Section 3: Key Component Summary

The following are the required key components of the COMPASS intervention model.

1. **Enrollment in COMPASS (See Annotations 1, 2)**

   Eligibility Criteria for COMPASS Care:

   - Adult patients
   - AND sub-optimally managed depression (PHQ-9 > 9)*
   - AND treatable, sub-optimally managed diabetes or cardiovascular disease

   *At physicians' discretion, based on patient underreporting and the patient population, those with PHQ-9 < 10 may be enrolled. It is recognized that the PHQ-9 is a screening tool and therefore has limitations. Further assessment is recommended.

   Optional: Criteria above AND substance misuse based on AUDIT ≥ 7 for females or ≥ 8 for males and/or DAST-10 ≥ 2 (If this focus has been chosen by the practice)

   Priority Populations

   The following are recommended as **priority populations:**

   - Adult patients with Medicare or Medicaid insurance
   - A diagnosis of diabetes with one of the following: HgbA1c ≥ 8.0% **OR** SBP ≥ 145 mmHg **OR** LDL ≥ 100 mg/dL
   - Existing cardiovascular disease (e.g., history of ischemic heart disease diagnosis, coronary procedure, CHF or stroke) with one of the following: SBP ≥ 145 **OR** LDL ≥ 100 mg/dL (patients with essential hypertension or hyperlipidemia without end organ damage are not included in this definition)
   - Patients 65 years and older with uncontrolled hypertension (SBP > 160)
   - Recent hospitalization or ED visit related to diabetes or cardiovascular disease

   Optional: Individual care systems may decide to define their priority population differently.

   Identification of Potentially Eligible Patients

   - Establish connections with area EDs and hospitals to find opportunities to enroll and link patients.
   - Establish processes to identify patients with upcoming encounters, who might be eligible.
   - Establish processes to proactively identify patients from claims data, the medical record, or other registries for outreach, who might be eligible.
   - Establish process to confirm with primary care team that identified patients are appropriate to be contacted about enrollment.

Enrollment and Intake

- Establish a process for "warm hand-offs" in the clinic between the primary care team and the care manager.
- Establish processes to reach out to patients to invite them to enroll, following PCP visit, or outreach call.
- Establish a process for the care manager to complete the intake visit.

2. Treatment Plan Development/Population Management (See Annotations 3, 4, 5)

The following teams and individuals need to be identified for each enrolled patient:

- Primary care team (treating primary physician and others based on patient care needs, for example: nurse, medical assistant, etc.)
- Care manager
- Consulting psychiatrist
- Consulting medical physician
- Other providers and caregivers as identified by the practice (e.g., CDE, pharmacists)

Robust, interactive, communication channels between the primary care (PC) team and the SCR team must be determined. This can be achieved by ensuring the following:

- The SCR is a weekly meeting between the care manager, consulting psychiatrist and consulting medical physician to review the patient caseload. New patients and those patients not progressing to meet treatment goals are reviewed and recommendations about treatment intensification are made for the PC team.
- The SCR team's recommendations will be reviewed by the PC team, and orders placed, as needed.
- If the PC team disagrees with the SCR team's recommendations, a process is needed to record this and communicate to the SCR team.
- The care manager is key, but should not be the only link between the PC team and the SCR team.
- Primary care teams must have a process to decide upon individual patient goals for PHQ-9, HgbA1c, LDL, and blood pressure.
- Treatment intensification protocols* need to be agreed upon by the practice.
- Identification of hospital and ED use in the past and prospectively in a timely way requires systematic attention and support by the care manager, including identifying those patients requiring special attention and/or action to reduce unneeded use.
- The care manager is responsible for needed information being available in the registry.
- Ensure that all who provide care to the patient are updated on treatment plan and changes.

* Lipid management guidelines significantly changed during the implementation of the COMPASS model *(Stone, 2014)*.

3. **Outcome-oriented Care Management (See Annotations 6, 7)**

Care Manager Role Includes:

- Identifying and engaging patients in COMPASS
- Active follow-up of patients not at treatment goals and to partnering with the patient to set and achieve goals
- Monitoring and reducing unneeded hospital and ED use is essential
- Activating patients and building patients' self efficacy skills by using motivational interviewing, behavioral activation, problem solving, and other techniques
- Completing needed registry information for ongoing patient care for each active problem, as well as for quality improvement data and study completion
- Ensuring the patient has information needed to contact their care manager with questions, concerns or other needs (such as hospital or ED use)
- Actively coordinating/engaging with other professionals, consultants, agencies, and clinics that are part of the patient's care team or community
- Developing a process to reach out to patients who have not returned for care as expected
- Prioritizing which patients are discussed at the SCR and presenting the pertinent facts to the SCR team

Consulting Physician Roles Include:

- Attending weekly SCR team meetings
- Making treatment intensification recommendations based on evidence-based guidelines as agreed upon by the practice and/or organization
- Making recommendations to the PCP team to reach treatment targets

SCR Team Roles Include:

- Participating in regular, weekly meetings (preferably in person, but can be done virtually)
- Reviewing population caseload via the organization's population management tool
- Reviewing prioritized patients' data via electronic health record and/or registry
- Intensifying treatment to goals
- Assessing risk of ED/hospital use
- Frequently communicating with primary care providers on the patient's treatment plan and the SCR recommendations
- Documenting SCR consultation per patient
- Utilizing outcome data and quality improvement reports to improve the care of both the individual patients and the total population

Primary Care Team Role Includes:

- Coordinating and communicating with the SCR Team regarding SCR recommendations
- Communicating with the care manager to act on urgent patient concerns (suicide risk, dangerous SBP measurement, other medical emergencies)

- Arranging with commonly used hospitals to notify the practice and care manager when they admit and discharge the patient
- Possible ad hoc consulting with the SCR team
- Creating a process to ensure regular review of all COMPASS patients for delivery of optimal care
- Creating a back-up plan for when the care manager is not available

4. Maintenance Planning and Relapse Planning

A maintenance plan helps support patients in their effort to maintain healthy behaviors, identify early signs associated with poor disease control, and prevent relapse. Teams will want to ensure the following:

- A detailed and condition-specific plan for ongoing maintenance and monitoring devised with each patient as treatment targets are met for at least three months, including warning signs that may indicate need for prompt interventions to prevent unneeded hospital or ED use
- A process for regular contact for 6-12 months after all treatment goals are met
- Practices to determine criteria for transitioning a patient from the case manager caseload back to the primary care team