January 2015 – The COMPASS Consortium

Annotation 3:
Primary Care Team

The primary care team has overall responsibility for COMPASS patients' care. This team has in-depth knowledge of not only the medical history of the patient, but knows the patients personal circumstances, their values and beliefs, and other information important for directing their overall care. The primary care team is centered on the patient's primary physician, nurse practitioner, or other clinician. The remainder of the team composition is based on the local practice, and availability of specialized resources. Primary care team members may include but are not limited to: primary care provider (PCP), team nurse, specialty care provider, chronic care coordinator, diabetes care manager, cardiac care manager and others.

While team composition may vary by practice and by patient, it is important that the team be specifically defined for each patient, such that the care manager is able to coordinate efforts to avoid duplication and assure the patient that all caregivers are working together, effectively.

Individualized Patient Treatment Goal Setting

Overall goals for COMPASS include:

- Achieve depression improvement measured by a decrease in PHQ-9 by 5 points or PHQ-9 of less than 10
- Improve diabetes and hypertension control rates:
  - HgbA1c $\geq$ 8%
  - SBP $\geq$ 145 mmHg
  - LDL $\geq$ 100 mg/dL
- Decrease unneeded hospitalization and ED visits

* These goals should be consistent with overall COMPASS targets as well as patient specific goals.

The disease-specific treatment goals for patients are based on substantial medical evidence, and require some customization based on overall health. For example, the recommended target for HbA1c may be seven for many patients with diabetes but a level of eight may be more appropriate in the frail elderly. When beginning treatment, care managers should set goals based on current status, but maintenance and relapse prevention should be considered early on as well. Patients should be encouraged to recognize triggers and self-manage their diseases.

The primary care team is responsible for determining the individualized patient's goals. These goals form the basis for the patient's treatment plan. This can be accomplished in a number of settings, and access to the patient's full medical record is of key importance. This may require gathering information from sources outside of the primary care clinic. Other information may be useful, including recommendations from the SCR team and information from the case manager's first discussion with the patient. Minimally, the PCP and care manager should work together to set the disease-specific target goals and ensure the SCR team is aware of and agrees with the treatment goals. Optimally, this activity should be scheduled soon after the patient is enrolled in COMPASS.

The treatment goals will be entered into the registry by the care manager and used for the ongoing work with the patient by all who provide care to the patient and are part of his/her designated care team. Local systems will determine effective ways for this information to be communicated.

Implementing Recommendations from the SCR Team

Most often, it is the responsibility of the care manager to communicate the recommendations of the SCR team to the primary care team. However, specific cases or teams may require physician-to-physician communication.

The PCP should review all recommendations prior to implementation. While the SCR team has considerable expertise in managing the target diseases, the PCP needs to consider the recommendations in the entire context of each patient's individual situation and needs. If the PCP chooses not to endorse and implement the SCR team's recommendations, the reason should be noted in the registry. The PCP should also communicate with the SCR team via the care manager as to the prudent course of treatment. Direct communication between the PCP and SRC Team should always be encouraged to ensure that all are providing the best care recommendations.

Local practices that use standing orders and other protocols that allow nurses to make medication and other treatment changes, without consulting the PCP, should be considered in developing the specifics of this process. The goal is to increase effective time use by all members of the teams.

Supporting Documents

- *Care Management Phases and Follow-Up Guide*
- *Admissions, Readmissions and Transitions*
- *Preventing a Relapse of Depression*
- *Team Roles and Operations Worksheet*
- *Physician Champion Summary*