Section 4: Supporting Annotations

Annotation 1:
Eligibility Determination, Patient Identification, and Enrollment in COMPASS

Eligibility Criteria:

- 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 Population

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.

Ineligibility Criteria

Patients are ineligible for COMPASS if they have a life-limiting illness or are under the age of 18.

Although it is not required, local care systems may determine other ineligibilities based on local needs, for example: excluding patients with bipolar disease, schizophrenia, and language barriers. If a care system decides to include patients with severe psychiatric illness, ensure there is appropriate psychiatric backup and support.

Patient Identification and Engagement

Proactive patient identification and rapid enrollment is critical for the success of COMPASS.

Patients who meet COMPASS criteria are, by definition, typically less engaged with primary care. Therefore, organizations will likely need to put considerable effort into determining how best to identify and engage potential patients.

Patient Identification Strategies

- Administer a PHQ-9 at all office visits for diabetes and CHD, because depression is often under diagnosed in patients with diabetes and CHD.
- Review clinic/practice appointment schedules on an ongoing basis to identify patients who may be eligible.
- Consider cultural sensitivities regarding mental health and other chronic illnesses.
- Remind the primary care teams to solicit referrals.
- Review other local clinician's appointment schedules that may serve eligible patients (pharmacy medication management, nutritionist, social worker, etc.).
- Review hospital admission and discharge reports. Work with primary care team to identify priority patients to call and schedule hospital follow-up appointments. (Many hospitals are engaged in projects to decrease avoidable readmissions. Link to these efforts locally.)
- Review ED discharge records to identify priority patients to call and schedule for follow-up appointments.
- Review any existing care management lists/registries.
- Gather patient lists from existing disease management programs run by insurers (Medicare Advantage programs, etc).
- Do a claims review for all patients on an antidepressant medications, statins, etc.
- Review hospitalization reports for the last 18 months, with the targeted conditions as discharge diagnoses.
- Use laboratory databases to seek patients with out of range tests.
- Ask primary care teams and other office staff about high-needs patients.

Patient Engagement Strategies in Enrollment

Patients who are identified as eligible for COMPASS should be provided information about the program, emphasizing that this is the standard way of providing care at the practice. A warm hand off from the primary care team to the care manager is a highly effective trigger to start COMPASS care. The care manager then introduces the program, initiates patient engagement and discusses participation in team-based care. The care manager completes the initial contact form, reviews the PCP's current care plan and determines next steps with the patient. If the care manager is not available, information about COMPASS should be given by a care team member (or other proxy) with written material to take home. Specific follow-up steps should be determined before leaving the clinic (phone call, e-visit, etc).

Identified patients who have not been recently seen by their primary care team may need an initial evaluation/re-evaluation by the PCP, including screening for relevant comorbidities. COMPASS patients may need to be briefly reviewed by the primary care team prior to contacting them to capture relevant information that the team may have that would impact the likelihood of engaging the patient at this time. This is a prioritization step, not primarily an eligibility step, though ineligibility criteria should be reviewed. (For example, the patient may have been diagnosed with a life-limiting illness by another caregiver, a patient's spouse may have very recently died, or a patient may be spending winter in another state.)

Patients may be prioritized for initial engagement based on local assessment. This may include such factors as recent or frequent hospitalization, frequent ED visits, frequent clinic visits with little progress toward goals, frequently missed appointments or other adherence concerns, patient's motivation to change, or PCP's concern about immediate health risk.

Other engagement strategies include:

- Enlisting members of the primary care team to call patients, inviting them to a visit with care manager.
- Sending a letter from the primary care team explaining COMPASS and introducing the care manager as a member of the team. The care manager could then complete a follow-up phone call within a week.
- Calling patients who have evidence of at least one of the three parameters of poor medical control and evidence of depression to explain the COMPASS program and schedule an appointment for the patient.

Supporting Documents

- *Team Role Descriptions*
- *List of Usual Codes for Relevant Conditions*
- *Patient Brochure*
- *Sample Recruitment Letter*
- *Patient Outreach Flyer*
- *Patient Engagement Letter*
- *Initial Intake Form*
- *Care Manager Talking Points to Engage Primary Care Teams and PCP's*
- *Talking Points: Physician Buy-In*
- *Office Workflow Examples*
- *PIC Comorbidity Brief Assessment Tool*
- *Patient Encouragement Letter (30-Days)*
- *2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults*
- *ICSI Adult Depression in Primary Care guideline*
- *ICSI Hypertension Diagnosis and Treatment guideline endorsement*
- *Patient Health Questionnaire (PHQ-9)*
- *Implementation Strategies*