Appendix A: Overview of the COMPASS Consortium

Collaborative care management for patients with chronic medical and mental health conditions can greatly improve their quality of care, outcomes and satisfaction, as well as be cost-effective and even cost-saving in the long run. However, this care model has not been widely used, in part because it requires major changes from the traditional way of doing things and in part because existing payment designs do not compensate its costs.

Through a three-year cooperative agreement with the Centers for Medicare and Medicaid Services (CMS), a consortium of 10 organizations developed, implemented and evaluated the success and sustainability of a collaborative care management model (CCMM) to improve the care of patients with both mental and physical health problems.

The goal of COMPASS is to show effectiveness in treating adult Medicare and Medicaid patients in the primary care setting who have depression along with diabetes and/or cardiovascular disease and also (optional) substance misuse. Doing so could help care systems achieve the Triple Aim *(Berwick, 2008)* of improving the health of the population, the patient's care experience, and the affordability of care for these patients.

The COMPASS model targets a population of underserved and low-income people multiple comorbidities and risk factors who tend to have disparate rates of services and outcomes.

The COMPASS model was implemented in eight states though a consortium of partner organizations led by the Institute for Clinical Systems Improvement (ICSI). They include the Community Heath Plan of Washington, Kaiser Permanente Colorado, Kaiser Permanente Southern California, Mayo Clinic Health System, Michigan Center for Clinical Systems Improvement (MI-CCSI), Mount Auburn Cambridge Independent Practice Association (MACIPA), and the Pittsburgh Regional Health Initiative. The HealthPartners Institute for Education and Research (HPIER) and the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington are provided technical assistance with registry, implementation and evaluation.

COMPASS was co-created by the consortium partners, drawing on several widely supported approaches to improving primary care practice for individuals with chronic illnesses and research evidence that suggests that the application of such approaches for patients with specific illnesses such as depression, diabetes, and heart disease can improve the effectiveness and cost effectiveness for patients with these conditions.

The COMPASS intervention builds on several foundational frameworks to improving health care:

- Explicit evaluation of the importance of outcomes of alternative management strategies.
- Wagner's Chronic Care Model to lay the groundwork for organizing multiple levels of health systems needed to make this work possible.
- Practice Coaching *(Grumbach, 2012)* to emphasize a systematic approach to supporting the transformation necessary in primary care *(Bodenheimer, 2010)*.
- Patient Centered Medical Home principles to ensure consistency and continuity with NCQA accreditation standards. These are: whole person orientation, physician-directed medical practice, coordinated and/or integrated care, quality and safety, personal physician, access to care, and payment that recognizes appropriate value.

COMPASS is not usual care. A team approach of care managers and consulting psychiatrists and medical physicians help primary care providers 'treat patients to target' goals for identified medical conditions. This demonstrates the use of evidenced-based research in collaborative care programs implemented for chronic care principles in primary care.

There is significant evidence that an application of the chronic care management model to depression in primary care improves patient outcomes, both in the short term and over 18-24 months *(Gilbody, 2006; Glied, 2010; Klinkman, 2010)*. A recent study of intervention known as TEAMcare showed that a multi-condition collaborative care model can be used to improve both depression and medical disease control in patients with co-morbid depression, diabetes and/or heart disease *(Katon, 2010; Lin, 2012)*.

The COMPASS model was designed by integrating several existing and proven CCMMs and the best practices discovered in their implementation. These include: the IMPACT model for depression; the DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program (based on IMPACT); TEAMcare, which addresses depression and diabetes and cardiovascular disease, and SBIRT (Screening, Brief Intervention, and Referral to Treatment) for risky substance use. The approach taken in COMPASS for implementation is based on extensive experience in implementing those care models plus our collective experience with organizational approaches to quality improvement of any care process.

Top leadership must be able to support this work, make it a priority, and plan for the resources needed for sustainability. We believe that the COMPASS model is an excellent foundation on which to redesign primary care, transforming it from the traditional approach to those supportive of accountable care organizations and the patient-centered medical home. System requirements should be in place to support and drive COMPASS, including clinic leadership, payment models, data-driven quality improvement, performance reporting, health information technology, and training and coaching.

COMPASS Goals

One third of Medicare patients have diabetes and another 30% have coronary artery disease, and when depression is present (as it is 15% of the time), health care costs are 65% higher *(Adler, 2007; Bambauer, 2007; Unützer, 2009)*. Also, many patients with depression have other chronic problems. Approximately 70% of people who have comorbid depression and diabetes have depression for two years or more *(Katon, 2004)*.

There is a bidirectional relationship between depression and many chronic medical disorders, with each side contributing to disease and care costs for the other *(Dirmaier, 2010; Katon, 2011; Rush, 2008)*. For example, among health plan members with the 15% highest number of office visits in two successive years, 20% were depressed, and 42% of them had one or more chronic medical conditions, as well as 50% more hospitalizations and hospital days/year than high utilizers without depression *(Pearson, 1999)*.

Overall goals for COMPASS:

- Achieve depression improvement measured by a decrease in PHQ-9 by 5 points or a PHQ-9 of less than 10 for 40% of the patients
- Improve diabetes (DM) and hypertension control rates by 20%
- Decrease un-needed hospitalizations and emergency department visits
- Improve patient and clinician satisfaction with care process by 20%
- Reduce healthcare costs of Medicare and Medicaid measured patients by $25 million (which relies in the short run almost entirely on reduction of unneeded hospitalizations and emergency department visits)

Supporting Documents:

- *COMPASS Executive Summary*
- *The Medical Science Supporting the COMPASS Program*
- *COMPASS QandA*
- *Potential Cost Savings*