at least 5 days a week, few patients actually carry out physical activity for such duration and frequency. Patients who are this active or who approach this level of activity should receive frequent, positive verbal reinforcements—emphasizing its effect on reducing depression, decreasing disease risk, and improving health.
Medical Issues

The majority of patients have long-term patterns of relative inactivity. In general, inactive patients know they should exercise regularly, but lack confidence that they could do it regularly or cannot determine how to begin a program of regular activity. A discussion with an inactive patient, therefore, can include checking for readiness and simple, practical plans for beginning exercise. Examples of readiness questions include:

- “On a scale from 0 to 10, where 0 is not motivated at all and 10 is extremely motivated, how motivated are you right now to get more active?”
- “Why are you at a __ (number given by the patient) and not a 0?” This counterintuitive response evokes reasons why the patient may be interested and can stimulate further discussion toward action.
- “What do you think the next step is for you?”

In a similar way, the following can be asked about the patient’s confidence about exercising more frequently.

- “On a scale from 0 to 10, where 0 is not confident at all and 10 is extremely confident, how confident are you right now to get more active on a regular basis.”
- The question, “Why are you at a __ (number given by the patient) and not a 0?” will often evoke prior successes by the patient in similar endeavors—again serving to stimulate discussion about moving to action.

For patients who are interested, pedometers can help to monitor daily walking activity. Patients may want to wear the pedometer for a week to determine the average number of steps they take per day over an average week. Afterward, they may want to increase the average number of steps/day by 100 steps a day. Having a pedometer helps make the goal measurable and concrete. Patients are likely to be more active and feel proud of their increased activity, even if they do not achieve the oft-recommended goal of 10,000 steps a day.

C. Diet

Most patients treated by the TEAMcare intervention will be overweight. Most patients are well aware that they do not eat the recommended amount of vegetables, that they eat too much fat, or that they have too high an overall daily caloric food intake. Most patients will have been exposed to a variety of “diet plans,” including the American Diabetes Association diet and carbohydrate counting. The majority will have found
these structured, complex plans overwhelming. For many, initial steps in their eating strategies should be very basic—such as not eating in the late evening or substituting water for the quart of juice they may regularly drink. Emphasis should be on diet strategies that have worked in the past, choosing healthy foods, reducing portion sizes, and limiting “unimportant foods” (high fat or carbohydrate-rich foods that are not important to the patient). When more complex diet plans, like carbohydrate counting, are appropriate and acceptable to patients, the TCM can help the patient learn and live with them.

D. Weight

Weight goals chosen by overweight patients should be small (less than 10% of their body weight) in the initial stages. For example, focusing on weight loss in two-pound increments is helpful. Patients find these intermediate goals reasonable and insulin metabolism can be positively affected even by these small decreases in weight.

E. Self-Monitoring

Patients receiving the TEAMcare intervention have a variety of conditions that can be monitored at home.

Patients working to improve their blood pressure can be given home blood pressure monitors. Optimum blood pressure measurement and strategies for monitoring can be discussed with the TCM and PCP. Patients in an active phase of titration of antihypertensive medications may benefit from checking their blood pressure every morning.

Patients with diabetes should have a functioning blood glucose meter and ample strips to allow testing at the recommended frequency. Ideally, glucose meters should be downloaded into clinic computers to provide a “glucose map” to help the patient see the change in readings over time. If in a phase of titration of metformin or evening NPH, the patient can check fasting morning blood sugars. When patients are on pre-meal fast-acting insulin the TCM may recommend checking readings as much as four times a day.
Medical Issues

F. Insomnia

Many patients will have difficulty getting to sleep or staying asleep. It is recommended that strategies for insomnia begin with behavioral strategies, including recommendations about good sleep hygiene.

- Maintain a regular sleep schedule.
- Maintain the bedroom as a sleeping space and use other rooms to watch television or read.
- Skip taking naps until night-time sleep is adequate.
- Avoid evening exercise.
- Avoid stimulants like alcohol, coffee, tea, sodas, chocolate and smoking.
- Avoid over-the-counter sleep aides.
- Use prescription sleep medications when necessary for limited time periods.

The first medication to be considered if behavioral strategies do not work is trazodone. Dosage could start at 25 mg nightly as needed and increase weekly to a dose of 100 mg nightly, if needed. Trazodone is an antidepressant with strong sedative action and low dosages often restore normal sleep.

G. Pleasurable Activities

Depression can lead to an ever-narrowing circle of activity, withdrawal from social events, diminished mood, and lack of motivation and energy to try anything. The notion of doing something for fun seems foreign. Research has shown that regularly engaging in pleasurable activities is a form of behavioral activation that can lead to reduction in depression. However, one of the hardest self-care behaviors for patients to identify and participate in is engagement in pleasurable activities.

During the early visits, the TCM may want to help patients engage in pleasurable activities between visits by providing a list of pleasurable activities for them to review. They identify “fun” activities that might work for them (*Pleasant Events Schedule* is in Appendix 7). This becomes part of the care planning work for patients (i.e., identifying and planning one or more pleasurable events that would occur between TEAMcare visits). Initially, identified activities can be simple and relatively small in scope—like watching a television program with a spouse or cleaning off an area of a desk. Small goals are encouraged at first, so that patients experience success early in their participation. Over time, more formalized pleasurable activities can be planned.
21. TEAMcare Approach to Enhancing Medication Adherence

A number of strategies can be used in the TEAMcare intervention to enhance and optimize adherence to medications.

A. Assess Medication Routine

During every visit, the TCM should review medications with patients to check how often they managed to take it, to check dosage, and to discuss any concerns or problems. Simple and practical questions that can non-judgmentally determine whether patients have missed doses include:

- “I know it must be difficult to take all your medications regularly. How often do you miss taking them?”
- “Most people – even those taking the simplest medication regimens – can miss doses from time to time. How about you? How often do you miss doses of your medications?”

B. Offer Complete Information About Medications

- Generic and trade names, including spelling, of the medication
- Purpose(s) of taking the medication
- Expected duration of use
- Potential side effects
- Number of tablets, frequency, and time of dosing
- Strategies to help the patient manage to regularly take the medication with their particular schedule

C. Discuss the Importance of the Medication

Use practical, down-to-earth but evidence-driven language to discuss the expected effects of a medication. Emphasize that the patient’s PCP has ordered the medication.

- “Dr. Smith ordered this medication to help lower your blood sugar. One of the great things about metformin is that it really works to make your body use your own insulin more effectively—it works directly on the blood sugar problem you
Medical Issues

have. It will generally lower your blood sugar without giving you dangerously low blood sugars that you can get with other drugs.”

D. Limit the Number of Medications

It is not uncommon for patients to be on a half dozen or more medications. Non-adherence and side effect frequency can increase with higher numbers of medications. Whenever possible, it is helpful to consolidate medications to reduce the complexity of the medication regimen.

When possible, patients should be started on combination medications. For example, prinizide is a diuretic (HCTZ) and an ACE inhibitor in one pill. The TCM may also review the patient's medication list to see if any medications may no longer be necessary. Many geriatric patients are on multiple unnecessary medications that can cause side effects and are expensive. The cost of taking multiple medications, even for people with insurance coverage, can be high.

E. Ways to Decrease Cost

Even with insurance coverage for medications, copayments and Medicare “doughnut hole” gaps can make affording medications difficult. When patients have limited resources, the TCM can work to ensure that, whenever possible, medications are specifically ordered as generic forms and that they are ordered through a pharmacy that offers very low or no copayments.

F. Simplifying Medication and Dosage Routines

It is difficult to remember to take medications that are dosed more than twice a day or that must be taken in different ways (e.g., 30 minutes before you eat). Once a day dosing is the best way to increase adherence. The TCM should work with the PCP to make medication dosage routines as simple as possible.

G. Tying Medication Administration to Daily Task

Patients are asked to consider activities of their day that occur at times when medications are due. For some people, it is much easier to leave their blood glucose meter and metformin by their toothbrush, because morning oral care was an automatic
part of their day.

H. Long-acting Medications

If medication adherence seems unlikely, long-acting medications (e.g., metformin SE) might be chosen.

I. Discontinuing Medications

Some medications, such as antidepressants, should be tapered if they are discontinued. It is important to discuss the rationale for continuing medications once symptoms improve, and to understand negative effects that might occur with abrupt discontinuation.

J. Medisets

Patients should be educated about the benefits of medisets. For those who are interested, medisets should be provided, if possible.

22. TEAMcare Approach to Pain Assessment and Treatment

A. Etiology of Chronic Pain

Chronic pain persists beyond an acute illness or injury and usually lasts for longer than 3 months. The pain may be of neurologic origin (nerve entrapment or damage) or of musculoskeletal origin. It may arise from degenerative changes, inflammation, visceral stress, or progressive damage from cancer. Chronic pain usually has a relapsing and remitting course. It cannot usually be “cured” by a short-term regimen of typical analgesics.

There is a difference between nerve stimulation, pain (sensation received and processed by the brain), suffering, and behavioral responses to pain. A number of psychological mechanisms can enhance or suppress nerve stimulation, the degree of suffering, and pain behavior. “Secondary gain” involves positive consequences of pain such as financial or social benefit.
Medical Issues

B. Assessment

Chronic pain is common in patients with depression. Pain can be exacerbated by depression. Pain complaints can also be a way for patients to communicate psychological distress and ask for help. Patients with chronic pain often experience significant losses in their physical and social functioning. Some patients who have relied on physical activity of some form to help them cope with stress in their life lose this coping mechanism. This, in addition to other feelings of loss and guilt about their functional decline, may contribute to worsening depression. Some patients experience a vicious cycle of decreased functioning and inactivity and worsening depression, or a vicious cycle of pain, insomnia, and worsening depression.

Past history in patients with chronic pain may reveal physical abuse, a family history of chronic pain, depression, or substance abuse, or dependent personal relationships. Patients with these disorders may have a high degree of anxiety regarding their physical health and a limited capacity to express their psychological needs verbally. They can be difficult to work with and cause feelings of frustration, helplessness, and anger in their caregivers, leading to suboptimal clinical care.

C. TEAMcare Treatment of Pain

The first step in treatment involves validation of the patient’s pain. **ALL PAIN IS REAL.** Pain is a sensation we all have, but we all interpret differently.

Treatment should involve the setting and periodic review of specific goals. Goals of treatment should include:

- some degree of pain relief
- improvement of functioning (physical strength, movement, activity level, range of motion, and social functioning)
- enhancement of quality of life

Pain patients often develop a range of “pain behaviors” that can lead to serious functional limitations. For example, patients may avoid physical activity due to fear of more pain and become inactive. Pain behaviors often have to be systematically “unlearned.” An overall goal of treatment is for patients to learn skills that allow them to become active in managing their pain, rather than relying solely on the use of analgesic medications. **Physical and social reactivation** often leads to improved quality of life.
In addition to setting specific goals for pain relief and reactivation, it is important for patients to **pace themselves**. Patients often wait until they feel better and then go do everything they could not do when they were in more pain. A sudden increase in physical activity may worsen the pain. Consider using simple instruments (such as a pain rating scale and daily activity tracking tool) to keep track of pain and level of functioning.

Many patients with chronic pain have severely limited their range of physical activity and are physically “deconditioned.” A safe exercise program—with **gradual increase in frequency and intensity** and a behavioral contingency plan that rewards and Reinforces exercise—can be a very important component of the overall treatment program. For example, in osteoarthritis, non-weight-bearing exercise (warm-water pool exercise) is a very important part of pain management. Pain patients should avoid sporadic strenuous exercise.

Analgesic medications play an important role in the management of chronic pain. However, many patients with chronic pain have developed a reliance on pain medications as their only coping skill. Medications such as opioids and benzodiazepines are not usually recommended for long-term use because of their potential to cause physical dependence and physical and cognitive side effects.

The primary pain medication recommended by **TEAMcare** is sustained release acetaminophen. Sustained release (or arthritis) acetaminophen can be taken every 8 hours. Patients should not exceed 4,000 mg per day on a chronic basis. Acetaminophen has no gastrointestinal side effects, but can cause liver toxicity in overdose (especially in those with liver disease or heavy alcohol users who may have impaired liver functioning), so it is advisable to stay at lower doses in this group.

### 23. **TEAMcare Treat-to-Target Rationale**

Historically, registered nurses have helped to manage patient medications in a variety of ways. At times, nurses have been given wide latitude—such as being asked to “fix” a patient’s insulin management. This wide latitude of medication management sometimes
results in lack of clarity about treatment routines between physician, nurse and patients—often resulting in nurses practicing outside the scope of their legal licensure. However, when treatment regimens are very rigid, helping patients to titrate medications can be very time-intensive of physicians and can result in sub-therapeutic medication dosage regimens. When we began to craft tools for the TEAMcare program, we wanted to avoid these two extremes. We wanted to design medication treatment regimens that were clear and detailed enough to:

- Allow primary care physicians to review and customize the intervention to each of their patients
- Allow registered nurse care managers to titrate medications within the criteria defined by the primary care physician
- Allow patients to have consistent medication options and to have information about likely next steps
- Allow consistency of medication information throughout all our teaching materials

Our TEAMcare treatment algorithms were modeled after Kaiser Permanente Treat-to-Target protocols and were based on recommendations from Group Health evidence-based chronic condition guidelines. These materials are presented in two ways: the TEAMcare Intervention Timeline (Appendix 1) and the TEAMcare Treat-to-Target tools (Appendix 2).
Medical Issues
Behavioral Interventions

24. Behavioral Interventions

A. Rationale for Behavioral Activation for Depression

What you do affects how you feel, and vice versa. Depression can lead to restricted activity and contact with others. Many patients who are overwhelmed or depressed leave their homes less frequently. It is important to address this bidirectional link between mood and lack of activity or withdrawing from friends. Several approaches are suggested below.

- “It sounds like lately you feel like you don’t have much energy or motivation to do get things done and to take care of your health. As you know, getting yourself to feel better is not an easy thing to do, or you would have done it already!”
- “Sometimes the things you do to try to cope with depression may make you feel even worse and you get caught in a loop. So, we want you to try something different.”
- “We believe that for you to start to feel better, you must first become more active and put yourself in more positive situations. So instead of focusing on things ‘inside’ yourself (like what you’re thinking and feeling), we’ll be focusing on things ‘outside’ of yourself (like changing how you act around friends and family or coworkers, how you spend your free time, or how you approach tedious tasks).”
Behavioral Interventions

- “We’re not ignoring thoughts and feelings. However, it is difficult to feel depressed and bad about yourself if you are regularly doing activities that bring you pleasure and accomplishment.”
- “This may feel really hard for you right now, but it will become easier as positive experiences occur. You are probably questioning your ability to make changes at this time in your life, but I will help you through this process. And, we will work at a pace at which you feel comfortable.”

B. Interviews that Engage and Motivate

Welcome the patient and explain your role:
- Present the model of patient-centered care.
  - “You’re not just a collection of illnesses and symptoms.”
  - “This program is about a collaborative (team) approach to helping you feel better and more in charge of your health.”
- Define the role of TCM as care coordinator and coach. Instill hope and confidence.
  - “I’m going to stick by you.”
- Highlight the patient’s central role in treatment.
  - “You’re the boss of your health.”

When you first meet a patient, conduct a brief psychosocial assessment:
- “We will be getting to know each other more over time but, for now, what are the important things I should know about you?”
- Probe for information regarding family, living situation, jobs and hobbies, stresses and supports, as well as the patient’s perceptions of current health conditions.
- Provide feedback and brief information about test results—PHQ-9 score, HbA1c, blood pressure, etc. Describe what the results mean, what normal values are, etc.
- Assess the person’s interpretation and understanding of the information.
  - “What do you make of this information?” “What most concerns you?”

Use elicit-provide-elicit framework:
- Elicit: “What do you know about your current health conditions?”
- Provide:
- Elicit: “What have you tried in the past?”
C. Helping Patients to Change

**General Principles:**

- The capacity and potential for behavior change is within everyone.
- People are more persuaded by what they hear themselves say than by what someone tells them.
- People are more motivated to make change when it is based on their own decisions and choices, rather than an authority figure telling them what to do.
- Ambivalence is often the principal obstacle to overcome in increasing motivation.
- Motivation is often influenced by the helping style and skills of the health care professional.

**Strategies for Encouraging Behavior Change:**

1) **Introduce Yourself**
   - Open an encounter with a statement that tells the patient who you are, why you are there, and how much time you have.

2) **Set the Agenda**
   - Visits are most productive when the TCM is clear about his/her agenda and negotiates with the patient about their agenda.
     - “My agenda today is to make sure we discuss how the citalopram is working for you. What do you want to make sure we discuss?”
     - “We’ve talked about your interest in changing diet, improving blood sugar, and stopping smoking. I’m wondering if is there one in particular that you might be interested in focusing on? Or is there something else?”
     - “Smoking is the one behavior that I think you might especially want to consider changing, but what do you think?”
3) **Listen**
   - Seek to understand things from the patient’s perspective.
   - Listen with your *EARS*. Hear the tone. Hear the word choice. What don’t you hear? What is not said?
   - Listen with your *EYES*. See the non-verbal message. What is the person’s body saying?
   - Listen with your *HEART*. Listen for the person’s feelings.
     - Listen without judgment
     - Listen without interruption
     - Use attentive silence
     - Use encouragers
       - “…mm—hmm…”
       - “…I see…”
       - “…go on…”
       - “…tell me more…”
       - “…oh?”
       - “…and?”
       - “…for instance?”
       - “…really?”
       - “…what else?”
     - Summarize (reflecting back in your own words what you heard the patient say)

4) **Provide Feedback**
   - Give the facts; leave the initial interpretation to the patient.
   - Present personalized feedback in a clear, succinct, and neutral manner.
   - Elicit the patient’s response to, and interpretation of, the feedback.
     - “Your HbA1c is 10%. For adults with diabetes, a desirable level is generally something below 7% and certainly below 8%. What do you think about this result?”

5) **Explore Ambivalence**
   - Before most people are ready to make a change, they commonly feel both positive and negative about it.
Behavioral Interventions

- Begin by asking the patient the “pros” (advantages/good things) of a current behavior. These are the reasons for not changing.
  - “What are some things you like about eating high fat foods?”
  - “What are some of the reasons why you would want things to stay just the way they are?”

- Ask the patient the “cons” (disadvantages/not-so-good” things) of a current behavior. These are the reasons for changing.
  - “What are some things you don’t like about eating high fat foods?”
  - “What are some of the reasons for making a change?”

- Summarize both sides of the patient’s ambivalence. Start with the reasons for not changing, followed by the reasons for change.
  - “Let me see if I have understood what you’ve said. On the one hand you see several advantages for not following the dietary plan such as enjoying a daily ice cream cone with your grandson. And on the other hand, you see several disadvantages for not following it, such as your continued worry that your health won’t hold out long enough to see your grandson marry.”

- Ask if you “got it all.”
  - “Is that about right?”

- Ask about the next step.
  - “Where does this leave you now?”

- Ask specific, open-ended questions to elicit “change talk.”

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**The question of action or inaction, change or no change, often arises out of the process of exploring pros and cons.**

*Let the patient raise the topic of action.*

*We are most likely to change when we hear our own voice advocating change.*

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6) **Assess Readiness to Change**

- Help people to think about change.
- Show the patient a figure of a “ruler” and ask them to indicate where she/he is in relation to a particular behavior.
Behavioral Interventions

- “On a scale from 0-10, how ready are you to stop eating pizza after 10 pm?”
  - Ask specific, open-ended questions to elicit “change talk.”
  - Backwards question: “Why did you pick a 4 and not a 1?”
  - Forward question: “What would need to be different for you to move from a 3 to an 8?” “What would it take for you to move a step further?”

7) Offer Advice, Suggestions or Ideas
   - Do this with caution and care. Ideally, offer advice only in the following circumstances:
     - The patient asks for advice.
     - You ask permission to offer the advice and the patient says yes.
     - You feel professionally bound to offer advice.
     - You offer advice in a clear, succinct, and non-judgmental manner.
     - You elicit feedback.
     - “I believe there are several important things you can do for your health. One important thing is to get more physical activity. This is important because it can improve your mood and your blood sugars.”

8) Limit the Amount of Educational Materials
   - Clinicians often give patients a lot of educational materials. Their feeling that there is “lots they need to know” is not always shared by patients.
     - “They gave me lots of stuff. None of it seemed practical. Nobody helped me understand what I might do.”

9) Emphasize Freedom of Choice
   - “I strongly encourage you to take this medication. Lowering your blood pressure helps to lower your risk of a heart attack. But of course, this is your decision. What do you think?”

10) Respectfully Acknowledge Patient Decisions
    - No matter how much you want a person to do something different in his/her life, you cannot make the decision for that person. It is ultimately his/her choice.
    - This often means you have to let go of “owning” the patient’s decision.
      - “You’re the best judge of what is best for you.”
Behavioral Interventions

- “It’s ultimately your decision…”
- “Even though I see things differently, I respect your decision.”

**A paradox of change:**

*When patients feel accepted for who they are and what they do, it allows them the freedom to consider change rather than needing to defend against it.*

11) **Be a Hope Cheerleader**
   - Your belief in a patient’s ability to change can affect outcome!
   - Seek out opportunities to affirm, compliment, and reinforce the patient in a sincere way.
   - Focus on successes and efforts. Have the patient talk about his/her past and current successes.
     - “You’ve already quit smoking. That’s the most important thing you can do for your diabetes and your health. I’m really proud of you.”
   - Emphasize the many different options and pathways to change. Failure to change can be viewed as not yet having found the right approach.
     - “The average smoker takes seven tries to quit for good. Look how far you’ve come on the first try!”

12) **Facilitate Decision-Making**
   - When the patient has decided on a course of action, help him or her articulate a specific plan, including when, how, and what. The more specific the plan the better.
     - “What could you do? What are some of your ideas?”
     - “What might get in the way of making this change?”
     - “Where will your support come from?”
     - “How will you reward yourself?”

13) **Roll with Resistance**
   - In other words, don’t fight resistance.
   - It is a sign to back-up and try a new direction.
   - You may actually contribute to generating resistance by:
     - Using a judgmental or confrontational approach
Behavioral Interventions

- Assuming someone is ready for something, when in fact, they are unsure
- Discounting a person’s thoughts and feelings
- Using restrictive language ("you have to", "you must", "you can’t", "you need to")
- Letting yourself want change more than the patient

D. Helping Patients to Solve Problems (Problem Solving Treatment)

Goal:
The goal is to help the patient learn to effectively solve their own problems. Effective problem solving can help to create positive experiences, thereby increasing the patient’s confidence and feelings of self-control.

Key Aspects:
- Increase the patient’s understanding of the link between their current depressive symptoms and their current life problems.
- Increase the patient’s ability to clearly define their problems and set concrete, limited, and realistic goals.
- Teach the patient a specific, structured problem solving procedure.
- Target rumination (thinking about the misery of life or mood or health symptoms) as a behavior problem by focusing on how it affects behavior.
- Focus on current, real-life problems that are occurring now.
- Focus on establishing routines and overcoming avoidance patterns.
E. The Seven Steps of Problem Solving

1) Clarify and Define the Problem
   - Clarify, define, and break down the “mountain” of a problem into “hills”
   - Break down complex problems into smaller steps
   - Make sure the problems are clearly defined

2) Set Realistic Goals
   - Make the goals “SMART”
     - Specific
     - Measurable
     - Achievable
     - Results-oriented/Relevant
     - Timed

3) Generate Multiple Solutions
   - Brainstorm multiple solution alternatives

4) Evaluate and Compare Solutions
   - Evaluate the “pros” and “cons” of alternative solutions
5) **Select a Feasible Solution**
   - Considering the pros/cons and likelihood of completion, choose a solution

6) **Implement the Solution**
   - Identify specific steps for a plan of action

7) ** Evaluate the Outcome**
   - Review the outcome after the plan has been implemented

F. **Strategies for Working with “Difficult” Patient-Provider Interactions**

When encountering a patient that is “difficult to work with,” it is helpful to try to understand the patient’s view of themselves and view of others. It is also helpful to try to understand ways that the TCM’s style may be contributing to the difficulty. Changing our approach may help the patient become more likely to achieve better self-care and better health. One such approach is based on a conceptual model derived from attachment theory. It can help clinicians to have a more empathic understanding of behaviors such as missed appointments, treatment non-adherence, and poor collaboration.

In developing attachment theory, British psychiatrist John Bowlby proposed that all individuals incorporate early experiences with caregivers to develop cognitive “maps” of relationships. Such maps are learned methods of interacting with others throughout life, particularly at times of distress (e.g., managing a chronic illness). They influence whether individuals deem themselves worthy of care and whether others are perceived as trustworthy to provide it. Thirty years of empirical research has identified distinct relationship or “attachment” styles.

1) Two of the attachment styles (“dismissing” and “fearful”) are associated with difficulty trusting others. They are the predominant relationship styles in 48% of adult primary care patients with diabetes (36% have dismissing style and 12% have a fearful style).

   - **Dismissing Style:**
     - Also known as a “self-reliant relationship style”
Behavioral Interventions

- Develop strategies early in life in which they become highly independent
- Uncomfortable trusting others
- On the surface, they appear highly self-reliant
- Underlying core belief is that they will be rejected if they get close to another person or that other people will not be available for them

- **Fearful Style:**
  - Also known as a “cautious relationship style”
  - Initial desire for social contact at times of distress that is inhibited by fear of rejection
  - Lack of trust in relationships
  - Approach-avoidance behavior
  - Discomfort in relying on others
  - Underlying core beliefs are being hurt, rejected, or abandoned if they get close to another person

2) Secure Attachment Style
   - Comfortable depending on and are readily comforted by others
   - Also known as the “collaborative relationship style”
   - Just under one-half of patients with diabetes

3) Preoccupied Attachment Style
   - Appearance of high levels of support-seeking behavior
   - Also known as the “support-seeking relationship style”
   - Fewer than one in ten patients with diabetes.

Research has shown that patients with dismissing (self-reliant) or fearful (cautious) relationship styles missed significantly more primary care visits (by 46% and 64%, respectively), and were significantly less satisfied with care, than those with a secure (collaborative) relationship style. Patients with a cautious relationship style scheduled and missed more “same-day” primary care visits and scheduled 25% fewer preventive care visits than patients with a collaborative relationship style. Relative to patients with a collaborative relationship style, patients with a self-reliant style were more likely to be non-adherent to foot care, exercise, diet, oral hypoglycemic medication, and quitting smoking, and were 33% less adherent to exercise. Mean HbA1c level was higher for patients with a self-reliant relationship style than those with a collaborative relationship style among both type 1 and 2 patients with diabetes.
Behavioral Interventions
Appendix 1

TEAMcare Treat-to-Target Protocol

TEAMcare Intervention Timeline ........................................ A - 1
TEAMcare Treat-to-Target Tools .......................................... A - 3
Antidepressant Medications .............................................. A - 11
Patient Health Questionnaire-9 (PHQ-9) .......................... A - 13
GAD-7 .............................................................................. A - 17
Appendix 1

TEAMcare Intervention Timeline

Before “Go Live”

1) Obtain “OK” from providers @ Initial Clinic Meeting (2 months prior). TCM or Proj Mgr to obtain consents from all other providers who didn’t sign earlier.
2) If provider requests Pat. pre-screen, do ASAP after provider OK signed.
3) Survey sends patient list to TCM who orders initial labs (HbA1c, SrCr, MA, and fasting lipids done) if not done in the past 4 weeks.
4) Medical assistant completes patient visit. BP and PHQ score sent to TCM.

Week 1

Focus: Relationship building, Depression assessment, Chronic disease assessment related to depression
Intake, PHQ-9*, Tools, EMR note*, shared decision-making*, PHQ9, Tools, EMR note & My Better Health Plan

Week 2

Focus: Focused in-depth chronic disease assessment, Relationship, & Chronic Disease Depression link
PHQ9,工具, EMR note & My Better Health Plan

Week 3

Focus: Plan-specific follow-up
PHQ9, EMR note

Week 4 & every 2 weeks for 16 weeks

Focus: Plan-specific follow-up
PHQ9, EMR Study Nurse Summary cc to MD & RN (then q mo)

6 & 18 months

Follow-up

12 & 24 months

Follow-up

BP, HbA1c, fasting lipid, urine microalbuminuria
5) TCM sends staff message to provider to inform of Control Status OR follows 6 & 7 for intervention patients.
6) TCM to complete draft Care & Supervision plan prior to 1st visit.
7) Talk w/ provider prior to each visit when significant changes considered.

<table>
<thead>
<tr>
<th>Collaborative goal-setting*</th>
<th>Depression book, CD &amp; Tools My Better Health Plan</th>
<th>BG, BP, diet or exercise log and plan-specific materials &amp; My Better Health Plan</th>
<th>My Better Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>K+ &amp; SrCr initially (Lisinopril); Lipid panel &amp; K+ (statin); SrCr (metformin)</td>
<td>K+ &amp; SrCr after 2 wks (ACE) or K+ 2 wks after diuretic</td>
<td>AST if statin, then q 6 wks until @goal.</td>
<td></td>
</tr>
</tbody>
</table>

**Provider check-ins**

Check-in with provider before beginning to work with a patient and whenever new treatments are considered or if changes in outcomes occur.

**Outcome checks**

<table>
<thead>
<tr>
<th>Aspirin</th>
<th>HbA1c Fasting Lipid level Microalbumuria, Sr Creat</th>
<th>HbA1c Fasting Lipid level Microalbumuria, Sr Creat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of use discussion or inability to take by week 3.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Blood Glucose**

Mean BG and range; BG pattern @ each visit when meter brought in.

**Blood Pressure**

Home measures reported at each visit when BP interventions occurring.

**Blood Fats**

Taking medications as ordered (per EMR).

**Depression**

PHQ-9 weekly OR @ each visit. Expect PHQ score to reach <5 or decrease by 50% by week 6. Self reported symptoms, particularly sleep and anxiety.
Appendix 1

TEAMcare Treat-to-Target Tools

TEAMcare Care Manager – Primary Care Provider
Treat to Target Discussion Tool for
Treatment Enhancement Activation and Motivation (TEAM)
Depression, Diabetes and Coronary Heart Disease (CHD) Intervention

The TEAMcare Treatment Protocol and Discussion Tool

Note: This tool is based on current Group Health Cooperative (GHC) clinical guidelines, but has been written for a broader audience with systems that may differ from GHC. It does not take the place of medical orders. Changes in medication dosage are documented in the medical record and are co-signed by the PCP. All plans, interventions, and outcomes of medical care must be appropriately documented in the patient’s medical chart.

Eligibility Criteria: Patients can be included if: they are 18-80 years old, have diagnosis codes for diabetes or coronary heart disease, have at least one measure of poor disease control (LDLc > 130, BP > 140/90 or HbA1c ≥ 8.5), and meet DMS IV criteria for major depression or dysthymia.

Exclusion Criteria: Patients are excluded if their systolic BP > 200 or their diastolic BP > 115; if they have ICD 9 codes indicating alcohol or substance abuse, bipolar disorder, schizophrenia, or end-stage renal disease (dialysis); are taking antipsychotic medications or lithium; are enrolled in hospice or are living in a skilled nursing facility, or are currently managed by the Clinical Pharmacists (metformin therapy, lipid therapy or BP therapy).

1) TEAMcare Interventions for all patients include:

   _____ Order all outstanding labs
   _____ Encourage medication adherence by discussing medication’s desired effect and dosage when first ordered, by inquiring about side effects and missed doses at each visit, and encouraging the use of medication reminder tools.

   ASPIRIN:
   _____ ASA enteric coated 81 or 325 mg/day
BEHAVIORAL ACTIVATION FOR HEALTHY LIFESTYLE CHANGES:

**Nutrition:** Goal is to maintain weight or 5% weight loss initially (if overweight); progress to greater weight loss if needed and able; self-described decrease in intake of saturated fats, sweets, and salt; and a diet high in fruits, vegetables, whole grains and nonfat dairy products.

- TCM to discuss Healthy Lifestyle changes and their anticipated effects (including the importance of small amounts of weight loss on insulin action), patient interests and readiness to change, and past lifestyle efforts. Brainstorm options with patient and problem-solve ways to improve nutritional pattern. Details of this discussion are incorporated into **My Better Health Plan**.

**STEP 1:** Salt restriction; DASH, ADA, AHA, or Mediterranean diets; Weight Watchers® OR other “healthy plan” that patient has had success with in the past or is ready to try.

- TCM to discuss behavioral activation strategies, “emotional eating,” or other monitored programs (dietitian consult, Take Charge if > 20 pounds overweight, or Weight Watchers®).
- TCM to encourage use of diet diary and daily weights.

**STEP 2:** Carbohydrate counting to be considered when patient beginning on daytime insulin with Aspart given before lunch and dinner.

**Physical Activity:** Goal is to increase current activity, as able, to 30 minutes walking per day or equivalent OR

- TCM to elicit patient’s current activity level, past lifestyle change efforts, patient interests and readiness to change. Brainstorm patient options and problem-solve ways to increase physical activity. Details of this discussion incorporated into **My Better Health Plan**.

2) **Blood Pressure**

- **Goal:** BP < 130/80 or _________

  - TCM to teach home blood pressure monitoring using optimum technique and ask patient to take BP daily when titrating medications (or weekly to monthly when medication titration completed).
  - TCM to discuss indications, benefits and risks of antihypertensive therapy as well as when to call PCP Team (e.g., if dizzy or SBP < 110), and urgent care services (concerns after hours or weekends).
  - TCM to order K+ after 2 weeks if using diuretics or K+ & SrCr after 2 weeks if using ACE inhibitor.
  - If ACE inhibitor is not tolerated or patient complains of cough, TCM to use their organization’s HTN guidelines for follow-up care discussion with PCP.
  - TCM to consult with TEAMcare Specialists and PCP if starting antihypertensive medications for patients with evidence of heart failure.
Appendix 1

- If starting Beta Blocker, TCM to teach patient to check pulse. If pulse rate < 60, teach patient to hold the Beta Blocker and call PCP team.
  
  **STEP 1:**
  
  ______ Prinzide 10mg lisinopril/12.5mg HCTZ. ½ pill/day X 2 weeks; 1 pill/day for 2 weeks; 2 pills/day X 2 weeks (diabetes and no evidence of CHD) **OR**
  
  ______ Atenolol 25mg. ½ pill/day X 1 week; 1pill/day X 1 week; 2 pills/day X 1 week (CHD).

  **STEP 2:**
  
  ______ Add Atenolol 25mg. ½ pill/day X 1 week; 1pill/day X 1 week; 2 pills/day X 1 week (if not previously started) **OR**
  
  ______ Add Lisinopril 20mg. ½ pill/day X 2 weeks; 1 pill/day for 2 weeks; 2 pills/day X 2 weeks (if not already on Prinzide)

  **STEP 3:**
  
  - Consult with TEAMcare supervisors, consultants and PCP for follow-up orders if needed to bring BP to goal.

3) **Cardiac Risk Reduction**  **Goal:** LDLc < 100 **OR** ______

______ Lisinopril 20mg. ½ pill/day X 2 days; then 1 pill/day

- **Order:** K+, SrCr initially and 2 weeks after goal dose reached, then yearly.

- TCM to discuss medication adherence, side effects, and when to stop medication and call (hives or dizzy standing).

______ Simvastatin  For all patients with diabetes ≥ 55 or patients with ASCVD (peripheral arterial disease or CHD). If LDLc < 140, 20mg in pm with food. If LDLc > 140, 40 mg in pm with food.

- **Order:** lipid panel (non-fasting OK if patient unable to have fasting level drawn), K+, AST at 4 weeks, then AST every 6 weeks until reaches target, then fasting lipid panel yearly.

- TCM to discuss medication side effects, and when to stop medication and call (muscle aches). TCM to order CPK and cc chart note to PCP if simvastatin stopped due to muscle aches.

4) **gluCose**  **Goal:** Weekly average or pre-meal FBG 80-120 and HbA₁c < 6.5 **OR** _______

- TCM to discuss healthy lifestyle changes and their anticipated effects, past lifestyle efforts and assess patient interests and readiness to change. Details of this discussion incorporated into *My Better Health Plan*. 

---

**TEAMcare**

A - 5
HYPOGLYCEMIC MEDICATIONS:

- TCM to teach blood sugar monitoring technique and when to call PCP (if significant hypoglycemia symptoms, if BG < 70 or concerns) and when to call urgent care (if concerns or hypoglycemia after hours or on weekends).
- **Order:** HbA\textsubscript{1c} quarterly, SrCr

**STEP 1: Metformin**

**Indications:** Patients with type 2 diabetes who are doing the best they can with lifestyle changes and have HbA\textsubscript{1c} and BG levels that exceed targets.
- TCM to discuss side effects, their usual course and ways to manage them.

**Contraindications:** Metformin should not be prescribed if SCr > 1.5 mg/dL, creatinine clearance < 50 mL/min, age > 80, or if patient is a frail elder, abuses alcohol, has severe CHF, or has progressive liver disease.

---

**Standard Metformin Titration:** 250 mg/day with dinner X 2 days.
Then 250 mg twice daily, with breakfast and dinner, for 2–3 days.
Then 500 mg twice daily, with breakfast and dinner, for 2 weeks.
Tritrate metformin slower if GI side effects.

---

**Continued Metformin Titration:** Take 1000 mg Metformin twice daily. If patient has diarrhea when taking metformin, TCM may substitute Metformin in liquid preparation.

**STEP 2: Initiation of Late Evening Insulin**

**Indications:** Patients with type 2 diabetes who are doing the best they can with lifestyle changes, are taking full therapeutic doses of metformin and who haven’t reached target FBG or HgA\textsubscript{1c} targets.

---

**Metformin:** Continue at current dosage if appropriate and tolerated

**OR**

---

**Initiation of Late Evening Insulin:**

- Teach patient to prepare and inject NPH insulin. Discuss expected action of NPH and when to inject evening insulin (8–9 hours before usual wake-up time). Review symptoms of and treatment of hypoglycemia.
- **Stop insulin titration and discuss with PCP if:** patient has symptoms of hypoglycemia that accompany a low blood glucose level.
- Put a note in the patient’s chart to PCP if patient reaches a dose of 50 units NPH. For doses of 50 units or more, better and more predictable absorption may be achieved by having patient divide the dose and inject half in one site and half in another site.

**HS Insulin dosing** (as below) **OR**

- For patient <200lbs and FBG <200. Begin with 12 units NPH qhs
- For patient <200lbs and FBG >200. Begin with 16 units NPH qhs
Appendix 1

- For patient >200lbs and FBG <200. Begin with 20 units NPH qhs
- For patient >200lbs and FBG > 200. Begin with 30 units NPH qhs
- Increase evening NPH dose by 2 units/2 days until am FBG target reached.
- When patient reaches FBG target, encourage them to test BG at least two times pre-lunch, pre-dinner and HS in one week. These results can help determine if daytime insulin is needed.

STEP 3: Initiation of Daytime Insulin

Indications: Patients with type 2 diabetes who are doing the best they can with lifestyle changes, are taking full therapeutic doses of metformin, and are taking evening insulin doses high enough to result in target FBGs, but continue to have HbA1c and blood sugar levels that exceed targets.
- These insulin dosages are to be given in addition to maintenance HS insulin.
- TCM to encourage patient test FBG each day and prior to meals when titrating insulin or at least 4 pre-lunch, pre-dinner and before bedtime tests/week.

A) Preferred option: Aspart (Novolog) Before Lunch and Dinner

Rationale for Use: While this approach is more complex than simply adding NPH at breakfast, it may improve overall HbA1c with less weight gain and less hypoglycemia.

Requirements for Managing This Insulin Pattern:
- This dosing regime works best when the patient is willing and able to count meal carbohydrates, as this increases likelihood of getting the most accurate pre-meal Aspart dose requirement. If a patient is unable or unwilling to count carbohydrates, then the simple titration scale (below) should be used.
- Have patient report blood glucose data every 2-4 days after this insulin dosage pattern is begun to assure that titration pattern is working well.

A-1) Sophisticated Titrination of Aspart (Novolog) for the patient who’s able to CHO count. All Aspart should be taken immediately before beginning to eat a meal.
- Blood glucose 70-130: 1 u Aspart for every 15 grams of anticipated CHO intake
- Blood glucose 131-160: 1 u Aspart plus 1 unit of Aspart for every 15 grams of anticipated CHO intake
- Blood glucose 161-190: 2 u Aspart plus 1 unit of Aspart for every 15 grams of anticipated CHO intake
- Blood glucose 191-220: 3 u Aspart plus 1 unit of Aspart for every 15 grams of anticipated CHO intake
Appendix 1

- Blood glucose 221-250: 4 u Aspart plus 1 unit of Aspart for every 15 grams of anticipated CHO intake
- Blood glucose over 250: 5 u Aspart plus 1 unit of Aspart for every 15 grams of anticipated CHO intake

*** If patient is quite insulin-resistant (requires 50 u HS NPH or more), may begin Aspart dosage at 1 u per 10 grams of anticipated CHO intake.

TCM may increase pre-meal Aspart by 2 units/week as needed to reach targets.

A-2) Simple Titration of Aspart (Novolog)

- TCM to review patient’s dietary pattern (usual intake, predictability of meal times and “usual” CHO intake) and work to moderate CHO intake. Aspart insulin to be given based on pre-meal blood sugar.
- Blood glucose less than 110mg/d: no additional insulin
- Blood glucose 111-150: 1 u Aspart immediately before meal
- Blood glucose 151-200: 2 u Aspart immediately before meal
- Blood glucose 251-300: 4 u Aspart immediately before meal
- Blood glucose over 300: 5 u Aspart immediately before meal

Follow-Up Titration (if needed)
- If pre-dinner or h.s. BGs remain elevated, add an additional 2 units Aspart for every 50 mg/dL that the pre-meal BG is above 150.

B) Alternative: Daytime NPH

Indications: This insulin regime can work for patients who are unable to count CHOs or eat predictable amounts of CHOs. However, daytime NPH tends to cause weight gain and can make people hungry and hypoglycemic in the middle of the day. When taken in the a.m., the regimen usually requires that the patient does not omit or delay lunch.

Daytime NPH and Aspart (Novolog) Before Dinner

Indications: This routine can decrease the total dose of NPH needed in the a.m. and lessen the risk of mid-day hypoglycemia.

Begin dosage at one-half the h.s. dosage. Increase by 1–2 units every 2–4 days until pre-lunch BG range is within target.

If h.s. BG still exceeds target range, add sliding scale Aspart before dinner (as above).

Initial Titration of a.m. NPH: dosage equal to one-half the h.s. dosage. Increase by 1–2 units every 2–4 days until pre-lunch BG range is within target.
Appendix 1

5) Depression  
Goal: PHQ-9 < 5 OR at least 50% decrease from baseline in PHQ-9

- TCM to encourage patient to fill out PHQ-9 weekly until reaches a “steady state”, then prn.
- TCM to discuss behavioral activation methods, medication adherence strategies, rationale for initial and long-term maintenance therapy with antidepressants (e.g., don’t decrease dose or stop without checking with TCM or PCP; take regardless of symptoms), and side effects (most disappear at 2 weeks).
- TCM to contact PCP and team psychiatrist if patient has: acute suicidal symptoms, psychotic symptoms, manic symptoms, severe lack of appetite with insufficient oral intake or weight loss, suspected alcohol or drug misuse, or severe medication side effects.
- Create *My Better Health Plan* initially and update at each visit.

ANTIDEPRESSANT MEDICATION

_____ Citalopram OR Fluoxetine 10 mg/day X 1 week; then 20mg/day X 1 week. If PHQ-9 hasn’t decreased by 50% or more, increase to 30mg/day. At week 4, if PHQ-9 hasn’t decreased by 50% or more, increase to 40mg/day.

_____ If two or more negative SSRI trials or for those patients with preexisting diabetes-related sexual dysfunction, start Buproprion SR 100mg/day for 1 week; then 100mg 2X/day for a week; then 200mg in am & 100mg in pm. If PHQ-9 at 4 weeks isn’t decreased by 50%, increase dose to 200mg BID.

_____ If patient doesn’t fit above criteria, or has severe diabetic neuropathy, or has significant medical or psychiatric symptoms, antidepressant medications to be suggested by CAREteam consulting psychiatrist or PCP.

6) Smoking Cessation  
Goal: Quit

- TCM to discuss behavioral activation and supported cessation strategies.
- TCM can refer to Free and Clear® or other quit smoking programs.
# Antidepressant Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting dose</th>
<th>Usual Dose</th>
<th>Indications</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting antidepressants:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Improvement often seen in first two weeks. If not seen by 8 weeks, likely needs new agent or second agent. Check in at least weekly when starting antidepressants. 3/3 of people with depression will improve with antidepressants.</td>
</tr>
<tr>
<td><strong>Stopping antidepressants:</strong></td>
<td></td>
<td></td>
<td></td>
<td>Recurrence of depression is common. 64% of patients with depression had a recurrence 10 years after stopping their antidepressants. If patients do decide to stop their antidepressants, encourage them to talk with their PCP prior to stopping and help them understand that there are fewer problems when antidepressant dosages are tapered over a two week period.</td>
</tr>
<tr>
<td>Selective serotonin reuptake inhibitors (SSRIs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10</td>
<td>20-60</td>
<td>First line</td>
<td>Jitteriness, restlessness, agitation, increased GI distress, insomnia usually improve in 2 weeks.</td>
</tr>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>10</td>
<td>20-60</td>
<td>First line</td>
<td>Weight loss in 5-10% of patients.</td>
</tr>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>50</td>
<td>50-300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>20</td>
<td>20-60</td>
<td>Good for folks w/ diarrhea</td>
<td>Worst for orgasmic problems, can cause weight gain, has mild anticholinergic effects.</td>
</tr>
<tr>
<td>Paroxetine CR (Paxil CR)</td>
<td>25</td>
<td>25-75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>50</td>
<td>50-200</td>
<td></td>
<td>Can cause diarrhea in folks older than 75.</td>
</tr>
<tr>
<td>Dopamine-norepinephrine reuptake inhibitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bupropion SR (Wellbutrin SR) <strong>When dose &gt; 100 mg give bid.</strong></td>
<td>100</td>
<td>300-400</td>
<td>Weight gain less likely than with other agents. Sexual function may improve or not be affected. Useful for lethargic patients.</td>
<td>Check seizure history before starting.</td>
</tr>
</tbody>
</table>
### Appendix 1

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting dose</th>
<th>Usual Dose</th>
<th>Indications</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Serotonin-norepinephrine reuptake inhibitors (SNRIs)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine XR (Effexor XR)—</td>
<td>37.5, 75 &amp; 100</td>
<td>75-300</td>
<td>Effective for diabetic neuropathy.</td>
<td></td>
</tr>
<tr>
<td><strong>When dose &gt; 75 mg, give bid.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine (Cymbalta)—</td>
<td>30</td>
<td>60-120</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Serotonin modulators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trazodone (Desyrel)</td>
<td>50 25-50 (sleep)</td>
<td>75-300</td>
<td>Useful for impaired sleep with depression.</td>
<td>Doses &gt; 50 mg can cause orthostatic hypotension or (rarely) priapism.</td>
</tr>
<tr>
<td><strong>Tricyclics and tetracyclics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amitriptyline (Elavil)</td>
<td>25-50</td>
<td>100-300</td>
<td></td>
<td>Anticholinergic side effects and weight gain. Elders particularly susceptible to memory change, confusion, hallucinations, sedation and orthostatic hypotension. Contraindicated in patients with cardiac condition problems.</td>
</tr>
<tr>
<td>Amoxapine (Asendin)</td>
<td>50</td>
<td>100-400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clomipramine (Anafranil)</td>
<td>25</td>
<td>100-250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desipramine (Norpramin)</td>
<td>25-50</td>
<td>100-300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxepin (Adapin, Sinequan)</td>
<td>25-50</td>
<td>100-300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imipramine (Tofranil)</td>
<td>25-50</td>
<td>100-300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maprotiline (Ludiomil)</td>
<td>50</td>
<td>100-225</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nortriptyline (Pamelor)</td>
<td>25</td>
<td>50-200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protriptyline (Vivactil)</td>
<td>10</td>
<td>15-60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Noradrenergic and specific serotonergic antidepressant</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mirtazapine (Remeron)</td>
<td>15</td>
<td>15-45</td>
<td>Causes weight gain in 50% of patients.</td>
<td></td>
</tr>
<tr>
<td><strong>Monamine oxidase inhibitors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenelzine (Nardil)</td>
<td>15</td>
<td>15-90</td>
<td>Less effective in people with severe depression Dietary restrictions due to need to avoid tyramine (cheese, beer, wines &amp; many other foods).</td>
<td>Can potentiate HTN and sexual dysfunction.</td>
</tr>
<tr>
<td>Tranylcypromine (Parnate)</td>
<td>10</td>
<td>30-60</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 1

## Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Name</th>
<th>Consumer Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**CONFIDENTIAL**

Do not release without specific authorization for release of mental health information.

This chart cannot be disclosed without a written consent of the person to whom it pertains or is otherwise permitted by such regulation (Uniform Health Information Act Title 70.02)

---

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th></th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half the days (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please subtotal each column. Then add columns 1, 2, & 3 for **Total Score = _____**

Please turn over and continue
Please answer these additional questions.

### Complicating Factors

<table>
<thead>
<tr>
<th>Consider each question, then…</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>At any point in your life, have you gone through periods when you felt the opposite of being depressed—very “high” or “speeded up,” with lots of energy? Didn’t need sleep? Felt you could do anything? Circle “yes” if you had these symptoms and they lasted at least a few days and caused trouble for you in your life.</td>
<td>Y N</td>
</tr>
<tr>
<td>In the last two weeks, have you occasionally heard or seen things that other people couldn’t see or hear, things that might really not be there?</td>
<td>Y N</td>
</tr>
<tr>
<td>Have you ever made any plans to harm or kill yourself?</td>
<td>Y N</td>
</tr>
<tr>
<td>Have you taken any steps toward carrying them out, or do you intend to do so?</td>
<td>Y N</td>
</tr>
<tr>
<td>Has any family member attempted or committed suicide?</td>
<td>Y N</td>
</tr>
<tr>
<td>Please count the number of drinks you have had during a typical week this past month. One glass of any beverage counts as “one drink.”</td>
<td>[   ] drinks</td>
</tr>
<tr>
<td>Have you ever felt you should cut down on your use of drugs?</td>
<td>Y N</td>
</tr>
</tbody>
</table>

### Previous Episodes & Treatment

<table>
<thead>
<tr>
<th>Consider each question, then…</th>
<th>Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have your symptoms of depression lasted longer than two years?</td>
<td>Y N</td>
</tr>
<tr>
<td>Have you had the same number and types of symptoms before in your life? <strong>Answer YES only if your symptoms lasted at least two weeks, caused you significant distress, or interfered with your functioning.</strong></td>
<td>Y N</td>
</tr>
<tr>
<td>If you answered YES above, how many times has this occurred?</td>
<td>[   ] number</td>
</tr>
<tr>
<td>Have you received treatment for depression before?</td>
<td>Y N</td>
</tr>
<tr>
<td><strong>If Yes: Counseling or Psychotherapy?</strong></td>
<td>Y N</td>
</tr>
<tr>
<td>Antidepressant medication?</td>
<td>Y N</td>
</tr>
<tr>
<td>If you have received treatment in the past, what helped?</td>
<td>Y N</td>
</tr>
<tr>
<td>Counseling? …………………………………………………………</td>
<td>Y N</td>
</tr>
<tr>
<td>Medication? …………………………………………………………</td>
<td>Y N</td>
</tr>
<tr>
<td>Both Counseling and Medications? ……………………………………………………………………</td>
<td>Y N</td>
</tr>
<tr>
<td>Do you remember the name of the antidepressant medicine you took?</td>
<td>Y N</td>
</tr>
<tr>
<td>NAME: ……………………………………………………………………………………………………</td>
<td>Y N</td>
</tr>
<tr>
<td>Have you had a prior psychiatric hospitalization for depression?</td>
<td>Y N</td>
</tr>
</tbody>
</table>
Appendix 1

PHQ-9 is an improved version of the prior depression clinical tools. Using just one questionnaire, you can both diagnose and monitor clinical progress of depression. Please use both page 1 and 2 for diagnosis.

Only page 1 is needed for monitoring depression severity.

SCORING THE PHQ-9

A. Diagnostic Criteria for Major Depression:
1) IF patient reports a score of 2 or 3 ("more than half of the days") to EITHER of the first 2 questions ("sadness" or "anhedonia")
2) AND a total score of 10 or higher for the PHQ 9.

B. Clinical Interpretation of Depression Severity:

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Depression Severity Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 – 27</td>
<td>Severe</td>
</tr>
<tr>
<td>15 – 19</td>
<td>Moderately severe</td>
</tr>
<tr>
<td>10 – 14</td>
<td>Moderate</td>
</tr>
<tr>
<td>5 – 9</td>
<td>Mild (or good treatment response)</td>
</tr>
<tr>
<td>0 – 4</td>
<td>None, or Remission</td>
</tr>
</tbody>
</table>

* If suicidal, please assess risk and institute your clinic’s procedures for dealing with patients exhibiting self-harm behavior.
Appendix 1

GAD-7

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Please subtotal each column and add columns for total score**

<table>
<thead>
<tr>
<th>Add Columns</th>
<th>______</th>
<th>______</th>
<th>______</th>
</tr>
</thead>
</table>

**Total Score = ______**

A score of >10 on the GAD-7 indicates a high likelihood of one or more anxiety disorders (Panic, PTSD, Social Phobia, or GAD).

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

![Teammcare logo]
Appendix 2

TEAMcare Visit Tools

TEAMcare Visit 1 ............................................................. A - 19

TEAMcare Visit 2 ............................................................. A - 21

TEAMcare Follow-up Visits .............................................. A - 25
Appendix 2

TEAMcare Visit 1:
Depression & Chronic Disease Assessment & Care Plan

Introduction to TEAMcare Program:
- Using tools to manage your chronic diseases
- Thank you for working with me
- Partnership—but you are the captain of the ship
- TEAMcare Care Manager role—offer options and coach
- Connection to Primary Care Team
- Call Primary Care Team for illnesses and acute problems
- Supervision of care managers by physicians

Personal and Family History:
- Getting to know each other better over time.
- For now, what are the important things that I should know about you?
  - Living situation?
  - Family?
  - Job?
  - Hobbies?

Depression Assessment (PHQ-9):
- When did you start feeling like this? Have your symptoms changed during this time? Have they changed recently?
- How many times have you been depressed in your life?
- What treatments have you tried for your depression? How effective were they? Did you ever take anti-depressants? If so, how long did you take them? Has anything else helped?
- **If sleep problems:** Is the problem getting to sleep or staying asleep? Is it due to frequent nighttime urination? Do you eat when you get up at night?
- Have any of your blood relatives had the following problems? If so, describe.
  - Been depressed?  Y  N
  - Had anxiety problems or bipolar disease?  Y  N
  - Heard voices?  Y  N
  - Had drug or alcohol problems?  Y  N
  - Tried to kill themselves?  Y  N
Appendix 2

Other Symptoms:

- **Anxiety**: Did you ever have a time when all of a sudden you felt frightened, anxious or very uneasy? Did you ever have a time when for no reason your heart began to race, you felt faint or nauseous, or couldn’t catch your breath?

- **If yes to either**: Did you ever have a time when all of a sudden you felt:
  - chest pain or discomfort
  - chills or hot flashes
  - feeling of being “outside of yourself”
  - fear of dying
  - fear of losing control or going crazy
  - feeling dizzy, unsteady, lightheaded or faint
  - feeling of choking
  - nausea or abdominal fullness
  - palpations, pounding heart or fast heart rate
  - numbness or tingling sensations
  - shortness of breath
  - sweating
  - trembling or shaking

  **KEY**: *More than 4 of 13 panic attack symptoms = panic disorder*

- **Other Psychiatric Conditions**: Schizophrenia (hearing voices or seeing things), alcohol abuse/dependence, or use of non-prescription drugs?

- **Pain**: Are you having any problems with pain or headaches? Pain Score (1-10 Scale): ______

Social:

- Activities affected:  ○ Social  ○ Personal  ○ Family  ○ Work

  Patient last felt good: _______ [days ~ weeks ~ months ~ years] ago

- Overall function during the last 2 weeks (0 = worst, 10 = best):
  0 1 2 3 4 5 6 7 8 9 10

<table>
<thead>
<tr>
<th>Stressors</th>
<th>Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

TEAMcare Visit 2:

Scripting for the second visit is quite long. After using this script several times, most TCMs may find that they won’t need it and can use shorter visit reminders.

<table>
<thead>
<tr>
<th><strong>Check-in</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal Symptom Assessment:</strong> PHQ-9. Administer front and back on the initial visit. Thereafter administer front only, unless patient has 1, 2 or 3 response to Questions 1 or 2 or 9.</td>
</tr>
<tr>
<td><strong>Assessment of Risk:</strong> If answer to Question 9 of PHQ-9 is 1, 2 or 3. Thoughts, plans, actions and prevention.</td>
</tr>
<tr>
<td><strong>Care Plan:</strong> Details about what worked and what didn’t.</td>
</tr>
</tbody>
</table>

**Review of Medications and Adherence, if not done at Visit 1.** I’d like to check our records that list the medications you’re taking.

**Adherence Check:** It’s hard for most of us to take medications regularly. Is that a problem for you?

<table>
<thead>
<tr>
<th><strong>Chronic Disease Assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managing Chronic Disease and Depression:</strong> It is complex; problems are “interwoven”.</td>
</tr>
<tr>
<td><strong>Self Care Tasks:</strong> Management of diabetes when you’re depressed can be very difficult. How are you doing with: SBMG, dm or CHD medications, eating pattern?</td>
</tr>
</tbody>
</table>

**Elevated Blood Pressure:**

1. Do you know why blood pressure is emphasized? *** Relationship to CVD.
2. Do you know what your last blood pressure was?
3. Have you and your doctor set a target for your blood pressure? Y N
4. What is your target?
5. What actions do you and your doctor think you should be taking to help you get your blood pressure under control?
### Elevated Cholesterol or Lipid Levels:

1. Do you know what your last cholesterol level was?  Y   N
2. Have you and your doctor set a target for your LDL and HDL?  Y   N
3. What is your target?
4. What actions do you and your doctor think you should be taking to get your cholesterol level under control?
5. What problems do you have sticking to those goals?

### Diabetes:

**HbA₁c**

1. Do you know what your last HbA₁c is?  Y   N
2. Have you and your doctor set a target for your HbA₁c?  Y   N

### Blood Sugar

1. Do you check your blood glucose?  Y   N
2. When?  How often?
3. What actions do you and your doctor think you should be taking to help you get your blood sugar under control?
4. What problems do you have sticking to those goals?
### Appendix 2

<table>
<thead>
<tr>
<th><strong>Insulin:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> How are you usually taking your insulin?</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> It's common to miss insulin doses. Is that ever a problem for you?</td>
<td>Y N</td>
</tr>
<tr>
<td><strong>3.</strong> Details about daily regimen:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Nutrition:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Tell me about a usual day. When and what do you usually eat?</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> How often do you eat differently? And how?</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> What actions do you and your doctor think you should be taking to help you get your eating pattern under control?</td>
<td></td>
</tr>
<tr>
<td><strong>4.</strong> What problems do you have sticking to those goals?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Shared Decision Making:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brainstorm Range of Options and Materials Needed:</strong></td>
<td></td>
</tr>
<tr>
<td>- What you’re currently doing well and the likely effects.</td>
<td></td>
</tr>
<tr>
<td>- Tools for Managing Your Chronic Diseases (see Appendix 8)</td>
<td></td>
</tr>
<tr>
<td>- Other options supported by research</td>
<td></td>
</tr>
<tr>
<td>- Other options suggested by patient</td>
<td></td>
</tr>
</tbody>
</table>
### What problem do you want to work on?

1. Define the problem
2. Brainstorm multiple solutions
3. Evaluate pros and cons of each solution
4. Do you need information to help make your plan?
5. Choose a plan
6. Identify steps or parts of the plan and prioritize them
7. Choose and define your beginning step(s)
8. Rate likelihood of success

### Complete Initial Visit 2

Include messages about outstanding lab tests or chronic disease in EMR alerts by calling physician.

Set the next contact session

### Record Keeping and Feedback in Medical Chart, Access, and/or Tracking Tool:

- Complete documentation the same day patient seen.
- Order any lab tests or medications.

### Communication with Practice Team:

- Check with Primary Care Provider and document prior to ordering new medication.
- Check with Primary Care Provider when patient’s condition changes.
Appendix 2

TEAMcare Follow-up Visits

Check-in:
- How was your week?

Depression Check:
- Ask to complete PHQ-9
- Discuss any changes
- Any high risk answers, explore and talk with psychiatric supervisor [Question 9 (suicidality): if 1,2 or 3, ask about suicide thoughts, plans, actions and prevention]. Consult with psychiatric supervisor.
- If started on new antidepressant: How's it working? Able to take every day? Any side effects?

Medication Review:
- Let's take some time to check our clinic information and make sure the medications are written correctly.
- It's hard for most of us to take our medications every day. How are you doing with ______?
- Check each medication for dosage, timing, and number of times taken last week.
- Troubleshoot problems with medications not being taken as ordered.

Chronic Disease Assessment:
Diabetes:
- Management of diabetes can be very difficult. How is it going for you?
  - Medication adherence
  - Usual eating pattern
  - Blood glucose testing
- You've identified a number of problems with your diabetes routines. Which would you like to talk about first?

Cardiac Risk Reduction:
  **Smoking Cessation**
- Information check in: Your chart indicates that you smoke.
  - Do you know the tie between smoking and diabetes/heart disease?
Appendix 2

- Stopping smoking will help you more than anything else you can do for your heart disease or your diabetes.
- Do you know about Free & Clear® smoking cessation program?
  - Have you ever considered quitting? Are you ready to set a quit date?

**Elevated Blood Pressure**
- Do you know your chart suggests you have high blood pressure? Do you know what your blood pressure was?
- Information check in:
  - Do you know the relationship of elevated blood pressure to heart disease?
  - Have you and your doctor set a target for your blood pressure? Y N
  - What actions do you and your doctor think you should be taking to help you get your blood pressure under control?
  - Would you consider checking your blood pressure at home?

**Elevated Cholesterol or Lipid Levels**
- Do you know that your chart suggests you have high blood fat levels (LDL levels)? Do you know what your last LDL was?
- Information check in:
  - Do you know how LDL is related to cardiac problems?
  - What actions do you and your doctor think you should be taking to help you get your LDL under control?
Appendix 2

Shared Decision Making:

Brainstorm Range of Options:
- What are they currently doing well?
- Other options supported by research
- What else do you think might be helpful?

What problem do you want to work on?
- Define
- Brainstorm multiple solutions
- Evaluate pros and cons
- Do you need information to help make your plan?
- Choose a plan
- Identify steps or parts of the plan & prioritize
- Choose & define your beginning step/s
- Rate likelihood of success

Visit Completion Activities:
- Remind of any outstanding tests or follow-up due.
- Complete care plan and review.
- Set next appointment.
Appendix 3

TEAMcare
My Better Health Plan

Patient Name: ______________________________

Special Medication Instructions
____________________________________________________________________

Monitoring My Health

<table>
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<th>PHQ</th>
<th>BP</th>
<th>LDL</th>
<th>HbA1c</th>
<th>Glucose Range</th>
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<tbody>
<tr>
<td></td>
<td></td>
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Baseline

Previous

Most Recent

Target

My Essential Medications

Reason for Taking

My TEAMcare Care Manager: ______________________

Clinic Consulting Nurse: ______________________

My Primary Care Physician: ____________________

My Primary Care Clinic: ________________________

Reaching My Health Care Team

<table>
<thead>
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<td>My TEAMcare Care Manager:</td>
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<tr>
<td>Clinic Consulting Nurse:</td>
<td></td>
</tr>
<tr>
<td>My Primary Care Physician:</td>
<td></td>
</tr>
<tr>
<td>My Primary Care Clinic:</td>
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</tr>
</tbody>
</table>
## TEAMcare
### My Better Health Plan: Next Step

### My Health Goals: What do I want to change?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

### What will I do?

<table>
<thead>
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</tr>
</tbody>
</table>

### What might get in my way?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

### Medical Follow-up Scheduled

____________________________
Appendix 4

Documentation

Medical Record Documentation Tools .......................... A - 31

Initial Note ........................................................................... A - 32

Progress Notes ........................................................................ A - 33
  Medication Change Suggested to PCP .............................. A - 33
  Intervention Completed and Transfer Back to PCP .......... A - 33

TEAMcare-PCP Transition Letter to Patient .................... A - 34

Maintenance Note for Patient ........................................... A - 35

Your Relapse Prevention Note .......................................... A - 36
**Appendix 4**

**Medical Record Documentation Tools**

The TEAMcare study created tools to document intervention visits, making current status and next steps clear to both patients and their providers. These tools were made for EPICare, an electronic medical record (EMR). But, the text and ideas may be applicable to other EMRs as well as paper medical records. Shown below is a screen shot from the EPICare EMR to illustrate how TEAMcare can be incorporated into existing medical record systems.

**EPICare EMR Patient List Tracking Tool**
Suggested templates or information to be included in various documentation notes are provided below. These serve as general guidelines; they will need to be adapted to integrate with your medical clinic and records systems. When a triple asterisk (*** ) appears in the text, the EMR searches for the last value for that clinical or demographic measure.

Initial Note

OUTCOME MEASURES: ***.LHEMA1C, .BMI, .LLLIPID, .LLMICROALBUMIN, .LLCREATININE, ***BP ***

SUBJECTIVE: Depression: PHQ= ***. Patient’s most troublesome symptom/s are ***. Panic screen was ***. Previous treatments include: {treatments}. This treatment {was/was not} judged helpful by the patient. Last time patient felt really good was: ***. Family psychiatric history is ***.

OBJECTIVE:
Social/Stressors: <name> is {marital status} and has support from {family and friends}. Stressors include: ***. Previous/current occupation: ***. Hobbies and pleasant activities: ***. Daily Life: {use of tobacco, alcohol, and drugs}.

Diabetes: <name> has had diabetes for about {time frame}. Complications of diabetes include: {complications}. Hypoglycemic medications: ***. <name> is using the following self-care routines:***. .CAPHIS major chronic disease concerns are: {DM CONCERNS:10024}.

Cardiac Disease/Risk Reduction: History ***. Cardiac risk reduction medications: ASA use: {YES/NO:12635}, ACE {YES/NO:12635} ; STATIN {YES/NO:12635}. Blood pressure lowering agents: {YES/NO:12635}, list: ***.

Is .CAPHE taking all medications as ordered?

ASSESSMENT:

PLAN:
Medication Changes: ***.

Patient Goals: ***

Patient Education: {example: Given TEAMcare depression materials. Rationale for intervention, choices regarding ways to improve mood and health, including medication and therapeutic interventions for depression, effects and side effects of antidepressant medications, and complexity of managing a chronic disease when depressed when depressed.}
Appendix 4

**Follow-up:** Next visit to focus on depression follow-up and specific ways to improve cardiac risk and chronic disease self-management. To follow-up with me in ***.

TCM Name and Number

**Progress Notes**

- **Medication Change Suggested to PCP**

  Dear Dr. ***,
  I've been seeing <name>, a patient in the TEAMcare Intervention. My clinical supervisors are suggesting the following changes:

  - Depression: *** <recommended change>
  - Diabetes: *** <recommended change>
  - Cardiac risk reduction: *** <recommended change>

  OK to proceed? I'll follow up with <name> accordingly. My notes are in EPIC if you're interested in more detail.

  Thanks!
  TCM Name

- **Intervention Completed and Transfer Back to PCP**

  These notes are created during the last patient visit.

  Dear Dr. ***,
  Your patient, <name>, has completed the TEAMcare intervention for depression, diabetes and heart disease.

  At the end of the study, <name>’s outcomes are:
  - Depression screening: (PHQ = ***), indicating depression in *** control
  - Diabetes: HbA$_{1c}$ ***
  - Hypertension: BP results (**/* ***)
  - Hyperlipidemia: LDL ***
The plan of care that we developed with <fname> is written EPIC in the letter dated ***.

With the completion of the intervention on ***, please continue to manage <name> in your practice. I will not be seeing him/her further, nor following up with you about his/her care.

TCM Name

FYI: Your patient’s most current My Better Health Plan is below: ***

TEAMcare-PCP Transition Letter to Patients

This letter, along with the Maintenance Note and Your Relapse Prevention Plan, are given to patients at their last visit.

Dear <name>,

Thanks so much for participating in the TEAMcare Program. Our work together is now completed. As I explained when we started, you will now work with your Primary Care Physician and Nurse for all your care. You have made some good progress to improving your health, and I commend you for all your effort.

Your current plan of care and relapse prevention plans are attached.

I appreciate having had the opportunity to work with you. I wish you all the best.

Sincerely,

TCM Name
Appendix 4

Maintenance Note for Patient

Your Better Health Plan

**DEPRESSION:** Your current PHQ score is ***.
Your goal is ***.
Your current plan is:
Medications: ***
We recommend continuing on your antidepressant medication for at least a year. If you've been depressed for a long time, you can continue taking the medication for the rest of your life. Please talk with <pcp> if you're considering stopping your antidepressants.
Experiments in changing behavior or routines: ***
Pleasurable activity: ***

**DIABETES:** Your last hemoglobin HbA$_{1c}$ was *** on ***.
Your goal is ***.
Your current plan is:
o Medications: ***
o Blood sugar testing routine: ***
o Next Hemoglobin A$_{1c}$ is due: ***
o Eating plan: ***

**HIGH BLOOD PRESSURE:** Your last blood pressure taken on *** was **/**.
Your goal is ***.
Your current plan is:
o Medications: ***
o Blood pressure monitoring routine: ***
o Salt intake: ***

**HEART DISEASE RISK:** Your last LDL test was ** taken on **.
Your current plan is:
o Medications: ***
o Next LDL test is due: ***
o Consider calling a smoking cessation program for help to stop smoking.

**PHYSICAL ACTIVITY:** Your goal is: ***
Your plan is: ***

**HOME ROUTINES:**
***
Your Relapse Prevention Plan

A Relapse Prevention Plan focuses on stress reduction and self-monitoring and can help you to recognize depression early.

**First:** Use the depression-fighting strategies that have worked for you in the past, including taking your antidepressant medication regularly, increasing your pleasurable activities and maintaining a healthy lifestyle.

**Second:** Write down the problems that can trigger your depression and strategies that have helped you in the past.
- What are some of my everyday stressors?
- What coping strategies have worked for me in the past?
- What strategies do I think will be most useful for combating my everyday problems?
- Are these skills I can use every day or every week?
- How can I remind myself to use these skills daily?

**Third:** Try to identify three or four specific actions that will help you. Be realistic about what you can and will do.

**Fourth:** Prepare yourself for high-risk situations.
- What are some problems or predictable stressors that might affect you in the future?
- Can you do anything to make a particular event less likely or less stressful?
- If you can't avoid a stressful situation, can you avoid negative reactions (like criticizing yourself) or react in a more positive way?

**Fifth:** Watch for warning signs by regular self monitoring. You can check routinely for personal warning signs or telltale patterns of thought or behavior. You may want to ask a partner or friend to let you know if they notice any warning signs.

**Sixth:** Use the PHQ test to check your depression score. If your score goes up over 10, it's time to get help again.
Appendix 4

Staying on Track with other Changes

When we've made changes in our behavior, there's always a tendency to drift back towards old habits.

How can you stop the backward drift?

- Think about reasons that you might drift. Make a list of reasons that you might not keep up with healthy changes.

- Keep an eye on yourself. Monitor your behavior enough that you can catch your drift early, before you feel like you're in a deep hole.

- Keep an eye on your blood work. Tests to check on diabetes control (like hemoglobin A1c) or heart disease risk (like cholesterol tests) are like early warning systems. It’s best to do them every three months, so you can know if you've drifted.

- If you feel you need to change medications, please call your Primary Care Team. Your Physician or Nurse can help you decide the safest options for medication changes.

- Use your coaches or partners to help you realize that you're drifting. Give them specific behaviors that you'd like them to notice and ways that you'd like them to give you feedback.

- Put drift into perspective. We all make plans, but all of us drift away. The key is catching yourself and getting back on track.
Appendix 5

TEAMcare Tracking Tools

Patients can be tracked using an Access database developed for the TEAMcare intervention. Other tracking may be done through the EMR. The Access database displays all the information followed by the TEAMcare supervisors, but requires data entry by TCMs. Conversely, the patient list function of an EMR could automatically add data, but may not include all of the variables you would like to track. Examples of both tracking tools follow.

TEAMcare Tracking database (example of part of the data)

<table>
<thead>
<tr>
<th>Initial</th>
<th>Clinic</th>
<th>Enroll Date</th>
<th>PHQ BL</th>
<th>PHQ Now</th>
<th>BP BL</th>
<th>BP Now</th>
<th>HbA1c BL</th>
<th>HbA1c Now</th>
<th>LDL BL</th>
<th>LDL Now</th>
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<tr>
<td>NSH</td>
<td>5/19/08</td>
<td>19</td>
<td>19</td>
<td>141/69</td>
<td>127/77</td>
<td>7.3</td>
<td>6.8</td>
<td>168</td>
<td>138</td>
<td></td>
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<td>NSH</td>
<td>1/9/08</td>
<td>15</td>
<td>2</td>
<td>118/80</td>
<td>130/80</td>
<td>9.2</td>
<td>8.3</td>
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<td>124</td>
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<tr>
<td>EVM</td>
<td>11/12/07</td>
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<td>9</td>
<td>160/98</td>
<td>150/85</td>
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Appendix 5

EPICare EMR Patient List Tracking Tool
Appendix 6

TEAMcare Supervision Action List
### TEAMcare Supervision Action List

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<tr>
<th>Case Manager:</th>
<th>Date:</th>
<th>SUGGESTED ACTIONS:</th>
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<tr>
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<td>My Better Health Plan</td>
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<td>Patient ID:</td>
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<td>SIMPLIFY, consolidate</td>
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<td>Check formulary</td>
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<td>Check lowest prices</td>
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<td>Assess adherence</td>
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<td>Assess side effects</td>
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<td>Patient ID:</td>
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<td>Behavioral activation</td>
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<td>Next contact:</td>
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<td>Physical activation</td>
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<td>Social activation/support</td>
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<td>Pleasant events</td>
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<td>Labs (e.g. HbA1c, Lipids)</td>
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<td>Disease- &amp; Self-management:</td>
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<td>BP cuff, BP records</td>
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<td>Move to maintenance</td>
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<td>Next contact:</td>
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<td>Move to groups</td>
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Appendix 7

Patient Education Materials

Pleasant Events Schedule ................................................... 43

Patient Education Materials ................................................ 43

Tools for Managing Your Chronic Diseases ......................... 43
Appendix 7

Pleasant Events Schedule

Sometimes it is helpful for patients to have a list from which to choose pleasant activities. For those interested in more information about the Pleasant Events Schedule, refer to these citations.

A. Original Paper


B. Original Journal Publications


Patient Education Materials

Patients receive self-care materials including: *The Depression Helpbook*, a DVD on depression care, and a booklet on chronic disease management (*Tools for Managing Your Chronic Diseases*). Patients receive other evidence-based educational materials and self-monitoring devices (blood pressure or blood glucose meters) appropriate to their condition.

*The Depression Helpbook* can be ordered from the Bull Publishing Company (www.bullpub.com).

Tools for Managing Your Chronic Diseases

This booklet on chronic disease management is included here in this appendix.
Tools for Managing Your
Chronic Diseases
# Booklet Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
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<td>The TEAMcare Project</td>
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<td>The Depression Diagnosis doesn't fit</td>
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<td>5</td>
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<td>Depression's Downward Spiral</td>
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<td>23</td>
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<tr>
<td>Making Choices for Better Heart Health</td>
<td>24</td>
</tr>
<tr>
<td>Monitoring Your Blood Pressure</td>
<td>25</td>
</tr>
<tr>
<td>Better Health with Diabetes</td>
<td>26</td>
</tr>
<tr>
<td>Using Blood Sugar Readings</td>
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</tr>
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<td>When Your Blood Sugar is too Low</td>
<td>29</td>
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<td>Sick days and diabetes</td>
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</tr>
<tr>
<td>Communicating with Your Doctor</td>
<td>31</td>
</tr>
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<td>Using all the Tools: My Group Health</td>
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<tr>
<td>Your Relapse Prevention Plan</td>
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<tr>
<td>Staying on Track with other Changes</td>
<td>35</td>
</tr>
</tbody>
</table>
The TEAMcare Program

Thanks: We are glad that you decided to work with us. You have a special opportunity to improve your own health.

What's this program and how might it help you?
This program is the Treatment Enhancement Activation and Motivation ("TEAMcare") Program. Our goal is to help you feel better and take better care of yourself. We know it's a challenge to manage chronic diseases and life—we're here to stand by you and help you.

How does the TEAMcare Program work?

✓ The services you receive from the TEAMcare program are in addition to the regular care you get from your Primary Care Team. That means you will still use your Primary Care Team when you need regular health check-ups, have emergencies, or have questions not related to our work together.

✓ Your TEAMcare Care Manager is in regular contact with your Primary Care Physician and Registered Nurse.

✓ Your TEAMcare Care Manager has weekly supervision sessions with a TEAM of specialty experts, including Internal Medicine Physicians, Psychiatrists, and Psychologists who will help make your treatment choices up-to-date and good for you.

✓ You're in charge of your care. We have information, techniques and medications that have helped other people like you. You're the “captain of the team” who decides where you want to start and where you want to go.

✓ There will be no charge for the visits with your TEAMcare Care Manager.

How long will we work together?
We'll work together as long as you're changing your chronic disease routines.

What should I expect to happen?
✓ When we first start working together, we'll want to see you in person. We'll also want to see you in person if you're starting to monitor blood pressure or are starting a new medication such as insulin.
✓ We will also have discussions by phone.

**What should I expect from My TEAMcare Nurse?**

You should expect us to:

✓ Give you the best information we can about your self-management options and their predicted effects.

✓ Understand that you’re not perfect (and neither are we). We’re here to help you manage your health in ways that fit into your life.

✓ Understand that the problems you face may seem like mountains. We can help you break down these mountains into smaller hills and then can help you with the steps along the way.

✓ Help you figure out which medications may be useful for your health problems and help you manage taking the ones that you choose.

✓ Understand that you are in charge of your health. We’re here to help you, but you’re the captain of your healthcare ship.

**My Better Health Plan**

We’ll work together to create *My Better Health Care Plan*. This is a plan that we’ll work on together to make sure we’re on the same page about plans to improve your health and help you reach goals that are important to you.

---

**I’m not sure the Depression Diagnosis fits. . .**

**I’m just tired. . .**

**Some people with depression** are troubled by negative thoughts and feelings of sadness or hopelessness. Others are most aware of physical symptoms such as low energy, poor sleep, poor appetite or overeating, and feeling agitated or ‘slowed down’.

**The diagnosis of depression** is made by reviewing your mood, your physical symptoms and your score on the PHQ 9 test. This test is a good predictor of depression. The test results are scored by:
Scores of 10 or greater = major depression
Scores of 5-9 = mild depression
Scores of 0-4 = no depression or good response to your treatment.

You can use the PHQ-9 Depression Questionnaire (page 22 of this booklet) tool to check up to see how you're doing—as often the first improvements are hard to see.

What causes depression? Life stresses and medical problems can cause changes in certain brain chemicals. Imbalances in brain chemicals can result in some of the common symptoms of depression such as sleep and appetite problems, loss of energy, loss of concentration, and chronic pain.

The good news is: that there are a number of treatments that help depression and the symptoms it can cause. We're here to find a treatment that works for you.

What is Depression?

Basic facts about depression:
- Depression is a medical condition—not a sign of personal weakness.
- About 30% of people with chronic disease will experience clinical depression at some time in their life.
- The best research indicates that depression is caused by a combination of inherited or genetic factors and life stresses—just like high blood pressure or heart disease.

Common symptoms of depression: An individual’s symptoms of depression can vary, but often feelings include sorrow, dejection, despair or irritability. Most people feel sad or blue occasionally, but when these feelings persist, worsen or interfere with work or personal relationships, depression is suspected. In addition to these feelings, people will often describe physical symptoms, such as backache, headache, or stomach trouble.
People with depression may feel like staying at home more and avoiding other people, they may lose interest in life and have a more difficult time enjoying usual activities. **Living with a chronic disease is always more complex when you are depressed.** Depression can make health care routines seem totally overwhelming.

The good news about depression is that it can be helped:

- Taking antidepressants makes most people feel much better in 2-4 weeks.
- Psychotherapy helps people improve their relationships and participate in more pleasant activities.
- Psychotherapy can help most people feel better in 6-8 weeks.

**Depression’s Downward Spiral**

Depression influences your physical well-being, your thoughts, and your feelings. People who are depressed usually stop doing things they once enjoyed, like talking to friends or getting projects done around the house.
Depression can feed upon itself, making you feel worse and worse. This Downward Spiral is sometimes caused by stressful events or physical problems.

Interrupting Depression's Downward Spiral

It's possible to break Depression's Downward Spiral. You can turn it into an upward spiral by:

- Taking an antidepressant.
- Getting more active.
- Doing things you enjoy.
- Putting a positive spin on your thinking.
- Improving relationships with friends and family.
- Establishing a regular sleep pattern.
What can you do to get better
when you don’t feel like Doing Anything?

Often when you’re depressed, it’s easy to stay inside—to withdraw from friends and spend lots of time thinking about problems. We want you to try something different. We believe that you must become active and must be in more positive situations before you begin to feel better. We’ll help you focus on things “outside” yourself—like changing how you spend your free time, how you act around others and how you approach tedious tasks. By doing these activities, we believe that you’ll begin to feel better. We’d like you to “experiment” with one or more of the following:

✓ Getting physically active.
✓ Enjoying pleasant experiences.
✓ Accomplishing something.
✓ Connecting with others.
✓ Having fun with others.
✓ Create something.
✓ Take care of your health.
✓ Solve problems systematically by breaking them down into smaller problems.

We’ll ask you to “experiment” to see what works best to help your depression and your chronic disease. We’d like you to get specific about what you’re going to do.

You’ll check the effect of these experiments by monitoring your health. When you find things that work, we’ll build on them together. Some of these activities may seem strange or odd at first. We’ve seen them help other people with complex lives. In fact, we use some of these techniques to help manage our lives.
Why is there so much emphasis on Getting More Active?

Researchers have found that exercise improves mood by:
- Increasing the levels of neurotransmitters (mood-altering chemicals) that antidepressants target.
- Increasing blood levels of endorphins, the body’s own painkillers, which improve mood and reduce physical pain.
- Becoming more active often helps people reduce their stress levels and have more energy.
- Physical activity improves the way glucose is used by the body, improves blood lipid levels and helps to reduce blood pressure.
- Physical activity helps us to lose weight and helps to maintain weight loss.

What kind of activity is recommended?
We recommend walking. It's an activity that most of us can do. We recommend working towards 30 minutes of walking on most days. If you prefer, we can give you a pedometer to measure your steps. We recommend working towards a goal of 10,000 steps on most days.

The keys to increasing your activity are:
- Choosing an activity that you like.
- Keeping up with the activity.
- Knowing that you don’t have to “work up a sweat”—walking should be right for you and your health.
- Start slowly—so that you can keep it up.
- When you miss exercising for a few days, it’s most important to start up again.
- Work with your TEAMcare Nurse to figure out an Initial Activity Plan that will work for you.
- After you start getting more active, we can work together to update your plan as often as you like.
How do you decide if you’re willing to take an Antidepressant Medication?

How do antidepressant medications work? Antidepressants help restore the correct balance of neurotransmitters (brain chemicals).

How well do antidepressant medications work?
Antidepressant medications are all very effective. Most people who take antidepressant medications will get better in 4 to 8 weeks. The people who don’t improve during the first 8 weeks usually improve with another medication.

Often your friends and family will notice improvements before you do. Usually your sleep and appetite will improve first and your mood, energy and negative thinking will improve later. In addition to improving depression symptoms, antidepressants can help improve sleeplessness and pain. If you have side effects from an antidepressant medication or don’t improve, chances are excellent that you will improve on a different medication.

What about side effects?
Side effects usually occur in the first two weeks when taking antidepressants. Side effects can include:

- Nausea
- Headaches
- Jitteriness
- Difficulty sleeping or feeling overly sleepy

Side effects almost always are decreased within two weeks.
**Common Questions about Anti-depressant Medications**

**My problem is sleep.** How can an antidepressant help with my sleep?
- Often poor sleep is related to major depression. Once the depression lifts, sleep often improves as well.
- Antidepressants can help restore normal sleep, even in people who do not have major depression. They are better than other sleeping pills in that they are not habit-forming, and they usually do not impair concentration or coordination.

**My problem is pain.** How can an antidepressant help with this?
- Antidepressants are often used to treat pain—even in people who aren't depressed.
- Antidepressants may also help restore normal sleep and ‘reverse’ a vicious cycle of pain and poor sleep.

**My problem is being tired and having no energy.** How can an antidepressant help with this?
- Low energy and fatigue commonly occur in people with major depression. Once the depression improves, their energy starts to return as well.

**My problem is stress in my life.** How can an antidepressant help with this?
- Life stress can cause or worsen the symptoms of depression. The depression can then worsen the impact of such stressors (such as work stress, family problems, physical disabilities or financial worries) and your ability to cope with them. Treating the depression can help some patients break out of this vicious cycle.

**How long will I have to take the medication?**
- Once you are completely recovered from your first episode of depression, you should stay on the medication for another 6 - 12 months to prevent having another depression episode.
- Some patients who have had depression multiple times or have been chronically depressed for longer than 2 years are at high risk for a recurrence and should take a ‘maintenance’ dose of antidepressants for longer periods of time.
- Some people, with a long history of depression, choose to stay on antidepressants for the rest of their lives.
Is it safe to take antidepressants together with alcohol or other medications?

✓ Antidepressants can increase the sedating effects of alcohol. Be careful to limit alcohol intake to one glass of wine or beer per day while on these medications.

✓ If you start taking a new over-the-counter or herbal medication, let your doctor or TEAMcare Care Manager know.

What should I do if I miss the medication one day?

✓ Don’t ‘double up’ and take the dose you forgot. Just keep taking your medication as prescribed each day.

Will I get better?

✓ With adequate treatment, between about 80% of people will have a complete recovery.

✓ Should you not respond to the first antidepressant treatment you try, there is an excellent chance that you will respond favorably to another medication or to psychotherapy.
Keys to Getting the Best Action from Antidepressant Medications

- Antidepressants aren’t addicting—they just help you make more key brain chemicals (neurotransmitters). Some people have been taken antidepressants for up to 30 years without any significant problems.
- Take your medication each day.
- Check with your Physician or TEAMcare Care Manager before stopping your antidepressant.
- Expect to begin feeling better slowly. The medications may take 2 to 4 weeks to work.
- As the figure below shows, medication side effects decrease after 1 to 2 weeks. Call us if you’re bothered by side effects—we can often suggest ways to help.
- Keep taking your antidepressant medication even when you feel better.
Getting a Good Night’s Sleep

Depression disrupts your normal sleep pattern. It makes you feel restless because your body is getting mixed messages about whether it’s daytime or nighttime. Pain, alcohol or drugs, and late-night coffee can also disrupt your sleep.

**DO’s and DON’Ts for Restful Sleep.**

- ✓ Don’t drink caffeine close to bedtime.
- ✓ Don’t drink alcohol close to bedtime.
- ✓ Don’t lie in bed if you’re tossing and turning for more than 20 minutes. Get up & go to another room. Do something quiet and relaxing. When you feel sleepy, go back to bed.
- ✓ Do exercise—but not close to bedtime.
- ✓ Do establish a regular bedtime.

**Set a regular waking time.** Set a regular time that works for you. Keep to it even if you slept poorly the night before.

**Try not to vary your schedule from day to day.** Avoid taking a nap when you’re having trouble sleeping at night.

**You may need less sleep.** As we age, we may need less sleep. This amount varies from person to person, but when you get your ideal sleep, you’re likely to get up feeling better.

**Antidepressants** can improve your sleep. Some have a sedative effect. All antidepressants can help by increasing the levels of chemical messengers in the brain. This leads to a more restful sleep.
Relaxing

Sometimes the hassles of everyday life can make you feel tense. Feeling tense can reduce the levels of key chemicals in the brain—worsening depression. Relaxation techniques can help reduce tension—if you find one you like and practice it!

**Deep muscle relaxation** is one way to learn to recognize when you need to relax. Sit in a chair that supports your entire body. First, tense your muscles in your shoulders by crunching your shoulders up towards your ears. After 5 seconds, relax the muscles in your shoulders completely—paying attention to how your muscles feel when they’re fully relaxed. Tense and relax your face, neck, arms, hands, abdomen, back, buttocks, thighs, calves and feel. Tense and release each area twice before starting on the next area.

**Using your breath** to relax is easy, quick and effective. Let your shoulders drop. Breathe in as slowly and deeply as you can through your nose. Hold your breath while you count to four. Breathe out slowly and completely. Repeat five times.

**Stretching**, by taking a 2-minute stretch break to stretch your neck, back, shoulders and legs, can work quickly to help you relax.

**Imagery.** Think of a time or a situation when you felt relaxed. Close your eyes and imagine that time or place. Think about how it felt and looked.

Other steps to relieve tension include:

- Taking a walk
- Listening to music
- Taking a warm bath or a shower.
Thinking More Constructively

Everyone has negative thoughts once in a while. If your negative thoughts occur too often, you'll feel down all the time. Here are things you might try:

✔ Identify negative thoughts.
✔ When you recognize negative thinking, try substituting a positive thought for the negative one. For example, if you take the wrong bus and think “I’m really stupid”, you might substitute “now I’ve really figured out the bus routes”.
✔ **Remember most negative thoughts aren’t rational.** Negative thoughts are often overreactions which impose unrealistic expectations or conclusions.
✔ Argue with your irrational thoughts. When you recognize your self-critical thoughts, you can learn to confront them. Think of yourself in a debate with your self-critical thoughts—you can say “that’s not true” to an irrational idea.
✔ Replace negative thoughts with positive ones.
✔ Accept some negative thoughts. Everyone has some negative thoughts. However, you can take back some control over your thinking.
✔ Tame your expectations. Often depressed people have extremely high, often unrealistic, expectations and are more critical of themselves than they are of others.

**Ways to reduce negative thoughts:**

✔ Thought stopping
✔ Set a worry time
✔ Buddy “check-in”
Ruminating: When You Can't Get it out of Your Mind

Sometimes we get stuck and can go over and over something bad that’s happened. Sometimes it’s easy to spend a lot of time worrying about something that may happen in the future. This is called ruminating—like a cow chewing its cud. Painful thoughts and feelings or worrying about things that happened in the past is very common in depression.

Because it’s so easy to get stuck in the ruminating process, it’s important to gain control over this behavior. There are other choices that you can make.

First: Recognize what you’re doing. Check if:

✓ You’re thinking over and over about negative thoughts, feelings or situations.
✓ The process of thinking over and over is not helping you feel less depressed, less critical, or more hopeful.
✓ The process hasn’t helped you solve a problem.

Second: Recognize the situation. Are there times or places when you tend to ruminate?

Third: Spring into ACTION. The ACTION Strategy is described on the next page.
**ACTION Strategy**

<table>
<thead>
<tr>
<th>A=Assess</th>
<th>How will my behavior affect my depression?</th>
</tr>
</thead>
<tbody>
<tr>
<td>C=Choose</td>
<td>I know that activating myself will increase my chances of improving my life situation and mood. Therefore, if I choose not to self-activate, I am choosing to take a break.</td>
</tr>
<tr>
<td>T=Try</td>
<td>Try the behavior I have chosen.</td>
</tr>
<tr>
<td>I=Integrate</td>
<td>Integrate any new activity into my daily routine.</td>
</tr>
<tr>
<td>O=Observe</td>
<td>Observe the result. Do I feel better or worse? Did this action allow me to take steps toward improving my situation?</td>
</tr>
<tr>
<td>N=Never</td>
<td>Never give up.</td>
</tr>
</tbody>
</table>
Managing Your Medications

Most of us have trouble remembering to take our medications. If that's a problem for you, there are some things that you can try:

- We'll always try to change medications to once a day or twice a day scheduling. It's difficult for everyone to take medications 3 or more times a day.
- If you have concerns about taking a medication, tell your TEAMcare Care Manager or Physician.
- Make sure that we tell you the name of each medication, reason for taking the medication, how to take it (how many times a day and when during the day), how long to take it, and the side effects that could occur.
- Many of us get advice from our friends or family about medications. Sometimes this creates fears. Please tell us what your fears are so that we can talk about them.
- Please check with your TEAMcare Care Manager or Physician before stopping medications.
- If you are taking many medications, a medication set may help. We have medication sets that we give you and help you learn to use daily.
- Ways of taking medications can get very complex. We will work to make routines as simple as possible.
- However, please let us know what is (and isn’t) working well for you.
Managing Persistent Pain

Is persistent pain a natural part of growing older?
No. Even though pain is very common, it is not normal or healthy. If pain is interfering with your activities, it should not be ignored or dismissed.

Can I take over-the-counter medications for pain?
Over-the-counter pain medications are safe and helpful to take for mild to moderate pain. If you have pain that lasts more than a few days, or severe pain, please talk with your Primary Care Physician about medication choices.

What over-the-counter medicine is best?
Acetaminophen (Sustained-release or “arthritis” Tylenol) may be the best choice for mild-to-moderate pain, such as osteoarthritis or low back pain. If you use over-the-counter medicines long-term, please check with your Primary Care Physician to make sure your routine is safe.

What can I do besides taking medications?
Physical activity is extremely important. Contrary to popular belief that exercise worsens joint pain from arthritis, regular physical activity can improve muscle strength, flexibility, and decrease pain.

What if my pain is not relieved?
Although you may not get complete relief from pain, don’t give up! The most important goal is to have the best quality of life that you can. Discuss persistent pain with your Primary Care Physician and your TEAMcare Care Manager to help you solve problems and make your treatment plan work best for you.
Monitoring your Health

As we begin to work together, it’s important for us to understand how different treatments are working. You may want to know if a behavioral treatment or a medication is working. For example:

✔ If you’re taking a new antidepressant, how is your mood changing?
✔ If you’re working to change eating habits, are there certain times of the day that are a problem for you?

In order to make changes in our medication routines or in our lives, it can help to know what we’re doing and how we’re changing. Many people have success monitoring behavior or measures more often when they’re working to change. After a while the change can get so routine, you may be able to manage with fewer monitoring check-ups.

If we’re working together to improve your blood pressure or your blood sugar, we’ll be asking you to check those measures fairly often. Most people also find it helpful to monitor their mood—by rating their PHQ 9 score.

Keep in mind that this monitoring is to help you and your TEAMcare Care Manager understand how behavior treatments and medicines are working for you. Monitoring is not a report card that labels you or your efforts to change. Monitoring allows you to chart your progress and make changes when necessary.
Monitoring Your Depression: The PHQ 9

The PHQ 9 is a way that we’ll use to follow how you’re progressing with your depression treatment. It will also be a way that you can check your symptoms yourself.

<table>
<thead>
<tr>
<th>Over the LAST 2 WEEKS how often have you been bothered by any of the following problems?</th>
<th>0 = Not at all</th>
<th>1 = Several Days</th>
<th>2 = More than Half the Days</th>
<th>3 = Nearly all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
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<tr>
<td>2. Feeling down, depressed, or hopeless</td>
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<tr>
<td>3. Trouble falling or staying asleep OR sleeping too much</td>
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<td>4. Feeling tired or having little energy</td>
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<tr>
<td>5. Poor appetite OR overeating</td>
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<tr>
<td>6. Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
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<td>7. Trouble concentrating on things, such as reading a newspaper or watching television</td>
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<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? OR the opposite - being so fidgety or restless that you have been moving around a lot more than usual?</td>
<td></td>
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</tr>
<tr>
<td>9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way?</td>
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</tbody>
</table>

Add all the numbers together to get your PHQ 9 score. An ideal goal is to keep your score less than 5 or to keep your score stable. When your score doubles or goes over 10, it’s time to get help.
Your TEAMcare Care Manager wants to help you manage your health. The way you manage will be your choice. Our job is to give you the best information and support so that you make choices that work for you.

**Improving your mood:** Depression is common in people with chronic disease. Depression can make it difficult to manage your health. Medications, counseling and physical activity are successful at helping people who are depressed.

- Increasing your physical activity is very important to helping improve your mood. Getting more active can help your mood and can help your heart disease or diabetes.
- Taking antidepressant medications makes most people feel much better in 2-4 weeks.
- Psychotherapy helps most people improve relationships and depression in 6-8 weeks.
- Working on strategies to improve relationships, problem-solving skills and mood can be helpful.

On the next several pages, we’ll list some choices you can make to improve your diabetes or heart health. Diabetes and heart disease last for life. Managing them means that you will always make choices, do your best and learn from mistakes. We know you will never be perfect, but we want to be your partners to support you as you make choices that can improve your health.
Making Choices about Your Health
**For Better Heart Health**

Below, you’ll see a number of ways that you can improve your health and lower your risk of complications.

**Stop smoking:** If you smoke, stopping smoking decreases your risk of heart attack and early death more than any other treatment. There are several programs available that can help you prepare to quit, help you manage withdrawal symptoms, and help you learn the new behaviors and skills needed to remain tobacco-free.

**Taking Aspirin:** Taking an aspirin every morning decreases your risk of heart attacks and early death.

**Improving your blood pressure:** High blood pressure increases your risk of an early death. People with heart disease or diabetes who lower their blood pressure to less than 130/80, decrease their risk of having a heart attack or stroke. Exercising and losing weight can help people lower their blood pressure. For most people, medications are needed.

**Lowering your cholesterol.** Changing your eating habits or taking medications can lower your cholesterol level. Diets low in saturated fat or higher in monounsaturated fats improve blood cholesterol. “Statin” medications can lower cholesterol levels and lower your risk of having a heart attack or stroke.
Monitoring Your Blood Pressure

Our blood pressure varies quite a bit during the day. If you're active, have a cup of coffee or a cigarette, your blood pressure may be higher. When you start working to lower your blood pressure, it's important to have reliable blood pressure measurements. The steps that have been found to be important in getting a reliable blood pressure measurement are:

- Take the measurement at the same time each day. Most people take their blood pressure in the early morning or in the evening.
- Don't have a beverage containing caffeine (including coffee, tea or 'pop') for 30 minutes prior to taking your blood pressure.
- Don't have tobacco or alcohol for 30 minutes prior to taking your blood pressure.
- Sit in a chair with back and feet supported and your arm bare and supported at about your mid-chest level.
- Try to take your blood pressure in quiet and calm surroundings.
- Wait two minutes and repeat your blood pressure. The readings should be very close. If they are very close, write down the second blood pressure number. If the numbers vary by more than 5 points, take a third blood pressure and write it down.
- Expect that the blood pressures will be different every day.
Making Choices about Your Health

**For Better Diabetes Management**

**Getting more active:** Increasing your activity may help you lower your blood glucose, lose weight and improve your mood.

**Eating Habits:** Most of us eat too much food and weigh too much. Eating smaller portions of food, limiting the amount of saturated fats, or balancing carbohydrate eaten at different times of the day can help you lose weight, improve your blood pressure and improve your HbA1c.

**Improving your Hemoglobin A1c (HbA1c)—your long-term blood sugar:** The lower your blood sugar, the lower your risk of early death, heart attacks, eye disease, kidney disease and nerve disease. For many people, having their HbA1c level about 7 would lead to important health improvements. Getting your HbA1c down to 7 may require working on your eating pattern, getting more active and taking blood-sugar lowering medications. You will need to test your blood sugar to know how well you are doing.

**Finding a medication routine that works for you and following it.** Different medication routines work for different people. The key is working with your medical team to understand how your diabetes medications are working and how they may work differently if you’re sick, if your weight changes, or if you get more active.

**Take lisinopril:** People with diabetes, who are older than 55 or have high risk of heart attacks, are less likely to have heart attacks, stroke, or develop kidney disease if they take lisinopril. It’s your choice: we’re here to help you!
For People with Diabetes: Using Blood Sugar Readings to Manage Medications and Feel Better

**Why should I bother testing my blood sugar?** Everyone reacts differently to diabetes. For some people, a change in exercise and activity or a small amount of a diabetes pill, like metformin, will bring down blood sugar. For others, higher doses of pills or insulin are needed. The best way to tell how the medications are working is by testing your blood sugar.

**I’ve just been diagnosed with diabetes. When’s the best time to check my blood sugar?** If you’re going to start taking one blood sugar reading a day, we usually recommend taking a morning blood sugar reading. This reading, called a “fasting blood sugar” should be taken before eating or drinking anything (other than water or black tea or coffee).

**How can I use a morning blood sugar to tell how my diabetes medication is working?** Blood sugar readings vary each day. The goal for fasting blood sugar readings for most people is 80-120. If your blood sugar reading is higher than this most days, a change in your medication routine may be needed.

**What does my fasting blood sugar test tell me if I'm taking insulin at bedtime?** The first dose of insulin ordered is almost always too low. Taking fasting blood sugar tests can tell you how well your night time dose of insulin is working. Your TEAMcare Care Manager or Primary Care Team may teach you how to use your fasting blood sugar to increase your bedtime insulin dose until you’ve found the right amount for your body.

**How will I use blood sugar results if I'm taking two doses of long-acting insulin (NPH or Lantus)?** You will use the before breakfast and before bed blood sugar results to see how well your insulin doses are working.

Two before breakfast blood sugar readings in a row give a good idea of how well your bedtime dose of insulin is working.
Two **bedtime** blood sugar readings in a row give a good idea of how well your **morning** dose of insulin is working.

**How about taking tests before meals?** Sometimes it can be very helpful to take blood sugar tests prior to meals. These tests can be used to tell how well your daytime insulin is working or, for people who need meal-time insulin, to predict how much insulin to take for a meal.

**What if I have low blood sugar symptoms:** We’d always like you to take a blood sugar test, if possible, if you have symptoms of a low blood sugar reaction.

**Taking blood sugar tests after meals.** Some people like to take blood sugar tests after eating to see how a particular food changes their blood sugar. **We do not recommend** testing blood sugars after meals when you’re first working to get better control of your diabetes. The results of after meal blood sugar tests can be hard to understand and aren’t often as important as other tests.
For People with Diabetes:  
What to Do When Your Blood Sugar is too Low

Who can get low blood sugar reactions?
✓ People who are taking insulin or diabetes pills (like glipizide or glyburide).

How do you feel with low blood sugar reaction?
Symptoms include:
✓ dizziness, blurred vision
✓ confusion, irritability
✓ headache
✓ feeling weak or shaky
✓ tingly lips, tongue, or fingers

However, these feelings can occur when your blood sugar drops quickly or when other things are going on. How do you know if a low blood sugar is causing your symptoms?
✓ If you can, take your blood sugar. If you can't take your blood sugar, you should treat the symptoms.

How do you treat a low blood sugar reaction?
Eat or drink something with carbohydrate in it. Examples include:
✓ 4 oz. fruit juice or regular soda
✓ 5-6 life savers or 2-3 glucose tablets

After 10 to 15 minutes, recheck your blood sugar. If your blood sugar is still low, eat more carbohydrate. Don't eat protein to treat a low blood sugar reaction. New research suggests that protein can increase the action of your insulin and can cause blood sugars to go lower.
What to Do When You’re Sick

What’s special about illness and diabetes?
✓ Usually, when you’re “fighting off” an infection or when you’re sick, your blood sugar results will be higher than you’d expect.
✓ When you’re not feeling well, you may not be able to eat, drink, or exercise as usual.
✓ High blood sugars and drinking smaller than usual amounts of fluid can make you very ill.

What’s most important to know about being sick?
✓ If you take metformin and have a bad problem with diarrhea or vomiting, stop taking metformin and call your physician or consulting nurse right away.
✓ If you’re taking other diabetes medications, keep taking them when you’re sick.

Drinking fluid:
✓ It’s important to try to drink fluids when you’re sick. Try to sip at least 8 ounces (one cup) of fluid every hour when you’re awake.
✓ If you’re too ill to eat any regular food and your blood sugars are less than 240, drink non-diet liquid (like Gatorade or regular pop).

When should you call your Primary Care Team?
✓ If you’re throwing up and can’t take your medication.
✓ If you’re taking metformin and can’t eat and drink like normal.
✓ If your blood sugar levels are much higher than normal.
✓ If you need help figuring out what to do to get feeling better.
**Communicating with Your Doctor**

Talking with your doctor can be challenging. We’re all busy—sometimes a doctor can seem so busy that you may be hesitant to mention your problems. It’s also hard to talk about depression or other medical problems. Five steps can help to improve communication with your doctor.

- **Come prepared.** Come with a clear objective. What do you hope to get from this visit? It’s also useful to make a list of symptoms and questions before you get to the doctor. List your most important concern first. Refer to your notes during the visit.

- **Ask questions.** In order to make choices about your care, you need to understand what the choices mean.

- **Discuss problems.** In particular, mention problems that you’re noticing with any medication or therapy.

- **Ask for reading materials.** It can help to review information after leaving your doctor, so you can better understand your care choices.

- **Ask for your After Visit Summary.** This is a copy of the important information from your clinic visit and often has information about any medications or other treatments that have been ordered.

These steps can help you develop a plan for managing your health. Your TEAMcare Care Manager will help you!
Using all the Tools

If you have access to a computer and the Internet, you can use it to:

✓ “Talk” to your TEAMcare Care Manager. Let your TCM nurse know that you have Internet access. You can contact each other directly by email messages.
✓ Ask questions of your Primary Care Doctor and your Health Care Team.
✓ Look up health information.
✓ Refill medications and have them sent to you at home.
✓ View your medical record.
✓ Request appointments.

Your Relapse Prevention Plan

A Relapse Prevention Plan focuses on stress reduction and self-monitoring, and can help you to recognize depression early.

First: Use the depression-fighting strategies that have worked for you in the past, including taking your antidepressant medication regularly, increasing your pleasurable activities, and maintaining a healthy lifestyle.

Second: Write down the problems that can trigger your depression and strategies that have helped you in the past.

✓ What are some of my everyday stressors?
✓ What coping strategies have worked for me in the past?
✓ What strategies do I think will be most useful for combating my everyday problems?
✓ Are these skills I can use every day or every week?
✓ How can I remind myself to use these skills daily?

Third: Try to identify three or four specific actions that will help you. Be realistic about what you can and will do.
Fourth: Prepare yourself for high-risk situations.

- What are some problems or predictable stressors that might affect you in the future?
- Can you do anything to make a particular event less likely or less stressful?
- If you can't avoid a stressful situation: can you avoid negative reactions (like criticizing yourself) or react in a more positive way?

Fifth: Watch for warning signs by regular self monitoring. You can check routinely for personal warning signs or telltale patterns of thought or behavior. You may want to ask a partner or friend to let you know if they notice any warning signs.

Sixth: Use the PHQ test (page 22) to check your depression score. If your score goes up over 10, it's time to get help again.
My Relapse Prevention Plan

My depression medications and their doses are:

1. 

2. 

I’ve been taking these medications since: _______

Most people take antidepressants for at least 6 months. Many take them for many years. If you decide to stop taking antidepressants, please check with your Primary Care Physician about safe ways to decrease the medication.

My PHQ score today is:

In the past, I recognized that I was depressed because I felt the following symptoms:

1. 

2. 

3. 

✓ If these personal warning signs recur, I will get help!

My plan for getting help is:

To reduce stress and keep daily hassles from adding up, I will:

1. 

2. 

3. 

Finally, I will remember that I deserve to feel good!
Staying on Track with other Changes

When we’ve made changes in our behavior, there’s always a tendency to drift back towards old habits.

How can you stop the backward drift?

✓ Think about reasons that you might drift. Make a list of reasons that you might not keep up with healthy changes.
✓ Keep an eye on yourself. Monitor your behavior enough that you can catch your drift early, before you feel like you’re in a deep hole.
✓ Keep an eye on your blood work. Tests to check on diabetes control (like hemoglobin A1c) or heart disease risk (like cholesterol tests) are like early warning systems—best done every three months so you can know if you’ve drifted.
✓ If you feel you need to change medications—please call your Primary Care Team. Your Physician or TEAMcare Care Manager can help you decide the safest options for medication changes.
✓ Use your “coaches” or “partners” to help you realize that you’re drifting. Give them specific behaviors that you’d like noticed and ways that you’d like them to give you feedback.
✓ Put drift into perspective. We all make plans, but all of us drift away. The key is catching yourself and getting back on track.