



## COMPASS Intervention Guide

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### Section 1: COMPASS Core Principles

#### Population Health Focus

Population health has been defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” (*Kindig, 2003*). Medical care is only one of many factors that affect those outcomes; behavioral health and social determinants of health also bear a significant impact. Population health management is the key to health-care reform, requiring medical teams to be held accountable for all patients on their panel, not just those who access care. COMPASS ensures two population health functions: first, that all patients who need care for these comorbid conditions receive it, not only those who routinely visit a clinic; and second, that the population is regularly monitored for improvement and engaged in treatment intensification as needed to achieve goals.

#### Team-Based Care with Systematic Case Review

COMPASS is not the usual primary care-consultant relationship. A new team is convened, consisting of a care manager, a consulting psychiatrist, and a consulting medical physician, to support the work the primary care team is doing for these more medically complex patients. This team meets regularly to conduct **Systematic Case Review (SCR)** serving the following core functions:

- 1) Ensure individual patient treatment intensification takes place until goals for targeted conditions are met and sustained
- 2) Review the caseload to ensure all patients are engaged in COMPASS care and prioritized for interventions
- 3) Improve team functioning around the care of the patient, including the patient, SCR team members, and the patient’s regular physician/primary care team.

COMPASS requires that both the primary care team and the SCR team establish clear roles and treatment protocols. In addition, these teams must seek to partner in a truly respectful and trusting collaboration with the patient. A new sense of accountability and ownership for improved outcomes should be shared equally by all team members and the patient.

It is very important that the SCR team has regular, weekly meetings and focuses its time and attention on patients who have not yet achieved **Treat-to-Target** goals. Patients who are high-utilizers, have recent or frequent hospitalization or emergency department (ED) use, or are out of range on disease indicators should receive high priority review by these teams.

These teams consistently use data from the patient registry and quality improvement feedback from reports to impact and improve the care of both the individual patients and the population at large. These activities require routine and effective interactions between the patient’s primary care team and the consultant physicians who serve on the SCR team.

#### Care Management/Care Coordination

The care manager is a crucial link between these teams. He/she is part of both teams and responsible for assuring that a personalized treatment plan is developed for each patient in the program. Care managers work to assure that there is a good working relationship and communication between these teams. They also help the patient implement the plan and achieve his/her goals by having frequent contacts. Depending on local organizational context, state licensing, and patient population,



this role varies. Different job titles may include care manager, care coordinator, and health coach; for purposes of this guide the term “care manager” and “care management” are chosen. Care managers may also have different credentials and therefore some differences in duties. These include registered nurses, social workers (BSW, MSW, LCSW), medical assistants, and physician assistants or nurse practitioners.

### **Treatment Intensification**

COMPASS care uses treat-to-target action steps with proactive follow-up care, which require consistent and persistent treatment adjustment until individualized care goals are reached. The key output of this work is a treatment plan that includes personalized goals for PHQ-9, laboratory parameters, behavior changes and medication regimes (appropriate to diagnoses), and avoidance of unneeded hospital stays or ED visits. Documentation of this plan and all contacts in the tracking system is essential for both patient and panel management. While COMPASS has originally focused on depression, diabetes and heart disease, the treatment plan does not need to be limited to these chronic conditions.

### **Patient Engagement in Care**

A key finding in COMPASS is that complex patients with these co-morbid conditions need extra effort by the care team to meaningfully engage the patient in their own care. It is worthwhile to note that this target population has not achieved optimal outcomes through the usual care processes for managing their chronic conditions. There are many possible reasons this might occur: time pressures in primary care, clinical inertia, and social as well as medical complexity. Further, during implementation many care managers reported that they found patients to not only be disengaged in health care, but mistrustful of the health care system. The presence of depression can also affect an individual’s ability to be hopeful of improvement. Therefore, developing skills and methods to meaningfully engage patients in their own care is critically important.

Upon first contact with the patient, the care team begins to establish a therapeutic partnership with the patient. By eliciting a patient’s own expertise about themselves while sharing its medical expertise, the care team works to move the patient down a path to greater self-management.