

♣ Measure #132: Patient Co-Development of Treatment Plan/Plan of Care

DESCRIPTION:

Percentage of patients aged 18 years and older identified as having actively participated in the development of the treatment plan/plan of care. Appropriate documentation includes signature of the practitioner and either co-signature of the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

INSTRUCTIONS:

This measure is to be reported at least one time for each unique episode of care for patients seen during the reporting period. For the purpose of this measure, a unique episode of care is defined by the care given for each unique diagnosis (ICD-9 code) during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:

CPT service codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Patient's active participation in development of treatment plan/plan of care is documented

Definitions:

Unique episode of care – For the purpose of this measure is defined by each unique ICD-9 code billed in combination with an appropriate CPT service code during the reporting period. Multiple diagnoses on a claim form will count as one episode.

Active participation – Patient involvement in discussions, decisions, objectives determination, and goal setting to the extent that the patient is a co-author of, and responds affirmatively to, the care plan/treatment plan.

Care plan/treatment plan – A roadmap or course of action involving input and approval from the patient.

Authorized representative – A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for himself or herself, but not against the patient's wishes. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, this individual is appointed by the patient.

Not eligible – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent health or crisis situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

- Episode of care began either prior to or extends beyond reporting period and Treatment Plan/Plan of Care was co-developed outside reporting period.

Numerator Coding:

Active Participation Documented

G8437: Documentation of clinician and patient involvement with the development of a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

OR

Active Participation not Documented, Patient not Eligible

G8439: Documentation that patient is not eligible for co-developing a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

OR

Active Participation not Documented, Reason not Specified

G8438: No documentation of clinician and patient involvement with the development of a treatment plan/plan of care including signature by the practitioner and either a co-signature by the patient or documented verbal agreement obtained from the patient or, when necessary, an authorized representative

DENOMINATOR:

Patients aged 18 years and older

Denominator Coding:

A CPT service code is required to identify patients for denominator inclusion.

CPT service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0270

RATIONALE:

Collaborative interventions involving both client and care provider are significantly more acceptable and likely to produce follow through than directive approaches. This is consistent with the findings of Ed Wagner's "The Chronic Care Model," which states that evidence-based change concepts foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.

CLINICAL RECOMMENDATION STATEMENTS:

The Siskin Hospital for Physical Rehabilitation states that patients' basic treatment plan and initial goals should include input and agreement of the patient before treatment begins, while the Scottish Intercollegiate Guidelines Network (SIGN) suggests that patients and their caregivers should have an early, active role in the multidisciplinary rehabilitation team.

The Institute for Clinical Systems Improvement (ICSI) recommends that patients and their families should be educated and actively engaged as to diagnosis, prognosis, and treatment options, while the National Collaborating Center for Mental Health recommends that health care professionals

should make all efforts necessary to ensure that a patient can give meaningful and properly informed consent before treatment is initiated.

The 2005 Standards of Practice for Occupational Therapy recommends in Standard III, 1: An occupational therapist has overall responsibility for the development, documentation, and implementation of the occupational therapy intervention based on the evaluation, client goals, current best evidence, and clinical reasoning (American Occupational Therapy Association). A 2001 American Psychiatric Association guideline states that treatment of patients with borderline personality disorders should be a collaborative process between patient and clinician and that patient preference is an important factor to consider in developing an individual treatment plan (APA).

The 2004 Department of Defense (DoD) and Department of Veterans Affairs (VHA) guideline states that treatment options for persons with psychoses should be presented and discussed with the person/legal guardian and then proceed with treatment if the person/legal guardian consents (DoD and VHA).

Institute for Clinical Systems Improvement 1995 guideline suggests that providers should recognize that it is a sign of progress when a patient becomes more ready to change a health-related behavior (ICSI).

In a Substance Abuse and Mental Health Services Administration 2005 guideline for substance abuse treatment for persons with co-occurring disorders, motivational interviewing was cited as being proven effective in helping clients clarify goals and commit to change (SAMHSA).

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: e.g., improved treatment outcomes, e.g., improved follow through with recommendations and improved follow-up percent days abstinent; increased patient satisfaction; and reduced costs, but not consistently high quality evidence

Amrhein, P. C., et al. (2003). "Client commitment language during motivational interviewing predicts drug use outcomes." Journal of Consulting and Clinical Psychology 71(862 - 878).

Motivational interview sessions revealed commitment strength language during a change plan was more common among maintainers and changers and was predictive of follow-up percent days abstinent.

Study quality level 2 (limited-quality patient-oriented evidence)

Geller, J., et al. (2003). "Collaborative versus directive interventions in the treatment of eating disorders: Implications for care providers." Professional Psychology: Research and Practice 34: 406 - 413.

Clients and care providers related collaborative interventions as being significantly more acceptable and likely to produce follow through with recommendations than directive approaches.

Study quality level 2 (limited-quality patient-oriented evidence)

Ruback, S., et al. (2005). "Motivational interviewing: a systematic review and meta-analysis." The British Journal of General Practice 55(513): 305 - 312.

Motivational interviewing in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioral problems and diseases.
Study quality level 2 (limited-quality patient-oriented evidence)

Swenson, et al. (2004). "Patient-centered communication: do patients really prefer it?" Journal of General Internal Medicine 19(11).

A randomized study revealed that 82% of participants < 30 years old, 68% of participants aged 30-59; 55% of participants aged > 59 preferred patient-centered communication. Additionally 76% of participants with post-college education, 73% of participants with some college education, and 49% of participants with a high school education preferred patient-centered communication.
Study quality level 2 (limited-quality patient-oriented evidence)

Wagner, E. H. (1998). "Chronic disease management: What will it take to improve care for chronic illness?" Effective Clinical Practice 1: 2-4.

The chronic care model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.
Study quality level 2 (limited-quality patient-oriented evidence)